INFORMED CHOICE: REPORT OF THE COOPERATING AGENCIES TASK FORCE

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REPORT OF THE COOPERATING AGENCIES TASK FORCE ON INFORMED CHOICE

Executive Summary

The Cooperating Agencies Task Force on Informed Choice, consisting of representatives of 17 organizations working in international family planning programs, met in April and November 1988 and in February 1989. The following recommendations represent the consensus of the CA Task Force members regarding the most important actions needed to promote informed choice in developing countries:

Recommendation No. 1

Expanded Definition of Informed Choice

Informed choice is effective access to information on reproductive choices and to the necessary counseling, services and supplies to help individuals choose and use an appropriate method of family planning, if desired. The Cooperating Agencies Task Force broadened the definition of informed choice from a choice of family planning methods to encompass various reproductive choices, including the possibility of choosing pregnancy. Thus, informed choice begins prior to the choice of a particular method, at the time when a person first learns that there is a way to control his or her fertility.

Recommendation No. 2

Continual Process

Informed choice should be seen as a continual process as new acceptors try out one method and then shift to other methods or nonuse as their needs or preferences change.

Recommendation No. 3

Method Choices

Within each given service area, an appropriate range of contraceptive methods should be available to meet the needs of various types of contraceptive users. Available methods should include male and female methods, some reversible methods which are temporary as well as long-acting ones, and permanent methods. Program administrators should strive for "effective access," which means that, at a minimum, major groups of contraceptive methods are available in each regional area of a country.

Recommendation No. 4

Referrals

Providers that offer only one or a limited range of family planning methods should tell clients where alternative methods are available, regardless of how distant they may be. Referral systems should be established and coordinated with providers at the local level, using written materials as appropriate.

Recommendation No. 5

Clinic Education

To complement counseling, service providers should seek to improve client education by using waiting areas for visual displays, lectures and audio-visual presentations and by providing client counselors with visual aids and audio-visual and print materials. Client education materials should be accurate, appropriate to their intended audience, and understandable.

Recommendation No. 6

Client Counseling

Each local institution should ensure that client counseling is done sensitively and effectively. The goal of counseling is to have the client arrive at a choice that he/she is satisfied with and, if the choice is to use contraception, to prepare the client to use his/her chosen method effectively. Counseling should be a two-way interaction, based on a positive relationship.

Recommendation No. 7

Monitoring and Evaluation

CAs and local institutions should build information needed for monitoring and evaluation of informed choice into their standard reporting requirements. Such information might include indicators that client counseling guidelines have been followed and service statistics on method mix and referrals (as appropriate). Evaluations should look at the structure of services, the actual delivery of services and service outcomes to assess the extent of informed choice. While CAs can provide technical support, local institutions must take primary responsibility for promoting informed choice and for monitoring service delivery sites to ensure that the appropriate steps are being taken.

Recommendation No. 8

Public Outreach

Family planning agencies should make more use of culturally sensitive mass media to reach not only potential and current contraceptive users but also others who influence reproductive decisions

such as spouses, other relatives, and policymakers. All modes of public education such as television, radio, press, magazines, group meetings, exhibits, cultural events, folk theatre, all types of entertainment, field worker visits, inserts in contraceptive packages and point-of-purchase displays should be expanded. Whenever feasible, they should include information about specific methods.

Recommendation No. 9

Protocols for Service Delivery

Both public and private agencies in developing countries should develop national or regional guidelines on family planning methods and the client education process. Emphasis should be placed on continuous support of clients, not simply the first contact.

Recommendation No. 10

Training

Service delivery staff need to be trained in client counseling and interpersonal communication, since good counseling and a positive relationship with the client are essential to informed choice. Counseling staff should receive on-site training, assistance, supervision, and periodic evaluations. Each agency should develop or adapt from other agencies a portion of a training module specifically on informed choice. Trainers should encourage service providers to be attentive to the client's needs and life situation.

Recommendation No. 11

Male Involvement

Family planning programs need to pay more attention to the role of men in reproductive decisions and to expand male outreach programs. Many programs focus mainly on women, even though men have a major role in making family reproductive choices in many countries.

Recommendation No. 12

Family Planning and STDs, Including AIDS

The prevention and treatment of sexually transmitted diseases (STDs) is important to reproductive health. Family planning providers should offer basic STD services. In view of the widespread concern regarding acquired immune deficiency syndrome (AIDS), family planning providers should seek assistance from various sources for programs to prevent transmission of the virus that causes AIDS. These programs may include staff training, counseling, peer group activities, condom promotion and distribution, the development of communication strategies and materials, and HIV testing (where appropriate).

Recommendation No. 13

Research Needs

More research should be conducted on various elements of informed choice, including method availability, referrals, counseling, public and clinic education, and training. Operations research can be useful to assess the most effective ways of promoting informed choice.

Recommendation No. 14

Informed Consent Requirements

While clients should make informed decisions for any contraceptive, written informed consent should be required only for voluntary sterilization, because it is intended to be (and effectively is) permanent.

Recommendation No. 15

The Role of Cooperating Agencies

CAs should review their policies and procedures in regard to informed choice, provide adequate staff training, and adopt appropriate monitoring and evaluation procedures. CAs preparing international guidelines should seek input from service providers in developing countries.

Recommendation No. 16

AID Support to CAs

AID should provide CAs with up-to-date, accurate information pertaining to informed choice, especially in key areas such as contraceptive safety and efficacy and AIDS prevention.

The Task Force concluded that much progress has been made in promoting informed choice and that future initiatives may depend upon correcting erroneous assumptions about informed choice. In fact, the stereotypical activities associated with informed choice—boring lectures, lengthy forms and rigid guidelines—may have little to do with helping the client to make and implement choices, to understand and remember pertinent information, and to feel comfortable seeking additional information or services, as needed.

Family planning and health care professionals need to understand that implementation of programs to promote informed choice will make their job easier, not harder. Satisfied users are not only the key to high continuation rates but also the most effective promoters of family planning.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AID	U.S. Agency for International Development
AIDS	Acquired immune deficiency syndrome
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CBD	Community-based distribution
CEDPA	Centre for Development and Population Activities
FHI	Family Health International
FPIA	Family Planning International Assistance
HIV	Human immunodeficiency virus
IEC	Information, education and communication
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	Johns Hopkins University/Population Communication Services
JHU/PIP	Johns Hopkins University/Population Information Program
OR	Operations research
SOMARC	Social Marketing for Change
STDs	Sexually transmitted diseases
UNFPA	United Nations Population Fund

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Background

The Cooperating Agencies (CA) Task Force on Informed Choice was formed in February 1988 at the request of Dr. Duff Gillespie, Agency Director for Population, U.S. Agency for International Development (AID). Dr. Phyllis T. Piotrow, Director of the Population Information Program and the Center for Communication Programs of the Johns Hopkins University, was designated to chair the Task Force. Cynthia P. Green, Ph.D., served as the Task Force consultant and drafted the report.

The CA Task Force was convened to follow up on the recommendations of the AID Office of Population Informed Choice Task Force, which issued its report in November 1987. The AID Task Force recommended that a CA Task Force be established "to share information on their experiences in implementing informed choice" and "compile a small collection of exemplary materials" for wide distribution. The report also recommended that CAs implement "a routine review of informed choice in their subprojects."

Due to the strong interest among CAs, the CA Task Force, which was originally intended to be a small working group, has grown to 17 agencies, including three non-AID-funded agencies—UNFPA, IPPF and World Bank. Appendix A contains a list of the current Task Force members.

The CA Task Force met in April 1988, November 1988 and February 1989 to share information and develop a consensus on the necessary actions for CAs. This report grew out of these three meetings and is organized according to the major recommendations of the Task Force. It is intended to provide practical suggestions for CAs to assist their subgrantees in implementing improved procedures for promoting informed choice. Since many CAs work in specific subject areas such as training or research rather than in service delivery, the recommendations and guidelines need to be applied and adapted as appropriate.

