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# Four strategies to help women use combined oral contraceptives

**Kerry Aradhya**, Senior Science Writer, **Tricia Petruney**, Technical Officer, **Kathleen Shears**, Senior Science Writer, Family Health International, Research Triangle Park, NC, USA; and **Christine Lasway**, Senior Technical Officer, Family Health International, Dar es Salaam, Tanzania

## The strategies

- Use a simple eligibility checklist to rule out pregnancy and medical conditions that may preclude the safe use of oral contraceptives.
- Provide a woman with oral contraceptives before she plans to start using them, for example when you cannot rule out pregnancy during her first clinic visit.
- Start a woman on oral contraceptives during her first clinic visit, regardless of the time in her menstrual cycle, as long as you can be reasonably sure she is not pregnant.
- Promote the World Health Organization's updated instructions on what a woman should do if she misses one or more pills in a pill cycle.

More than 100 million women are using combined oral contraceptives (those that contain both estrogen and progestin) to prevent pregnancy. This makes them the most popular hormonal method of birth control in the world. Yet medical barriers still stand in the way for many eligible women who want to use oral contraceptives.

Some healthcare providers have misconceptions about what medical conditions restrict a woman's use of oral contraceptives. Others are reluctant to offer a woman pills unless she is menstruating at the time of her clinic visit, for fear that she might be pregnant. Another problem is that some women have trouble remembering to use oral contraceptives regularly. Inconsistent or incorrect use of the pills can decrease their effectiveness. It can also exacerbate side-effects such as intermenstrual bleeding and spotting, which can lead to early discontinuation. Any of these situations can leave a woman at risk of an unintended pregnancy.

'Contraceptive access, as well as

good information and counselling, are important factors in whether a woman chooses to use oral contraceptives and in whether she continues using them correctly,' says Pamela Lynam, a reproductive health expert based in Nairobi. Lynam is the regional technical director for East and Southern Africa for Jhpiego (an affiliate of Johns Hopkins University) and has seen firsthand how medical barriers can limit contraceptive access. 'It is essential that we continue to develop strategies to overcome these barriers and give African women better opportunities to use the methods of birth control they choose – hormonal or otherwise,' she says.

## Check it off

Research has established that combined oral contraceptives are safe for use by most women, including those who are at risk of sexually transmitted infections and those living with or at risk of an HIV infection. However, the use of combined oral contraceptives is not recommended for women with certain medical conditions, such as breast cancer, ischemic heart disease, or stroke.<sup>1</sup> A woman who



Service providers from Senegal's Thies District participate in a family planning and reproductive health training on interpersonal communication and counselling. Here, the counsellor in training discusses oral contraceptives.

wishes to use combined oral contraceptives should be screened for these medical conditions to determine if she is an appropriate candidate.

Breast and pelvic exams, pregnancy tests, and other physical exams and laboratory tests are not necessary to screen a woman for oral contraceptive use. A self-reported medical history is all that is needed, even if a woman has a known medical or other condition.

To help determine a woman's eligibility for combined oral contraceptives, scientists at Family Health International (FHI) have developed a simple 17-question checklist that providers can use in place of a medical history (see 'Tools for providers'). The current version of the checklist is based on the most recent recommendations from the *Medical Eligibility Criteria for Contraceptive Use*, which the World Health Organization (WHO) last updated in 2008.<sup>1</sup>

'The checklist was originally designed about a decade ago to help community-based health workers begin providing pills in addition to condoms,' says Irina Yacobson, an associate medical director at FHI who makes sure that the checklist stays up to date. 'It has evolved into a helpful tool for a range of clinical and nonclinical professionals including doctors, nurses, and pharmacists who provide hormonal methods,' she says.

The first 11 questions help identify medical conditions that would prevent the safe use of oral contraceptives or that require further evaluation before a woman can start using the pills. A woman who is ruled out because of her answers to some of the questions may still be a good candidate if the suspected condition can be excluded.

The last six questions help providers rule out pregnancy with a reasonable degree of certainty. If, however, a woman accidentally takes combined oral contraceptives during pregnancy, there is no evidence that they would harm her, her pregnancy, or the fetus.

### Plan ahead

When pregnancy cannot be ruled out using the checklist, or when a woman wishes to wait until her next menses to begin taking oral contraceptives, a provider should not send her home empty-handed. If a woman faces high costs or an extensive travel time to return for a supply (or resupply) of pill packets, she may never be able to start using the pills.

Advance provision is a practice in which a provider gives a nonmenstruating woman one or more packets of pills to take home and begin using once she menstruates. Research has shown that the practice is safe and feasible,<sup>2</sup> and it has the potential to reduce unwanted pregnancies. An expert working group convened by WHO recommends that a provider give a woman as many as 13 pill packets at a time, if supplies allow.<sup>3</sup>

In one small study in Kenya, a group of 48 women who received an advanced supply of oral contraceptives did not differ significantly from a control group of 629 oral contraceptive users in terms of bleeding and spotting, problems related to pill taking, compliance, and continuation of use.<sup>2</sup>

'Sadly, family planning providers in some countries are extremely unwilling to provide clients with pills for later use,' says John Stanback, the lead investigator of the Kenyan study and the deputy director of FHI's PROGRESS project to improve family planning and reproductive health in developing countries. 'This is unconscionable given the significant risks associated with unintended pregnancy and the difficulties some women face in reaching health clinics.'

