

Review

Contraceptive Counseling: Navigating Strengths, Gaps, and Opportunities in Patient-Centered Practice—A Narrative Literature Review

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Abstract

Background: Contraceptive counseling is a critical component of reproductive healthcare, directly influencing method uptake, continuation, and user satisfaction. While global health guidelines increasingly emphasize person-centered, rights-based approaches to counseling, wide variations in practice persist, with significant implications for equity and autonomy. **Objective:** This narrative review aims to synthesize current evidence on the strengths, limitations, and future opportunities of contraceptive counseling within person-centered care frameworks, with particular attention to adolescents and other populations facing structural or sociocultural barriers to equitable care. **Methods:** A comprehensive literature search was conducted across six indexed databases (PubMed, Scopus, Embase, Web of Science, CINAHL, and PsycINFO) for peer-reviewed articles published between January 2010 and April 2025. Eligible studies included original quantitative, qualitative, and mixed-methods research examining contraceptive counseling practices, user experiences, provider–client communication, counseling interventions, or implementation strategies in reproductive healthcare settings. **Results:** Emerging strengths in the field include the increasing adoption of shared decision-making, motivational interviewing, and culturally tailored counseling approaches, all of which contribute to improved client satisfaction and method adherence. Digital tools and mHealth platforms have expanded the reach of counseling and show promise in supplementing in-person care. However, significant gaps remain. Provider bias, limited training, communication barriers, and a lack of socio-cultural tailoring frequently undermine the quality of care, especially for adolescents, migrants, women with disabilities, and socially vulnerable populations. Ethical challenges—such as coercion, inadequate informed consent, and structural inequities—persist in many healthcare settings. Moreover, contraceptive counseling is often treated as a one-time event rather than an ongoing, adaptive process. **Conclusions:** To maximize its impact, contraceptive counseling must be reframed as a longitudinal, relational, and ethically grounded practice. Future efforts should prioritize the development of structured training programs, integration into broader health services, and qualitative research that centers patient experiences. Embedding counseling within reproductive justice frameworks will be essential for advancing equity and autonomy. High-quality

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contraceptive counseling, when informed by evidence and empathy, is a strategic tool for reproductive empowerment and public health advancement.

Keywords: contraceptive counseling; person-centered care; reproductive autonomy; health equity

1. Introduction

Access to effective contraception represents a cornerstone of reproductive autonomy and a fundamental component of global public health strategies. Over the past decades, modern contraceptive methods have significantly contributed to reductions in unintended pregnancies, maternal mortality, and unsafe abortions [1,2]. Despite these advancements, disparities in contraceptive use and access persist across and within countries, influenced by sociocultural, economic, and systemic factors [1,3].

In this context, contraceptive counseling emerges not only as a clinical interaction but as a critical determinant of method uptake, continuation, and user satisfaction [4]. The global landscape of contraceptive use is characterized by marked heterogeneity. While countries in Northern and Western Europe report contraceptive prevalence rates above 70%, many regions in Sub-Saharan Africa and parts of South Asia exhibit rates below 30%, with high unmet needs [1,5]. Even within high-income countries, marginalized populations, such as adolescents, migrants, or women with disabilities, often encounter structural and interpersonal barriers to effective contraceptive care [6,7]. As contraceptive choices become increasingly diverse and complex, the role of skilled, patient-centered counseling becomes ever more pivotal [8].

Contraceptive counseling is not a mere exchange of information. It is a dynamic, relational process where healthcare providers guide patients in making informed decisions consistent with patients' values, about fertility and contraception [8,9]. Counseling encounters that prioritize patient autonomy, shared decision-making, and contextual understanding have been shown to enhance contraceptive satisfaction, adherence, and continuation rates [10,11]. However, in real-world settings, the quality of counseling remains inconsistent. Reports indicate that many users experience counseling as overly directive, judgmental, or not tailored to their specific needs and circumstances [12,13]. Furthermore, providers themselves often report lack of training, time constraints, or systemic pressures that limit the scope of personalized care [14,15].

Despite a growing body of literature on contraceptive counseling practices and outcomes, no recent narrative review has systematically synthesized the multidimensional strengths and limitations of current approaches within a person-centered care framework. Existing systematic reviews tend to focus on specific methods or populations (e.g., LARC uptake, adolescents), often missing the broader contextual and ethical dimensions that shape counseling practices [16,17]. Moreover, while international guidelines by WHO, CDC, and NICE provide evidence-based recommendations for contraceptive counseling, their real-world implementation remains variable and under evaluated [18–20].

The importance of revisiting contraceptive counseling is amplified by evolving societal and technological contexts. Digital health tools, mobile health (mHealth) interventions, and culturally tailored communication strategies are increasingly being integrated into reproductive health services [21,22]. Simultaneously, ethical concerns such as reproductive coercion, informed consent, and equitable access demand renewed attention, especially when working with socially or medically vulnerable populations [23–26].

This narrative review critically examines the current state of contraceptive counseling, focusing on its strengths, limitations, and opportunities for future development.

Unlike systematic reviews that focus on narrowly defined clinical questions, narrative reviews are particularly suited to synthesizing complex, heterogeneous, and interdisciplinary evidence, allowing for a broader conceptual exploration [27,28].

Particular attention is given to adolescents, who represent a population with high unmet contraceptive needs and distinct counseling challenges related to developmental transitions, confidentiality concerns, and sociocultural influences. However, similar challenges are also experienced by other socially or medically vulnerable groups. Therefore, this review adopts a broad perspective on contraceptive counseling across diverse populations in order to inform more equitable and patient-centered reproductive health services.

This approach is consistent with the objective of identifying and critically discussing the multifaceted components of contraceptive counseling as both a communicative practice and a structural determinant of reproductive health.

The review will be structured to first present the theoretical foundations of contraceptive counseling, including key models and global recommendations [23,29]. We then explore the documented strengths in the literature such as improved adherence through personalized counseling, the adoption of patient-centered approaches, integration with digital tools, and success in culturally diverse or vulnerable settings [24]. This will be followed by a detailed discussion of common gaps and limitations, including provider bias, communication barriers, lack of specialized training, rigid informational models, and sociocultural mismatches [14]. Special attention will be devoted to ethical concerns and challenges faced by special populations, including adolescents, migrants, and women with disabilities [17].

