

FAMILY HEALTH RESEARCH

A forum for putting knowledge into practice

NOVEMBER 2007 VOLUME 1, ISSUE 3

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TOOLS FOR SERVICE DELIVERY

In this issue of our quarterly newsletter, we present materials that can help health care workers provide better family planning services.

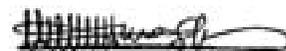
These tools for service delivery offer ready reference and practical guidance to providers, based on the most current evidence from research and programs. This issue examines some of the research behind such tools, and it reports on efforts to encourage their use.

A new international publication for family planning providers (described on page 2), brings together many service delivery tools in one easy-to-use handbook. The tools include instructions for what a woman should do if she forgets to take contraceptive

pills (see page 3) and FHI's checklists for determining a client's eligibility for various contraceptive methods (see pages 4 and 8).

In countries including Uganda (see page 8) and Kenya, FHI is working with partners to promote a package of service delivery tools. This package (described on page 8) is designed to guide providers so that they can help their clients make informed choices about safe and effective use of contraception.

We hope you find this issue of our newsletter useful and informative. We would also like to hear from you. Please send your comments to familyhealthresearch@fhi.org.



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In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

Visit us at www.fhi360.org.

WHO'S FOUR CORNERSTONES OF FAMILY PLANNING GUIDANCE

- **Decision-Making Tool for Family Planning Clients.** <http://www.searo.who.int/EN/Section13/Section36/Section129/Section1920.htm>
- **Family Planning: A Global Handbook.** <http://www.fphandbook.org>
- **Medical Eligibility Criteria for Contraceptive Use.** <http://www.who.int/reproductive-health/publications/mec/>
- **Selected Practice Recommendations for Contraceptive Use.** <http://www.who.int/reproductive-health/publications/spr/>

GLOBAL FAMILY PLANNING HANDBOOK

A new resource provides evidence-based recommendations for providers.

Health care providers with questions about a client's eligibility for the contraceptive method she desires or with concerns about counseling a client on the relative merits of a method can now turn to a comprehensive handbook for advice based on the best available scientific evidence.

Family Planning: A Global Handbook is one of the World Health Organization's (WHO's) "four cornerstones" of family planning guidance (see left). It is published by the WHO, the Johns Hopkins Bloomberg School of Public Health, and the U.S. Agency for International Development.

The handbook complements the other cornerstone documents by helping providers apply research findings in their everyday practice, explains Dr. Irina Jacobson, FHI's assistant medical director, who served as one of the six key technical advisors to its authors. "We realized that we needed to translate the international guidelines and the evidence behind them into practical recommendations," she said. "The evidence is more or less universal, but how you act on it may vary in different situations."

Consensus recommendations

The handbook is designed to help family planning providers serve the needs of their clients at all levels of a health care system. Its content represents a consensus among technical experts from more than 30 organizations in many countries, built through a collaborative process that included several expert meetings and frequent consultation.

The format and organization of the handbook are similar to those of the publication it replaces, *The Essentials of Contraceptive Technology*, which was first published by the Johns Hopkins Center for Communication Programs in 1997. The information in the new book has been updated and expanded, with many new features.

The core of the book consists of 19 chapters about contraceptive methods, including how a method works, its effectiveness and side effects, how to provide it to a client, and how to support its continued use. Other chapters address important service delivery topics. A section at the back of the book contains job aids and other tools for providers.

Encouraging use

The handbook's authors, advisors, and publishers will work with colleagues from the 46 leading family planning and health organizations that endorsed the publication to encourage providers to use it. They expect the book to be used as a daily reference for family planning providers, but also to revise clinical practice guidelines and to develop or update training courses. By the end of September 2007, more than 40,000 copies of the handbook had been distributed, and it was being translated into nine languages.

Obtaining copies

Family Planning: A Global Handbook is available free of charge to readers in developing countries. Copies may be ordered by mail from: Orders, INFO Project, Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health, 111 Market Place, Suite 310, Baltimore, MD 21202, USA; by telephone at 1.410.659-6315; by fax at 1.410.659.6266; or by e-mail at orders@jhuccp.org. The handbook or individual chapters can be downloaded at <http://www.fphandbook.org>.



THE GLOBAL HANDBOOK: WHAT'S NEW

- Expanded coverage of methods such as emergency contraceptive pills, female condoms, and new and simpler fertility awareness methods
- Lists of reported side effects, health benefits, and health risks of methods
- Updated checklists on medical eligibility
- More on how to manage common problems with contraceptive use
- Guidance on family planning methods for people with HIV
- New sections on topics such as adolescents, men, women nearing menopause, maternal and newborn health, infertility, and infection prevention

MISSED-PILL INSTRUCTIONS

FHI research leads to clearer guidance for oral contraceptive users.

