

# Network

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# News Briefs

## WHO STUDY ON EC EFFECTIVENESS

A World Health Organization study in 14 countries concludes that progestin-only oral contraceptives used for emergency contraception are more effective and cause fewer side effects than pills that combine progestin with an estrogen.

Pills containing only a progestin (levonorgestrel) prevented an estimated 85 percent of the pregnancies expected to occur if no emergency contraception had been used. Pills combining both a progestin and estrogen prevented an estimated 57 percent. In the study, there were 11 pregnancies among 976 women using the levonorgestrel pills (about 75 pregnancies would be expected without emergency contraception) and 31 pregnancies among the 979 who used combined pills (72 pregnancies expected without emergency contraception).

Another important finding is that either emergency contraception approach works better when initiated sooner. "Women should receive treatment as soon as is practicable after unprotected coitus," the authors write in the study, published in the August 8 issue of *The Lancet*. When progestin-only treatment began within the first 24 hours, 95 percent of expected pregnancies were prevented.

Nausea, vomiting, dizziness and fatigue were all significantly less common among the women taking the levonorgestrel regimen. In that group, 23 percent had nausea and 6 percent vomiting. Using combined pills resulted in twice as much nausea (51 percent) and three times as much vomiting (19 percent). For both regimens, women are encouraged to take the first dose within 72 hours of unprotected intercourse, followed 12 hours later by a second dose.

In September, the U.S. Food and Drug Administration (FDA) approved for use a combined hormonal product called Preven as the first package of pills in the United States specifically labeled for emergency contraceptive use. "We hope the arrival of a product specifically packaged and advertised for emergency contraception will lead more physicians to offer emergency contraception and educate their patients about it," says Gloria Feldt, president of Planned Parenthood Federation of America in New York.

## CANCER PROTECTION MECHANISM

Recent animal studies in the United States may explain for the first time why oral contraceptives protect against ovarian cancer. The findings suggest that one of the hormones in birth control pills, progestin, may trigger the death of damaged ovarian cells before they can turn cancerous.

The study, published in the September 9 *Journal of the Society for Gynecologic Investigation*, was conducted in monkeys by Duke University Medical Center in Durham, NC. It suggests that giving progestin periodically throughout a woman's life to target precancerous cells in the ovarian lining could be effective in preventing ovarian cancer. The researchers plan to study the safety and efficacy of the therapy in humans.

Many studies over three decades have demonstrated that taking birth control pills for just three years can reduce a woman's lifetime risk of ovarian cancer by 40 percent, but the mechanism involved has not been clearly documented. One widely held theory has been that oral contraceptives reduce ovarian cancer risk by simply reducing the opportunities for cells to mutate. Since the pills suppress monthly ovulation, a woman using oral contraceptives experiences fewer ovarian cell divisions and fewer occasions for genetic damage to initiate ovarian cancer.

## FHI EXPANDS ORGANIZATIONAL STRUCTURE

Family Health International (FHI) has expanded its organizational structure, an adjustment designed to facilitate new initiatives while strengthening current capacity to respond to a growing agenda of reproductive health activities.

FHI has evolved into two divisions with complementary purposes — Family Health Institute and Health Futures. Public sector work continues under the Family Health Institute, funded through agreements with the U.S. Agency for International Development, the National Institutes of Health and other public sector agencies, as well as private foundations. Health Futures becomes a vehicle for new business ventures, including research and development services for pharmaceutical, biotechnology and medical device companies in the area of women's health and infectious diseases. Willard Cates Jr., MD, MPH, who was previously FHI's senior vice president of biomedical affairs, became president of Family Health Institute.

"These adjustments in organizational structure are part of an FHI strategic plan carefully developed by our board and senior staff," said Albert J. Siemens, PhD, FHI's chief executive officer. "To help implement the expanded vision, several key leaders have joined FHI senior management during the past year."

David A. Grimes, MD, formerly vice chairman of the Department of Obstetrics and Gynecology at the University of California at San Francisco, became FHI's vice president for biomedical affairs. Kenneth F. Schulz, PhD, an internationally renowned biostatistician from the U.S. Centers for Disease Control and Prevention, filled the new position of vice president of quantitative sciences, heading data management and biostatistical services, as well as FHI's prevention research unit in HIV/AIDS. Peter Benedict, PhD, who directed country missions for USAID and managed Ford Foundation programs in Africa and the Middle East, serves as vice president for planning and development. They join a veteran team of other senior scientists and leaders based at FHI's headquarters in North Carolina and at the HIV/AIDS Prevention and Care Department in the Washington office.

"FHI is well-positioned to meet the evolving reproductive health challenges of the twenty-first century," said Dr. Siemens. "We will continue to build upon the strong foundation of our staff expertise and global collaborative ties to improve the health and well-being of populations worldwide."

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*A doctor explains contraceptive options to a client at an Amman, Jordan clinic in the cover photograph by Philip Wolmuth of Panos Pictures, London.*



# Menstrual Changes Influence Method Use

**W**omen throughout the world are acutely aware of their menstrual bleeding and are concerned with bleeding changes. Contraceptive-induced menstrual irregularities can result in refusal to start or continue using the contraceptive methods.

Modern methods can profoundly affect menstrual bleeding patterns, with disturbances ranging from heavier bleeding, to prolonged or irregular bleeding, to no bleeding at all.

Providers may discount or minimize such disturbances when discussing contraceptive method choices with clients or when women complain about these side effects. Some disturbances, providers may correctly point out, are transient or can change over time. Unless bleeding irregularities result in medical problems, such as anemia, they may be minor health concerns. Some women, however, will not tolerate bleeding changes that are acceptable to others.

Women notice even minor changes in menstrual bleeding, according to a study conducted by the World Health Organization (WHO) of 5,322 women in 10 countries. Most women surveyed (well over half in most of the countries), including rural and urban women from various socioeconomic strata and various religious groups, did not want their menstrual cycles to change.<sup>1</sup>

Yet, women's perceptions of what constitutes normal menstrual bleeding varied remarkably in different regions of the world due, in part, to natural variations in menstrual bleeding patterns associated with both environmental and genetic factors. The WHO study showed that in non-contracepting women throughout the

world, for example, the average number of bleeding days over three months ranged from 12 days for Mexican women to 18 days for English women (the English women's cycles were more frequent, and their bleeding during each cycle lasted longer).

