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# Effect of Intensive Counseling Training on Participation of Clients in Long-Acting Reversible Contraceptives

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## Abstract

**BACKGROUND:** One of the pillars of safe motherhood is family planning (FP). The FP program aims to avoid unwanted pregnancies or birth by long-term contraceptive methods (long-acting reversible contraceptives [LARCs]). However, percentages of LARCs usage in Indonesia, in 2017 were still far from the target, 14% per 21.7%. This was influenced by Information Education and Communication given by health-care workers, counseling mechanisms, and mother's knowledge.

**AIM:** This study aims to find a new counseling training technique that may improve the counseling skills of health workers and provide a better outcome (clients' knowledge and attitude).

**METHODS:** Phase one, a qualitative approach by conducting focus group discussions and in-depth interviews with midwives and clients as the basis for making intensive counseling modules. Phase two, quantitative approach to health-care workers using a t-paired group analysis test. Phase three, analysis using T-unpaired group test for clients.

**RESULTS:** The qualitative phase showed that the appropriate LARCs intensive counseling training model was 2 days, 8 h each, emphasizing communication techniques. A significant difference was found in the counseling competition of health-care workers before and after training ($p < 0.001$). The interest in LARCs after receiving counseling (intensive or others) also showed significant differences ($p < 0.001$).

**CONCLUSION:** The LARCs intensive counseling training module affects the competency of counseling skills and increases the participation of clients.

## Introduction

Indonesia is a country that has implemented maternal and child health policies since the World Health Organization (WHO) launched the safe motherhood initiative in 1987 [1]. Safe motherhood is an effort to reduce maternal mortality and improve the welfare or safety of mothers. There are four components to safe motherhood, family planning (FP), good quality antenatal care, clean and safe delivery, and essential obstetric services [2]. MMR in 1991–2015 has been fluctuating for the past years. In 2015, MMR decreased to 305/100,000 live births from 359/100,000 live births in 2012 [3].

FP is one of the important interventions to reduce MMR in couples of childbearing age. There are around 20% of unintended pregnancies in Indonesia. FP programs aim to avoid unwanted pregnancies or births, thereby reducing the rate of unsafe abortions and costs [4]. The strategy given in FP is the use of long-term contraceptive methods (long-acting reversible contraceptives [LARCs]) with high effectiveness to delay, space out pregnancies, and stop fertility that is used in the long term compared to non-LARCs methods. It is also more cost-effective [5]. The drop-out rate of non-LARCs methods continues to increase from 4.2% to 4.5% [6], [7].

The use of LARCs which is still low is influenced by several factors including educational information and communication (IEC) of health workers who are not good at recommending LARCs, counseling done was not according to standard procedures and knowledge about LARCs is still low [8], [9]. Increased knowledge of prospective LARCs acceptors is influenced by the quality of FP contraceptive method counseling conducted by trained health workers. An important component of counseling is education, which aims to provide information to clients before making decisions about which contraceptive method to use [10], [11], [12], [13].

The percentage of primary health facilities that have implemented maternal and neonatal health and FP services is 97.5%, but only 58% of health workers who have received FP training and only 32.2% of primary health facilities have sufficient resources in the FP program. The adequacy of these resources includes service competence, availability of officers at the primary health facility, availability of guidelines and standard operating procedures, and technical guidance [14].

Appropriate clinical training methods are needed for health workers, especially in installing LARCs contraceptive devices [15]. Since 2003, the national clinical training network in reproductive health

in collaboration with the Johns Hopkins Program for the International Education in Gynaecology and Obstetrics has held contraceptive technology update (CTU) training based on competition. The CTU training was carried out for 5 days with the transfer of knowledge and skills of the latest contraceptive services. In the training, various methods of contraception were taught, but there is no specific methods that were emphasized. Time provided for counseling skills on intrauterine-post-placental contraceptive training (IUD-PP), was only 90 min or 6.2% of the total time (24 h of training), and on CTU training, counseling materials, and practices were provided for 90 min or 4.7% of the total time (32 h of training) [16], [17].

The objective of the study was to improve health-care workers competency in LARCs counseling and improve the participation of clients by producing a counseling training module specifically for LARCs.