Inconsistent use and other incorrect uses of oral contraceptive pills are a major cause of unintended pregnancy. Research suggests that many clients and even some family planning providers are not sure what a woman should do when she fails to take her pills regularly.

Users of the World Health Organization's (WHO's) instructions on what to do after missing one or more pills in a cycle reported that the instructions were difficult to follow and to explain to clients. Published in *Selected Practice Recommendations for Contraceptive Use*, the instructions were scientifically accurate but complicated.

The WHO and other organizations have worked together to simplify their missed-pill instructions. Some of these simplified versions were field tested with providers, but until recently, no one had examined how well they were understood by oral contraceptive users.

FHI assessed comprehension of four different types of missed-pill instructions among 864 current and past users of oral contraception in Kingston, Jamaica. The study's participants were asked to use one of four sets of instructions to determine what should be done in eight to 10 different scenarios. In each scenario, a woman had forgotten to take one or more pills in either a 21-day or 28-day cycle.

Results

More than 60 percent of the respondents knew what to do when one pill was missed, but most did not give the correct answer for missing two or more pills on consecutive days, no matter which instructions they used. The women found the three instructions that used graphics easier to understand than the text-only version. Of those three, the two that had been simplified proved easier for the women to comprehend.

Impact on service delivery

"The FHI study provided valuable evidence for the need to simplify the rules and to provide easy-to-follow instructions to pill takers," said Sarah Johnson of WHO's Department of Reproductive Health and Research.

Experts convened by the WHO in 2004 to make recommendations for the second edition of *Selected Practice Recommendations* used the study results to develop a simpler version of the missed-pill instructions with graphics. It focuses on the mistakes most likely to lead to unintended pregnancy — missing three or more pills, particularly in the third week.

The new missed-pill instructions were first published in the 2004 edition of *Selected Practice Recommendations*, which has been used in countries throughout the world to update service delivery guidelines and training curricula. They also appear on the inside back cover of the new global handbook for family planning providers (see page 2).

KEYPOINTS

- Failure to take pills regularly may cause many unintended pregnancies.
- Complex instructions on what to do after missing pills are difficult to understand.
- Using graphics to convey a few messages improves a pill user's comprehension.

If You Miss Pills

Always take a pill as soon as you remember, and continue taking pills, one each day.
Also...



If you miss 3 pills or more, or if you start a pack 3 days or more late:



Use condoms or avoid sex for the next 7 days

OR



FOR



If you miss those 3 pills or more in week 3:



Use condoms or avoid sex for the next 7 days



Also, skip the non-hormonal pills (or skip the pill-free week) and start taking pills at once from the next pack



If you miss any nonhormonal pills (last 7 pills in 28-pill packs only):



Discard the missed pills and continue taking pills, one each day



KEYPOINTS

- FHI's checklist is highly effective in ruling out pregnancy.
- Use of this screening tool helps women access family planning.
- Four FHI checklists facilitate client screening.

PREGNANCY CHECKLIST FOR PROVIDERS

A simple screening tool improves access to family planning.

When a woman says she wants to begin using a contraceptive method, her family planning provider may ask her if she is having her period. Providers often rely on the presence of menstruation to rule out pregnancy when laboratory tests are unavailable or unaffordable.

Family planning providers are required to determine whether a woman might already be pregnant before giving her a hormonal method, inserting an intrauterine device, or performing a sterilization procedure because of concerns about possible harm to an unrecognized pregnancy and because pregnant women do not need contraception. But if a client is not having her period, she may be sent home empty handed.

FHI studies in Kenya, Senegal, Mali, Egypt, and Guatemala found that from 17 percent

to 47 percent of all new, nonmenstruating family planning clients were denied their desired contraceptive methods because of their menstrual status. Most of these clients were sent home without any method, which put them at risk of unintended pregnancy.

But the evidence from several FHI studies shows that a woman need not wait until she is menstruating to receive her contraceptive method of choice. These studies assessed the effectiveness of a simple checklist that FHI designed to help providers rule out pregnancy among clients who wish to initiate contraceptive use.

Part of a series of screening tools that FHI has developed and tested (see list, page 5), the pregnancy checklist consists of six questions a provider can ask a woman while taking her medical history. These questions are based on criteria established by the World Health Organization to help providers rule out pregnancy with a reasonable degree of certainty.

The FHI studies found that if a client answers yes to any of the questions and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure the woman is not pregnant.

