

Family planning, fertility care, and contraceptive counselling: a person-centred continuum

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Introduction

Family planning, fertility care, and contraceptive care are interrelated yet distinct components of reproductive health, each reflecting evolving paradigms in health policy, human rights, and clinical practice. According to the World Health Organization (WHO), *family planning* refers to the ability of individuals and couples to anticipate and attain their desired number of children and determine the timing and spacing of pregnancies through the use of contraceptive methods and the treatment of involuntary infertility. [1]. Traditionally, family planning has been associated with population control and primarily measured in terms of contraceptive uptake, often focusing on married women and overlooking broader reproductive goals.

In contrast, *fertility care* is a more inclusive, rights-based framework that encompasses the full spectrum of services and support to help individuals make autonomous decisions regarding reproduction. This includes not only access to contraception and infertility care, but also menstrual health, preconception counselling, and fertility preservation, extending its reach to all people regardless of marital status or reproductive intention [2,3]. *Contraceptive care*, meanwhile, is a component of both family planning and fertility care, defined by the provision of counselling, access to a broad range of contraceptive options, management of side effects, and follow-up services that uphold informed choice and personal autonomy [4,5].

Counselling plays a critical role across the continuum of family planning, fertility care, and contraceptive care by facilitating informed, voluntary, and person-centred decision-making. In this context, counselling is not merely an additional service but a fundamental core element of quality reproductive healthcare. It ensures that individuals receive comprehensive, unbiased information about their options, including the benefits, risks, and side effects of various contraceptive methods or fertility treatments, and that this information aligns with their personal values, health status, and

reproductive goals. Effective counselling helps address misconceptions, mitigate fears, and support shared decision-making, particularly in contexts where social, cultural, or gender-based barriers may influence reproductive choices [5,6]. In fertility care, counselling is also essential for emotionally supporting individuals undergoing infertility treatments or making decisions about fertility preservation. In contraceptive care, method-specific counselling enhances satisfaction, continuation rates, and correct use.

This section addresses the unmet need for family planning, fertility care, and contraceptive care, highlighting the importance of a person-centred approach. This approach includes structured counselling tailored to individual preferences, needs, and circumstances, ensuring equitable, respectful, and effective contraceptive care for all.

Family planning, fertility care and counselling

Family planning plays a critical role in enabling individuals to achieve their desired number of children, if any, and to determine the timing and spacing of pregnancies. This goal is facilitated using contraceptive methods and, when necessary, the treatment of infertility.

Traditionally framed around preventing unintended pregnancies, family planning is now increasingly understood within the broader concept of fertility care, which encompasses both the prevention and achievement of pregnancy, as well as reproductive counselling, menstrual health, and fertility preservation. Fertility care reflects a rights-based and person-centred approach that affirms reproductive autonomy across diverse life stages and goals. It expands on traditional family planning by not only preventing unintended pregnancies but also by optimising reproductive health throughout the fertile years to procure healthier

pregnancies when desired. Effective contraception during peak reproductive age helps ensure appropriate interpregnancy intervals, which are associated with lower risks of preterm birth, low birthweight, and maternal morbidity [1,7].

Although the conceptual boundaries between contraception and infertility care have evolved, a dichotomy remains in service provision: contraceptive care is predominantly delivered in the public sector, whereas infertility treatments are concentrated mainly in the private sector [8]. Structurally, family planning and fertility care differ in their organisation, delivery, and target populations. Family planning services are typically integrated into primary health care, emphasising population-level prevention, contraceptive provision, and counselling for women of reproductive age. These services follow standardised protocols, are often publicly funded, and prioritise accessibility, especially in low-resource settings. By contrast, fertility care is generally concentrated in specialist clinics, most often in the private sector, with individualised and technology-intensive protocols such as assisted reproductive technologies. Fertility services primarily target couples experiencing infertility and involve higher costs, more complex diagnostics, and limited public funding, which contributes to persistent disparities in access [9].