Recommendations of the AID Informed Choice Task Force

In its November 1987 report, the AID Informed Choice Task Force recommended that AID take the following measures to promote more extensive implementation of AID's informed choice policy:

1. Convene a special CA task force to share information on implementing informed choice policies and procedures and to compile a small collection of exemplary materials;
2. Develop basic guidelines for all AID-provided family planning methods and disseminate them widely;
3. Establish among CAs a routine review of informed choice in their subprojects;
4. Disseminate information on AID's informed choice policy to international and national family planning organizations and encourage them to adopt similar policies and procedures;
5. Conduct studies on the implementation of informed choice principles;
6. Continue to provide information to AID overseas staff on the program implications of AID's informed choice policy;
7. Continue to monitor and document the progress of CAs in implementing AID's informed choice policy; and
8. Provide additional financial resources to the AID Informed Choice Task Force so that it can continue its work in refining guidelines for implementation of informed choice policy and work more closely with specific CAs.

The recommendations of the Cooperating Agencies Task Force on Informed Choice build on these earlier recommendations, especially those pertaining to CA implementation and monitoring of informed choice.

Recommendation No. 1

Expanded Definition of Informed Choice

Informed choice is effective access to information on reproductive choices and to the necessary counseling, services and supplies to help individuals choose and use an appropriate method of family planning, if desired. The Cooperating Agencies Task Force broadened the definition of informed choice from a choice of family planning methods to encompass various reproductive choices, including the possibility of choosing pregnancy. Thus, informed choice begins prior to the choice of a particular method, at the time when a person first learns that there is a way to control his or her fertility.

The Task Force identified five major components of informed choice:

1. Provision of information to couples and individuals on reproductive choices, including counseling concerning pregnancy, breastfeeding, and infertility;

2. Provision of appropriate information on a *range* of family planning methods, their advantages and disadvantages, locations where services and supplies may be obtained, and costs;

3. Provision of comprehensible information on the correct usage of the client's chosen method;

4. Provision of counseling to ensure comprehension of information and to assist with decisionmaking; and

5. Efforts to ensure that a range of methods is actually available to the user, either through the service provider or through referral to another agency.

Many people do not have informed choice because they do not know that it is possible to control their fertility. As Simmons et al. (1986:16) state, in many cultures "childbearing represents a learned, unquestioned response to the very definition of what it means to be a woman." Thus, informed choice does not begin at the clinic door but instead encompasses all efforts to inform men and women about their basic right to determine the number and spacing of their children. Creating general public awareness of reproductive health issues and choices greatly facilitates free and informed decisionmaking by individuals.

Informed choice is constrained by many factors, including:

- Cultural and religious values promoting large families or specific spacing patterns or discouraging contraceptive use altogether;
- National policies, which may limit availability of specific methods or impose unnecessary requirements on would-be users;
- Donor policies promoting self-sufficiency, which may lead service providers to promote methods generating the greatest profit;
- Time and resource limitations, which may influence program operations (e.g., staffing, supplies and transportation);
- Target-setting within family planning programs, which leads service providers to emphasize some methods over others;
- Incentive payments to clients, which may influence them to adopt specific methods;
- Significant payments to provider staff, particularly per-case payments for specific methods, which may influence the information provided to the client and ultimately the client's choice; and
- Service provider biases, which may limit choice of methods.

These barriers need to be taken into account in developing policies and programs to promote informed choice.

The specific components of informed choice vary according to social and cultural values. It is impossible to apply rigid, detailed criteria to every country. Furthermore, the amount of information that is considered "adequate" is highly subjective. Measuring client understanding can be very difficult. It should be acknowledged that information can never be "complete": service providers have limited time to educate and counsel clients, and clients in turn may not wish to hear extensive information and will not remember it. The most important dimension of informed choice is not a barrage of information directed to new and poten-

tial contraceptive users but rather development of a relationship between the provider and the client so that the client trusts the information being provided and feels comfortable to return for additional information and services when he or she wants them.

Informed choice should be differentiated from informed consent, which refers specifically to making a decision regarding a particular method or procedure without coercion, undue influence or fraud. Informed consent entails the patient's understanding of the risks and benefits of a proposed medical intervention; this understanding is sometimes documented by a written authorization to proceed. Voluntary sterilization programs funded by AID are required to obtain written consent from clients undergoing sterilization procedures; clients must also receive information on the procedure's risks and benefits, its intended permanence, and the availability of other methods. (Informed consent is also required for participants in clinical trials.)

One often overlooked point is that informed choice also includes the client's right *not* to adopt a contraceptive method and the right to limit the amount of information provided. Some clients reject an extensive review of all available contraceptive methods or a lengthy explanation of the physiological aspects of contraception; they want only a specific method, provided with the greatest possible dispatch. Their wishes should be respected as long as the method is safe for them, they have adequate information to use their chosen method properly, and they understand that they may return to the service provider for alternative methods.

The Distinction Between Informed Consent and Informed Choice

The Agency for International Development Informed Choice Task Force provided the following differentiation between informed consent and informed choice:

- **Context**

—Informed consent is a Western concept closely associated with the judicial process, especially in litigation related to medical malpractice and negligence, while

—Informed choice seems to be a term coined by the international family planning community and especially AID to include all activities that help to ensure a voluntary choice of family planning method.

- **Method of Expression**

—Informed consent has a more specific connotation; i.e., it is a written agreement to a medical procedure, while

—Informed choice is less defined, implying a decision-making process that generally precedes consent.

- **Parameters**

—Informed consent conveys the sense of knowing to what one is agreeing and therefore of choosing the agreed-upon action from several alternatives. Thus it is possible to develop a precise operational term of informed consent, while

—Informed choice is a more elusive term. What constitutes adequate information and appropriate levels of understanding is highly subjective and varies from culture to culture.

Recommendation No. 2

Continual Process

Informed choice should be seen as a continual process as new acceptors try out one method and then shift to other methods or nonuse as their needs or preferences change.

Informed choice should be seen as a continual process: first the client and provider establish a positive relationship in which the client discusses the concerns important to him/her regarding reproductive choices and, if pregnancy prevention is chosen, use of family planning; secondly, the client selects a method and tries it; later the client may have questions or problems or a new situation and switch to another method or discontinue use. Service providers should encourage contraceptive users to return if problems arise and should ensure that clients understand that they can change methods at any time and will receive appropriate information, services and/or referrals for alternative methods.

The program implication of this perspective is that the emphasis is on the quality of the provider-client relationship, not on the quantity of information, much of which may not be understood or remembered.

Recommendation No. 3

Method Choices

Within each given service area, an appropriate range of contraceptive methods should be available to meet the needs of various types of contraceptive users. Available methods should include male and female methods, some reversible methods which are temporary as well as long-acting ones, and permanent methods. Program administrators should strive for "effective access," which means that, at a minimum, major groups of contraceptive methods are available in each regional area of a country.

One of the obvious cornerstones of informed choice is ensuring that a range of family planning methods is available to those wishing to space or limit births. Within a given geographical area, methods should be available to meet the needs of several types of users: men and women, those who wish to space births as well as those who want no more children, breastfeeding women, and adolescents.

Multiple methods are needed because potential users are at various stages of the family formation cycle, user preferences vary, some methods have side effects or may be contraindicated on medical grounds for certain individuals, and users may have difficulty using some methods correctly or consistently. The relationship between spouses often affects contraceptive choice and usage. Some methods are rejected because they cannot be concealed from one's partner or others, because they require the partner's cooperation, or because they interfere with sexual relations due to irregular bleeding or other factors.

National program administrators should strive for "effective access," meaning that barriers such as cost, distance and transportation are removed for individuals seeking reproductive health services. At a minimum, administrators should make sure that major groups of family planning methods are available in each regional area of the country. Programs directed at specific population categories such as adolescents or breastfeeding women may not need to offer all methods, but a range of methods should be accessible within a region or community.

In many countries, several methods may be offered at the national level and in large cities, but transportation difficulties and supply shortages may lead to only one method being offered at rural clinics and community-based distribution (CBD) depots. Program administrators need to pay careful attention to logistical procedures to ensure that methods are continuously available at all locations.