## Materials and Methods

This study was conducted using mixed methods with a sequential exploratory model consisting of three research stages. The first research phase used a qualitative method by collecting data through focus group discussions (FGD) and in-depth interviews with health workers and potential acceptors. Phase two and phase three were done using quantitative methods. The second phase of the research used quasi-experiments with health workers as subjects and the third phase used pure experiments with prospective acceptors in an analytic and interventional study to find out the need of counseling training needed to improve healthcare competency in doing counseling and improve participation of clients.

The first phase of the FGD study for health workers and prospective recipients was carried out by the author herself, as the Obstetrics and Gynaecology Social Consultant at the National Central General Hospital Dr. Cipto Mangunkusumo (RSCM). Sessions were done on a different day, face-to-face for healthcare workers and clients. For the first phase, purposive sampling was used by The Chief of the Indonesian Midwives Association. Followed by the second and third phase at some private midwives clinics, with a population of a healthcare workers found in RSCM and Private Midwives Clinics for phase two, and all prospective contraceptive acceptors in Jakarta for phase three, by consecutive sampling. No audio or video recording was used during the sessions. Each session was done in 2–3 h.

The profile of health-care workers included in phase one was a midwife, with age >40 years, active in providing FP services at RSCM and/or Private Clinics, active in providing FP counseling at RSCM and/or Private Clinics, has received CTU/AKDR-PP/other FP seminars and/or training and willing to participate in research. If, all of the criteria above does not meet the minimum length of practice (minimum 5 years) then, the subject was excluded from the study.

The profile of health-care workers included in phase one for training was a midwife, active in providing FP services at Private Clinics, active in providing FP counseling at private clinics, has more than 20 patients/day, with more than 5 patients for contraception per day, has and has not received CTU/AKDR-PP/other FP seminars and/or training, has not received any training for contraceptive counseling and willing to participate in training and willing to participate in all of the intensive training course for LARCs. Subjects included were then excluded if they do not participate in all training series or with less than a year of experience in giving FP services in private clinics.

The profile of prospective acceptors included in phase one was woman with a history of normal menstrual cycles, duration and frequency, women of childbearing age (15–49 years), currently is doing antenatal care or during the postpartum period before returning from a health care facility, is currently not pregnant, has a desire to use FP, and willing to participate in research. Criteria of exclusion include having contraindications in receiving LARCs.

The inclusion criteria for the second and third phase were the same with the criteria for health-care workers and prospective acceptors in phase one.

First, the analysis of the FGD and WM is to form a matrix according to the material discussed during the FGD and WM, then carried out an analysis to produce conclusions that are used as material for the LARCs intensive counseling training module. Participants in the first phase were according to the criteria listed above. There WERE 15 midwives chosen by the chief of the Indonesian Midwives Association to join the FGD and give input to our research.

This was then followed by the second phase by comparing baseline and comparing health-care workers' competencies. Baseline comparisons between groups were assessed descriptively. Categorical variables are presented in amounts and percentages. Numerical variables with normal distribution are presented in the mean and standard deviation. Numerical variables with non-normal distribution are presented in the median (minimum–maximum). Comparison of the competence of counseling skills between health workers before and after intensive counseling training for health workers on the Participation of Prospective LARCs acceptors was tested using the paired t-test if the data distribution was normal. If the data distribution is not normal, the Wilcoxon test is used with 5% significance limit. If there are variables that are not comparable, the researcher controls these variables using ANCOVA analysis. The subject involved in this phase was the same as the first phase.

Third phase was done using the same cycle as second phase, which was first comparing the baseline and continued with comparing the score of interest of the clients in receiving LARCs. Baseline comparisons between groups were assessed descriptively. Categorical variables are presented in amounts and percentages. Numerical variables with normal distribution are presented in the mean and standard deviation. Numerical variables with non-normal distribution are presented in the median (minimum–maximum). A comparison of interest scores between prospective acceptors is tested using the unpaired T-test if the distribution of data is normal. If the data distribution is not normal, then the Mann–Whitney test is used. 5% significance limit. If there are baseline variables that are not comparable, the researcher controls these variables. The analysis used is ANCOVA analysis.

Subject data are kept confidential and then processed by statistical analysis. This study was approved by the Department of Obstetrics and Gynaecology and the Ethics Committee. The subject involved in the third phase was gathered by consecutive sampling. A total of 150 clients, with 50 clients dropping out caused of a non-suitable age group, did not come to the location appointed and other reasons. A total of 100 clients are suitable and willing to participate.