The discussion section will synthesize the key themes that emerge, offering practice-based recommendations and policy implications. We will also link our findings to broader public health goals, such as reducing unintended pregnancies and promoting reproductive autonomy [30]. Finally, the review will outline research gaps and future directions, advocating for the development of structured training programs, the evaluation of novel counseling models, and qualitative studies that center patients' lived experiences [31].

Ultimately, this review seeks to position contraceptive counseling not merely as a clinical act but as a strategic lever for reproductive empowerment [1]. By embracing a patient-centered, context sensitive, and ethically grounded approach, healthcare systems can move closer to achieving equitable, informed, and autonomous contraceptive care for all [23,30].

2. Materials and Methods

This narrative literature review was conducted using an interpretive approach to synthesize evidence on contraceptive counseling across clinical, sociocultural, ethical, and health system domains. A narrative review methodology was selected because it allows for the integration of heterogeneous and multidisciplinary evidence and facilitates broader conceptual analysis than narrowly focused systematic reviews [27]. This approach enabled a contextualized examination of counseling practices, implementation challenges, and emerging developments across diverse populations and healthcare settings.

2.1. Search Strategy and Databases

A structured search was conducted across four major bibliographic databases: PubMed, Scopus, CINAHL (Cumulative Index to Nursing and Allied Health Literature), and PsycINFO. Additionally, Embase and Web of Science were searched to ensure broader coverage and inclusion of both biomedical and interdisciplinary literature. The search included peer-reviewed articles published between January 2010 and April 2025 to capture

developments over the last 15 years, including shifts in counseling models, integration of digital technologies, and evolving patient–provider dynamics.

2.2. Search Terms and Boolean Strategy

The search strategy combined terms related to contraceptive counseling with terms addressing counseling approaches, communication processes, and reproductive decision-making. In PubMed, searches were conducted using combinations of the following terms: (“contraceptive counseling” OR “family planning counseling” OR “family planning consultation”) AND (“shared decision making” OR “person-centered care” OR “motivational interviewing” OR “health communication” OR “reproductive autonomy”). Equivalent search strategies were adapted to the indexing systems and search interfaces of the remaining databases.

2.3. Inclusion and Exclusion Criteria

Articles were included if they met the following criteria:

- Focused explicitly on contraceptive counseling or related patient–provider communication in the context of family planning.
- Included primary research (qualitative, quantitative, or mixed-methods), systematic reviews, or evidence-based guidelines.
- Published in English between January 2010 and April 2025.
- Indexed in one or more of the following: PubMed, Scopus, Embase, Web of Science, CINAHL, or PsycINFO.

Exclusion criteria were:

- Studies focusing exclusively on contraceptive method efficacy without discussing counseling.
- Editorials, commentaries, or opinion pieces not based on empirical evidence.
- Articles not available in full text or not peer-reviewed.

2.4. Screening and Selection Process

Following the database searches, records were reviewed for relevance to the objectives of the review. Studies were assessed against the predefined inclusion and exclusion criteria, and articles judged to be most relevant to contraceptive counseling practices, experiences, communication processes, and implementation strategies were retained for narrative synthesis. The final corpus comprised 92 studies.

2.5. Data Extraction and Thematic Organization

A data extraction matrix was developed to capture key variables from the included studies: author/year, country/setting, study design, population focus, counseling model used, outcomes measured (e.g., contraceptive uptake, satisfaction, autonomy), and major findings. Studies were thematically grouped into domains derived from the objectives of the review and recurrent concepts identified during data extraction: (1) theoretical foundations, (2) strengths in current practice, (3) weaknesses and gaps, (4) special populations and ethical challenges, and (5) implications and future directions.

The narrative synthesis was guided by a critical interpretive approach, allowing the integration of diverse forms of evidence while maintaining an emphasis on patient-centered principles, equity, and implementation challenges in different sociocultural settings [28].

Representative studies supporting the thematic findings are presented in Supplementary Table S1. Studies were purposively selected to reflect the diversity of

populations, methodological approaches, geographical settings, and key concepts discussed within each thematic domain.

3. Results

3.1. Theoretical Background

Contraceptive counseling is a complex, multidimensional process situated at the intersection of clinical care, communication science, reproductive ethics, and health systems. At its core, it aims to support individuals in making informed, voluntary, and value-congruent decisions about if, when, and how to prevent pregnancy. While traditional approaches to counseling often emphasized information dissemination and method selection, contemporary models increasingly recognize the importance of dialogic engagement, emotional support, and structural sensitivity [8,9]. This section outlines the conceptual foundations of contraceptive counseling, key theoretical models, and international evidence-based guidelines that shape best practices [30,32].

3.2. Definition and Objectives of Contraceptive Counseling

According to the World Health Organization (WHO), contraceptive counseling should be a client-centered, rights-based process that facilitates autonomous decision-making and ensures access to appropriate and acceptable contraceptive methods [18]. The objectives of high-quality counseling include enhancing knowledge, addressing misconceptions, fostering informed choice, supporting consistent and correct use, and building trust between provider and patient.

A key shift in the past two decades has been the move from provider-led decision-making to shared, person-centered approaches. This transition reflects broader transformations in healthcare that value patient agency, diversity of preferences, and context-specific care [33].

3.3. Key Theoretical Models

Several conceptual models underpin contemporary contraceptive counseling practice. While their emphases vary, they converge in promoting personalized, empathetic, and autonomy-respecting interactions [8,34]. These models are not mutually exclusive and are often integrated into practice through hybrid frameworks or adapted protocols.

3.4. Shared Decision-Making (SDM)

Shared decision-making is a collaborative model where clinicians and patients jointly engage in health-related decisions, taking into account clinical evidence and the patient's values, preferences, and life context [29]. In contraceptive counseling, SDM has been shown to increase satisfaction and reduce decisional conflict by validating the patient's role as an active partner in care [11,33]. This model is particularly effective in navigating trade-offs between method characteristics (e.g., efficacy vs. side effects vs. control) and in supporting patients with ambivalence or complex contraceptive needs [8].