Studies have shown that contraceptive prevalence rates increase as the number of methods offered grows; each method added attracts new users. Furthermore, the availability of multiple methods enables users to switch methods more readily, thus improving overall continuation rates. Satisfied users are more likely to recommend family planning to others and thus should be seen as contributing to both adoption and continuation rates.

Recommendation No. 4

Referrals

Providers that offer only one or a limited range of family planning methods should tell clients where alternative methods are available, regardless of how distant they may be. Referral systems should be established and coordinated with providers at the local level, using written materials as appropriate.

CAs should encourage better coordination at the local level among service providers which offer several methods and those which specialize in particular types of methods such as voluntary surgical contraception or natural family planning. Within each region or community, multi-method and specialized service providers should ensure that the information they are providing to clients on various methods is consistent and unbiased so that clients are not given conflicting information which may limit or influence their choice.

Referrals can be facilitated by giving appropriate family planning agency staff a brief description of methods offered at other service points and a listing of the name, address and hours of sources of alternative services. Such a summary could be compiled and reviewed by all participating agencies. It is helpful to give the client a card with the address, hours, and other pertinent information about the agency to which he/she is referred. In some settings, if telephones are available, making an appointment for the client at the other agency may help to ensure that the client is not discouraged from obtaining alternative services.

Where feasible, family planning agencies should explore ways of publicizing the various service outlets in a community. For example, social marketing and commercial distribution programs could provide package inserts which describe other available methods and local sources of services, information and supplies.

Many clinics and health centers are not required to report referrals to other service sites and therefore consider such activities unimportant. In some cases, the headquarters requests information on a few specific methods, leading service providers to conclude that they need not inform clients about other methods. Requesting information on the number of referrals could help to ameliorate this situation.

Recommendation No. 5

Clinic Education

To complement counseling, service providers should seek to improve client education by using waiting areas for visual displays, lectures and audio-visual presentations and by providing client counselors with visual aids and audio-visual and print materials. Client education materials should be accurate, appropriate to their intended audience, and understandable.

While health centers and clinics should not shoulder the entire burden of public education on reproductive options, there are a number of steps they could take to further informed choice. Specifically, they could make better use of waiting areas to provide client education through lectures and discussions, posters, wallcharts and audio-visual displays. Videotapes or simple homemade visual aids could be developed to explain the advantages and disadvantages of available methods so that clients could consider their options prior to one-on-one contact with service providers. The media used for clinic education may depend upon factors such as the noise level, amount of time and space, security, and client preferences.

Many clinics in developing countries have bare walls that could be used for visual displays. The few posters in evidence tend to have a vague exhortation such as "Plan your family"; a wallchart showing the available methods and options would be more helpful to would-be clients. A model poster promoting informed choice which could be adapted for national or local use might help to reinforce the idea of clinic displays. Clinics could also display pictorial stories of women who have changed methods over time to illustrate that women have various contraceptive needs and preferences and that switching is acceptable.

In many cases, contraceptive methods themselves make excellent visual aids and are more effective than drawings, which may lead to erroneous impressions about specific methods. Nevertheless, providers need to be alert to client reactions; when the IUD was displayed on a wall with its inserter, clients thought that the inserter was also left inside them.

In counseling clients, service providers and health educators could make more and better use of methods charts, flipcharts and other visual aids. Such materials can be handmade.

One barrier to the use of audio-visual aids in counseling is the administrative requirement of many agencies that individual staff members be held responsible for specific pieces of equipment or materials. Since a slide projector or video monitor may cost more than the staff member's annual salary, it is safer to leave it locked in a cabinet than to risk damage or theft. Client educators need to be told to use audio-visual equipment and materials until they wear out, and administrators need to allocate sufficient funds to ensure that equipment and materials are replaced in a timely fashion.

Print materials also may be stored rather than used. Reference materials are not always circulated among clinic staff, and client education materials are often deemed too valuable to be given away to clients. While the shortage of materials is clearly related to very real financial constraints, the problem is compounded by a tendency of administrators to print materials in small quantities or in expensive formats. Printing large numbers of simple material at one time may reduce the cost per copy and ensure that materials are widely distributed.

Recommendation No. 6

Client Counseling

Each local institution should ensure that client counseling is done sensitively and effectively. The goal of counseling is to have the client arrive at a choice that he/she is satisfied with and, if the choice is to use contraception, to prepare the client to use his/her chosen method effectively. Counseling should be a two-way interaction, based on a positive relationship.

The most important aspect of counseling is helping the client to make a decision regarding reproduction choices and, if desired, a specific contraceptive method. The counselor should encourage the client to discuss her/his needs, concerns and preferences. Developing a relationship of trust between the provider and the client is the main goal in counseling, not overwhelming the client with a barrage of information that may not be understood or retained. Clients need to be encouraged to return to the clinic or health center if they have questions, are having problems with their chosen method, or desire to change methods. They need to be reassured that alternative methods are available and that switching methods is not bad.

While it is not possible to specify what constitutes the necessary information to be provided in all settings, the Task Force believes that new clients should receive, *at a minimum*, the following information:

1. The concept that there are various reproductive options, including pregnancy and contraceptive use.

2. The idea that there is a choice of family planning methods, available directly from the service provider or by referral, and some general information about each of these methods;

3. More detailed information about the client's chosen method, including proper usage and potential side effects (if any); and

4. Reassurance that the service provider will continue to be available in the future for a review of health issues, assistance in switching and referral, and removal of provider-dependent methods.

The specific content should be tailored to the individual client's situation and desires.

In assisting new clients, the counselor should first ascertain whether the client wishes to become pregnant soon or to space or limit births. If the client wishes to become pregnant, the counselor provides information on prenatal care and other measures to ensure a safe pregnancy. If the client wishes to space or limit births, the counselor asks the client questions in order to ascertain which methods the client favors and which would be appropriate to the client's life situation. The counselor should screen clients for medical conditions that may preclude use of specific methods and should discuss the client's sexual practices in reference to the selection and use of a contraceptive method and/or sexually transmitted diseases (STDs) and acquired immune deficiency syndrome (AIDS).

After describing available methods, the counselor should help the client to decide which method is most suitable. For example, a woman who has several sexual partners should be advised that the IUD may not be suitable for her due to the increased risk of pelvic infection. Then the client receives information on the correct usage of her/his chosen method, including any necessary follow-up visits.

Service providers should not assume that the client arrives at the clinic with no idea about which family planning method he/she desires. Often the client has a specific method in mind, and the service provider needs to determine whether the method is appropriate. When the client requests a specific method, the service provider should ask about his/her medical history and find out whether he/she knows about alternative methods and has an accurate idea of their benefits and risks. If the method requested by the client is contraindicated, the client needs to understand why the method is inappropriate and what alternatives are available. One study found that usage and continuation rates were higher when the client received the method he/she initially requested (Pariani et al., 1987). Being responsive to the client is the best approach.

If the client expresses a desire to limit or space births but rejects all contraceptive methods, the counselor needs to ascertain whether she is fearful about contraceptive side effects and may be misinformed about contraceptive safety. If so, the counselor needs to provide accurate information on the relative risks and benefits of specific contraceptive methods and health risks associated with contraceptives in relation to those associated with

pregnancy and childbirth. If the client has any known risks associated with a future pregnancy (based on her health status and history), the counselor should discuss them without causing undue fear. Counselors need to be careful not to use mortality risks in an unscientific or exaggerated way. If appropriate, they should discuss the relative risks of contraception and childbearing in light of the individual's personal situation and in terms she can understand.

Clients receiving long-acting methods such as the IUD or implants need to know that the method is effective for a specific period of time, when they should return for scheduled removal, and that they can request removal at any time prior to then.

