



Characteristics of good contraceptive counselling – An interview study

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ABSTRACT

Objective: One key component in preventing unplanned pregnancies is to provide effective contraceptive counselling. This study aimed to investigate what characterises good contraceptive counselling from the woman's perspective.

Methods: A qualitative study with a phenomenological approach. Twenty-four women aged 15–45 participated in semi-structured, individual, face-to-face interviews that lasted, on average, one hour. Data were analysed by latent content analysis.

Results: One overall theme emerged, *person-centred contraceptive counselling – an interactive process*, with three main categories: (i) a trustworthy healthcare provider, (ii) creating a liaison and (iii) the right time and place.

Conclusions: The healthcare provider's attributes as well as what happened between the healthcare provider and the woman, and the surrounding context, had a bearing on the women's descriptions of good contraceptive counselling. The process of the counselling was described as more important than the actual outcome; thus, healthcare providers need to be aware that this seemingly straightforward consultation is rather multi-layered and has great health promoting potential.

Introduction

Global estimates suggest that about 48 per cent of all pregnancies between 2015 and 2019 were unintended, with 61 per cent of these ending in abortion [1]. According to the definition of not using contraception, even with no intention of becoming pregnant, being infertile or only having same-sex sexual behaviour, about nine per cent of women in Sweden had an unmet need for contraceptives [2]. The highest level of those with unmet needs, thirteen per cent, was in the age group of 21–30 years, who also presented the highest level of unwanted pregnancies.

One key component in preventing unplanned pregnancies is to provide effective contraceptive counselling. Several studies have investigated different contraceptive counselling models or methods, and its effect on contraceptive use and reduction in unplanned pregnancies. However, a systematic review including 61 unique studies found limited evidence for the effectiveness of contraceptive counselling interventions, other than the finding that additional counselling during pregnancy or postpartum increased the use of contraceptives [3]. The results may indicate there are other factors than the counselling

technique that have an impact on the initiation, and continued use of, contraceptives. A review study by Dehlendorf et al. [4] addresses the need for not only task-oriented communication in contraceptive counselling, such as information and treatment plans, but also relational communication, where a therapeutic relationship is created between the healthcare provider and the woman. This was also confirmed in a later review study by Schivone and Glish [5] who found that shared decision-making, induced by a patient-centred approach and relationship building, results in satisfied patients who are empowered to use the chosen contraceptive method correctly, which constitutes effective contraceptive counselling.

Regardless of the impact of various models of contraceptive counselling on contraceptive use and unplanned pregnancies, it is unclear whether these address the needs of women seeking contraceptive counselling. However, it is known that the care recipient's expectations and wishes at the time of consultation have a great impact on satisfaction with care. We want to provide effective contraceptive counselling so that patients can make informed decisions that are best for them, and the aim of the present study was therefore to investigate what characterises good contraceptive counselling from the woman's perspective.

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Materials and methods

Context

In Sweden, 80 % of all contraceptives are prescribed by midwives [6], and contraceptive counselling is mostly given at midwifery clinics or youth clinics (age limits vary between regions, but is usually available for youth aged between 13 and 25). The national guidelines formulated by the Swedish Medical Products Agency state that the contraceptive counselling should help the individual to prevent an unplanned pregnancy, preserve fertility until pregnancy is considered, and promote sexual and reproductive health [7]. Contraceptive counselling is available free of charge throughout the woman's reproductive life cycle and is always given in connection with legal abortion as well as after childbirth. A minor (younger than 18 years) can receive health counselling without the presence of a legal guardian. This includes counselling on contraceptives, and sexual and reproductive health; contraceptives can also be prescribed from age 15. Furthermore, contraceptives are free of charge for individuals younger than 21 and are subsidised up to age 25 (regional differences exist).

Study design

The study had a qualitative design and phenomenological approach with semi-structured individual face-to-face interviews.