Whereas historical family-planning policies primarily emphasised contraceptive approaches to reduce

unintended pregnancies, postpone or terminate pregnancies, and curb population growth, with remarkable success in slowing global population increases [10], fertility care encompasses proactive measures to support conception at the optimal time. Indeed, today, nearly half of all countries report fertility rates below the replacement level, and many are projected (absent migration effects) to experience population declines of more than 50% between 2017 and 2100, resulting in profound social and economic shifts [10,11]. In response, several developed countries are increasingly implementing child-friendly reforms to mitigate declining birth rates and promote family building [12,13].

Implementation approaches, however, differ markedly across contexts. In countries such as France and Japan, pro-natalist incentives include generous parental leave, childcare support, and, in some cases, subsidies for assisted reproductive technologies, including in vitro fertilisation (IVF) [14,15]. By contrast, Nigeria and India continue to prioritise fertility-reduction goals in light of rapid population growth and high unmet contraceptive needs, focusing resources on expanding access to family-planning commodities and reducing maternal mortality [16,17]. Meanwhile, countries such as Sweden and the Netherlands have adopted high-quality, rights-based counselling models that integrate family planning and fertility care, emphasising autonomy, informed choice, and gender equity within universal health coverage systems [18].



Additionally, family planning has a positive influence on societal development by enhancing educational opportunities for girls and expanding economic and social participation for women, including access to paid employment [3]. It is particularly beneficial for vulnerable populations, such as adolescent girls who face heightened risks from early childbearing, women with underlying health conditions, and older women at increased risk of pregnancy complications, as it helps address both health and social inequalities [19]. Family planning also plays a critical role for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other identities (LGBTQIA+) individuals, who often face stigma and a lack of tailored services, making inclusive approaches essential to meet their contraceptive and fertility needs [20]. Migrants and refugees encounter disrupted healthcare access, economic insecurity, and increased exposure to gender-based violence, heightening the importance of safeguarding reproductive autonomy [21]. People with disabilities frequently experience discrimination and systemic neglect in reproductive health, despite equal or greater need for contraception and counselling [22,23]. For people living with human immunodeficiency virus (HIV) infection, integrated family planning and HIV services help prevent unintended pregnancies, reduce mother-to-child transmission, and enable safer conception [24].

Contraception remains a cornerstone of both family planning and fertility care, as it empowers individuals to make informed, autonomous decisions about their reproductive health while also contributing to broader health, well-being, and societal development. When integrated with high-quality contraceptive counselling, preconception care, menstrual health management, and access to fertility diagnostics or treatments, fertility care and family planning ensure not only that pregnancies occur when intended, but also that maternal and neonatal outcomes are optimised [2,3,25]. Access to accurate contraceptive information and a diverse range of methods, supported by person-centred counselling, is fundamental to safeguarding the health and human rights of individuals.

Despite their anticipated individual and societal benefits, the unmet need for fertility care and family planning remains a significant global challenge. As of 2023, an estimated 257 million women of reproductive age lack access to adequate and acceptable contraceptive care. This unmet need is driven by factors such as limited availability and diversity of contraceptive options, fear or experience of side effects, cultural or religious opposition, poor quality of available services, and gender-based barriers [19]. Cultural norms and gender roles influence reproductive autonomy, often dictating who holds decision-making power over contraceptive use within households and communities [26,27]. In many contexts, myths and misconceptions about hormonal contraceptives, particularly around side effects, fertility, and religious permissibility, further hinder uptake [28,29]. Culturally rooted beliefs around hormonal contraception influence not only acceptability

but also perceptions of bodily autonomy [30]. Other barriers include a lack of method availability, low service quality, and gendered power dynamics within households and communities [27,31].

These barriers are often amplified in populations that view hormonal contraception as an intrusion on the body's natural state or as morally questionable, especially when the hormones are perceived as synthetic or "unnatural" [32]. Preventing unintended pregnancies significantly reduces maternal morbidity and mortality and contributes to improved public health outcomes. Additionally, contraception lowers the risk of unsafe abortion, enhances the likelihood of healthy pregnancies, and reduces the risk of HIV transmission from mothers to newborns.