### Start 'quick'

Another strategy for initiating oral contraceptives is 'Quick Start.' With this approach, a woman starts the pills under the supervision of a healthcare provider during her first clinic visit, at any point during her menstrual cycle, as long as her provider is reasonably certain that she is not pregnant. WHO had previously recommended that a provider rule out pregnancy and then give a woman



Family planning providers at Koibatek District Hospital in Kenya's Rift Valley Province post checklists, including the checklist for clients who want to initiate combined oral contraceptives, on the wall for easy reference.

pills so she can start taking them at home the same day. Quick Start is unique in that the provider actually observes the woman taking her first pill.

Quick Start is based on the idea that delaying oral contraception until menses is counter-productive if a woman loses motivation, is confused about when to start taking the pills, or becomes pregnant while waiting for her menses.

‘We thought that starting the pill while the patient was in the clinic asking for it might address all of these issues to some degree,’ says Carolyn Westhoff, a professor of obstetrics and gynecology at Columbia University in New York and one of the developers of Quick Start.

The Quick Start approach may even help some women continue to use their pills – at least in the short-term. In a study published in 2002, Westhoff and her colleagues evaluated short-term continuation rates among 227 Hispanic women who received oral contraceptives at family planning clinics in New York.<sup>4</sup> When all the variables associated with continuation were taken into account, the women who took their first pill at the clinic were nearly three times more likely to start their second packet of pills than the women who planned to start their pills later.

Westhoff and her colleagues also conducted a randomized trial to compare continuation rates and pregnancy rates for some 1700 young women, some of whom used Quick Start and others a traditional approach to starting oral contraceptives.<sup>5</sup> The results confirmed that Quick Start increases the chances that a woman will start her second packet of pills. Although the approach did not improve longer-term continuation rates, the women in the Quick Start group were slightly less likely than the other women in the study to become pregnant within 6 months of starting the pills.

Scientists at Case Western Reserve School of Medicine (in Cleveland, Ohio) and Allegheny General Hospital (in Pittsburgh, Pennsylvania) conducted another study of Quick Start among nearly 200 young US women.<sup>6</sup> Nearly three-quarters of Quick Start initiators, compared with just more than half of the young women who were instructed to initiate their pills after their next menses, were still using oral contraceptives after 3 months. The results also

showed no differences between the groups in terms of nausea, vomiting, or breakthrough bleeding up to one year after the women started using the pills.

‘Quick Start has great potential for the developing world,’ says Stanback, ‘but we also need to make sure that providers remember that advance provision is a safe alternative for initiating pills, for example when pregnancy cannot be ruled out or for a woman who wishes to wait until her next menses to begin pill taking.’

When a woman initiates pills using Quick Start, her provider should feel secure in giving her at least three packets of pills to take home for later use if possible, Stanback adds.

### Catch up

Another strategy for helping a woman continue to use oral contraceptives is to make sure she knows what to do if she forgets to take one or more of her pills. Because many oral contraceptive failures can be linked to missed pills and incorrect use, instructions for missed pills must be easy to understand.

Many women and even some healthcare providers are not sure what a woman should do when she fails to take her pills every day. Even family planning providers who used WHO’s 2002 missed-pill instructions reported that they were difficult to follow and to explain to women. The instructions were scientifically accurate but complicated, they said.<sup>7</sup>

In a study in Jamaica, published in 2006, FHI assessed how well 864 current and past users of oral contraceptives comprehended four different sets of missed-pill instructions.<sup>8</sup> Each participant was asked to use one set of instructions to determine the course of action for 8 to 10 scenarios in which a woman had forgotten to take one or more pills in a single-pill cycle.

More than 60% of the women knew what to do when one pill was missed, but most did not give the correct answer for what to do when two or more pills were missed on consecutive days, no matter which instructions they used. The women said that the three instructions that contained both text and graphics were easier to understand than the instructions that contained only text. Of the instructions

## Tools for providers

<http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/cocchecklists/index.htm>

Clinical and nonclinical providers can use the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives* to help determine whether a woman is medically eligible to start using combined oral contraceptives. The checklist is accompanied by a training and reference guide for program managers, administrators, trainers, and providers who are interested in learning to use the checklist.

<http://www.fhi.org/en/RH/Pubs/servdelivery/index.htm#COCstratguide>

The *Combined Oral Contraceptives Strategy Guide* can support healthcare providers in implementing evidence-based strategies for helping women use combined oral contraceptives. Intended to be used alongside the eligibility checklist, the guide includes detailed information about Quick Start, advance provision, providing multiple pill packets to women who are already using oral contraceptives, and what to do if a woman misses pills.

that contained both text and graphics, the simpler versions were the easiest to understand.

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

In 2004, WHO convened an expert working group to make recommendations for the second edition of *Selected Practice Recommendations for Contraceptive Use*.<sup>3</sup> (The first edition had contained the version of missed-pill instructions that some providers found confusing.) The group used the results of the FHI study to develop a simpler version of the instructions that includes graphics. This simplified version focuses on the mistakes most likely to lead to unintended pregnancy, such as missing three or more pills, particularly in the third week of a pill cycle (see ‘If You Miss Pills’).<sup>9</sup>

### Together as one

Each of these evidence-based strategies alone has been shown to improve access to oral contraceptives, but together they may have an even bigger impact.


For instance, offering a woman Quick Start while also sending her home with extra pill packets (a variation of advance provision) gives the woman more flexibility in her family planning decisions. Allowing her to take her first pill in the clinic decreases the chance that she will be confused about initiating use, and sending her home with pill packets saves time and resources for both the woman and her provider.

‘Family planning usage is stagnating in many countries, while unmet need for contraception remains high,’ says Lynam of Jhpiego. ‘Now more than ever, we must use as many strategies as we can to make contraceptive choices available to women in Africa. We must also do all we can to make the strategies understandable, easy to use, and available to the frontline healthcare workers.’


## 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**




**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):**



Nonhormonal pills

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



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