Study participants and procedure

The participants were recruited between April and November 2018. Information about the study was spread through social media, and posters on public bulletin boards, for example, in high schools, university campuses, libraries, and cultural centres. In addition, snowball sampling was used, where women who had been interviewed were asked to inform friends about the study. To obtain rich data, emphasis was placed on recruiting a wide range of women in terms of age, marital status, reproductive health history (abortion/STI/miscarriage/childbirth), sexual orientation, ethnicity, socio-economic status, and geographical residence. Exclusion criteria were: being under the age of 15 and unable to communicate in Swedish. Women interested in participating in the study (n = 61) contacted the last author (JS). JS provided further information about the study and informed that participation was voluntary and could be cancelled at any time. Women who agreed to participate and represented characteristics not previously captured in interviews were booked for an interview (n = 26). Two women cancelled or did not come to the agreed interview. Time and place for the interview were decided based on the participants' preferences, such as the participants' homes, cafés, or the university. Before the interviews, all participants signed a consent form as well as completed a brief background questionnaire; see Table 1. Individual face-to-face interviews were conducted in Swedish, using open-ended questions from a semi-structured interview guide, developed by the last author (JS) and pilot tested before the main data collection. All interviews were performed by JS or MG, both health professionals not involved in the individuals' health care, holding PhDs and having previous experience with qualitative methods. The interviews lasted, on average, one hour (between 24 and 117 min) and were digitally recorded and transcribed verbatim. The interviews started after informing the participants that they could withdraw from participation at any time during the interview. All interviews started with one main question: *What comes to your mind when you hear the term contraceptive counselling?* The interviews then covered the following areas: General view of contraceptive counselling (e.g. *from your point of view, what is the purpose of contraceptive counselling?*), Desires and expectations of contraceptive counselling (e.g. *what do you desire and/or expect from contraceptive counselling?*) and Own experiences of contraceptive counselling (e.g. *tell me about your own experiences of contraceptive counselling. What has been*

Table 1
Socio-demographics (n = 24).

Variable	
Age at time of study	
Mean (SD)	26.4 (8.6)
Range (MD)	15–45 (25.5)
	n (%)
Educational level at time of study	
Secondary education ^a	7 (29.2)
University	17 (70.8)
Sexual orientation	
Heterosexual	19 (79.2)
Bisexual	3 (12.5)
Other/Did not answer	2 (8.3)
Relationship status	
Steady relationship	17 (70.8)
Single	7 (29.2)
Desire to have a/another child	
Yes	14 (58.3)
No	5 (20.8)
Unsure	5 (20.8)
Contraceptive use last intercourse	
None	2 (8.3)
Condom	6 (25.0)
Contraceptive pill	5 (20.8)
Intrauterine device (IUD)	5 (20.8)
Contraceptive implant	4 (16.7)
Other	4 (16.7)

^a Two to four years of education after compulsory school.

positive versus negative?). Supplementary questions were asked when clarification was needed. Study recruitment continued until saturation was reached, that is, when no more new information was obtained [8]. The study follows the Standards for Reporting Qualitative Research (SRQR) [9] and is reported according to the SRQR Checklist (Supplemental File) [9]. After the interview, informants received a €15 gift card as a token of appreciation.

Data analysis

Data were analysed by thematic content analysis [10,11], and an inductive approach was used. Each interview was read repeatedly to get a sense of the individual's story. By using open coding, meaning units related to the study's aim were identified and summarised in codes reflecting their content. Codes describing the same content were then brought together into categories. These were then sorted hierarchically into main categories, sub-categories and one theme. The first author (GA), a registered nurse midwife, who provided insights into and knowledge of the research field, a pre-understanding considered valuable, was responsible for the initial analysis. At a later stage, the whole research group discussed the analysis, including categorisation and abstraction, to problematise the interpretation and to find other alternative interpretations if necessary. The results are illustrated by quotations; moreover, the interviewer's questions, clarifications and excisions (three dots) are marked with squared brackets. Following the criteria for reporting qualitative research [9], quotes are presented to substantiate the content and to give the reader an opportunity to interpret the findings in order to strengthen the credibility. The software programme NVivo version 11 (QSR International) was used to facilitate data management during the analysis.

Ethical considerations

The study followed the ethical standards of the Helsinki Declaration of 1964, as revised in 2013 [12]. Questions about contraceptive counselling can be perceived as intimate, evoking negative emotions. To obtain valid data, the interviewers strived to have a respectful and non-

judgmental attitude and were attentive to any signs of distress. In addition, the interviewers were prepared to offer contact information for further support from an adequate body, for example, at a youth- or midwife clinic. However, none of the participants expressed any extensive distress and made use of this service. The study was approved by the Swedish Ethical Review Authority (Dnr. 2017/640).