Addressing these challenges requires the integration of culturally sensitive counselling and the expansion of access to newer contraceptive formulations that are perceived as more natural, chemically closer to endogenous hormones, and therefore more acceptable to patients. In such contexts, contraceptives formulated with body-identical estrogens, such as estradiol or estetrol, may provide not only biomedical benefits but also greater cultural acceptability, aligning more closely with prevailing ideals of naturalness, bodily integrity, and religious permissibility [28,33,34].

In parallel, digital health tools and tele-counselling have emerged as essential strategies to expand access [35,36]. Mobile applications, telemedicine platforms, and chat-based services can provide confidential, non-judgmental counselling and follow-up, improving reach among underserved populations. Self-managed contraceptive methods, such as oral pills, subcutaneous injectables, and emergency contraception, further empower individuals by reducing dependence on facility-based services while maintaining safety and effectiveness when linked to appropriate information and support [37]. Tackling these barriers is crucial to ensuring equitable access to family planning services and advancing the Sustainable Development Goals, particularly Goals 3 (Good Health and Well-being) and 5 (Gender Equality) [38].

Structured contraceptive counselling

Comprehensive family planning must include not only structured, medically accurate contraceptive counselling but also meaningful engagement with the cultural, social, and gendered contexts in which reproductive decisions are made. Empowering women to make informed choices requires more than the provision of information; it also depends on the relevance of that information, the communication style of healthcare providers (HCP), and the extent to which women's values, beliefs, and social circumstances are respected [39,40].

Shared decision-making, supported by tailored information that aligns with individual needs, lifestyles, and health conditions, is fundamental to reproductive autonomy and well-being. Structured contraceptive counselling refers to a deliberate, stepwise process of information sharing, needs assessment, and shared decision-making that is guided by standardised tools or protocols, while remaining responsive to individual preferences [41]. Structured counselling improves decision-making, supports continued method use, increases satisfaction, and contributes to the prevention of unintended pregnancies.

Modern contraceptive counselling has shifted from a directive, provider-driven approach to a structured, person-centred model that prioritises shared decision-making and minimises potential provider bias and external pressure [42-44]. However, even within person-centred models, unconscious provider biases, prevailing social hierarchies, and performance incentives, such as the promotion of long-acting reversible contraceptives (LARC), can still distort counselling quality and limit genuine reproductive autonomy [45]. Trust, respect, and open dialogue are crucial to fostering strong provider-user relationships and effectively addressing individual concerns [42,46]. Culturally responsive counselling must also account for prevailing misconceptions and socio-cultural narratives around hormones, menstruation, fertility, and morality, which often shape contraceptive choices [28,29,40]. Enhancing the accessibility of information through visual aids, storytelling, and content adapted for literacy levels, alongside verbal and audiovisual materials, can improve engagement and understanding in diverse populations [47].

In regions such as South Asia and sub-Saharan Africa, couples counselling plays a pivotal role in improving reproductive outcomes. Involving male partners in contraceptive discussions enhances shared decision-making, reduces misinformation, and strengthens partner support, factors that are associated with improved satisfaction and continuation of contraceptive use [48,49]. Counselling strategies that include both partners can be especially impactful in contexts where men influence reproductive decisions or where gender dynamics limit women's autonomy.

Where feasible, contraceptive counselling should also be integrated into other health service touchpoints, such as postpartum care, adolescent health programmes, and immunisation visits to maximise reach and access. This approach is efficient in settings with limited health-seeking behaviour explicitly related to contraception [50,51]. Integration allows providers to normalise contraceptive conversations within broader health contexts and to reach individuals at critical reproductive decision points.

In addition, counselling should address method switching and discontinuation as part of a continuous contraceptive care approach [42]. Normalising and

supporting method switching ensures that users who experience side effects or dissatisfaction remain engaged with family planning services rather than abandoning contraception altogether. Discussing discontinuation options also reinforces autonomy and trust, especially when users' reproductive goals evolve [42,43]. This comprehensive approach promotes long-term satisfaction, continuity of care, and better reproductive outcomes.