For various reasons, some clients are discriminated against by some family planning service providers. A client's age, marital status, social class, caste, occupation, language, and ethnic or tribal identity may cause a staff member to be disrespectful, disapproving, patronizing, or even reluctant to help the client choose the contraceptive method best suited to him or her. Women who are insulted or turned away by family planning clinics are at risk of unwanted pregnancy and may seek abortions if they become pregnant. Training for family planning staff should include sensitization to discrimination against clients who are very young or unmarried or poor or otherwise different from staff members.

To encourage a free and frank discussion, counseling sessions should be held in a private setting whenever possible. If that is not possible, the discussion should be at least sufficiently distant that others cannot hear what is being said. Counselors should reassure clients that their privacy will be respected and that all records are confidential.

Educational materials used in counseling should include information on *all* available family planning methods, as well as on the impact of breastfeeding on amenorrhea and on methods compatible with breastfeeding. The counseling guide developed by JHU/PIP ("Why Counseling Counts!") provides basic information on counseling techniques, specific contraceptive methods, AIDS, and breastfeeding which can be adapted for local use.

Guidelines and checklists as well as training in counseling techniques and skills should be made available to all appropriate staff members.

Making the Best Use of Staff Time

While it is undeniable that careful client counseling takes considerable staff time, counseling has many positive benefits, including more satisfied users, proper contraceptive use, and fewer unnecessary visits. Program managers need to consider ways of maximizing the amount of time staff spend interacting with clients. Some techniques to use staff more efficiently include:

- Improving clinic efficiency through patient flow analysis or other ways of restructuring staff functions;
- Altering clinic space;
- Providing group talks, print materials and audio-visual programs in clinic waiting rooms to educate clients on contraceptive methods;
- Training staff to counsel clients efficiently;
- Recruiting volunteer counselors;
- Improving staff attitudes toward their work and toward clients; and
- Eliminating medically unnecessary visits by encouraging better client self-monitoring and self-care, when appropriate.

Recommendation No. 7

Monitoring and Evaluation

CAs and local institutions should build information needed for monitoring and evaluation of informed choice into their standard reporting requirements. Such information might include indicators that client counseling guidelines have been followed and service statistics on method mix and referrals (as appropriate). Evaluations should look at the structure of services, the actual delivery of services and service outcomes to assess the extent of informed choice. While CAs can provide technical support, local institutions must take primary responsibility for promoting informed choice and for monitoring service delivery sites to ensure that the appropriate steps are being taken.

CAs and local institutions should develop a collaborative approach to monitoring implementation of informed choice and evaluating the effectiveness of efforts to promote informed choice. At the project planning stage, CAs and prospective grantees in developing countries should discuss how informed choice will be monitored. As part of project start-up orientation, CAs can provide grantees with guidelines and checklists as well as advice on data collection and interpretation.

FPIA has established specific procedures to orient grantees to grant requirements, including informed choice. In developing a project, a preliminary understanding is reached about the specific activities to be undertaken. Informed choice is discussed as part of project design. During the start-up visit, the grantee staff receive training in the terms and conditions of the grant. Some regional offices have developed checklists and quizzes to facilitate the training process.

Following are five techniques that can be used by either CAs or grantees in developing countries to monitor implementation of informed choice in service delivery programs:

1. **Reviewing National Data.** National survey data can provide important information on user characteristics, method mix and urban/rural differentials. Analysis of method use by age can reveal inappropriate method use. Comparing local or clinic-level data with national data can sometimes pinpoint problem areas.

2. **Checking Service Statistics.** Data on contraceptive method choice among new and continuing users can be used to ascertain whether the mix of methods is appropriate. Heavy reliance on one or two methods could be a sign of provider bias, supply shortages, or inadequate client education and counseling. Similarly, data on trends in method use could reveal patterns which suggest undesirable influences. A sudden surge in acceptors or shifts in usage should be assessed to determine possible causes, including changes in the delivery system, supply shortages, a media campaign, or introduction of quotas or incentives. For agencies offering a limited number of methods, the number of referrals to other agencies can be an indication of appropriate counseling.

3. **Noting Program Policies.** Program monitors need to be alert to conditions likely to lead to a weakening of informed choice, including setting program targets, providing incentives to clients, providers, or referral agents, and evaluating staff performance by numbers of clients selecting a specific method.

4. **Visiting Clinics.** Field visits are essential to monitor informed choice. Supervisors or representatives from headquarters can visit clinics, observe how clients are served and counseled, assess counselor/client relationships, examine clinic records regarding numbers of acceptors and method mix, check contraceptive supply inventories, spot-check informed consent forms for voluntary sterilization, review the provider's policies on service delivery, and look at forms used in appraising staff performance or supervising workers. Structured interviews of service providers, CBD workers, supervisors, and clients using a standard questionnaire can also be used to monitor informed choice. Monitored visits may be announced in advance or unannounced.

5. **Conducting Client Studies.** Various types of studies can ascertain not only what information clients receive but also how well they comprehend and retain it. Focus group discussions with clients, intercept interviews with clients leaving the clinic, debriefing of informants hired to act as family planning clients, and follow-up surveys of clients are all possible ways of assessing the quality of client education. Although surveys may be expensive and time-consuming, they may provide important information on clients' knowledge of

their chosen method and their satisfaction with the counseling and services they received.

The problem with all types of client-centered studies is that it is not always possible to separate the information clients were actually given from their current knowledge, which may be a mixture of information, opinions and misconceptions derived from the client's own beliefs and various external sources. A brief counseling session or a six-week media blitz cannot be expected to change deeply held beliefs or to counter strong opinions of respected confidantes.

"Quick and useful" research methods are to be encouraged. It is important for CAs and their grantees to make an initial assessment, even if based on incomplete information and informal observations. A "desk-top audit" of key documents and a fact-finding field visit can be very useful. If this review suggests that serious problems exist, more formal and comprehensive information-gathering systems can be instituted.

CEDPA recently developed checklists for monitoring quality of medical care in clinics offering reversible contraceptive methods. The checklists, which resulted from a five-country field assessment, include reviewing client history-taking procedures and method-prescribing practices and evaluating both verbal and written information provided to clients.

In many cases, extensive research is not needed to identify program areas needing improvement. Often program managers are aware of their program's deficiencies but lack the funds and/or political clout to correct them. Donor agencies must make it clear that they give priority to informed choice and that they will evaluate grantees accordingly.

In evaluating implementation of informed choice, there are three points of observation:

1. **Preparation:** This element encompasses all the activities needed to support informed choice throughout the agency's service delivery system, including established policies and guidelines, staff training, mass media campaigns and materials, adequate contraceptive supplies and distribution systems, and appropriate educational programs within various types of service delivery, community distribution and commercial sales. Internal documents and reports from managers are the main sources of information.

2. **Delivery:** This element focuses on the interaction between staff and client, as determined from observation, clinic records, and staff reports.

3. **Outcome:** The third element assesses how the preparation and delivery actually affected clients. It can be assessed from exit interviews with clients, focus group discussions with clients, service statistics, surveys and national data.

Appendix B, Program Monitoring Checklist, provides a basic format for evaluating the extent of informed choice in family planning programs. The information-gathering techniques described in the previous section on monitoring are applicable to evaluation as well.

Recommendation No. 8

Public Outreach

Family planning agencies should make more use of culturally sensitive mass media to reach not only potential and current contraceptive users but also others who influence reproductive decisions such as spouses, other relatives, and policymakers. All modes of public education such as television, radio, press, magazines, group meetings, exhibits, cultural events, folk theatre, all types of entertainment, field worker visits, inserts in contraceptive packages and point-of-purchase displays should be expanded. Whenever feasible, they should include information about specific methods.