Results

In total, 24 women, aged between 15 and 45-years-old (MD 25.5), participated in the study. The majority (n = 20, 83.3 %) had experience of more than one contraceptive counselling. All but one of the participants was born in Sweden. However, ten (41.7 %) had one or two parents that were born outside of Sweden. Eight of the women had been pregnant at least once (33.3 %); six women had one or more child (25.0 %), five had gone through at least one miscarriage (20.8 %), and two had decided to undergo one or more abortions (8.3 %). The most common contraceptive methods used among the participants were contraceptive pills, an intrauterine device (IUD, hormonal, or non-hormonal) and condoms. For a more detailed sociodemographic background, see Table 1.

The analysis resulted in three main categories: *A trustworthy healthcare provider*, *Creating a liaison* and *The right time and place*, together with the underlying sub-categories. Through the categories, one theme emerged, *Person-centred counselling – an interactive process* (Table 2).

Theme: Person-centred counselling – An interactive process

This theme emerged from how the women described the contraceptive counselling as an interactive process where they exchanged knowledge and perspectives with the counsellor to arrive at the best choice of contraceptive method. The interactive process was dependent on the counsellors' attributes, a mutual recognition of the women's knowledge base and knowledge needs, together with a consensus regarding the goal of the counselling. This process was described as more important than a specific outcome in terms of prescription. Also, administrative aspects, such as the clinical milieu and time constraints, affected the quality of the counselling. A good interactive process widened the women's knowledge and understanding of their needs, which was a prerequisite for achieving person-centred counselling. Person-centredness was described as counsellors seeing them as a whole being, by considering their previous experiences, knowledge, wishes and values. The women felt they had received good contraceptive counselling if it was person-centred.

What was common in both the descriptions of good and not so good contraceptive counselling was that the encounters had left a long-lasting feeling in the women. One woman illustrated this by quoting Maya Angelou:

I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel'.
Maya Angelou, 1928–2014

Table 2
Overview of theme, main categories, and sub-categories.

Person-centred contraceptive counselling - an interactive process		
A trustworthy healthcare provider	Creating a liaison	The right time and place
Empathic and open-minded	Exchanging knowledge	Allowing time
Knowledgeable	Widening the view	Comfortable environment
Dedicated	Considering long-term perspectives	Easy accessibility
	Supporting decision-making	

1. A trustworthy healthcare provider

The women described how it was important for the healthcare provider to have a personality that was compatible with them and their needs. The personality was not so much about the healthcare provider's own personality, but more about the professional attributes. Incompatibility, when the woman's expectations about how a good and competent healthcare provider should be were not met, led to discontentment. While some, due to young age, inexperience or in fear of conflicts, accepted the situation, others sought another healthcare provider who met their needs.

1.1. Empathic and open-minded

The most common attribute described was that of open-mindedness. It was important that the healthcare provider did not have any preconceived ideas about the woman's sexual orientation, sexual habits, or about race and culture, or previous experiences of contraceptive methods. By being open-minded, the healthcare provider made the woman feel safe and accepted as the individual she was. If the woman perceived any hint of preconceived ideas or judgement, it could hinder the communication between her and the healthcare provider, as she felt she could not reveal important aspects about herself that could have an impact on the choice of contraception. The women also indicated it was important that the healthcare provider had an affirmative approach and recognised their experiences, instead of brushing them aside.

She treated me so calmly and nicely. She said, "Yes, it can be that way, but it doesn't have to. We're going to sort it out". She didn't take out the IUD, but she treated me as I was, in all the stress of recurrent yeast infections where I had previously been told, "Blame yourself for being fat". [She] didn't take out the IUD at that time but later on. I will never forget it, her treatment of me, how she made me feel that... "Yes, there is nothing wrong with me".

Informant D

1.2. Knowledgeable

The women regarded the healthcare provider as a source of knowledge, at a more professional level than what they could acquire from other sources, such as from friends, brochures, and the internet. This was largely dependent on the extent to which the healthcare provider could provide well balanced and nuanced information about different contraceptive methods, including alternatives and negative side effects. It was important that the healthcare provider was sensitive to the woman's individual needs regarding the level of information, and not giving too much or too little information, with the latter being a more common feeling. The women felt it was important that the healthcare provider was knowledgeable regarding the latest research and contraceptive methods. Hence, if these requirements were not met, the women lost their trust in the healthcare provider.

One thing that I can find quite troublesome is that [counsellors] say different things. For example, they say that when you take birth control pills, you can skip the sugar pills, that you shouldn't take them at all. And then my friend and I were like "Yeah? It sounds strange". And then you go to another [counsellor] who says "No, but every three months, you have to take the [the sugar pills]". Then you feel like "But the other one said you didn't need to take them at all". And then you get really confused. [...] I didn't like that at all. Now I am all confused about what to do.