3.5. Patient-Centered Counseling (PCC)

Patient-centered counseling emphasizes empathy, active listening, and attention to the whole person—not just their reproductive goals but also their emotional, cultural, and relational context [13,18,30]. PCC has been linked to higher continuation rates of contraception and lower feelings of coercion, particularly in populations historically marginalized or stigmatized in reproductive health services [35]. The approach underscores the importance of tailoring information delivery and interpersonal style to each individual.

Closely related to person-centered counseling is the concept of trauma-informed care (TIC), which recognizes that previous experiences of violence, discrimination, reproductive coercion, displacement, or other forms of trauma may influence contraceptive decision-making and interactions with healthcare providers. Trauma-informed approaches emphasize emotional safety, trust, collaboration, empowerment, and respect for autonomy, particularly among individuals experiencing social vulnerability or adverse life experiences. Increasingly, these principles are being incorporated into contraceptive counseling to promote equitable and respectful reproductive healthcare.

3.6. Motivational Interviewing (MI)

Motivational interviewing is a counseling technique originally developed for behavioral change in addiction treatment, which has since been adapted to family planning contexts. MI focuses on exploring ambivalence, strengthening intrinsic motivation, and supporting clients in articulating their reproductive intentions [8,35,36]. Studies show that MI can be especially useful among adolescents, postpartum women, and individuals with inconsistent contraceptive use [37,38].

3.7. Evidence-Based Guidelines and Global Recommendations

International agencies have issued robust guidelines that synthesize best evidence and outline principles for high-quality contraceptive counseling.

The WHO's "Family Planning: A Global Handbook for Providers" recommends that counseling sessions be interactive, respectful, and adapted to the user's level of knowledge, preferred language, cultural background, and decision-making capacity [18]. It emphasizes five key counseling elements: (1) establishing rapport, (2) assessing needs, (3) discussing method options, (4) helping choose a method, and (5) ensuring correct use and follow-up.

The Centers for Disease Control and Prevention (CDC), through its U.S. Medical Eligibility Criteria (MEC) [19] and Selected Practice Recommendations (SPR) [32], also stresses the importance of providing evidence-based information without bias, promoting informed choice, and avoiding directive or judgmental language. The CDC framework encourages the use of structured decision aids, particularly for individuals with lower health literacy or limited prior contraceptive experience. More broadly, the assessment of health literacy represents a fundamental component of high-quality contraceptive counseling across all counseling models, as it enables providers to adapt communication strategies, support informed decision-making, and ensure that information is understandable and actionable for diverse populations.

The National Institute for Health and Care Excellence (NICE) in the UK provides guidance for contraceptive services (especially promoting long-acting contraception) among young people, explicitly stating that services should promote autonomy, reduce inequalities, and ensure that information is age-appropriate, confidential, and non-coercive [20].

3.8. Cultural Competence and Structural Awareness

A growing body of literature highlights that effective contraceptive counseling must also be culturally competent and structurally informed. Cultural competence involves understanding, incorporating, and responding to the beliefs, values, and communication styles of diverse populations, while structural awareness involves recognizing how systemic factors (e.g., poverty, financial barriers, racism, healthcare access constraints, confidentiality limitations, and legal requirements such as parental consent regulations or restrictions on contraceptive access) influence reproductive choices [39,40]. Counseling

models that fail to integrate these dimensions risk reinforcing health disparities or alienating clients who already face barriers to care.

For example, studies have documented that immigrant women, racial minorities, and those with limited English proficiency often receive lower-quality counseling characterized by reduced options, limited explanations, provider bias, or situations in which providers discourage or fail to support individuals' preferred contraceptive choices [41,42]. Conversely, culturally adapted counseling—delivered by trained, community-rooted providers—has been shown to improve trust, uptake, and continued use [43].

3.9. Decision Aids and mHealth Integration

The use of decision aids—whether paper-based, digital, or interactive—has emerged as a valuable adjunct to counseling sessions. These tools can standardize information delivery, enhance understanding, and support value clarification, particularly in time-constrained settings [22,44]. mHealth (mobile health) platforms are also increasingly employed to complement face-to-face counseling with reminders, tailored content, and interactive interfaces. However, their success depends on usability, digital literacy, and cultural relevance [21,45].

3.10. Ethical Principles in Counseling

Underlying all counseling models and guidelines are core ethical principles: respect for autonomy, beneficence, non-maleficence, and justice. Counseling that pressures individuals into certain methods—whether subtly or overtly—violates reproductive autonomy and can contribute to historical patterns of reproductive injustice, especially among marginalized communities [30,46]. Ethical counseling must ensure that all clients can make decisions that are informed, voluntary, and free from coercion, whether explicit or implicit.

3.11. Personalized Counseling and Improved Adherence

One of the most consistently documented strengths of modern contraceptive counseling is its ability to enhance adherence and continuation through individualized, patient-centered approaches. Several studies have demonstrated that when counseling is tailored to a woman's reproductive goals, personal circumstances, values, and beliefs, the likelihood of method satisfaction and continued use increases substantially [5,12]. Personalized counseling allows for deeper engagement with the client's concerns, myths, and expectations, facilitating better alignment between chosen methods and lived realities.

A large multisite study in the United States found that contraceptive continuation at 12 months was significantly higher among women who reported high-quality, person-centered counseling at method initiation [8]. In particular, counseling that included a balance of evidence-based information, emotional support, and encouragement of autonomous decision-making was associated with greater trust in providers and more sustained use, even when side effects were encountered.

Tailored counseling also plays a crucial role in method switching—a practice often necessary when side effects or life changes arise. When clients feel that their provider understands their situation and remains nonjudgmental, they are more likely to return for follow-up and seek alternative methods, rather than discontinuing contraception altogether [4,47].

3.12. Person-Centered Approaches and Equity Promotion

Adoption of person-centered frameworks has shown notable promise in mitigating reproductive health disparities. Person-centered contraceptive counseling—which emphasizes empathy, respect, autonomy, and responsiveness—has been shown to reduce

inequities in access and quality of care, especially among historically underserved populations such as adolescents, racial minorities, women with low health literacy and transgender or gender-diverse individuals [48,49].