In contracepting women, such ethnic variations in bleeding patterns have also been observed. Another WHO analysis of over 5,000 women using combined oral contraceptives (COCs or OCs), injectables or a progestin-releasing vaginal ring found that European women tended to have more frequent bleeding than women from Asia, Latin America, Africa or the Caribbean. This was true regardless of contraceptive method used. In contrast, North African women using injectables had the shortest bleeding/spotting episodes, longest bleeding-free intervals and least variable bleeding patterns.<sup>2</sup>

## CULTURAL INFLUENCES

Religious and cultural norms in various regions of the world also influence women's perceptions of normal or acceptable menstrual bleeding and, in many instances, dramatically affect women's daily lives. They define whether a woman is healthy, can perform routine domestic tasks, engage in sex or social activities, visit religious sites, or even bathe.

Menstruating Moslem women are forbidden by their religion to pray, fast, touch various holy books or conduct some pilgrimage rituals. Moslem women often consider menstrual blood to be polluting and their uncleanness to be contagious. While menstruating, they tend to avoid approaching small infants or pregnant women.

"In Egypt, towels and clothes stained with menstrual blood are washed separately from other household items," says Dr. Laila Kafafi, FHI senior resident research advisor in Cairo. "And, although their religion does not forbid women from showering while menstruating, some Moslem women believe it is unhealthy to do so."

In Yugoslavia, Christian women are sometimes prohibited from attending church festivals and performing domestic chores while menstruating.

"Given the reality of modern lifestyles, however, many menstruating women simply must perform domestic activities, even if they prefer not to," says Dr. Asha Mohamud, a Somali physician who has conducted research on health concerns of Somalian women and is a Washington-based senior

program officer at the Program for Appropriate Technology in Health. "Interestingly enough, religious prohibitions on various activities probably evolved as a means of enforcing cultural practices meant to protect and ease the burden of menstruating women."

Most women in the majority of regions studied by WHO viewed menstruation as a welcome event. It represents youth, fertility and femininity, and reassures women that they are not pregnant. It is often perceived as crucial to good health, although this idea is a misconception. Many women also perceive erroneously that lack of menstruation could cause cancer, heart disease, vision problems or mental illness. Similarly, an investigation of the acceptability and use of contraceptive methods in five groups (Bahamians, Cubans,

Haitians, Puerto Ricans and African Americans in the United States) revealed that regular menstrual bleeding was generally viewed as necessary for good health.<sup>3</sup>

Women in the WHO study expressed differing, yet clear, opinions about the type of bleeding that would be acceptable. For example, while the great majority of women preferred their menstrual cycles not to change, women tended to prefer less, rather than more, blood loss if changes were to occur. Such differences are essential for providers to take into account

when considering the acceptability of contraceptive methods that change menstrual patterns.

## HORMONAL METHODS

Hormonal contraceptives, particularly long-acting progestin-only methods like Norplant, three-month injectable depot-medroxyprogesterone acetate (DMPA) and the two-month injectable norethindrone enanthate (NET-EN) change menstrual bleeding patterns in the majority of users. Progestin-only methods rarely increase the number of days of heavy bleeding, but they often increase the number of days of light bleeding or spotting, irregular bleeding and — particularly in the case of injectables — amenorrhea (absence of bleeding).

The prospect of such changes can frighten women. In an FHI study in Indonesia, for example, a 32-year-old urban woman with two children decided not to use Norplant after hearing of her friend's experience with irregular bleeding: "I saw my friend using the implant. She got bleeding again and again. I was afraid to take this method."<sup>4</sup>

The majority of women using the six-capsule Norplant implant system experience disturbances during the first year of use. Over time, these menstrual disturbances tend to subside. Similarly, about 75 percent of more than 1,000 Indian users of the two-rod Norplant-II had bleeding disturbances, primarily "infrequent bleeding" or "frequent/prolonged bleeding," during the first year of use. Bleeding patterns improved over time, with only about a third of some 100 women who remained in the study at five years reporting disturbances.<sup>5</sup>

In a study of 100 Singaporean Norplant-II users, about 90 percent experienced "abnormal menstrual bleeding" — primarily irregular or prolonged bleeding — in the first three months of use; however, among some 60 women who remained in the study at five years, these changes had decreased to 30 percent.<sup>6</sup>

Notably, discontinuations among Norplant users due to menstrual irregularities are relatively few considering the large number of users reporting irregular bleeding patterns. In the Indian study, while 75 percent of Norplant-II users experienced bleeding irregularities in their first year of

RICHARD LORD



CULTURAL NORMS ABOUT MENSTRUAL BLEEDING AFFECT WOMEN'S DAILY LIVES IN MANY WAYS, INCLUDING WHETHER THEY CAN PERFORM ROUTINE DOMESTIC TASKS, ENGAGE IN SEX OR SOCIAL ACTIVITIES, VISIT RELIGIOUS SITES, OR EVEN BATHE. A CAMBODIAN WOMAN RETURNS FROM HER VISIT TO A MARKET.

use, only 8 percent discontinued for that reason. In a review of several studies, reported menstrual-related discontinuations before the end of five years of treatment have ranged from 4 percent to 31 percent.<sup>7</sup> In clinical trials of Norplant conducted by FHI investigators in 11 countries, approximately 16 percent of subjects had discontinued Norplant due to menstrual problems at the end of five years.<sup>8</sup>

Norplant's relatively low discontinuation rates, however, may not always accurately reflect women's satisfaction with the method. A study in Senegal showed that many providers strongly encourage continuation,<sup>9</sup> perhaps because the method is relatively expensive. "Most women who had problems obtaining removal of their implants requested early removal because of bleeding disturbances, but it appears that these bleeding disturbances were not considered serious enough by providers to grant immediate removal," says Elizabeth Tolley of FHI, who co-authored the study.

Treatment for Norplant-related bleeding disturbances can be successful and should be offered as an option. But the implants should be removed if a woman requests removal.

Counseling women about the advantages and disadvantages of Norplant, and encouraging them to report their concerns about side effects such as menstrual disturbances, can be crucial to a woman's sense of well-being and may also improve acceptance of the method. Similarly, poor counseling can cause unnecessary distress.