Ruling out pregnancy

FHI tested the validity of the checklist against a standard pregnancy test among 1,852 new family planning clients at seven clinics in three regions of Kenya in 1999. The study was repeated among 1,000 women in Egypt in 2005 and with 263 women in Nicaragua in 2004 and 2005.

In all three studies, the checklist correctly identified women who were not pregnant 99 percent of the time.

Overall, only 1 percent to 2 percent of the women who sought family planning services had a positive pregnancy test. "Given the low prevalence of pregnancy and the serious health consequences of unintended pregnancy, the real risk was that many women who were not pregnant would have been unjustifiably denied essential family planning



Family planning service providers at Koibatek District Hospital in Eldama Ravine, Rift Valley Province, have posted the checklists on the wall for easy reference.

services,” noted Dr. John Stanback, principal investigator of the study and a senior associate in FHI’s Health Services Research Division.

Improving access to services

From 2001 to 2003, FHI conducted operations research among 4,823 women at 16 family planning clinics in Guatemala, Mali, and Senegal to determine whether introducing the pregnancy checklist would improve women’s access to contraceptives services. The study found that the checklist was helpful in Guatemala and Senegal, where a substantial number of new clients were denied such services because they were not menstruating.

Among new family planning clients, those who were denied their desired method because of their menstrual status declined significantly, from 16 percent to 2 percent of new clients in Guatemala and from 11 percent to 6 percent of new clients in Senegal. In Mali, where the denial rate was only 5 percent of new clients before the checklist was introduced, it remained essentially unchanged (see figure). Reducing such a low denial rate may not have been feasible.

Impact on service delivery

After the results of the operations research were presented in Senegal, the country’s Ministry of Health (MOH) had the pregnancy checklist translated into Wolof and incorporated into the national family planning guidelines and the client cards used in contraceptive counseling. The results also prompted use of the checklist in clinics run by the national family planning association in Guatemala.

Since then, the pregnancy checklist has been used in at least 15 countries, often together with three additional checklists that FHI developed to help providers determine a client’s eligibility for contraceptive services (see list, far right). And FHI has worked with ministries of health and nongovernmental organizations in a number of countries to incorporate these checklists into practice.

- In the Dominican Republic, a 2007 assessment among 61 of the 1,700 MOH employees who had been trained to use the checklists in 2006 found that most of these clinicians were using the materials at least once a week.
- In Kenya, the MOH’s Department of Reproductive Health worked with FHI to adapt the checklists and is training providers to use the new versions, with plans to disseminate 5,000 copies in English and Kiswahili.
- In Uganda, where the MOH also adapted the provider checklists and incorporated them into various training courses, the checklists are in widespread use among family planning providers, nurse-midwives, and community-based health workers.

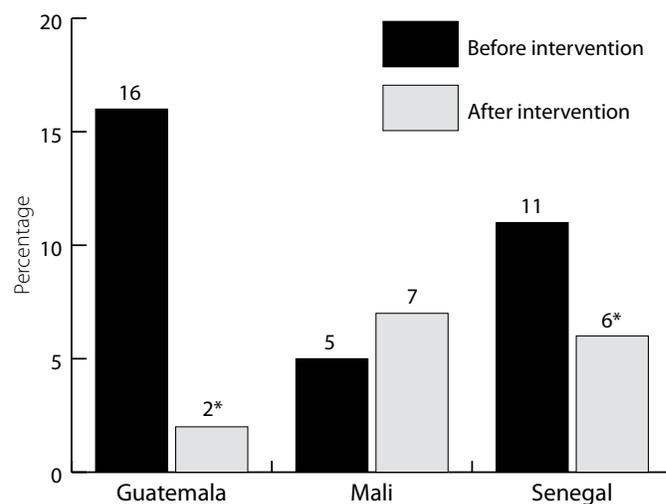
FHI continues to promote the use of its checklists to improve women’s access to contraceptive services. By September 2007, FHI had responded to requests for almost 10,000 copies of the checklists for use in a dozen countries. Inclusion of the pregnancy checklist in the new global handbook for family planning providers (see page 2) will encourage its use in other countries throughout the world.

FHI’s Provider Checklists

- *How to Be Reasonably Sure a Client Is Not Pregnant*
- *Checklist for Clients Who Want to Initiate COCs*
- *Checklist for Clients Who Want to Initiate DMPA (or NET-EN)*
- *Checklist for Clients Who Want to Initiate Use of the Copper IUD*

The checklists, along with a reference guide to their use and other resources, can be downloaded at: <http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/index.htm>.