The goal of informed decisionmaking regarding reproduction cannot be realized through clinic educational efforts alone. First of all, health workers are already overburdened and in short supply in many areas. Secondly, decisions regarding reproductive options are often heavily influenced by the client's spouse, mother-in-law or other relative, who may not attend the clinic. Thirdly, clinic programs do not reach policymakers and government officials who could be instrumental in removing legal and institutional barriers to wider access to services and to availability of additional family planning methods. Finally, many clients already come into clinics with definite method preferences that are based on mass media or personal contacts outside the health systems. These preferences may be deeply rooted. Unless they are based on accurate information, they may

Mass Media Support for Informed Choice

The mass media can be particularly important in promoting reproductive choices to the general public or special audiences. Specific uses of mass media include:

- Conveying the idea that it is possible to limit or space births;
- Promoting the clinic, health center, CBD worker and/or retail outlets as sources of family planning methods and counseling;
- Informing the public about the various family planning methods, including factors such as sources, cost, effectiveness, safety, reversibility and correct usage;
- Encouraging potential and current users to seek more information about family planning; and
- Supporting the idea that methods should be suited to the individual's needs and life situation and that many users switch methods as their needs change.

Entertainment formats are more effective than lectures or strictly educational formats in attracting large audiences, holding public attention, establishing role models, and probably in influencing health behavior. In several countries, JHU/PCS has demonstrated that the popular media can convey various family planning messages effectively.

In many countries, explicit policies or de facto practices prohibit mention of specific contraceptive methods on radio or television. Policymakers as well as broadcast executives need to understand the importance of educating the public on reproductive choices. Sometimes it is helpful to develop brief advertisements or short programs to show that discussions of contraceptive methods can be done tastefully. Audience research and pretesting can also establish what is acceptable to the public. In countries where broadcast media do not permit an explication of specific contraceptive methods, other ways of delivering a similar message through soap operas, dramas, comedies, folk theatre, panel discussions, or field interviews may be acceptable. Formats in which a discussion of contraceptive methods has been allowed include interviews in which guest experts are asked questions by audience members and dramas in which women or a couple visit a clinic and talk with a nurse.

adversely affect informed choice and ongoing contraceptive use. Thus, local institutions need to look beyond the clinic setting to other sources of client education, such as the mass media, group meetings, entertainment, formal and nonformal education programs, visits by outreach workers and many other channels in order to ensure that the choice made is truly informed and is reinforced by valid information from other public sources.

The mass media have a major role in shaping public consciousness by reflecting social norms and values and informing the public about new ideas and trends. Not only do media such as radio, television, newspapers and magazines reach large audiences, but also they can convey information in a memorable way and lend legitimacy to new or unfamiliar practices such as family planning. Role models from mass media can influence behavior in such varied fields as dress, food and family life.

The role of outreach workers in educating potential and current contraceptive users deserves more attention. In addition to providing basic information and contraceptive supplies, outreach workers can help to reduce fear of contraceptive methods, refute false rumors, overcome reluctance to visit a family planning clinic, promote male support for family planning, and facilitate husband-wife communication. Yet these workers often receive little support in the form of wages, training and recognition.

Program administrators should not overlook other ways of reaching current and potential users such as mounting displays at the point of purchase and adding package inserts in pills, condoms, and other contraceptives distributed through social marketing and CBD programs.

Educational interventions must be designed to meet the needs of specific target audiences. For example, adolescents who have been pregnant before need different materials from other adolescents. Materials used for multiple audiences need to be pretested with each audience.

Messages regarding contraceptive use must be consistent. It is very confusing to users if clinic staff tell clients to start taking their pills on the first day of their cycle while giving them a leaflet that tells them to wait until the fifth day.

Recommendation No. 9

Protocols for Service Delivery

Both public and private agencies in developing countries should develop national or regional guidelines on family planning methods and the client education process. Emphasis should be placed on continuous support of clients, not simply the first contact.

To ensure that clients receive accurate information and that service providers follow standard procedures in providing contraceptive methods and related counseling, each national and local agency needs *at a minimum:*

1. Protocols regarding service delivery for relevant staff, including appropriate physicial examinations, contraindications, and basic facts about fertility awareness and all available contraceptive methods;

2. Curricula for staff training in counseling skills and techniques; and

3. Guidelines for client counseling, including minimum information to be imparted to clients.

Many agencies have formulated such procedures but may not have distributed them in written form or used them in staff training and refresher courses.

Resource materials that might be helpful to program administrators in developing medical protocols and counseling guidelines are listed in Appendix C. (See sections on Service Delivery Guidelines and Counseling Guidelines.)

Because of the diversity of national and local programs, the Task Force did not feel that a single set of international guidelines on family planning methods would be useful. Service delivery guidelines developed by CAs are unlikely to be responsive to field conditions in developing countries. AVSC found that medical guidelines produced in collaboration with service providers from developing countries were much more useful and acceptable and that the process of developing the guidelines was valuable. In many cases they became the basis for national medical guidelines.

Guidelines, checklists and other materials promoting informed choice need to be distributed in sufficient quantities to ensure that lower-level staff who interact with clients have their own copies. Often such reference materials are retained by top-level administrators and kept in pristine condition to be shown to visiting foreign experts rather than incorporated into day-to-day procedures or used as a resource.

Practical Suggestions for...

Service Providers

To assist service providers in local institutions, following is a short list of practical suggestions for furthering informed choice:

- Include information on informed choice and the necessary background material in all training programs and orientation for new staff.
- Train counseling staff to assist clients in choosing a contraceptive method; these staff should be able to clarify doubts and assist the client in making a decision through various counseling skills, including reflective listening and synthesizing the client's problem for him/her.
- Hold regular, publicized information sessions in large clinic waiting rooms and display contraceptive devices and visual materials in waiting rooms and at purchase points of commercial contraceptives.
- Use educational aids in working with clients; whenever feasible, clients should receive print materials that they can refer to later and share with others.
- Take advantage of opportunities for public education through mass media, entertainment, promotional events, campaigns, displays in public places, cultural events, and purchase points.
- Review the management information system to identify ways to introduce reminders to service providers to provide informed choice (e.g., items to check on the client's registration card or other records).
- Give clients referred to other service providers a list or written notation of the agency's name, location, hours and telephone number.
- Develop a monitoring system appropriate to the service delivery system, such as checking client records and observing provider-client interactions.
- Discuss any issues or problems in implementing informed choice at in-service meetings with staff.
- Appoint a senior-level staff member to monitor promotion of informed choice, answer any questions and resolve problems.

Practical Suggestions for...

CBD Programs

In community-based distribution (CBD) programs, outreach workers typically talk with people having diverse views on family planning: some are opposed, some desire a pregnancy, some would like to try a method, and others are current users. Thus, CBD workers are an important source of information in the community. For methods not provided by CBD workers, links to other service delivery systems are important. Following are some basic ways for ensuring informed choice in CBD programs:

- Train CBD workers to discuss a broad range of topics, including: reproductive options; advantages, disadvantages, correct usage and sources of various contraceptive methods; STDs; and safe pregnancy. Provide periodic updates and refresher courses.
- When clients are referred to other service sites, make sure that CBD workers give them appropriate instructions and either accompany them or give them referral slips.
- Promote community awareness of CBD workers through signs or flags outside their homes, posters, advertisements in local publications, radio spots, or other culturally appropriate sources.
- Monitor client counseling by CBD workers through observation, regular supervisory visits, client interviews, spot checks and other methods.
- Hold regular meetings among CBD workers to discuss any issues or problems in counseling clients and identify information gaps.

Practical Suggestions for...

Commercial Programs

Contraceptive retail sales programs have great potential to inform the public about reproductive options. Basically they offer four ways to inform clients about their products and related issues: 1) Mass media advertising; 2) Promotional materials available at the point of purchase; 3) Package inserts; and 4) Advice from the pharmacist or shopkeeper. Contraceptive manufacturers and distributors are likely to resist efforts to expand these sources to include information beyond the brand names and products being sold, especially if such expansion includes promoting competing products and service points. National agencies such as the Ministry of Health may need to intercede to emphasize the importance of broad public education on reproductive options and all available methods. Cost-sharing, tax concessions or other financial incentives may lead commercial firms to broaden their approach.