In a Haitian study, providers and clients alike reported that the possibility of Norplant-induced prolonged or heavy bleeding was not adequately explained during counseling.<sup>10</sup> In contrast, in a clinic in the United States, providers carefully described the kind of bleeding that Norplant might cause and discussed how women might deal with such bleeding changes (including how to lower the ex-

pense of managing bleeding by using minipads rather than larger pads or tampons). As a result, initial Norplant use was lower but continuation rates were much higher than at other clinics in the same area, says Judy Norsigian, program director of the Boston Women's Health Book Collective and a member of an FHI advisory panel on contraceptive research.

However, even preliminary counseling may be insufficient to boost continuation rates. A survey of 98 North American women who had Norplant inserted and removed between 1991 and 1994 found that comprehensive pre-implant counseling received by all but one client did not influence their decisions to remove the implant. Irregular menstrual bleeding was the main reason given for requesting removal.<sup>11</sup> Thus, addressing women's concerns about menstrual bleeding irregularities during follow-up visits may be essential. Involving husbands in family planning decisions may also make contraceptive-induced bleeding disturbances easier to accept.

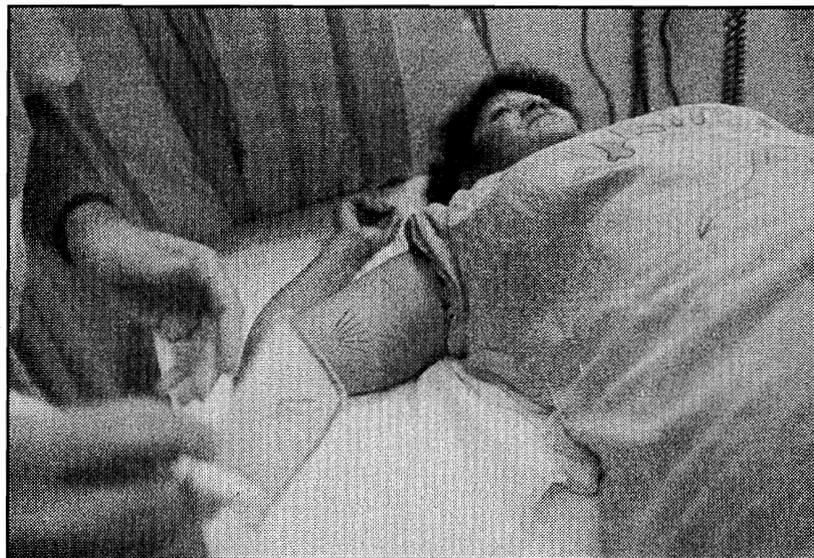
welcome sign that a contraceptive method is working effectively. A study of the bleeding patterns of 234 women using Norplant showed that, after one year of use, those women with regular cycles were at greatest risk for method failure. The five-year pregnancy rate for users with regular cycles was 17 percent, compared with 4 percent for users with irregular cycles and none for users with amenorrhea.<sup>12</sup>

## PROGESTIN-ONLY INJECTABLES

The majority of women using progestin-only injectables report prolonged or irregular menstrual bleeding or amenorrhea in their first year of use. During the first three to six months of use, progestin-only injectables are associated with episodes of irregular and prolonged bleeding. Later, they are associated with amenorrhea; approximately two of every three DMPA users experience amenorrhea by the end of the second year. NET-EN disrupts bleeding patterns somewhat less than DMPA and is less likely to cause amenorrhea.<sup>13</sup>

Discontinuation rates due to DMPA-associated menstrual disturbances are approximately 25 percent after one year. However, in a WHO trial, the percentage of women who discontinued after one year due to bleeding varied widely among seven countries: from 3.5 percent in Jamaica to almost 59 percent in Yugoslavia.<sup>14</sup> This may be due, in part, to cultural differences in the acceptability of bleeding disturbances. Also, population variations have been observed in studies of progestin-only injectables. Thai women, for example, absorb and eliminate DMPA more rapidly than do Mexican women.<sup>15</sup> And, in a study of DMPA use by Vietnamese women, the percentage of

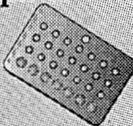
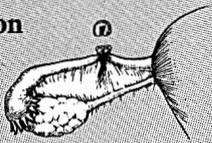
DMPA users with a normal menstrual pattern was two to three times higher than reported in previous DMPA studies in various other populations, probably due to ethnic differences in the agent's metabolism.<sup>16</sup>



DURING THE FIRST YEAR OF NORPLANT USE, MOST WOMEN EXPERIENCE MENSTRUAL DISTURBANCES, WHICH TEND TO SUBSIDE LATER. A NEW YORK PHYSICIAN USES A TEMPLATE TO MARK A WOMAN'S ARM, TO GUIDE WHERE THE SIX NORPLANT CAPSULES SHOULD GO.

Providers may justifiably stress the benefits of such menstrual changes as amenorrhea. Under normal circumstances, the absence of bleeding suggests pregnancy, making women anxious. However, amenorrhea may be a

## COMMON BLEEDING DISTURBANCES FROM METHOD USE

METHOD	BLEEDING DISTURBANCE
<b>Norplant</b> 	Increased days of light bleeding or spotting/irregular bleeding
<b>Injectables</b> 	Progestin-only Injectables (DMPA, NET-EN): Irregular and prolonged bleeding episodes/spotting first three to six months; later, amenorrhea  Combined Injectables (Cyclofem, Mesigyna): Predictable once-a-month bleeding for most women, but some may experience frequent, irregular or prolonged bleeding
<b>Oral Contraceptives</b> 	Progestin-only Pills: Increased days of light bleeding/irregular bleeding; amenorrhea  Combined Pills: Decreased number of days of bleeding/blood loss; spotting; amenorrhea
<b>IUD</b> 	Copper IUDs: Increased menstrual blood loss of 30 to 50 percent  LNG IUDs: Significantly decreased bleeding; amenorrhea
<b>Sterilization</b> 	More research needed, but menstrual changes in some women tend to reflect changes caused by discontinuation of a prior method

Furthermore, pretreatment counseling can affect DMPA discontinuation rates. This was demonstrated in a study of about 400 Chinese women, half of whom received intensive pretreatment and ongoing counseling about DMPA and half of whom received only brief counseling. After a year, women in the intensive counseling group reported more menstrual irregularity (40 percent) than did those in the other counseling group (26 percent), but their discontinuation rate was 11 percent compared with 42 percent for the routine counseling group.<sup>17</sup>

In a recent study of about 600 Vietnamese DMPA users, counseling influenced whether women experiencing amenorrhea continued using DMPA.<sup>18</sup> "Women who continued use reported receiving better quantity and quality of advice from health staff, as well as from other satisfied users, families or husbands," says Dr.