Informant B

1.3. Dedicated

The women felt it was important that the healthcare providers were dedicated to their work and showed an interest in the women and the subject of contraceptives. Some women described having met healthcare providers who seemed tired of the subject, who showed no dedication and interest in either contraceptive counselling or the women they were counselling. In these situations, women felt they had not received enough information about contraceptives to make an informed decision. They felt unsure that their prescribed contraceptive met their needs.

For us who start [with contraceptives], it's a one-time thing and I think that [the counsellors] don't realise [...] that they have to tell us all the information. Maybe they have done it many times and are tired of it. I don't know. They may not think that it's such a big deal. [...] My parents don't know that I'm on the pill. And when [the counsellor] asks "Has anyone in your family had a thrombosis?", should I go home and ask? [...] I don't know, you still want to feel accepted. [The counsellor] really has to show that he or she cares about you, otherwise you don't want to tell them anything. It just became, "No, no one in my family has had thrombosis".

Informant A

2. Creating a liaison

The women described how the quality of the meetings with the healthcare provider was dependent on the extent to which the women and the healthcare provider managed to create a liaison. Even if the liaison was described as developed through both the healthcare provider and the woman contributing with knowledge, the healthcare provider was deemed largely responsible for whether this was successful.

2.1. Exchange of knowledge

The women described the importance of a two-way communication, namely that there was an exchange of knowledge between the healthcare provider and the woman. This was made possible when the healthcare provider listened to the woman. By recognising her knowledge base, the healthcare provider could build on it further, resulting in the information becoming individualised. Exchange of knowledge included not only the woman's knowledge base, such as knowledge about anatomy, physiology and contraceptive methods, but also knowledge about the woman's life situation, such as age, sexual habits, marital status, beliefs and values, and her previous experiences. By also considering these aspects, the counselling built on the woman's specific needs.

There's a lot that comes into play when choosing. [...] I have major side effects from certain contraceptives and then I can get help choosing something that might be more suitable. Some people may find it difficult to remember to take a pill every day and then it may be better to take something else. [...] When I have met [the counsellor] as an adult, there has been a greater understanding. We have collaborated to arrive at the best decision [...]. It was a common goal to arrive at the best. At the youth clinic, there was a different type of meeting as I remember it. It felt like the people working there had a preconceived idea of what I wanted before I was able to express my thoughts fully.

Informant N

2.2. Widening the view

Good contraceptive counselling helped the women to see their choice of contraceptive method from a wider perspective. By acquiring new knowledge provided by the healthcare provider, the women learned to consider new aspects that they had not been aware of in their choice of method, such as risk factors, lifestyle choices or sexual habits, which should be considered when choosing contraceptive methods.

I thought it was a bit strange because I thought it didn't belong [to the counselling]. Well, the pregnancy test did, but not the test for STDs and stuff. I was like "Yes, I want the pill". But afterwards, I understood that it is good to know. [Interviewer: Did the counsellor explain more about it?] [She said] because I had a partner, it was always good to take a test, to find out for sure and stuff like that. Same thing with the pregnancy test.

Informant J

The women also emphasised it was important that the healthcare provider not only informed that a certain thing limited the alternatives at hand but also explained why this thing constituted a hindrance.

2.3. Considering long-term perspectives

In addition, women described how the counselling helped them to consider long-term perspectives in their choice of contraceptive method. They appreciated when the counsellors addressed the impact of a certain method on future health and fertility. This was mentioned, in particular, by women who were young or those who had hormonal contraceptives for an extended period. Overall, the women were positive when asked about their reproductive plans. However, the question could be experienced as intrusive or irrelevant based on the women's age, marital status or values. It was therefore important that the healthcare provider explained why this question was asked as well as remembered the answer. This was true, especially when the women had actively chosen not to have children, as repeated questions about family planning could be interpreted as a critique of her life choices.

When I was of childbearing age, he [the counsellor] was very discreet, but he still brought it up, "If you want to get pregnant, you can do so and so" but without rubbing it in, like "Yes, but now is the time for you to multiply". So, every fourth or fifth year, he brings up those big questions about pregnancy or saying "Well, now the menopause is starting to be more relevant" and so on. So, he has some kind of long-term plan. I get the impression that he is really thinking ahead about which birth control would suit me best. I like him.