Percentage of all new family planning clients denied their desired method as a result of their menstrual status before and after the checklist intervention, 2001–2003



* Difference is significant at $p \leq 0.001$.

KEYPOINTS

- Family planning is being integrated into one of the world's largest HIV projects.
- HIV project staff members recognize that their clients need family planning services.
- Providers of family planning and of HIV services are trained in contraception for HIV-positive clients.



Nursing mothers listen to a GHAIN health educator in Kano, Nigeria. By September 2007, GHAIN had provided antiretroviral treatment to more than 14,000 people. In its first three years, the project also gave counseling and HIV test results to almost 700,000 people and provided a complete course of antiretroviral prophylaxis to more than 4,300 women.

INTEGRATING SERVICES IN NIGERIA

HIV project trains providers in family planning.

Family planning services and HIV care and treatment are usually offered separately, resulting in many missed opportunities to address clients' needs.

But that is beginning to change. One notable example is the Global HIV/AIDS Initiative Nigeria (GHAIN), which has begun training its providers of HIV services in family planning.

This step is significant because GHAIN is the largest comprehensive HIV/AIDS project ever carried out in a single developing country, supporting HIV prevention, care, and treatment services in 36 hospitals in 22 states.

GHAIN is funded by the President's Emergency Plan for AIDS Relief, with additional funds from the Global Fund for Tuberculosis and Malaria, the Shell Petroleum Development Corporation, and the Clinton Foundation, among others. The U.S. Agency for International Development supports GHAIN to integrate reproductive health services with HIV prevention and treatment services.

In October 2005, GHAIN sent a consultant to a workshop that FHI held in South Africa to introduce its training module, *Contraception for Women and Couples Living with HIV*. Afterward, the consultant worked with GHAIN staff members to adapt the module into a training guide for Nigerian health care providers. Modules from the guide were then incorporated into the project's training sessions for providers of antiretroviral treatment (ART), HIV counseling and testing (CT), and services to prevent mother-to-child transmission (PMTCT) of HIV.

At first GHAIN focused on developing integrated services and providing training at 14 hospitals in Lagos State and the Federal Capital Territory. But GHAIN's technical advisors saw a

need to expand the integrated training beyond those sites, particularly for PMTCT.

"Family planning is already part of PMTCT, but it was not a strong component," said Nnenna Mba-Oduwusi, GHAIN's family planning-HIV-integration advisor. "I think it was just assumed that these providers would be up to date."

Now all GHAIN training sessions include content on family planning and contraceptive counseling. "Every time GHAIN establishes a new site, we have to train providers," said Mba-Oduwusi. "And every time that training takes place, it also includes the family planning training."

This training is designed to ensure that those providing HIV counseling and testing are able to give clients accurate information about their contraceptive options and to refer them to appropriate family planning services. PMTCT and ART providers receive more comprehensive training that includes a thorough grounding in the medical eligibility criteria for contraceptive use by HIV-infected women and couples.

GHAIN's technical advisors discovered that most family planning providers did not know how to advise HIV-positive clients. So GHAIN now offers family planning providers at the integrated sites a two-day training course that covers HIV issues such as confidentiality and stigma, as well as contraception for people living with HIV.

At the integrated sites, GHAIN strengthens systems for referring clients between HIV and family planning services and monitors integration efforts. The results will help guide further expansion to a total of 24 sites.

By September 2007, which marked the end of the first year of training, a total of 638 GHAIN providers had been trained in integrated services and more than 100 trained staff members were providing integrated services at the 14 integrated sites. Data from those sites shows that 611 ART, PMTCT, and CT clients had received family planning counseling or services, and family planning providers had referred more than 1,400 clients for HIV counseling and testing.

CONTRACEPTIVE EFFECTIVENESS

A simple chart helps clients understand risks and benefits.

Effectiveness is often the most important consideration when a woman chooses a contraceptive method. But many women do not understand how well various methods protect against pregnancy.

Providers usually explain effectiveness by informing their clients of the pregnancy rates for each method during typical use and during times when it is used consistently and correctly (perfect use). A randomized trial conducted by FHI among 461 U.S. women in 2001, however, found that this level of detail was confusing to many women.

The trial showed that a woman's knowledge of a method's effectiveness was significantly better when the information was presented in a simple chart that describes different contraceptive methods as either "more effective," "less effective," or simply "effective." The trial's participants did not understand the information as well when it was presented in two widely used charts that state the pregnancy rates associated with the methods.