For example, interventions incorporating shared decision-making and motivational interviewing have been particularly successful among young adults, increasing both satisfaction with care and method use [38,50]. Such models support clients in clarifying their own reproductive goals, while also ensuring that clinical encounters are respectful of diverse life situations, including gender-based violence, unstable housing, or chronic illness.

Moreover, clinics that institutionalize person-centered principles—such as confidentiality, cultural humility, and client-led pacing—report higher satisfaction with care and fewer instances of method discontinuation due to coercion or misunderstanding [51,52].

3.13. Digital Innovations and mHealth Integration

The integration of mobile technologies and digital health tools into contraceptive counseling represents another area of significant advancement. mHealth interventions—including apps, SMS reminders, interactive chatbots, and online decision aids—have enhanced both the reach and continuity of contraceptive support [44,53]. These tools offer private, accessible, and scalable means for clients to receive information, reinforce knowledge after consultations, and navigate method use over time.

Studies from diverse settings indicate that digital platforms, when well-designed, can support informed choice and autonomy [54,55]. For instance, in a randomized controlled trial conducted among adolescents in the United States, a smartphone-based decision aid increased the selection of long-acting reversible contraceptives (LARC) without reducing perceived choice or pressuring users [56]. In lower-income contexts, simple text-message reminders and interactive quizzes have been used to improve follow-up attendance and clarify method-related concerns [44].

Importantly, digital tools are most effective when integrated into broader person-centered care models, rather than functioning as stand-alone interventions. Hybrid approaches—where digital engagement is combined with in-person counseling—have demonstrated the most consistent improvements in knowledge, satisfaction, and continuation [2,22].

3.14. Positive Outcomes in Multicultural and High-Vulnerability Settings

Another strength identified in the literature is the successful adaptation of counseling practices in multicultural and high-vulnerability contexts. Tailoring counseling to clients' cultural backgrounds, migration histories, and socioeconomic constraints enhances relevance and acceptability [7,43]. Studies conducted among migrant populations in Europe and North America have shown that when language-appropriate, culturally sensitive counseling is provided, contraceptive uptake and trust in healthcare providers increase significantly [41,51,57].

In humanitarian and crisis-affected settings, trained community health workers have been particularly effective in providing counseling to women facing multiple layers of vulnerability—including displacement, trauma, and lack of legal protection. One study conducted in Syrian refugee camps in Lebanon reported that culturally adapted counseling sessions, delivered by female health workers from the same communities, led to a measurable increase in contraceptive uptake and follow-up attendance [58].

Similarly, programs working with survivors of gender-based violence or women living with HIV have demonstrated that when counseling is delivered in a trauma-informed and rights-based manner, women are more likely to express their preferences and maintain contraceptive use over time [59–61].

These successes suggest that flexible, culturally responsive models—especially those involving community engagement and task-sharing—can overcome many of the barriers previously associated with “hard-to-reach” populations [62].

3.15. *Respect for Reproductive Autonomy*

Across different delivery models and contexts, one of the most encouraging trends in modern contraceptive counseling is the growing recognition of reproductive autonomy as both a guiding principle and measurable outcome. Counseling sessions that foster autonomy—by respecting clients’ timelines, choices, and concerns—have been shown to improve the perceived quality of care and foster a sense of reproductive agency and personal empowerment [31,49].

Tools such as the Person-Centered Contraceptive Counseling (PCCC) scale and Decision-Making Autonomy Index (DMAI) have been validated to assess the degree to which clients feel respected, heard, and in control during contraceptive consultations [34]. Studies using these instruments have found strong correlations between higher autonomy scores and long-term method satisfaction and continuation [11,35].

These findings support the notion that quality contraceptive counseling is not merely a technical or informational intervention but a relational process grounded in respect, dignity, and partnership.

3.16. *Weaknesses and Gaps Identified in the Literature*

While contraceptive counseling has evolved significantly in recent years, a number of persistent weaknesses and systemic gaps remain across settings and populations. These shortcomings range from provider-level biases and inadequate communication strategies to structural inequities and insufficient cultural tailoring [13,63]. A critical review of the literature reveals that, despite advancements in theoretical frameworks and international guidelines, implementation in clinical practice often falls short of these ideals [4].

3.17. *Provider Bias and Communication Barriers*

Provider bias—whether implicit or explicit—continues to affect the quality and equity of contraceptive counseling. Studies consistently document that healthcare professionals may steer clients toward particular methods based on assumptions about age, race, socioeconomic status, or parity, rather than engaging in truly open, person-centered conversations [63,64]. For example, long-acting reversible contraceptives (LARC) are sometimes promoted more aggressively to low-income or minority women, which, while evidence-based in terms of efficacy, may unintentionally compromise reproductive autonomy when not presented in a balanced, choice-driven manner [65].

Communication barriers further compound this issue. Patients frequently report that counseling sessions feel rushed, overly technical, or lacking in emotional engagement [52,66]. Particularly in high-volume settings, providers may default to didactic, one-size-fits-all scripts rather than exploring patients’ unique needs and preferences. This communication gap undermines trust and can lead to method discontinuation due to unresolved concerns or misconceptions [43,67].

3.18. *Insufficient Provider Training and Continuing Education*

Another critical gap is the lack of consistent, high-quality training in contraceptive counseling across health systems. Despite the centrality of communication in effective counseling, many medical and nursing curricula provide minimal instruction on how to conduct non-coercive, values-sensitive reproductive health conversations [14,68]. Continuing education opportunities are often optional or limited in scope, contributing to variability in provider competency.

A study examining training programs in sub-Saharan Africa and South Asia found that, while providers had strong knowledge of method efficacy and side effects, they often lacked skills in addressing reproductive ambivalence, cultural sensitivity, and decision support [15,69]. Similar findings have been reported in high-income countries, where training tends to emphasize biomedical content over interpersonal communication and ethical reasoning [69].

Without formal and ongoing training in person-centered counseling, providers may inadvertently fall into directive or judgmental communication patterns—even when well-intentioned.