Possible ways to improve information and guidance to consumers within commercial programs include:

- Encourage manufacturers and distributors to support advertising campaigns that address consumers' concerns about specific methods and family planning in general, as well as the necessary research to identify these concerns.
- Ensure that relevant literature and visual displays are available at the point of purchase.
- Where feasible, distribute package inserts that contain easily understood information on correct usage, possible side effects and contraindications of the specific contraceptive method enclosed and on other available methods and their sources.
- Provide pharmacists and shopkeepers with basic information on the methods they sell, including their correct usage, possible side effects and contraindications as well as sources of further assistance in the event of problems or dissatisfaction.
- Offer training courses for contraceptive vendors.

The extent to which companies choose to implement these measures is likely to vary considerably, depending upon costs, expected profits, and political and cultural sensitivities.

The SOMARC project of the Futures Group is providing training on contraceptive options to retailers and pharmacy personnel in eight country programs and plans to evaluate the impact of this training on informed choice.

Recommendation No. 10

Training

Service delivery staff need to be trained in client counseling and interpersonal communication, since good counseling and a positive relationship with the client are essential to informed choice. Counseling staff should receive on-site training, assistance, supervision, and periodic evaluations. Each agency should develop or adapt from other agencies a portion of a training module specifically on informed choice. Trainers should encourage service providers to be attentive to the client's needs and life situation.

Family planning training programs have tended to teach clinical skills rather than counseling and interpersonal skills. However, in recent years service providers are recognizing the importance of good counseling, and training programs have given greater attention to this area.

A training module specifically on informed choice should be developed for use nationally or within national regions. Such a module might be called by a different term, e.g., interpersonal communication, counseling or health education, depending upon which term is best understood. Appendix C, Resource Materials, includes training curricula and exercises on client education and counseling. Several CAs have actively promoted informed choice in their training programs. JHPIEGO includes a session on informed choice and informed consent in all its training courses; most clinical courses include counseling as well. The Georgetown University Institute for International Studies in Natural Family Planning includes informed choice counseling in its training-of-trainers courses. AVSC has held regional and subregional seminars on counseling training; grantees have also set up training sessions on a national and local basis. INTRAH has developed exercises to provide information on multiple methods and to help the client in choosing a method. JHU/PCS and PATH have developed training modules in interpersonal communication and counseling.

All staff who have contact with clients and the general public should receive training in interpersonal communication. Staff members who assist clients in deciding about contraceptive use also need training in counseling. Training should be relevant to local circumstances..

Training programs need to encourage service providers to acknowledge their own personal biases in method choice and to respect the client's choice. They also need to be attentive to the practical aspects of contraceptive use and to the client's needs and lifestyle. Training in identification of personal values and in skills to adapt presentations to different audiences would be useful.

Counselors need to be trained as close to the service site as possible and in accordance with their current knowledge and skills. Counseling staff need training in the effective use of visual aids such as flipcharts; in some cases expensive educational materials have been left unused because staff did not know how to use them properly.

Training programs often deal with high-level administrators and physicians. They do not always reach down to the level of the nurse or health educator who counsels clients. Training programs should encourage teamwork among physicians, nurses and other service providers.

Follow-up of graduates of training-of-trainers courses is important to ensure that information on informed choice is included in second- and third-generation training sessions.

Local institutions should train staff to give educational talks in the clinic and in the community. Conducting group meetings requires different skills from individual counseling and needs different training materials and techniques. Staff making home visits also need special training and supervised practice in interpersonal skills.

Recommendation No. 11

Male Involvement

Family planning programs need to pay more attention to the role of men in reproductive decisions and to expand male outreach programs. Many programs focus mainly on women, even though men have a major role in making family reproductive choices in many countries.

Paradoxically, men often receive little information about reproductive choices, but they may have a major role in decisionmaking. Women, on the other hand, receive some information but often have limited choices. If informed choice is to become a reality, men need to receive more information about reproductive choices and need to be encouraged to discuss such matters with their wives.

Some programs have found that outreach workers, especially male workers, are effective in educating men on family planning. Programs at the workplace have also been effective in reaching men.

Because men as well as women are carriers of sexually transmitted diseases (STDs), which are a major source of female infertility and morbidity, it is important for educational programs and materials directed at men to include mention of STDs and their consequences. Some family planning presentations in factories and other work sites can combine discussions of family planning and reproductive decision-making with references to STDs and AIDS.

Joint counseling for couples or separate counseling for husbands might result in higher adoption and continuation rates. Focus group discussions done in several countries have found that husbands felt at a psychological disadvantage when their wives were their main source of family planning information. After separate counseling sessions for husbands were organized, the men were more amenable to supporting their wives' decision to use contraception.

Recommendation No. 12

Family Planning and STDs, Including AIDS

The prevention and treatment of sexually transmitted diseases (STDs) is important to reproductive health. Family planning providers should offer basic STD services. In view of the widespread concern regarding acquired immune deficiency syndrome (AIDS), family planning providers should seek assistance from various sources for programs to prevent transmission of the virus that causes AIDS. These programs may include staff training, counseling, peer group activities, condom promotion and distribution, the development of communication strategies and materials, and HIV testing (where appropriate).

STD prevention and treatment have long been components of family planning programs because of the relationship of STDs to reproductive health, contraceptive use, and infertility. The advent of AIDS is changing this situation. Family planning agency staff will be involved increasingly, either directly or indirectly, in the prevention of the sexual transmission of human immunodeficiency virus (HIV) and will face many questions and issues related to HIV infection and AIDS. For example, some STDs are associated with higher rates of AIDS transmission, and thus clients with STDs need to be diagnosed and treated promptly.

The specific approach that family planning workers take in relation to AIDS must be tailored to each community and each program. In high-prevalence areas, family planning workers will need to be trained to discuss AIDS in order to respond to clients' queries. Family planning workers should explore with communities realistic options to deal with problems relating to AIDS and HIV infection. These could include recommending specific practices such as abstinence, monogamy, condom use, or different sexual practices.

In counseling clients, service providers need to differentiate between contraceptives that are effective in preventing pregnancy and those which prevent STDs. Only the condom serves both purposes reasonably well. Counselors need to discuss the client's sexual practices in relation to his/her need for protection against pregnancy and STDs and clarify the implications of specific method choices. The choice of contraceptive method will be dependent on social and cultural factors and the perception of AIDS in each agency's environment. In areas or situations considered to be low-risk for HIV infection, clients should be encouraged to continue use of their preferred contraceptive method and reassured that there is no need to switch methods. Educational materials should include appropriate references to AIDs and other STDs.

Staff working in family planning clinics need training in counseling clients regarding HIV infection and AIDS. Counselors need to be trained to deal with sexual behavior in a sensitive and compassionate manner. Particularly in high-risk areas, they need to be able to answer questions regarding AIDS and HIV infection, advise clients on appropriate contraceptive methods, and refer clients for more information or care.

Many issues pertaining to AIDS counseling remain unresolved. Many family planning programs lack the funds to support the necessary staff training and blood testing programs. In addition, in most countries policy issues such as client confidentiality and disclosure of test results need further clarification. Family planning agencies should be cautioned against taking on testing programs without a thorough assessment of resource requirements, including finances, staffing and time.

Research is needed to identify essential mechanisms of protection against HIV infection and AIDS that women can use, which could range from the use of barrier contraceptives to societal changes. Condoms are the only contraceptive method proven to prevent AIDS, although they should not be considered totally foolproof. Spermicides containing nonoxynol-9 or menfegol prevent some STDs, but to date there has been insufficient research to determine their efficacy against AIDS. Therefore spermicides alone are not recommended as protection against HIV transmission, except for women whose partners will not use condoms or abstain and who therefore have no other options.

Recommendation No. 13

Research Needs

More research should be conducted on various elements of informed choice, including method availability, referrals, counseling, public and clinic education, and training. Operations research can be useful to assess the most effective ways of promoting informed choice.

Research is needed to find out what works and what does not work or is not practical and cost-effective in regard to furthering informed choice. As examples of the kinds of research that are needed, Task Force members provided the following suggestions for research projects:

1. Diagnostic case studies can determine: what instruments (e.g., clinic visits, client interviews and data analysis) are most effective in identifying problems related to informed choice; what remedial measures are most useful and acceptable; and how long it takes to see changes in contraceptive adoption and use.