Maxine Whittaker, an Australian-based physician and technical advisor to the Vietnamese study that was funded in part by WHO.

### MONTHLY INJECTABLES

Monthly injectables combining an estrogen with progestin create more regular menstrual cycles. In most women using these injectables, bleeding tends to occur predictably once a month after the first few months of use.

In general, about half of women using combined monthly injectables experience irregular bleeding during the first three months, while less than a third of users of Cyclofem (25 mg DMPA and 5 mg estradiol cypionate) and Mesigyna (50 mg NET-EN and 5 mg estradiol valerate) reported irregular bleeding patterns after one year.<sup>19</sup>

In a WHO study in which Cyclofem was introduced into family planning programs in Indonesia, Jamaica, Mexico, Thailand and Tunisia and given to about 8,000 women, discontinuation rates associated with menstrual disturbances at one year ranged from about 3 percent in Indonesia to about 40 percent in Tunisia.<sup>20</sup> Different cultural attitudes about disturbances may be among reasons why discontinuation rates vary so widely.

### ORAL CONTRACEPTIVES

Like other progestin-only methods, progestin-only contraceptive pills (POPs or minipills) usually produce irregular menses or increased days of light bleeding. They may cause amenorrhea.

## HOW TO MANAGE BLEEDING DISTURBANCES

Once gynecological disease is ruled out, the first approach to help women manage contraceptive-induced bleeding disturbances should be counseling and reassurance that such changes are to be expected. In addition, recommended approaches to managing bleeding disturbances include the following:

- Combined oral contraceptive pills can be used to treat bleeding problems associated with progestin-only contraceptives. Pills that contain 50 µg ethinyl estradiol and 250 µg levonorgestrel each, taken daily for 20 consecutive days, significantly reduce bleeding days in Norplant users.<sup>1</sup>

- Estrogen can treat bleeding problems associated with progestin-only contraceptives. Norplant-induced uterine bleeding also has been controlled by using 50 µg ethinyl estradiol taken daily for 20 days, although estrogen was significantly less effective than combined oral contraceptive pill use.<sup>2</sup>

- Non-steroidal anti-inflammatory drugs, such as ibuprofen, reduce heavier menstrual bleeding associated with intrauterine devices (IUDs).

However, the need to manage contraceptive-induced bleeding disturbances is debatable, especially the use of hormonal treatments (combined pills or estrogen) in women already using hormonal methods.

"It is not a good idea to play hormonal roulette," says Judy Norsigian, program director of the Boston Women's Health Book Collective and a member of an FHI advisory panel on contraceptive research. "Offering something else to counter bleeding is not necessarily a good idea. It is better to offer her a different method."

"Since bleeding usually presents no health risk, a little bit of patience to await regular cycles may be the best approach," adds Dr. Carlos Petta of the University of Campinas, Brazil, who has conducted extensive research on injectable contraceptives. "But if that is not possible, certainly another method should be offered."

— Kim Best

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Combined oral contraceptives, which are much more widely used than POPs, commonly decrease the number of days of bleeding and blood loss, with menstrual flow decreasing by 60 percent or more. However, missed periods, very scanty bleeding, spotting or breakthrough bleeding may occur and upset women. Amenorrhea also may be a side effect, especially in women using low-estrogen pills.

### IUDs

Increased menstrual bleeding and pain are frequently reported by women using intrauterine devices (IUDs). In some studies, as many as 80 percent of IUD users complain of these disturbances. With Copper T IUDs, menstrual blood loss is increased

moderately (defined as a 30 percent to 50 percent increase in bleeding compared with the average loss for women not using modern contraceptive methods). FHI research conducted in 23 developing countries, however, indicates that Copper T IUD-related bleeding disturbances tend to decrease after the first few months of use.<sup>21</sup>

Determining discontinuation rates due to increased menstrual bleeding for specific IUDs is difficult, says Dr. Patrick Rowe, medical officer in charge of IUD research at WHO in Geneva, "because there is great variation in removal rates for pain and/or bleeding for even the same device between centers and studies." However, bleeding problems — namely heavy, prolonged or irregular bleeding — are the main reason for IUD discontinuation. The bleeding-related

discontinuation rate for IUDs, in general, is approximately 7 percent to 15 percent at one year.

Hormone-releasing IUDs significantly reduce the volume of menstrual bleeding. Progestasert, which releases the naturally-occurring hormone progesterone, is costly, not widely available, and is approved for only a year of use in the United States. A levonorgestrel-releasing IUD, called LNG IUD, is available in several European and Asian countries. The number of bleeding and spotting days in LNG IUD users is markedly reduced when compared with non-users. A substantial proportion of users experience amenorrhea.

A multicenter WHO study involving more than 3,000 women indicated that, at one year of use, the removal rate for pain and/or bleeding — as well as amenorrhea — was significantly higher for the LNG IUD than for the Copper T 380A.<sup>22</sup> At three years of use, this difference in removal rates for pain and/or bleeding was less pronounced, but the difference in removal rates for amenorrhea was more pronounced. At three years of use, removals for pain and/or bleeding for the LNG IUD and the Copper T 380A were 17 percent and 11 percent, respectively. Removal rates for amenorrhea were 27 percent and 0.2 percent, respectively.<sup>23</sup>

"In the WHO study, counseling subjects that amenorrhea was normal and did not mean that they were pregnant did not appear to reduce amenorrhea-related LNG IUD removal rates," says Dr. Rowe. However, it is generally recommended that providers still counsel potential LNG IUD users that amenorrhea is not a disease. Rather, it is a sign that levonorgestrel is acting on the lining of the uterus.

Furthermore, the absence of bleeding can have important medical benefits. Reducing menstrual blood loss, and thereby increasing the body's iron stores, is particularly important for women with anemia. In several countries, an approved use of the LNG IUD, besides contraception, is treatment of excessive menstrual bleeding. In some cases, it offers an alternative to surgical treatment.<sup>24</sup> Amenorrhea may even be welcome relief for women who have normal monthly bleeding, but find it to be uncomfortable or inconvenient.