3.19. Rigid Informational Models vs. Empathetic Dialogue

Traditional models of contraceptive counseling often prioritize information provision, under the assumption that increased knowledge leads to better choices. While accurate information is undoubtedly essential, the literature suggests that this model, when applied rigidly, fails to engage the complex psychosocial dimensions of reproductive decision-making [6,41].

Empirical studies have shown that many clients, especially adolescents and women in vulnerable situations, do not respond well to didactic or overly clinical counseling styles. Instead, they benefit more from empathetic dialogue that acknowledges ambivalence, explores emotional concerns, and respects their lived experiences [51,66]. Unfortunately, such dialogic approaches require time, trust, and training—resources that are often constrained in overburdened health systems [70].

3.20. Lack of Socio-Cultural Tailoring

The failure to adequately integrate patients' cultural, linguistic, and social realities into counseling interactions remains a widespread limitation. While cultural competence is increasingly promoted in theory, its application in practice is uneven. Language barriers, mismatched cultural expectations, and stigma related to contraception can all hinder effective communication [40,71].

In particular, migrant populations and ethnic minorities often report receiving incomplete or judgmental counseling, with fewer method options presented and less opportunity to express concerns [31,35]. Moreover, counseling materials and decision aids are frequently designed for dominant-language speakers and do not always reflect the values or communication preferences of diverse populations [39].

This lack of contextual sensitivity can exacerbate health disparities and perpetuate provider biases, contributing to mistrust of healthcare systems, especially in communities with historical experiences of reproductive injustice [72,73].

3.21. Barriers Related to Health Literacy and Access

Health literacy is a fundamental yet often underrecognized determinant of effective contraceptive counseling. Assessing individuals' ability to obtain, understand, and use health information is essential for tailoring communication, supporting informed decision-making, and ensuring meaningful participation in contraceptive choices. Even when information is technically accurate, it may not be understandable or actionable for individuals with low literacy or limited health system experience [74]. This can lead to confusion, poor adherence, or passive acceptance of provider recommendations without true informed consent.

Furthermore, logistical barriers—such as time constraints, lack of privacy, limited clinic hours, and transportation difficulties—can reduce both the quality and frequency of counseling encounters [74]. These access-related issues disproportionately affect marginalized groups, including adolescents, rural populations, and those with unstable housing.

3.22. Fragmentation of Services and Lack of Follow-Up

Contraceptive counseling is too often treated as a one-time event rather than an on-going process. Many clients report that counseling is limited to the point of method initiation, with little or no follow-up unless a complication arises [5,75]. This episodic approach fails to support individuals whose needs evolve over time—such as postpartum women, those changing partners, or individuals undergoing life transitions.

Moreover, fragmentation between family planning and general healthcare services can lead to missed opportunities for counseling, especially in settings where reproductive health is siloed from primary care [58,76].

3.23. Special Populations and Ethical Challenges

Contraceptive counseling, while essential for all reproductive-age individuals, becomes particularly complex when addressing the needs of special populations [7]. These include adolescents, migrants and refugees, transgender and gender-diverse individuals, women with disabilities, and individuals experiencing socioeconomic or structural vulnerabilities [62,77]. In these contexts, counseling is not only a matter of clinical competence but also of ethical sensitivity. Ensuring autonomy, informed consent, and respect for diverse lived experiences requires a nuanced understanding of how intersecting factors—age, legal status, ability, stigma, trauma—shape reproductive decision-making [46,78,79]. This section examines key considerations in the delivery of contraceptive counseling to special populations, alongside critical ethical challenges such as coercion, power asymmetries, and informed consent [24].

3.24. Adolescents: Balancing Autonomy and Protection

Adolescents represent a population with unique contraceptive needs and counseling challenges [80]. They use a variety of contraceptive methods, including condoms, short-acting hormonal methods, and long-acting reversible contraceptives (LARCs). Contraceptive decision-making during adolescence is often shaped by concerns regarding side effects, future fertility, parental involvement, accessibility, and misconceptions about available methods. Consequently, contraceptive counseling plays a particularly important role in this population, providing an opportunity to address informational gaps, explore preferences and expectations, and support informed decision-making. They are often navigating identity development, first sexual experiences, varying degrees of independence from parental authority, and differing legal requirements governing adolescents' capacity to make autonomous reproductive health decisions. Although adolescent-friendly contraceptive services are recommended by WHO and other agencies, barriers such as provider bias, legal constraints, and confidentiality concerns persist [81,82].

Evidence shows that adolescents frequently face judgmental attitudes from providers, who may question their sexual activity or prioritize abstinence messaging over comprehensive method education [48,71]. These dynamics discourage disclosure, reduce trust, and limit effective contraceptive uptake.

Studies suggest that adolescent clients benefit most from counseling approaches that are nonjudgmental, developmentally appropriate, and emphasize privacy and autonomy [23,83]. Programs such as “One Key Question” have demonstrated success in helping adolescents articulate their reproductive goals, without presuming sexual behavior or promoting specific outcomes [78].

Ethically, counseling adolescents requires balancing their evolving autonomy with considerations of maturity, cognitive and decision-making capacity, safety, and informed consent. In contexts where parental consent is mandated for contraceptive services, this can present significant barriers to care—particularly for adolescents at risk of abuse or estrangement [81,82].

3.25. Migrants and Refugees: Cultural Sensitivity and Rights-Based Care

Migrant and refugee populations often face multifaceted barriers to reproductive healthcare, including legal precarity, language discordance, trauma exposure, and systemic discrimination [38,84,85]. Contraceptive counseling in these contexts must be both culturally responsive and grounded in a rights-based framework.

Research from European and North American contexts has documented that migrant women frequently report poor-quality counseling, characterized by limited choice, inadequate interpretation services, or coercion into sterilization or long-acting methods [11,31,86]. Some healthcare systems fail to account for differing reproductive norms or family structures, resulting in communication mismatches and diminished trust.

Culturally competent counseling—facilitated by professional medical interpreters, culturally matched providers, or community health workers—can significantly improve uptake and satisfaction [71,87]. For example, community-based reproductive health outreach among Syrian refugees in Jordan led to greater contraceptive knowledge and increased method use, especially when combined with gender-sensitive messaging and trauma-informed care [88].