2. Researchers could assess the value of training counselors by comparing method mix, adoption and continuation rates, feedback from clients, and other indicators in two sites—one in which the staff received special counseling training and the other with no special interventions. The effect of using counterparts versus program managers for training counselors could also be studied.

3. An operations research (OR) project could investigate whether the length of time clients are counseled makes a major difference in adoption and continuation rates, the client's satisfaction with her/his chosen method, knowledge, and correct usage. Researchers could also examine whether alternative approaches, such as group educational sessions, private or group viewing of an audiovisual presentation, mass media campaigns or print materials, can compensate for less counseling time.

4. Studies could ascertain what methods women initially request, whether they receive the method they request, if not, what influenced their final selection, and the outcome, as measured by continuation rates, compliance and client satisfaction.

5. An OR project could show videotapes on available contraceptive methods in clinic waiting rooms to see whether this increases knowledge, stimulates questions for providers, affects method choice, results in correct usage and improved continuation rates, and influences the time clinic staff spend with each client.

6. Operations research projects in several countries could find out where men fit into the decision-making process and how their views affect family planning. Also, it would be useful to know whether joint counseling of husband and wife is more effective than individual counseling in promoting adoption and correct usage of female methods.

7. An OR project could test whether counseling clients initially about fertility awareness and then discussing specific family planning methods influences their choice of methods and whether women who know about their most fertile period are less likely to become pregnant and more likely to use contraception.

In undertaking research studies related to informed choice, it is sometimes helpful to use different terminology, such as "method choice," "quality of care," or "client counseling." Staff from both donor and grantee agencies alike feel threatened by terms which suggest an investigation into unsavory practices, and terms are often given different shades of meaning. Therefore, flexibility in describing the area of research often prevents rejection and misunderstandings.

Some research methodology poses both practical and ethical issues. First of all, if informants or "mystery clients" (people hired to pose as clients) are used to monitor and evaluate client counseling sessions, they may give inaccurate or biased reports. Nevertheless, this technique has yielded much valuable information. Alternatively, if clearly identified observers are used, counselors will be giving their "best performance," which is likely to be much better than their ordinary counseling behavior. At the same time, researchers should be sensitive to the fact that family planning workers may resent being evaluated at all without prior notification. Studies exploring differences between husbands and wives in attitudes and knowledge may threaten client confidentiality unless researchers adopt appropriate safeguards.

Recommendation No. 14

Informed Consent Requirements

While clients should make informed decisions for any contraceptive, written informed consent should be required only for voluntary sterilization, because it is intended to be (and effectively is) permanent.

Informed consent is a state of mind in which a person freely and with full information agrees to take a particular course of action. Informed consent forms merely record this agreement or decision. It is important to emphasize that even though written informed consent is not required for contraceptive methods other than voluntary sterilization, clients should make informed decisions. Careful education and counseling are essential to informed consent and should be provided in a language that the client understands.

Recommendation No. 15

The Role of Cooperating Agencies

CAs should review their policies and procedures in regard to informed choice, provide adequate staff training, and adopt appropriate monitoring and evaluation procedures. CAs preparing international guidelines should seek input from service providers in developing countries.

For the most part, Cooperating Agencies funded by AID have written policies and guidelines regarding informed choice. Many agencies in developing countries also have such materials. What remains to be done is to translate the principles of informed choice into practical procedures appropriate for various settings and modes of service delivery. Of necessity, local institutions must take primary responsibility for implementing informed choice. CAs can provide background information and technical assistance and may require specific information to be included in regular project reports. To ensure regular reviews of informed choice in CA subprojects, information on the client education process should be incorporated into the standard reporting and monitoring mechanisms. In some cases, CAs may also wish to visit some facilities for spot checks or to review service records and statistics.

CAs have already taken some steps to safeguard informed choice in their subprojects. When some aspect of informed choice was threatened or compromised, CAs have turned down project proposals, cancelled or suspended ongoing projects, and engaged in intensive project reviews. In some instances, CAs have conducted protracted negotiations to change a grantee's practices because it was felt that this would be more conducive to improving the choice of methods than cancelling the grant.

A number of CAs have trained their own staff in the principles of informed choice and have sought to train their counterparts in grantee agencies through formal sessions and informal meetings and discussions. AVSC has designated "regional voluntarism advisors," who are more intensively trained and can provide technical assistance and address specific issues related to informed choice. FHI, through its Protection of Human Subjects Committee, has spent several years refining and simplifying informed consent forms and fact sheets used by grantees for clients considering participation in a clinical trial.

Recommendation No. 16

AID Support to CAs

AID should provide CAs with up-to-date, accurate information pertaining to informed choice, especially in key areas such as contraceptive safety and efficacy, AIDS prevention, and relevant AID policies.

Informed choice overlaps with many other areas of reproductive health and family planning, including service delivery, contraceptive safety, counseling, communication, operations research, training and AIDS prevention. The CAs would benefit greatly from receiving timely updates on the latest research findings, results of conferences, and new AID policy directives. Due to the large volume of research in the fields of reproductive health and family planning, it is not possible for every CA to be well informed on the latest research findings. The Task Force believes that AID can play a constructive role by providing all CAs with current information pertaining to informed choice. Some of this information is already being provided by *Population Reports, International Family Planning Perspectives, Studies in Family Planning,* and other publications supported by AID. Additional information could be provided by distributing published reports and copies of unclassified AID documents.

Future Task Force Activities

The CA Task Force on Informed Choice believes that there is a continuing need for information-sharing and discussion among CAs in regard to informed choice. The Task Force hopes that this report will challenge CAs and other agencies to do more to further informed choice and to assist their grantees to implement practical measures to ensure informed choice.

For 1989, the Task Force has identified the following tasks as priorities:

1. Circulate this report among family planning leaders based in developing countries and seek their input;

2. Revise, print and distribute this report throughout the international family planning and health community;

3. Make presentations on informed choice at appropriate international and national meetings;

4. Continue to collect exemplary materials on informed choice including print and audio-visual materials; and

5. Continue to monitor CA activities pertaining to informed choice including research, training, materials development and protocols for monitoring and evaluation.

After a highly productive first year, the Task Force members look forward to a broader dialogue on informed choice issues.

Conclusions

AID, CAs and other international and national agencies have made concerted efforts in recent years to promote informed choice principles and practices. Much progress has been made, and the number of new initiatives suggests that the momentum will continue. Nevertheless, the Task Force noted a number of areas in which improvement is possible.

Some of the resistance to broader implementation of informed choice is based on erroneous assumptions: that an exhaustive review of myriad details is required for each client; that efforts to identify areas for improvement will be used to reduce funding levels; that extensive paperwork is needed; and that local discretion regarding clinic procedures and client counseling will be taken away. It is important to emphasize that informed choice focuses on what the client understands and remembers. The stereotypical activities associated with informed choice—boring lectures, lengthy forms and rigid guidelines—may have little to do with helping the client to make and implement choices and to feel comfortable seeking additional information or services, as needed.

Family planning and health care professionals need to understand that implementation of programs to promote informed choice will make their job easier, not harder. Satisfied users are not only the key to high continuation rates but also the most effective promoters of family planning.

APPENDIX A

MEMBERS OF THE CA TASK FORCE ON INFORMED CHOICE

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APPENDIX B

PROGRAM MONITORING CHECKLIST: EVALUATING THE EXTENT OF INFORMED CHOICE IN FP PROGRAMS

The following checklist can be used to assess the scope and depth of informed choice in six components of family planning programs:

- Policy
- Training
- Clinic-based service delivery
- Community-based distribution
- Retail sales
- Information, education and communication.

Methods for assessment have been grouped into three categories:

- Document review
- Observation
- Interview/focus group/role play.

Questions which guide the assessment have been grouped into three categories:

- **Preparation**: the foundations for informed choice
- **Delivery**: interactions between client and provider
- **Outcome:** informed decisionmaking by the client

For each question, suggested assessment methods have been noted with an "X." However, users of the checklist may wish to add questions and employ additional evaluation methods.