## STERILIZATION

In an FHI-sponsored study by Centro de Pesquisas e Controle das Doenças Materno-Infantis de Campinas (CEMICAMP) in Campinas, Brazil, involving 236 women aged 30 to 49 years who were sterilized at least five years earlier, the most frequently reported physical change attributed to sterilization was related to menstruation. Over a third of sterilized women in the study reported increased menstrual flow.<sup>25</sup> Other studies suggest that female sterilization may cause such menstrual disturbances as painful menstruation, heavy bleeding or spotting, and changes in cycle length or regularity.

However, research has also shown that the contraceptive method used just prior to sterilization can affect women's reports of bleeding changes after the procedure. For instance, former OC users, accustomed to method-induced light bleeding, will notice increased bleeding when they stop taking OCs. Likewise, IUD users, accustomed to method-induced heavier bleeding, will tend to notice decreased bleeding when they no longer use an IUD.<sup>26</sup> These changes likely are not due to sterilization, but rather to discontinuation of the previous contraceptive method.

Further research is needed to determine whether sterilization can cause menstrual disturbances. Meanwhile, a literature review of more than 200 studies on menstrual and hormonal changes in women who undergo tubal sterilization concluded that, in well-controlled studies, the procedure was not associated with an increased risk of menstrual dysfunction, painful menstruation, or increased premenstrual distress in women who underwent it after age 30. Women in their 20s with histories of menstrual dysfunction before sterilization may be at higher risk of these disturbances, but do not appear to have significant hormonal changes.<sup>27</sup>

— Kim Best

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# A "Client Perspective" Helps Improve Services

Frameworks for improving quality of services have common features, including a client emphasis.

Family planning clinics throughout Egypt are displaying gold stars on their front doors, part of a campaign to promote client satisfaction. The Ministry of Health program trains family planning clinic supervisors to use a checklist of 101 indicators to evaluate services, ranging from availability of contraceptive commodities to the condition of facilities. Community television messages and posters ask people to look for the gold stars, which indicate clinics that meet quality service standards. One poster says, "We are behind every door here to serve you and take care of your family." Begun in 1992, the program is currently used by nearly 4,000 clinics nationwide.

Traditionally, family planning services worldwide have concentrated on increasing contraceptive use, in part to reduce fertility rates. More recently, they are focusing on the quality of service as well.

"When we talk about quality of care, we are looking at services from the client's perspective," says Dr. Carlos Huezo, medical director of the London-based International Planned Parenthood Federation (IPPF). Clients have the right to information, access, method choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion, he says.

In order to achieve these goals, providers need adequate training, current information, infrastructure, supplies, guidance and respect. IPPF has included client rights and provider needs in its service delivery guidelines,<sup>1</sup> and has widely circulated a poster on the rights of clients.

Another approach to thinking about quality care identifies six elements. The "Bruce framework," developed in the 1980s by Judith Bruce and an advisory committee at the Population Council, a research organization based in New York, gives method choice as "not only the first, but the fundamental element of providing quality in services." Other elements are the amount and quality of information given to clients, the technical competence of providers, the interpersonal relations between the client and provider, the mechanisms used by a program to encourage continuity, and the appropriate constellation of services provided.<sup>2</sup> The Pan American Health Organization and FHI have expanded this framework, adding such elements as the need to coordinate reproductive health services, including family planning, prevention and treatment of sexually transmitted infections and maternal and child health care.

These and other frameworks for improving services tend to have common features: They emphasize better ways to interact with clients, and they often address



EGYPTIAN FAMILY PLANNING BROCHURE  
WITH GOLD STAR.

how to approach specific management concerns, such as maintaining adequate contraceptive supplies.

## CLIENT INTERACTION

In recommendations on provider practices, the U.S. Agency for International Development (USAID) has summarized key processes involved in the interaction between clients and providers and the information that clients need during counseling. For services to be most effective, providers need to give clients their preferred method, treat clients well, individualize each session, be interactive and responsive to clients' questions, avoid information overload, and provide memory aids (see page 12).<sup>3</sup>

Studies have shown the importance of providing a client's preferred method. A study in Indonesia among nearly 2,000 women found that receiving the desired method resulted in much higher continuation rates. Among the nearly 1,700 women granted their method choice, only 9 percent had discontinued contraceptive use a year later. Among the 266 women who did not get their first choice, 72 percent were not using the method a year later.<sup>4</sup> A study coordinated by IPPF involving 11,000 women found that a key factor in method continuation was whether the women obtained the method they had intended to use before coming to the clinic. The study was conducted in Guatemala, Hong Kong, Jordan, Kenya, Trinidad and Tobago, and Nepal.<sup>5</sup>

Clear and complete information about side effects is important. FHI's Women's Studies Project found that both real and imagined side effects are a serious concern for many women, more than providers realize. In Bolivia, for example, the 25 percent of the contraceptive users who said they were dissatisfied with their method blamed side effects. The project found similar trends in Bangladesh, Egypt and Indonesia.<sup>6</sup>

"Part of the realignment of programs towards quality is truth in advertising," says an author of the USAID recommendations, Elaine Murphy of Program for Appropriate Technology in Health, a U.S.-based group providing technical assistance. "Good counseling will include the fact that you may have some symptoms that are upsetting but they will generally go away. If a client does not know that, she would not last through those

initial symptoms. Where women have been counseled on side effects, continuation is very high."

Counseling about family planning may be more effective if it is not overly promotional. "If you are promotional, you do not talk about the negative aspects of a method," says Murphy, who co-chairs a USAID committee on client-provider interaction.