## Results

### *First phase: Preparation of MKJP KB intensive counseling training module*

The FGD was attended by 12 midwives, each of which consisted of six midwives in the first FGD and the second FGD. The age range of FGD participants is 45–68 years with more than 15 years of working time. All FGD participants were still active in providing FP services, both in primary and advanced health-care facilities and PMB and had participated in FP seminars and/or training.

At this stage, the researcher also conducted FGDs for prospective acceptors. FGD to prospective acceptors are done to assess the needs of prospective acceptors for LARC method counseling that is suitable for the needs of prospective acceptors and can be well received by prospective acceptors. The findings of the FGD and in-depth interviews with prospective acceptors became material in the development of the LARC intensive counseling training module.

The results at the qualitative stage showed that the appropriate LARC intensive counseling training model was to cover 2 days with a duration of 7 h each day with a point of communication technique material when counseling (Table 1).

Based on Kirkpatrick's third evaluation, the researcher made a LARC intensive counseling skills competency assessment instrument made by researchers based on literature review, reviewing existing competency assessment instruments, processing data obtained through the FGD process on health workers and prospective acceptors, in-depth interviews with prospective acceptors, discussions and evaluations with experts, discussions with training facilitators, and training participants.

The module was done by conducting FGD and WM to health workers and prospective acceptors, discussions with module maker experts, counseling experts, residents of Obstetrics and Gynecology, and health workers who work at RSCM, testing the validity-reliability of training questionnaires, trial and training for residents of obstetrics and gynecology, and health workers who work at RSCM so that the MKJP intensive FP counseling training module is compiled and made in flipchart form (Table 2).

Competency assessment instruments were prepared based on literature review, review of instruments, processing FGD and WM data, discussions and evaluations with experts, discussions with training facilitators, and discussions with training participants. The following is a checklist instrument that is used to assess the competency of the LARCs intensive counseling skills.

The preparation and development of the modules resulted in three modules, namely the Reference Book, the Trainer's Handbook, and the Participant's Handbook as well as flipchart tools.

LARCs intensive counseling training was conducted for 2 days, consisting of six sessions, containing materials that focused on LARCs materials, LARCs intensive counseling materials, LARCs intensive counseling on models, and LARCs intensive counseling practices on standard patients.

The highest rating aspect was the mid-training questionnaire (96%) while the lowest assessment aspect was the 2 days of training (39.3%). The following is an evaluation table for the LARCs FP intensive counseling training.

### *Second phase: Learning and behavioral evaluation*

The counseling training is done with the use of a humanistic approach. The materials given in the counseling intensive training of LARC method are also done with interactive lectures, discussion, and simulation on the model and practice in standard patients. The interactive lectures and open discussions are able to improve the knowledge of the participants. Two days of counseling in Nigeria country showed positive impacts toward the knowledge of health workers and the quality of counseling service (Table 3).