Ethically, the challenge lies in ensuring that counseling is not only linguistically accessible but also free of coercion, especially when providers assume that limiting fertility is inherently beneficial for displaced or impoverished women [89].

3.26. Women with Disabilities: Overcoming Invisibility and Structural Barriers

Women with physical, intellectual, or sensory disabilities are often overlooked in contraceptive care programs, despite facing a higher risk of sexual violence, unintended pregnancy, and unmet contraceptive needs [77,79]. Historically, this population has been subject to overt reproductive coercion—including forced sterilization—and is still frequently denied full participation in reproductive decision-making [90].

A major barrier is the assumption, held by some providers, that women with disabilities are asexual or not at risk of pregnancy [72]. As a result, they may not be offered contraceptive counseling at all, or may receive limited, paternalistic information. Communication difficulties, lack of accessible facilities, and inadequate provider training further exacerbate these gaps.

Recent efforts to integrate disability rights frameworks into reproductive healthcare have begun to shift this narrative. Tools such as plain-language decision aids, accessible exam rooms, and supported decision-making protocols have shown promise in increasing autonomy and method choice for women with cognitive or communication impairments [75].

Ethically, respecting autonomy while ensuring informed consent requires additional vigilance in this group. For clients with intellectual disabilities, providers must assess decisional capacity in a way that maximizes inclusion and minimizes paternalism [91].

3.27. Women in Socially Vulnerable Conditions: Poverty, Violence, and Incarceration

Social vulnerability—including homelessness, intimate partner violence (IPV), substance use, incarceration, and experiences of sexual exploitation or human trafficking—creates profound barriers to contraceptive access and counseling. These populations often experience fragmented care, discrimination, and competing survival priorities that limit their engagement with preventive services [72].

Women experiencing IPV, for example, may face reproductive coercion from partners, such as sabotage of contraception or forced pregnancies. In such cases, traditional counseling approaches that emphasize shared decision-making may not be sufficient [92]. Trauma-informed counseling, which prioritizes safety, trust, and client empowerment, has been recommended as best practice [68]. For individuals experiencing intimate

partner violence, sexual exploitation, or human trafficking, contraceptive counseling should be embedded within a broader multidisciplinary response that may include legal advocacy, social support, safety planning, and referral to specialized services. Such integration can help address coercive circumstances that undermine reproductive autonomy and informed decision-making.

Comparable ethical and autonomy-related challenges have also been documented in correctional settings. In correctional settings, reproductive health care is often inconsistent and may involve coercive practices, such as conditional access to contraception or denial of method removal [33]. Ethical concerns also arise in programs offering financial incentives for sterilization or LARC uptake among poor women, raising questions about voluntariness and informed consent [55].

To address these ethical complexities, counseling must be situated within a broader commitment to reproductive justice—an approach that recognizes the right to have children, not have children, and parent in safe and supportive environments [93].

3.28. Ethical Principles: Consent, Autonomy, and Coercion

Across all special populations, contraceptive counseling must be guided by foundational ethical principles: respect for autonomy, informed consent, non-maleficence, and justice. However, these principles are often tested in real-world contexts, particularly when power differentials, implicit bias, or systemic pressures are at play.

Informed consent is frequently undermined when counseling directs individuals toward specific contraceptive choices rather than supporting autonomous decision-making, is time-limited, or is not provided in a language that is accessible to the individual. Studies have shown that clients may not fully understand side effects, method reversibility, or alternatives—particularly when under pressure to choose a specific method or when dealing with providers perceived as authority figures [46,51].

Autonomy can also be compromised when counseling is provided in institutional settings—such as shelters, detention centers, or hospitals—where individual may feel obligated to comply with recommendations or fear reprisal if they refuse [25].

To mitigate these risks, ethical counseling requires not only clear, culturally appropriate information but also an environment in which individuals feel free to ask questions, express doubts, and decline methods without judgment or consequence [94].

Overall, the literature highlights both important advances and persistent gaps in the quality, equity, and ethical delivery of contraceptive counseling across populations. Tables 1 and 2 provide a narrative synthesis of recurrent strengths, weaknesses, challenges, and ethical considerations identified across the reviewed studies. These tables summarize themes that emerged repeatedly during thematic analysis and are intended to illustrate overarching patterns within the literature rather than provide a quantitative frequency analysis.

To provide illustrative examples of the evidence identified across the major thematic areas of the review, selected representative studies were summarized in Supplementary Table S1.

Table 1. Strengths and gaps in contraceptive counseling.

Domain	Strengths	Gaps
Counseling approach	Personalized counseling	Directive practices
Communication	Person-centered interaction	Limited time/technical language
Provider competencies	Use of evidence-based models	Insufficient training
Service organization	Digital support/follow-up	Fragmented care
Equity	Culturally adapted interventions	Persistent disparities

Table 2. Challenges and ethical issues in special populations.

Population	Challenges	Ethical Issues
Adolescents	Confidentiality/legal barriers	Autonomy vs. protection
Migrants	Language/cultural mismatch	Risk of coercion
Women with disabilities	Limited access/invisibility	Informed consent
Socially vulnerable women	Fragmented care/instability	Reproductive coercion

4. Discussion

The findings of this narrative review reveal a multidimensional landscape of contraceptive counseling, characterized by important advances in person-centered care but also persistent gaps that hinder equitable and effective delivery. This discussion synthesizes key insights from the literature, explores clinical and policy implications, and connects the state of contraceptive counseling with broader public health objectives, particularly in relation to reproductive autonomy, health equity, and person-centered reproductive healthcare.

4.1. Critical Synthesis: Strengths and Weaknesses in Context

A central strength emerging across studies is the increasing adoption of person-centered models such as shared decision-making (SDM), motivational interviewing (MI), and culturally tailored counseling. These approaches have consistently demonstrated improvements in client satisfaction, method continuation, and alignment between chosen methods and individual preferences [11,50]. The shift away from directive or paternalistic counseling models toward approaches that prioritize empathy, autonomy, and relational trust is a significant achievement in reproductive health practice.

However, the review also exposes deep and systemic weaknesses that limit the impact of even the most theoretically sound counseling models. These include provider bias, structural inequalities, under-resourced systems, and inadequate provider training in communication and ethics [7,59]. Despite the emphasis on individualized care, counseling remains uneven in quality, particularly for socially marginalized populations such as adolescents, migrants, and women with disabilities [62,77].