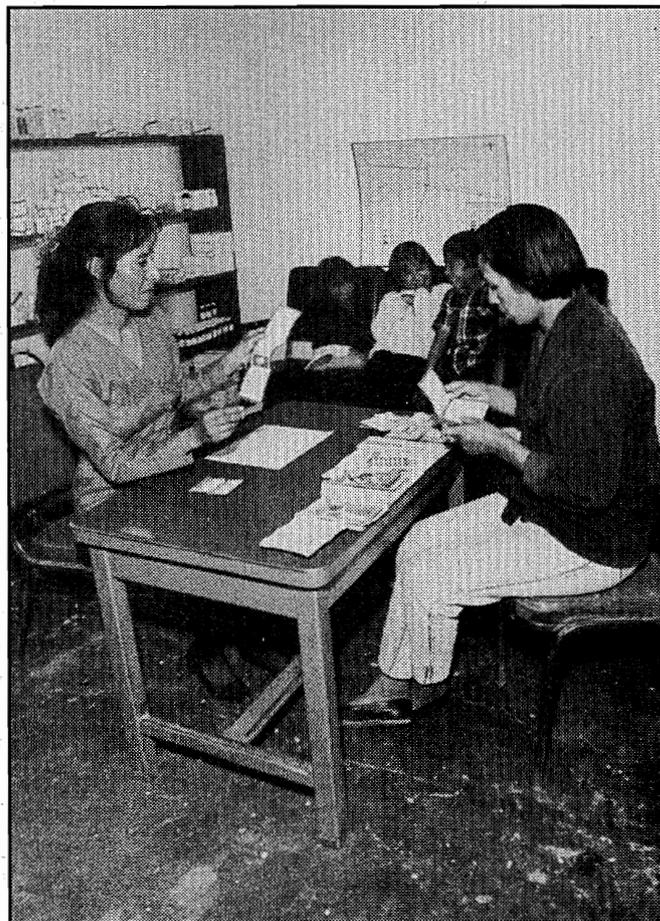
A study among 650 new contraceptive users in Niger and 570 in The Gambia assessed the reasons for discontinuation of use. After eight months, about 30 percent of new users had discontinued use. The most commonly cited reasons were side effects and fear of side effects. Among the women in Niger who said they did not receive adequate counseling, 37 percent discontinued using a method, compared to only 19 percent discontinuation among those who reported receiving good counseling. In The Gambia, 51 percent of those who said they received poor counseling discontinued, compared to 14 percent discontinuation among those who said counseling was adequate.<sup>7</sup>

In addition to adequate information about side effects, good counseling should include effectiveness, advantages and disadvantages, how to use the method correctly, when to return, and STD prevention. However, providing too much information can be counterproductive. "There are limits to the amount of information people can understand and retain ... counseling should not be dominated by a recitation about every method offered in a program," say the USAID recommendations. "Instead, providers should focus on the client's selected method and be brief, non-technical and clear."

Counseling on proper use of the method is the critical

element for changing contraceptive use behavior, says Dr. Deborah Oakley of the University of Michigan in the United States. Dr. Oakley, who has studied correct method use, has found that about 30 percent of women need more individualized counseling to help them use oral contraceptives effectively. "Most counseling deals largely with method choice and exhortation about only one specific use behavior, taking a pill every day at the same time," she explains.<sup>8</sup> Rather than giving uniform, generalized answers to all women regardless of their specific situations, individualized care should be provided. Providers should consider how different life stages or life situations affect counseling. A young woman who is a first-time user, a breastfeeding mother who wants to space the next birth, and an older woman who wants no more children have different counseling needs.

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IN ADDITION TO INDIVIDUAL COUNSELING, CLIENTS CAN LEARN MORE ABOUT METHOD CHOICES THROUGH VIDEOS, AUDIOTAPES AND GROUP TALKS. THESE WOMEN AT A FAMILY PLANNING CENTER IN PACHUCA, MEXICO, ARE READING LITERATURE ABOUT METHODS.

## USAID RECOMMENDATIONS

Recommendations from the U.S. Agency for International Development (USAID) for quality family planning services include these points:

- provide the client's preferred method, if available and appropriate
- treat the client with respect
- personalize counseling to specific situations
- be interactive and responsive to client's questions
- avoid information overload; focus on client's selected method
- use and provide memory aids

Key information to help clients choose methods should include:

- effectiveness
- side effects and complications
- advantages and disadvantages
- how to use method correctly
- when to return for follow-up or re-supply
- whether it prevents STD/HIV

Source: *Recommendations for Updating Selected Practices in Contraceptive Use, Volume II*. Washington: U.S. Agency for International Development, 1997.

BILL FINGER/FHI



A CLIENT RECEIVES PILLS FROM A FAMILY PLANNING COUNSELOR IN JAMAICA.

Individualizing a counseling session can also help first-time family planning users. Women under 24 years old have the highest discontinuation rates, according to an analysis of Demographic and Health Survey data.<sup>9</sup> These clients may benefit from the attention of individualized counseling.

Some providers should talk less and listen more. In Ghana, Kenya and Indonesia, studies found that providers spoke about two-thirds of the time during counseling. In addition, more than 70 percent of the clients' participation was passive, often involving

short responses or showing agreement with the provider. When clients actively participate, they often elaborate on a response and ask important questions.

"The findings suggest that changes are needed in both providers' and clients' behaviors if clients are to play a more active role in counseling sessions," says Young Mi Kim of Johns Hopkins University's Population Communication Services, who worked on the studies.<sup>10</sup> For example, at the beginning of a session, a provider could say, "I would like you to speak freely with me today.

Please ask me anything you wish." Providers should lead less and respond more, while clients should be encouraged to voice their needs and opinions. Local programs could use videos and audio tapes in the waiting rooms, hold group talks while clients wait, and have providers encourage clients to participate.

Outreach efforts can improve contraceptive use. A study in Bangladesh found that simply contacting the client at home contributes to better contraceptive continuation rates. "Overall odds of discontinuation are reduced by 65 percent if women are contacted at home at least once in a 90-day period," the study found.<sup>11</sup>

## MANAGEMENT CONCERNS

Approaches to improve reproductive health services management skills have emerged, with names such as "total quality management," "continuous quality improvement," "continuous assessment," and "Client-Oriented, Provider-Efficient (COPE)." In general, these approaches arrive at solutions for addressing specific problems, and include ways to motivate staff to use these solutions. Most of the approaches attempt to involve staff in the process and to include a regular assessment of progress.