Informant C

2.4. Supported decision-making

Some women already had an idea of what contraceptive method they wanted, and if the counselling did not provide any information that made her change her mind, she described that the choice was made by herself. Young women, however, with limited experience of contraceptives, described a different decision-making process, where the decision was made in collaboration with the healthcare provider. This was also confirmed by more experienced women when they described their first contraceptive counselling session.

[Interviewer: Whose decision is it ultimately regarding which contraceptive to take?] I think it's both together. Because when I got there, I didn't know much. But I received information and from that information I could say what I thought would work best.

Informant H

Generally, this supported decision-making was regarded as something positive. However, the women stressed that since the healthcare provider has more knowledge and experience of the subject, paired with the provider-patient imbalance in power, the healthcare provider must

be careful not to use undue influence. It was important that there were no hidden agendas, such as promoting a certain method or preparation based on other aspects than the woman's situation or needs.

Contraceptive advice has a very strong agenda – to avoid teenage pregnancies, and you really understand that it is a very important issue. In many cases, hormonal contraceptives, which you don't even have to keep track of yourself, like contraceptive implants or whatever it may be, can serve a purpose for certain people at certain ages and such. But I really wanted to know more about different types of natural family planning and understanding fertility.

Informant A

3. The right time and place

It was not only the healthcare provider's attributes and what happened in the meeting between the healthcare provider and the woman that had a bearing on the woman's descriptions of good contraceptive counselling. The surrounding context also had an impact on the experience, such as the time frame and the rooms in which the counselling was performed.

3.1. Allowing time

To develop good contraceptive counselling, time was a crucial factor. The women described how time constraints limited the possibilities for knowledge exchange. This could lead to women feeling they had made a rush decision and not having enough knowledge about how to use the contraceptive method and what to expect from it. The women requested more time to think about the options. This could be managed by having the possibility to book extra time for counselling or by having it on two separate occasions. The time constraints also seemed to have an impact on the healthcare providers, and some women described how healthcare providers were sometimes stressed, which did not encourage confidence, nor any questions from the women.

I mean, you notice if someone has no interest in talking to you, then you don't want to develop anything. You [the counsellor] should show some interest and even if you are pressed for time, you still have to try to take it easy. Because otherwise, the person will also be stressed. Yes, being calmer and showing interest and be... Actually, showing that you are there, not because you have to make money, but because you really want to help the person.

Informant A

3.2. Comfortable environment

The environment did not play a central role in the counselling. However, the women preferred surroundings that were not associated with hospitals, such as small, intimate and homey rooms, as opposed to large, bare, and white rooms, which made them feel uncomfortable. The women also wanted the environment to be calm and discreet, where they could feel they were anonymous.

It is probably quite a stressful situation for many people to go to a midwife, so it is very nice when the treatment rooms aren't too large. That it's not too much space. It feels like it's just you and the midwife there, and there doesn't need to be much else. And yes, if the room is a little smaller with the most necessary things, it feels like... I feel that it's possible to relax, even if I really can't find any logical explanation for [that feeling].

Informant N

Some women who lived in smaller cities often preferred to visit a clinic in another town to ensure they did not meet other patients or

healthcare providers whom they knew privately.

3.3. Easy accessibility

The accessibility played an important role in contraceptive counselling. The women described how the need for advice, or for an introduction or change in contraceptives, could arise suddenly, and it was therefore important to be able to book an appointment in the near future. They also appreciated the possibility of receiving advice via telephone consultation or drop-in service.

I know that if I have questions or need help, I always get it [at the youth clinic]. You can make an appointment and if you need a drop-in time, you can go there at any time. So even when I had my thoughts and concerns, I have always been able to go there and get help. It has felt like [a clinic with] good counselling.

Informant B

Discussion

Our main finding was that the women characterised good contraceptive counselling as a person-centred and interactive process with a trustworthy healthcare provider who could create a liaison at the right time and place. The healthcare provider's attributes, as well as what happened between the healthcare provider and the woman, and the surrounding context had a bearing on the women's descriptions of good contraceptive counselling.