Adapted from a checklist prepared by staff of the Program for International Training in Health (INTRAH), University of North Carolina, Chapel Hill, N.C.

QUESTIONS TO ANSWER	MOST APPROPRIATE EVALUATION METHODS												
	DOCUMENT REVIEW						OBSERVATION				INTERVIEW/FOCUS GRP/ROLE PLAY		
1. POLICY **Do FP policies contribute to informed choice?**	national stats	policy state-ments	service stats	trng curric	client records	eval forms	service provider	super-visor	clinic supplies	educ materials	of super-visors	of service providers	of clients
POLICY PREPARATION													
1.1 Are there any national or organizational FP policies which may inhibit informed choice, e.g., establishing method-wise contraceptive targets for various cadres of service providers? Are there policies that promote informed choice?		X										X	
1.2 Does the FP service policy specify what informed choice is?		X											
1.3 Does the FP service policy specify the range of methods to be available by service site?		X											
1.4 Is there a FP program monitoring policy which mandates collection of data on information dissemination (e.g., number of persons attending community meetings, booklets, radio and TV broadcasts)?	X	X	X			X							
POLICY OUTCOME													
1.5 Do national or regional data show increasing and appropriate contraceptive method use according to age, gender, ethnic/tribal identity, region, and service site?	X		X										

QUESTIONS TO ANSWER	MOST APPROPRIATE EVALUATION METHODS												
	DOCUMENT REVIEW						OBSERVATION				INTERVIEW/FOCUS GRP/ROLE PLAY		
2. TRAINING **What is the contribution of FP training to the family planning service provider's ability to provide informed choice?**	national stats	policy state-ments	service stats	trng curric	client records	eval forms	service provider	super-visor	clinic supplies	educ materials	of super-visors	of service providers	of clients
TRAINING PREPARATION													
2.1 Is the concept of providing FP clients with an informed choice included in the FP curriculum?				X									
2.2 Is training given in counseling on all methods?				X									
TRAINING DELIVERY													
2.3 What portion of curricular time is actually spent on counseling (theoretical and practical)?				X								X	
2.4 Do clinic-based service providers receive training and practice on providing all methods of contraceptives available at their clinic site?				X								X	
2.5 Do training materials reinforce informed choice?				X									
2.6 Does on-the-job continuing education or refresher training reinforce providing the whole range of methods?				X							X	X	
TRAINING OUTCOME													
2.7 Does training follow-up direct specific attention to counseling, appropriate provision of methods, and examination of clinic and client records?			X		X		X	X		X			

QUESTIONS TO ANSWER	MOST APPROPRIATE EVALUATION METHODS												
	DOCUMENT REVIEW						OBSERVATION				INTERVIEW/FOCUS GRP/ROLE PLAY		
3. CLINIC-BASED SERVICE DELIVERY **Are the resources and practices of clinic-based FP services conducive to providing informed choice?**	national stats	policy statements	service stats	trng curric	client records	eval forms	service provider	supervisor	clinic supplies	educ materials	of supervisors	of service providers	of clients
CLINIC PREPARATION 3.1 In order to provide the range of methods appropriate to the clinic, are all necessary contraceptive commodities, equipment, and supplies actually available?					X				X			X	
3.2 Is there a checklist used by the service provider during a counseling session to determine the appropriate method for a client? If so, does this checklist remind the provider to discuss all available methods?					X							X	
3.3 Is there a listing of referral sources and other pertinent information?										X		X	
3.4 Are posters and information materials representative of all available methods?										X			
CLINIC DELIVERY 3.5 If a checklist of contraindications is available, does the service provider use checklist?					X		X				X		
3.6 Do service providers counsel clients on all methods or are some methods preferred over others? Why?			X				X				X		
3.7 How much time is each client counseled?							X					X	X
3.8 Do counseling staff provide referrals when appropriate?							X					X	X
OUTCOME OF CLINIC-BASED SERVICES 3.9 When surveys are conducted of clinic clients served, are clients knowledgeable about the advantages and disadvantages of the method they are using, if any? Are they knowledgeable about other methods available at the clinic or by referral?													X

QUESTIONS TO ANSWER	MOST APPROPRIATE EVALUATION METHODS												
	DOCUMENT REVIEW						OBSERVATION				INTERVIEW/FOCUS GRP/ROLE PLAY		
4. COMMUNITY-BASED DISTRIBUTION	national stats	policy state-ments	service stats	trng curric	client records	eval forms	service provider	super-visor	clinic supplies	educ materials	of super-visors	of service providers	of clients
Are the resources and practices of CBD programs conducive to providing informed choice?													
CBD PREPARATION													
4.1 How frequently are CBD service providers supervised or monitored regarding their counseling skills and knowledge of contraceptive methods?						X		X			X	X	
4.2 Are all appropriate contraceptive commodities in sufficient supply for CBD workers?									X			X	
4.3 Do CBD workers have a listing of appropriate referral sources and other pertinent information?										X		X	
CBD DELIVERY													
4.4 Is there a checklist to be used by the CBD worker during a counseling session to determine the appropriate method for a client? If so, does this checklist remind the worker to discuss all available methods?					X	X						X	
4.5 How much time is each client counseled?							X						X
4.6 Do CBD staff provide referrals when appropriate?							X					X	X
OUTCOMES OF CBD PROGRAMS													
4.7 When surveys are conducted of FP clients served in a CBD program, do they perceive they were provided with appropriate information to make an informed choice?													X

QUESTIONS TO ANSWER	MOST APPROPRIATE EVALUATION METHODS												
	DOCUMENT REVIEW						OBSERVATION				INTERVIEW/FOCUS GRP/ROLE PLAY		
5. RETAIL SALES **Are the resources and practices of social marketing and other commercial programs conducive to providing informed choice?**	national stats	policy statements	service stats	trng curric	client records	eval forms	service provider	supervisor	clinic supplies	educ materials	of supervisors	of service providers	of clients
RETAIL SALES PREPARATION 5.1 Are informational materials on contraceptive methods provided to vendors? Is there a checklist to be used by the service provider during a counseling session to determine the appropriate method for a client? If so, does this checklist remind the provider to discuss all available methods?							X					X	
5.2 Are all appropriate methods offered and in stock?									X				
5.3 Are package inserts describing contraceptive usage and contraindications provided?							X			X		X	X
RETAIL SALES DELIVERY 5.4 Does the seller discuss methods available and answer questions about methods?							X						X
RETAIL SALES OUTCOMES 5.5 When surveys are conducted of FP clients who purchase contraceptives, do they perceive they were provided with appropriate information to make an informed choice?													X

QUESTIONS TO ANSWER	MOST APPROPRIATE EVALUATION METHODS												
	DOCUMENT REVIEW						OBSERVATION				INTERVIEW/FOCUS GRP/ROLE PLAY		
6. INFORMATION, EDUCATION AND COMMUNICATION **Is the existing IEC program sufficient and appropriate for promoting informed choice?**	national stats	policy statements	service stats	trng curric	client records	eval forms	service provider	supervisor	clinic supplies	educ materials	of supervisors	of service providers	of clients
IEC PREPARATION 6.1 What educational materials are available for the client on the range of methods?										X			
6.2 What materials are available for the client on how to use specific methods?										X			
6.3 What community education and mass media programs are conducted?										X		X	X
6.4 Are materials pretested with their intended audience?										X	X		
IEC DELIVERY 6.5 At the time of the visit, are educational materials on correct method usage and alternative methods actually available for distribution, or posted in clinics, CBD posts, and sales outlets?									X	X			X
6.6 Are the available materials actually used by service providers as intended?							X				X	X	
IEC OUTCOME 6.7 When interviewed, do clients cite any educational program (mass media, community talk, counseling using visual aids) as enabling them to make a choice between contraceptive methods?													X

APPENDIX C

RESOURCE MATERIALS

Background Materials on Informed Choice and Informed Consent

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