In addition, there remains a widespread tension between informational sufficiency and emotional engagement. Although contemporary frameworks such as Shared Decision-Making (SDM) and Motivational Interviewing (MI), together with recommendations from WHO, CDC, and NICE, promote individualized and collaborative counseling, many real-world encounters continue to fall short in addressing emotional ambivalence, relational contexts, or cultural belief systems that shape contraceptive decisions [6,19,20].

The quality and outcomes of contraceptive counseling are influenced by interconnected clinical, ethical, sociocultural, and health system determinants.

4.2. Clinical Implications: Toward High-Quality, Equitable Counseling

From a clinical perspective, the findings underscore the need to reframe contraceptive counseling as a relational and ethical encounter, rather than a purely clinical transaction. Clinicians should be equipped not only with technical knowledge about contraceptive methods but also with the interpersonal skills necessary to foster trust, elicit person values, and adapt recommendations to each individual's context.

Training programs for healthcare professionals—both pre-service and continuing education—must go beyond method-focused content to include competencies in trauma-informed care, cultural humility, and non-directive communication [68]. These trainings should be evaluated rigorously and integrated into licensure and quality assurance standards.

Furthermore, contraceptive counseling should be treated as an ongoing process, rather than a single-point intervention. Especially in primary care, postpartum care, or HIV clinics, there are multiple opportunities to revisit contraceptive preferences, reassess needs, and offer method switching or discontinuation support as appropriate [67].

Counseling should also address external barriers to contraceptive use, such as cost, transportation, and clinic hours, through referrals, community partnerships, or integration with broader sexual and reproductive health services. Integrating digital tools, such as decision aids or follow-up apps, can supplement counseling and reinforce person autonomy when designed thoughtfully and inclusively [2,49].

4.3. Ethical Considerations and the Importance of Reproductive Justice

The ethical challenges identified—particularly those related to coercion, informed consent, and access—highlight the importance of embedding contraceptive counseling within a reproductive justice framework. Reproductive justice extends beyond individual choice to include the social, economic, and political conditions that enable or constrain meaningful reproductive autonomy [29,72]. Counseling practices that fail to account for these contextual factors risk reinforcing structural inequalities under the guise of neutrality or efficiency.

For example, while long-acting reversible contraceptives (LARC) are highly effective and convenient for many, their promotion—particularly among low-income women and women of color—must be balanced with an awareness of historical abuses and contemporary power imbalances [51]. Counseling must be vigilant in avoiding coercive dynamics, especially in institutional settings such as prisons, shelters, or immigration detention centers where individuals may lack full freedom to make choices [75,82].

To ensure ethical integrity, contraceptive counseling should adhere to three core principles:

1. Voluntariness—Clients must feel genuinely free to choose or refuse any method.
2. Comprehension—Information must be presented in an understandable, accessible, and culturally appropriate format.
3. Support—Counseling must provide emotional and logistical support for decision-making over time.

Healthcare systems should establish feedback mechanisms, such as anonymous client satisfaction surveys or qualitative exit interviews, to monitor for coercive practices and identify opportunities for improvement [95].

4.4. Contributions to Public Health Objectives

Improving the quality and equity of contraceptive counseling is not only a clinical and ethical imperative but also a public health priority. High-quality counseling can support informed decision-making, reproductive autonomy, and equitable access to contraceptive care across diverse populations.

Moreover, person-centered counseling strengthens reproductive agency and aligns with global goals such as Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs)—specifically SDG 3 (good health and well-being) and SDG 5 (gender equality) [92,94]. By reducing barriers to informed, autonomous decision-making, counseling contributes to broader efforts to close gender and health equity gaps.

Evidence also suggests that when individuals feel respected, informed, and supported in their contraceptive decisions, they are more likely to engage with other aspects of preventive and primary care, improving overall health system responsiveness and trust [71].

4.5. Recommendations for Policy and Systems-Level Change

To translate existing evidence into sustainable practice, coordinated systems-level changes are required to strengthen the quality and equity of contraceptive counseling. First, mandatory and adequately funded training programs in person-centered contraceptive counseling should be implemented across all healthcare professions. Such initiatives should extend beyond technical knowledge of contraceptive methods to include competencies in communication, cultural humility, trauma-informed care, and ethical decision-making. Strengthening these competencies may enable providers to more effectively support informed and autonomous contraceptive decision-making [15,68].

Second, reproductive justice principles should be systematically integrated into clinical guidelines, quality indicators, and accreditation standards. This approach acknowledges the influence of social drivers of health such as poverty, migration status, gender inequality, exposure to violence, and experiences of sexual exploitation or human trafficking on reproductive decision-making. Embedding reproductive justice into policy frameworks can contribute to more equitable counseling practices and reduce the risk of coercive or directive interactions [29,72].

In addition, healthcare systems should invest in culturally and linguistically tailored counseling tools, including accessible materials for individuals with disabilities or limited health literacy. Decision aids, digital platforms, and educational resources designed in collaboration with target communities can improve comprehension, engagement, and satisfaction with contraceptive services [7,88].

Furthermore, accountability mechanisms are needed to monitor potential disparities in contraceptive provision and to identify coercive dynamics in clinical practice. The implementation of person-reported experience measures, anonymous feedback systems, and qualitative service evaluations may support continuous quality improvement and safeguard reproductive autonomy [25,96].

Finally, contraceptive counseling should be more effectively integrated into broader sexual and reproductive health strategies, including HIV care, maternal and postpartum services, adolescent health programs, and primary care pathways. Ensuring continuity of counseling across the life course can facilitate timely method switching, support adherence, and reduce missed opportunities for preventive care [61,76].

In addition, policy-level interventions are necessary to address structural and financial barriers that continue to limit equitable access to contraceptive counseling and services. Healthcare systems should ensure adequate funding for reproductive health programs, reduce out-of-pocket costs associated with contraceptive methods and follow-up care, and promote policies that facilitate timely access to counseling across diverse settings. Addressing economic barriers and strengthening service availability may be particularly important for adolescents, migrants, low-income populations, and individuals living in underserved areas. Such measures can complement provider-level interventions and contribute to reducing persistent disparities in reproductive healthcare access and outcomes.