An important finding was that the women described the process of the counselling as more important than the actual outcome. This correlates well with previous research that describe contraceptive decision-making as a journey [13] and emphasise the meaning of building a relationship between the healthcare provider and the individual [5,14,15]. A possible explanation is that building a relationship creates a trust that enables the woman to share her beliefs and values, which, in turn, also enables the healthcare provider to adapt the counselling based on those aspects. Indeed, a review article concludes that women who are satisfied with their contraceptive counselling more often adhere to and continue with the contraceptives prescribed [4]. The model of patient-centred care has been a work model for several decades in various clinical settings, in which the individual's specific needs are addressed not only for the physical needs but also, for example, his or her beliefs and values [15,16]. Some research suggest that a patient's well-being and satisfaction may be related to mediating variables, such as adherence and self-management behaviours [17]. Nonetheless, a large body of research mainly evaluates counselling strategies on outcomes such as chosen contraceptive method [18], although there is a heterogeneity in both interventions and outcome measures studied [19]. In light of our results, we believe it is important to include patient measured outcomes, such as satisfaction with care, in future research.

Another interesting finding is how the women described a seemingly straightforward consultation as complex, with many dimensions, including existential aspects. To be seen and treated as a person in one's own right, without preconceptions but with respect for the individual's choices and wishes, was valued. This is in line with the findings of Manze et al. [20] where the women indicated that they wanted a non-judgmental and respectful consultation. The finding that women perceived some healthcare providers as having their own agenda correlates well with a study by Gomez and Wapman [21], who found some women perceived that the counsellor pressured the women into choosing a certain contraceptive method that the healthcare provider favoured. One explanation is that there is a fine line between creating a liaison with the woman and the healthcare provider and overstepping the boundaries. Some women wish for a close relationship with their healthcare provider [22] and information pertaining to their personal experiences of the contraceptive, while healthcare providers are careful not to be personal [23]. At the centre of this is the underlying power (im)

balance between the healthcare provider and the woman. Alspaugh et al. [24] conclude that power relations and gender norms will always be present in connection with contraceptives, but healthcare providers have the possibility to reduce the imbalance, for example, by using open-ended, women-centric language. This might be even more important when there are differences between what the healthcare provider and the woman believe are the most important aspects of counselling [25], for example, because of prejudices of healthcare providers [26,27]. Education for healthcare providers should, of course, include knowledge about different contraceptive methods, but also focus on strategies to deliver person-centred care. On a societal level, efforts could be made on several arenas to increase women's sexual and reproductive health literacy and, thereby, also their sexual and reproductive health.

There was great interest in the study from the target group. The aim of this study seemed to evoke commitment and dedication among women, and many expressed the importance for women in general, not just for themselves. Another strength of our study is the method used to gather material. Efforts were made to make the participant feel safe enough to elaborate on both positive and negative aspects of the topic. For example, the participant chose the place of the interview; the interviewer was a healthcare provider, but not involved in this area of care; and the interview guide was semi-structured and open-ended. The research group were, in addition to PhD's, all registered nurses or midwives. The midwives had experience of contraceptive counselling but were not providing such counselling at time of the study. The interviews were conducted by nurses, and it was pointed out that the research group did not represent any health care organization to enable the women to be honest about their experiences. However, it is possible the women still perceived the interviewers as healthcare providers and thereby may not have been as forthcoming as desired.

As previous studies have often focused on specific vulnerable groups, we believe the perspective of the general population of women is an important supplement to this study. Our recruitment strategies were effective, and we succeeded in recruiting participants with a broad spectrum regarding age, educational level, experience and reproductive history. However, women born outside of Sweden were hard to reach, and representation from the northern parts of Sweden was lacking.

Conclusion/last paragraph

The healthcare provider's attributes, as well as what happened between the healthcare provider and the woman, and the surrounding context had a bearing on the women's descriptions of good contraceptive counselling. We conclude that the process of the counselling was described as more important than the actual outcome. Thus, healthcare providers need to be aware that this seemingly straightforward consultation is rather multi-layered and has great health promoting potential.

Previous presentations

An abstract with preliminary results was accepted to the 16th Congress of the European Society of Contraception and Reproductive Health 2020, Dublin, Ireland. The congress was cancelled due to COVID-19, but the abstract book was published online.

Author contributions

JS, MG and HV designed the study. JS and MG collected the data. GA performed the data analyses, and all authors participated in the writing and critical review of the manuscript and accepted the final version of the manuscript.

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CRediT authorship contribution statement

Gabriela Armuand: Data curation, Formal analysis, Software, Validation, Visualization, Writing – original draft, Writing – review & editing. **Maria Grandahl:** . **Helena Volgsten:** . **Jenny Stern:** Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Project administration, Resources, Validation, Writing – original draft, Writing – review & editing.

Declaration of COMPETING INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.srh.2024.100948>.

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