"Quality improvement is not a one-time exercise but an ongoing and ever-changing process," explains Janet Bradley in a review of how the Family Planning Association of Kenya (FPAK) has used the COPE approach. Working with New York-based AVSC International (AVSC), which works to improve reproductive health services worldwide, FPAK began using the four-step COPE system: self-assessment, client interviews, client flow analysis and a plan of action. It trained staff to perform these exercises at each clinic, since this approach emphasizes involving all staff at a location.<sup>12</sup>

Some changes have been simple, such as staff deciding to stagger their lunch breaks so that clients' waiting time could be shortened. In another case, a clinic had an inconsistent water supply, and managers were considering expensive solutions such as installing a new pump. Because the COPE process involved everyone at the clinic,

including the groundskeepers, they learned that simply fixing a leaking pipe could solve the problem.

Now used in about 35 countries, COPE can help motivate staff to work towards improving quality. "We have come to see that supervision is a very critical piece of the process," says Maj-Britt Dohlie, who heads an AVSC team that focuses on service quality. "But supervisors alone cannot improve quality. They need to involve staff at all levels." The approach encourages small groups to assess specific problems and develop action plans based on their assessments.

To gain a better understanding of how to motivate staff, IPPF has recently conducted a study in Uganda and Bangladesh involving about 40 workers and managers at government and nongovernmental clinics. Among the factors that seem to motivate them to perform better are a sense of altruism and learning that clients appreciate their work. Negative factors included low pay, delays in getting paid and job insecurity. Solutions to these problems may be difficult, but at least payments could be made on time. "The concepts of quality of care are now quite clear, but still nothing happens in many service delivery systems," says IPPF's Dr. Huezco. "One of the main reasons is the lack of motivation of the provider."

"If every provider has not been given the training they need, how can we expect them to meet the needs of clients?" asks Dr. Huezco. "Providers also need updated information, a proper infrastructure with properly established and equipped facilities, supervision that is supportive and not based on blaming — all of these are necessary for providers to perform to the optimum."

#### QUALITY MAKES A DIFFERENCE

Many factors influence why women and men adopt and continue using certain contraceptive methods. These factors include individuals' stage in life, the nature of their sexual relationships, their degree of STD risk, their medical condition, their access to services, the availability of the

method they want, and the type of counseling they receive. How the service delivery system addresses all of these issues affects the overall quality of service. Because so many issues are involved, measuring the quality of services is a challenge.

Quality of services can dramatically affect the use of family planning. A study in Peru, for example, estimated that contraceptive use would rise from 16 percent to 23 percent if all women lived where programs provided the highest quality of care, compared to living where programs provide the lowest quality of care. In general, the study found that rural areas had both lower quality and lower contraceptive use than urban areas. The study analyzed services at nearly 3,000 delivery points, measuring quality by such factors as method availability and restrictions, provider training, provider bias, information provided, cleanliness, privacy and interpersonal relations, and other reproductive services provided.<sup>13</sup>

However, quality is a subjective notion. A study in Jamaica assessed the perspectives of providers and clients on quality of services, using surveys and interviews of providers and supervisors. It also used reports from simulated clients (people trained for a study who pretend to be clients and observe the care they receive).

The study found that 93 percent of providers said they would recommend their health facility to others, but only 58 percent of simulated clients said they would recommend the health facility they visited. The study evaluated 344 of the 346 health facilities in Jamaica, interviewing about 1,200 providers and supervisors and using 20 female simulated clients who visited 50 randomly selected clinics.<sup>14</sup> The study also assessed the training providers have received, the information and services clients are given and how these relate to the training, skills and attitudes of providers, the physical environment of the facilities and working environment of providers.

— William R. Finger

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# Clients Prefer Method Choices

Counseling and offering a variety of method options improve client satisfaction.

**W**hen clients have adequate information about contraceptive methods, have several types of methods from which to choose, and make a decision without pressure or coercion, they are more likely to be satisfied and to continue to practice family planning.

However, achieving this level of informed and voluntary method choice can be difficult. Clients, especially women, are not always accustomed to making decisions, deferring instead to spouses and in-laws or following religious, government or provider dictates. Men, who have limited methods from which to choose, may be excluded from family planning programs. And health providers, although trained in the technical skills necessary to provide contraception, may not know how much or what type of information to provide.

Informed choices about reproductive health are more likely when services focus on client needs rather than client numbers. Through counseling, health workers can help clients make choices by offering information about a range of contraceptive methods, then providing details on the method the client requests, including what to do if problems arise. Providers should work to establish a dialogue with clients, so that clients will feel comfortable asking

questions or returning for services when their needs change. First-time users of contraception need facts and advice, but so do continuing users who may desire to switch methods.

"Before offering information to the client, the provider should ask what the client wants to discuss and what contraceptives the client had in mind," says Dr. Carlos Huezo, medical director of International Planned Parenthood Federation (IPPF) in London. "Then the provider should tailor the advice to the client's needs. Service providers should react to each client's agenda, not try to impose their own agenda. The first step in informed choice is education and information. Then clients should have access to counseling, then access to methods."

## INCOMPLETE INFORMATION

Informed choice is a continuing process in which women and men make decisions about contraceptive methods and try new methods or abandon methods, depending on their personal preferences. The decision-making process often begins long before clients meet health workers. Women and men gather information from their relatives, neighbors, co-workers and friends. They may learn about family planning from radio or television programs, billboards, newspaper articles or other media.

Counseling from health providers is a key element in helping clients make informed choices about family planning, says Jill Tabbutt-Henry, manager of AVSC International's (AVSC) Advances in Informed Choice program, which educates

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RELATIVES, NEIGHBORS AND FRIENDS OFTEN INFLUENCE CONTRACEPTIVE CHOICES. WOMEN IN BURKINA FASO PREPARE FOOD.

and trains providers. "There needs to be a partnership. The provider has the background to make medical decisions, but needs to work with the client to figure out which methods work best with the client's lifestyle."

Numerous studies have shown that, while well intentioned, providers often give incomplete information during counseling sessions. A study in Peru by the New York-based Population Council surveyed 112 women who used the three-month injectable, depot-medroxyprogesterone acetate (DMPA), and 38 women who had discontinued the method, to learn why discontinuation rates were high.<sup>1</sup> Researchers found that women did not receive sufficient information about how the method works. Also, many women were reluctant to ask questions if they did not understand what providers told them. "I would like to ask questions," said one client, "but the nurses are always hurried, and what is more, there are many people, and it makes me feel ashamed to be asking questions and saying my business out loud."