Global fertility care and family planning programmes are increasingly adopting user-centred counselling models to promote reproductive autonomy and informed choice [52,53]. However, implementation varies significantly across countries due to differences in healthcare infrastructure, policies, resource availability, training, and cultural norms. Clinical trials evaluating structured counselling have primarily focused on contraceptive uptake, with continuation and effectiveness as secondary outcomes. While HCPs often prioritise efficacy, users consider a broader range of factors, including side effects and non-contraceptive benefits, when selecting a method [54,55]. The Contraceptive Counselling (COCO) study, involving 92 gynaecologists, demonstrated that needs-based structured counselling increased high satisfaction rates by 30%, benefiting both new users and those switching or continuing methods [44]. Additionally, strategies such as quick-start initiation have proven effective in improving adherence to chosen methods [56].

While some countries have made progress in enhancing contraceptive services, caution is warranted when promoting highly effective methods such as LARCs. Overemphasis on LARCs may lead to neglect of user preferences, undermining reproductive autonomy and quality of care [40,57,58]. The WHO highlights the importance of self-care interventions, advocating for user-controlled methods such as oral pills, patches, and vaginal rings as part of high-quality, person-centred family planning services [59-61]. Ensuring that users receive individualised contraceptive care, including the freedom to choose and discontinue methods without coercion, is essential to achieving equitable, respectful, and effective reproductive healthcare.

Advancing structured counselling through performance metrics

Existing structured contraceptive counselling tools lack rigorous validation regarding user satisfaction, as well as their ability to capture lived experiences, cultural expectations, and trust dynamics. Evaluating these tools with standardised, validated measures would be valuable in refining performance metrics. Studies assessing the impact of counselling vary in outcome measures, and current tools lack psychometric validation across diverse contexts [62-64].

Three validated scales exist for assessing the quality of counselling. The Quality of Contraceptive Counselling (QCC) scale evaluates information exchange, interpersonal relationships, and disrespect/abuse [63,64]. It aligns with the QCC framework, which integrates counselling and relationship-building elements based on health communication and human rights [62]. The QCC scale has been adapted for Mexico, Ethiopia, and India. The Interpersonal Quality of Family Planning (IQFP) scale, an 11-item patient-reported outcome measure (PROM), was later condensed into a 4-item performance measure (Person-Centred Contraceptive Counselling [PCCC] scale) [65]. The Person-Centred Family Planning (PCFP) Scale provides a more comprehensive assessment, extending beyond patient-HCP communication to evaluate the healthcare facility environment [66,67]. Despite the growing use of these tools, there is a critical need for their contextual adaptation and validation in diverse populations, including rural, low-literacy, and marginalised communities. Without such adaptation, tools may fail to capture the nuances of patient experience or miss key determinants of contraceptive satisfaction.

Conclusions

Enhancing family planning and fertility care involves moving beyond fragmented methods to adopt an integrated, person-centred approach. This requires valuing lived experiences as much as clinical outcomes, ensuring services are fair, and building contraceptive care on trust, respect, and autonomy. By incorporating structured counselling and expanding access to acceptable options, health systems can better support individuals' reproductive journeys while boosting public health and social progress.

Gaps and future directions

Integration of family planning and fertility care remains poorly implemented across health systems.

Validation of counselling quality tools is lacking in diverse and resource-limited settings.

Cultural myths and stigma continue to hinder hormonal contraceptive acceptance.

Equity gaps in access persist for adolescents, LGBT-QIA+ individuals, migrants, and people with disabilities.

Uptake of digital health, self-care methods, and integrated service models remains limited.

Policy and financing frameworks fall short in ensuring sustainable, person-centred care.

Key messages

Family planning, fertility care, and contraceptive care are interconnected pillars of reproductive health.

Fertility care is broadening its scope to include prevention, achievement of pregnancy, and reproductive well-being.

There is a persistent unmet contraceptive need, with over 250 million women lacking adequate access.

Counselling is the cornerstone of person-centred, rights-based reproductive healthcare.

Cultural, gender, and social barriers continue to shape contraceptive use and acceptability.

Balanced method promotion strengthens trust and autonomy.



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