**Table 1: Matrix of health-care workers from FGD findings**

| Midwives Statements | Coding | Components in the LARCs Intensive Counseling Training Module |
|---|---|---|
| Complaints of prospective acceptors against LARCs | | |
| 1. IUD, it hinders from working and I am not able to have pleasant intercourse, there's something obstructing | Knowledge | 1. Focus on LARCs and correcting misunderstandings<br>2. Integrated in the study guide, checklist number 14 and the study guide |
| 2. Minimal LARCs, long period of menses, feels that there is something stinging, cannot work hard | | |
| Contraceptive interest in prospective acceptors | | |
| 1. Injection | Knowledge | 1. Training material for the LARCs method chapter which explains the effectiveness of LARCs and non-LARCs<br>2. The effectiveness of LARCs is included in the study guide, checklist numbers 10c, 11c, 12c, and flipcharts |
| 2. 3 months injection | | |
| 3. 1-month injection | | |
| Challenges faced during LARCs counseling | | |
| 1. The position of the acceptor candidate must be in lithotomy | Knowledge | 1. Explain the installation location of the LARCs method<br>2. Integrated in study guides, checklists for numbers 10d, 11d, and flipcharts |
| LARCs intensive counseling training material | | |
| 1. Contraceptive methods (KB devices) | Knowledge | 1. LARCs intensive counseling training material which explains the LARCs method<br>2. Integrated in the training schedule in the reference book, participant guide, and trainer's handbook |
| 2. Installation steps | | |
| 3. CLOP diagram | | |
| Ensuring understanding of prospective acceptors | | |
| 1. Using the patient's language | Attitude | 1. Integrated in the study guide, checklist number 19c and flipchart |
| 2. Recognize which tribes/race the acceptor candidates are from, using their language | | |
| Responding to constraints and concerns about LARCs | | |
| Approach in counseling to prospective acceptors | | |
| 1. Include your husband in counseling | Attitude | 1. There is informed consent that includes the husband<br>2. Integrated into the study guide, checklist numbers 10,11, 12, and 19 and illustrated on a flipchart |
| 2. Explanation of the types of KB MKJP with pictures and props | | |
| The attitude of midwives in providing counseling | | |
| 1. Do: smile, greet, greet, touch, and be polite | Attitude | 1. Integrated in the study guide and the Attitude component checklist and number 1 |
| 2. Be an example for patients | | |
| Counseling infrastructure | | |
| 1. The place is comfortable | Infrastructure | 1. Integrated in the study guide, checklist numbers 1, 19a, 19b, and flipchart |
| 2. There is a special counseling room | | |
| 3. Given a partition | | |
| 4. Props are provided | | |
| 5. Use assistive devices, to model the anatomy of the uterus | | |
| Suggestions for intensive counseling training for LARCs | | |
| 1. Prioritize those with a lot of patients | Training Model | 1. Implementation of LARCs intensive counseling training<br>2. Integrated into the training schedule in the participant's handbook and trainer's handbook |
| 2. 2 days of training is sufficient, considering that many midwives work at PMB | | |

FGD: Focus group discussions, LARCs: Long-acting reversible contraceptives.

This training is proven to be able to increase the knowledge of health workers and the competence of counseling skills of health workers. This increase was statistically significant. The average skill score before training was 46.44 and the average score after training was 87.63 with an increase of 40.59 ($p < 0.001$). This study found that health workers were easier to do the LARC FP intensive counseling with "SMARTS" method.

**Table 2: Matrix of FGD and WM findings of prospective acceptors**

| Statement of Prospective Acceptors | Coding | Components in the LARCs Intensive Counseling Training Module |
|---|---|---|
| Knowledge about LARCs | | |
| 1. Spirals | Knowledge | 1. Focus on the ability to explore the knowledge of prospective acceptors<br>2. Integrated into the study guide, checklist number 8 and flipchart |
| 2. Implant | | |
| 3. Sterile | | |
| Complaints using LARCs | | |
| 1. Spirals, lots of menstruation, may be dislodged, threads coming out, sore | Knowledge | 1. Explain specifically about LARCs and correct misunderstandings<br>2. Integrated in the study guide, checklist number 14 and flipchart |
| 2. Afraid to use it because I heard from other people | | |
| Family Planning Counseling Experience | | |
| 1. Have been counseled, said she was injected with a lot of analgesic, takes a long time to heal, long term effect, longer menstrual pain. Decided not to get it and went home | Knowledge | 1. LARCs material explaining the side effects of KB MKJP<br>2. Integrated into the study guide, checklist numbers 10, 11, and 12 and flipcharts |
| The information needed for each LARCs method | | |
| 1. Benefit | Knowledge | Integrated into the study guide, checklist numbers 10, 11, and 12 and flipcharts |
| 2. Information on side effects | | |
| 3. Risk | | |
| 4. Straighten the myths heard | | |
| The maximum duration of family planning counseling | | |
| An hour | Counseling Time | 1. The duration of the LARCs intensive counseling<br>2. Integrated into the reference book sub-chapter duration of LARCs intensive counseling |
| Family planning Counseling Time | | |
| 1. During pregnancy, 6 months | Counseling Time | 1. The duration of the LARCs intensive counseling<br>2. Integrated in the reference book sub-chapter duration of LARCs intensive counseling |
| 2. Born | | |
| Things that make potential acceptors feel comfortable | | |
| 1. Clean and comfortable room | Infrastructure | 1. Integrated into the study guide, checklist numbers 1 and 4 as well as flipcharts |
| 2. Closed and soundproof room | | |
| Attitude of Midwives | | |
| 1. Friendly | Attitude | 1. Integrated into the study guide, checklist numbers 19 as well as flipcharts |
| 2. Understandable | | |
| Appearance of Midwives | | |
| 1. Use the official clothes | Attitude | 1. Integrated into the study guide, checklist numbers 18 as well as flipcharts |
| 2. Be tidy and neat, so we can feel comfortable | | |
| Family planning counseling position | | |
| Face-to-face position, so we can look at the expression more clearly | Attitude | 1. Integrated into the study guide, checklist numbers 20 as well as flipcharts |

FGD: Focus group discussions, LARCs: Long-acting reversible contraceptives.