In a follow-up study, FHI researchers worked with colleagues from the World Health Organization (WHO) and the INFO Project at the Johns Hopkins Bloomberg School of Public Health to refine the simplified effectiveness chart. This working group developed three charts depicting the relative effectiveness of contraceptive methods — rather than the pregnancy rates — in different ways.

FHI then compared the three charts in a study among 450 women in India and 450 women in Jamaica. In each country, one-third of the study's participants were randomly assigned to use one of the charts. Each woman was asked two key questions about the relative effectiveness of various contraceptive methods before and after looking at a chart.

Results

In both India and Jamaica, more than half of the study's participants said that their most important reason for choosing a method was how well it prevents pregnancy. Many participants grossly overestimated the risk of pregnancy for a given category of effectiveness before looking at the one of charts.

Each of the three charts helped the participants answer the two questions. The number of women who answered a question correctly increased by 24 percent to 32 percent.

No chart improved knowledge significantly more than another, but the women said they found the simplest chart — which places contraceptive methods on a continuum from least to most effective — slightly easier to understand.

Impact on service delivery

The chart showing a continuum of effectiveness was finalized at a WHO expert working group meeting in June 2005. It appears on the back cover of the new global handbook for family planning providers (see page 2).

Electronic copies of the effectiveness chart can be downloaded at <http://www.fhi.org/nr/shared/enFHI/Resources/EffectivenessChart.pdf> and used without permission.

KEYPOINTS

- Informed choice requires an accurate understanding of risks and benefits.
- A simple chart evaluated by FHI improves a client's knowledge about the effectiveness of contraceptive methods.
- The chart is presented in a new global handbook for family planning providers.



FAMILY HEALTH RESEARCH is a newsletter of the FHI Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) program, which is supported by the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement No. GPO-A-00-05-00022-00. The contents do not necessarily reflect the views of USAID.

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Cover, page 6: Aminu Sarki/FHI

Page 2: David Alexander/courtesy
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November 2007
Volume 1, Issue 3

COLLABORATIONS

UGANDA ADAPTS CHECKLISTS

Provider tools introduced to facilitate client screening.

The Ministry of Health (MOH) is promoting the use of four simple checklists to improve women's access to contraception in Uganda. Adapted from similar tools developed and tested by FHI (see pages 4–5), these checklists help family planning providers determine whether clients are eligible to use various contraceptive methods.

Modern contraceptive methods are generally safe and effective for use by most women, including those who have not given birth, those who want to space births, those living with HIV, or those at risk of HIV infection. But some methods are not suitable for women with medical conditions such as genital cancer, high blood pressure, or current pelvic inflammatory disease. A woman who wants to initiate family planning must be screened for these medical conditions to determine whether she is an appropriate candidate for a particular method.

In the past, such screening usually involved laboratory tests and physical examinations. But current World Health Organization (WHO) recommendations state that tests and examinations do not contribute substantially to the safe and effective use of hormonal contraception. For a woman with a known condition, a self-reported medical history using a simple checklist is all that is needed to determine whether she is medically eligible to use a hormonal method. A similar checklist can help providers screen candidates for an intrauterine device (IUD), but a pelvic examination is also required.

Evidence-based tools

Three of the four FHI checklists were developed to help providers determine quickly and with confidence whether a client may safely use a particular method. The methods addressed are IUDs, injectable depot-medroxyprogesterone acetate (DMPA), and combined oral contraceptives.

The fourth checklist enables family planning providers to be reasonably sure a client is not pregnant before providing her with a contraceptive method (see page 4). It also can be used by health care providers who need to rule out pregnancy in a client before she begins a medical regimen.

The four checklists are based on the most current scientific research on safe contraceptive use, as recommended by the 2004 WHO guidelines for *Medical Eligibility Criteria for Contraceptive Use*.

Using checklists in Uganda

After working with FHI to adapt the checklists to the Ugandan context, the MOH endorsed them and printed 20,000 copies with its logo. Since then, the Ugandan checklists have been widely used by family planning providers and trainers. The MOH, with support from FHI, held a series of continuing medical education workshops in 2005 and 2006 to update provider skills and to disseminate the checklists.

Partners of the MOH and FHI report that the checklists are useful to community-based family planning workers, helping them safely screen potential clients for hormonal contraceptives.

To encourage their sustained use, the checklists have been introduced into nurse-midwife training courses. Family planning tutors and principals in nurse-midwife training schools in Mulago, Nsambya, Rubaga, and Mengo received training on the checklists, and they were given sufficient copies for all final-year students and their school libraries.

Please contact FHI or the MOH's Reproductive Health Division to request technical assistance, copies of the checklists in various languages, and the *Checklist Training and Reference Guide*.