Health systems must also allocate adequate time and organizational resources to enable meaningful person-provider engagement. Time-constrained or overly standardized counseling encounters may ultimately compromise both clinical effectiveness and the ethical foundations of person-centered reproductive care [70,87].

4.6. Future Directions and Research Gaps

Despite significant advancements in the theory and practice of contraceptive counseling, numerous knowledge gaps and implementation challenges persist. These gaps must be addressed through targeted research, interdisciplinary collaboration, and the development of scalable, context-specific innovations. The literature reviewed highlights

three major priorities for future inquiry and intervention: (1) qualitative exploration of users' experiences and perspectives, (2) rigorous evaluation of novel and hybrid counseling models, and (3) structured training programs that can be adapted across settings and populations [71].

Future research should also prioritize populations that remain underrepresented in the contraceptive counseling literature, including transgender and gender-diverse individuals, people affected by sexual exploitation or human trafficking, and other groups facing intersecting forms of social marginalization. Greater attention to these populations is needed to ensure that contraceptive counseling models are inclusive, equitable, and responsive to diverse reproductive health needs.

4.7. Understanding Subjective Experiences: The Need for Qualitative Research

While quantitative studies have established associations between counseling quality and contraceptive outcomes, they often fail to capture the complexity of persons' emotional, cultural, and relational experiences. Qualitative research offers a unique lens to examine how users interpret counseling encounters, negotiate decisions, and define what constitutes respectful and empowering care [35].

Existing studies have shown that user satisfaction is shaped not only by the information provided but also by the interpersonal dynamics of the interaction—such as tone, trust, and perceived respect [48,97]. However, there is a lack of in-depth data from underrepresented groups, including transgender individuals, survivors of sexual violence, and those with mental health conditions. Expanding qualitative methodologies (e.g., narrative interviews, participatory action research) in diverse contexts will allow for more inclusive, person-informed counseling frameworks [98,99].

4.8. Evaluating New and Integrated Models of Counseling

There is growing interest in hybrid models of contraceptive counseling that combine digital tools, peer support, and community-based approaches. While promising, these innovations remain under-evaluated. Randomized controlled trials and implementation studies are needed to assess their efficacy, acceptability, and cost-effectiveness across different health system environments [53].

For example, mHealth-based decision aids and chatbot-assisted counseling show potential for expanding access in low-resource or remote areas. However, their actual impact on autonomy, method satisfaction, and equity remains insufficiently explored [38,55]. Similarly, group-based counseling sessions or community health worker-led models—particularly in humanitarian or rural settings—require further investigation to establish best practices and sustainability [74].

Moreover, research is needed to determine how counseling can be better integrated into chronic care pathways (e.g., HIV, diabetes, or mental health care), especially in contexts where reproductive health is still siloed from general services [76].

4.9. Designing and Evaluating Training Programs for Providers

Despite widespread recognition of the importance of provider communication skills, few counseling training programs have been rigorously developed, tested, and scaled. There is a critical need for curricula that include experiential learning, simulation, and feedback mechanisms to enhance not just knowledge but also ethical reasoning, cultural humility, and person engagement skills [100].

Training initiatives should be context-sensitive and adaptable for different cadres of providers—from physicians and nurses to midwives and community health workers. They should also be accompanied by structural supports such as mentoring, supervision, and performance evaluation tools [83].

Studies should assess not only provider outcomes (e.g., attitudes, confidence) but also person-centered metrics such as satisfaction, method continuation, and perceived autonomy [16,56].

4.10. Cross-Cutting Research Gaps

In addition to the above, several cross-cutting issues merit urgent attention. Each represents a domain where the current evidence base remains insufficient to fully inform clinical practice or policy, and where targeted research investment would yield substantial gains for both individual persons and health systems.

The first cross-cutting gap concerns reproductive coercion and informed consent. Although the phenomenon has been documented across multiple contexts, the literature continues to rely heavily on retrospective accounts and lacks validated tools for prospective identification of subtle or structural forms of coercion. This gap is especially acute in closed institutional settings—such as prisons, detention centres, and emergency departments—where power asymmetries between person and provider are heightened and independent person advocacy is limited. Research that maps the specific mechanisms through which coercive dynamics emerge in these environments, and that rigorously tests intervention strategies to safeguard meaningful informed consent, is critically needed [30]. Future studies should also explore how multiple identities (e.g., race, gender, disability, migration status) intersect to shape contraceptive counseling experiences and how implicit and explicit provider biases may influence these interactions, adopting an intersectional perspective [79].

Furthermore, there remains a pronounced scarcity of policy and health systems research examining how institutional structures shape the quality of contraceptive counseling. Financing models, regulatory frameworks, provider credentialing requirements, and organisational priorities all exert powerful upstream influences on what happens within the counseling encounter itself. Yet these structural determinants have received comparatively little systematic attention in the empirical literature. Comparative analyses of health systems—particularly those that contrast models with strong primary care integration with those that deliver reproductive health services in fragmented or vertically organised programmes—could yield important insights into how policy levers may be used to improve both equity and quality [58,97].

Addressing these gaps will not only improve the effectiveness and equity of contraceptive counseling but also contribute to broader efforts to promote reproductive justice and health system responsiveness.

5. Conclusions

Contraceptive counseling has evolved from a predominantly information-based intervention to a person-centered process aimed at supporting informed and autonomous reproductive decision-making. This review highlights that personalized, respectful, and culturally responsive counseling is associated with improved satisfaction, method continuation, and reproductive autonomy. However, important challenges remain, including provider bias, inadequate training, fragmented services, and persistent inequities affecting adolescents and other vulnerable populations. Strengthening communication skills, integrating reproductive justice principles, and promoting continuity of counseling across healthcare settings are essential to improve quality and equity of care. Ultimately, contraceptive counseling should be understood not merely as a clinical activity but as a key component of reproductive health systems capable of supporting informed choice, person autonomy, and equitable access to care.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/adolescents6040049/s1>, Table S1. Representative studies supporting the thematic findings included in the narrative review.

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