**Table 3: Evaluation of LARCs intensive counseling training**

| No | Components | Percentage |
|---|---|---|
| 1. | The initial training questionnaire helped me study more effectively | 93.3 |
| 2. | The mid-training questionnaire helped me study more effectively | 96 |
| 3. | The role-play session in the counseling session really helped my learning process | 94.7 |
| 4. | There is sufficient time for counseling practice | 91.3 |
| 5. | Learning videos help me master counseling procedures and have confidence in carrying out procedures to prospective acceptors | 92 |
| 6. | The practice of using models and simulations helped me to master counseling procedures and to be confident in carrying out procedures for prospective acceptors | 93.3 |
| 7. | After this training, I was able to provide LARCs intensive family planning counseling services to prospective acceptors at my place of work/at a midwife's independent practice. | 92 |
| 8. | The methods and approaches and skills in this training have made me feel competent in providing quality counseling services | 84.7 |
| 9. | The LARCs intensive counseling training for 2 days was enough to increase my knowledge and skills in providing LARCs intensive counseling services | 39.3 |

LARCs: Long-acting reversible contraceptives.

In this study, there was a significant difference in the average score of LARCs intensive counseling knowledge before and after training (Table 4).

**Table 4: Knowledge comparison of intensive counseling LARCs**

| LARCs intensive counseling knowledge | n | Mean ± s.b | CI 95% | p |
|---|---|---|---|---|
| Before training | 15 | 49.73 ± **7**.74 | 27.67 (22.68–32.65) | <0.001 |
| After training | 15 | 72.40 ± 5.56 | | |

*Paired-13 (data normally distributed, paired, numerical). LARCs: Long-acting reversible contraceptives.

In this study, there was a significant difference in the average competency score of LARCs intensive counseling before and after the training (Table 5).

**Table 5: Comparison of Intensive Counseling Skills Competency LARCs**

| LARCs intensive counseling skills competency | n | Mean ± s.b | CI 95% | p |
|---|---|---|---|---|
| Before training | 15 | 46.44 ± **8**.48 | 42.05 | <0.001 |
| After training | 15 | 88.49 ± 5.38 | (37.31–46.79) | |

*Paired-t test (data normally distributed, paired, numerical). LARCs: Long-acting reversible contraceptives.

### *Third phase: Result evaluation*

Intensive counseling carried out refers to the humanistic approach and the theory developed by Carl Rogers. A humanistic approach focuses counseling on prospective acceptors. The interest score of prospective acceptors who get intensive LARC FP counseling is higher than those who accept other FP counseling. There was an increase in the LARC FP interest score for prospective acceptors who received intensive counseling. This proved to be statistically significant. Spearman correlation value is 0.767 which shows a positive direction. The higher the competency score, the higher the interest score of the prospective LARC FP acceptor. In line with Tumini's research, good counseling increases the success of FP and makes clients use contraception longer, and reflects the quality of services provided.

In this study, there was a significant difference in the MKJP FP interest score of prospective acceptors based on counseling which was obtained after controlling for the midwife's age category variable and the midwife's practice category variable (Table 6).

**Table 6: Comparison of LARCs interest scores for acceptor candidates**

| Variable | df | F | p |
|---|---|---|---|
| Corrected model | 3 | 26.87 | <0.001 |
| Acquired counseling | 1 | 156.28 | <0.001 |
| Midwives aged category | 1 | 8.65 | 0.08 |
| Length of practice category | 1 | 0.66 | 0.63 |

*ANCOVA test.

## Conclusion and Recommendation

This study succeeded in finding a LARC FP method in intensive counseling training module that could improve the competence of counseling skills of health workers in increasing the participation of prospective acceptors in the use of LARC method itself.

This research can be developed through advanced training to see the behavior of acceptors towards the use of LARC FP method.

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