In addition, amenorrhea, one of the side effects of DMPA, was disconcerting to women. In spite of assurances from providers that amenorrhea was not harmful, women viewed menstruation as beneficial to their health. Some women even skipped injections so their periods would start and they would know they were not pregnant. Many feared amenorrhea was a sign of permanent infertility. As a result of the study, the Peruvian Ministry of Health added training that emphasizes the need to counsel clients about side effects.

In Nigeria, a nationwide study found that in 395 client-provider interactions, nearly all clients said staff were friendly and easy to understand. However, clients did not always receive the information necessary to help them use their method correctly.

Twenty-three percent of new users said they would have preferred another method, fewer than one-third were told what to do if side effects occurred, and 43 percent were not told where to obtain additional contraceptive supplies. Fewer than one-third were asked if they were breastfeeding, but exit interviews revealed that 27 percent of women using combined oral contraceptives (COCs) were breastfeeding. Because they

contain estrogen, which can reduce the quantity of breastmilk, COCs are not recommended for women who are breastfeeding.<sup>2</sup>

In Kenya, researchers monitored 176 counseling sessions with clients. Eighty-two percent of new clients said they had some knowledge of family planning before they came to the clinic, and nearly half (46 percent) had a strong preference for a specific method. Providers respected informed choice and believed that the client should ultimately decide which method to use. Yet, providers did not offer complete information to help clients make decisions. For example, in only half the sessions with new users did providers explain when to begin taking oral contraceptives, and in less than one-third of the sessions did they tell clients what to do if they missed a pill.

In 80 percent of sessions with pill users and 65 percent of sessions with injectable users, providers explained when to return for re-supply, checkups or problems. However, only 20 percent of sessions included information about specific warning signs that could indicate a need to return to the health provider. In two-thirds of sessions, providers collected information on clients' medical history and discussed contraindications to method use. But providers rarely discussed risks of sexually transmitted diseases (STDs) or reproductive goals.<sup>3</sup>

An FHI study in Colombia found that new acceptors of COCs did not fully understand instructions for taking pills.<sup>4</sup> Of the 572 users, fewer than half knew what to do if they missed taking an active COC — to take the missed pill as soon as possible, then the next pill at the regular time even if that means taking two pills in one day. Only 15 percent knew that most side effects last less than three months. And the study also found that providers lacked correct information on pill taking. Interviews with 195 rural health promoters found that approximately half knew that side effects lasted less than three months or that women should use a backup contraceptive method if they miss three or more pills.

An FHI study of more than 1,200 pill users in Egypt showed that many women used oral contraceptives incorrectly. Researchers attributed incorrect use to client's lack of information about how pills work and why it is important to take pills daily. For example, about one in five women (22 percent) said they took the pills only "as

needed" (when they were sexually active).<sup>5</sup> Another FHI study, comparing pill compliance in four countries, found many women did not know the correct action to take after missing a pill. For example, only half of the women in Zimbabwe (49 percent) knew the correct response.<sup>6</sup>

During counseling sessions, providers may be reluctant to discuss side effects, fearing that candid information will discourage clients' contraceptive use. However, several studies show that side effects are a major concern for women. Lack of knowledge about what to expect and how to cope may discourage contraceptive continuation.

An FHI study of 1,076 clients at four clinics in Kenya, for example, found 80 percent of clients discontinued pills after 12 months, as did 39 percent of DMPA users and 20 percent of intrauterine device (IUD) acceptors. Clients said they were satisfied with clinic services but unhappy with side effects.<sup>7</sup> In FHI's Women's Studies Project, the majority of 490 women interviewed in Indonesia said they received the contraceptive method they wanted when they went to clinics. However, three-quarters of women in Jakarta and Ujung Pandang said they wanted more information about side effects to help them decide.

In Ghana, a study by Johns Hopkins University surveyed 49 new clients and 48 continuing clients and found that the majority of health workers greeted clients, treated them kindly, corrected misconceptions, and explained why a method might be inappropriate. However, workers seldom discussed side effects.<sup>8</sup> In Niger and The Gambia, more than 30 percent of 1,200 women interviewed stopped using contraception within a year. Side effects were the most common reason given by women in The Gambia and the second most common reason for discontinuation in Niger.<sup>9</sup>

## WHAT CLIENTS NEED TO KNOW

Health workers are often faced with the dilemma of what and how much information to provide, and how to inform thoroughly within the short time allowed with a client.

While health workers may want to begin counseling sessions by telling new clients about contraceptive options, providers should begin instead by asking questions. Providers should inquire about the client's

## QUALITY SERVICES OFFER INFORMED CHOICE

Informed voluntary choice about contraception — including which method to use or whether to use a method at all — is a cornerstone of high-quality reproductive health services.

People should have access to a variety of contraceptive methods, as well as information about efficacy and side effects of specific methods. Choice is one of the fundamental rights of clients outlined by the International Planned Parenthood Federation, and the World Health Organization has said in its eligibility criteria for contraceptive use that informed choice and counseling are important to high-quality care.<sup>1</sup>

An international task force of experts from many organizations, sponsored by the U.S. Agency for International Development (USAID), defines informed choice as “effective access to information on reproductive choices and to the necessary counseling, services and supplies to help individuals choose” to use — or not use — family planning.<sup>2</sup>

There are five elements of informed choice, according to the USAID task force:

- provision of information, including counseling on pregnancy, breastfeeding, contraceptive use and infertility
- appropriate information on the range of family planning methods, their advantages and disadvantages, costs, and the location of services and supplies
- comprehensive information on correct use of the client's selected method
- counseling to ensure that clients understand what is said to help them make decisions
- and efforts to ensure that a range of methods is available either at the clinic site, through community-based distribution, or through referral.

Another USAID study group of international experts recommends that “clients who already have a method preference should be given that method after screening and counseling unless it is inappropriate for medical and personal reasons. However, even clients with a prior preference should be told that other methods ... are available and asked if they would like to hear more about any or all of these methods.”<sup>3</sup>

— Barbara Barnett

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A WOMAN LEARNS ABOUT METHOD CHOICES AVAILABLE AT A MEXICO CITY CLINIC.

reproductive intentions: whether a couple desires to space pregnancies or end child-bearing, whether a woman has had other pregnancies, whether she is currently breastfeeding, both partners' views on contraception, and potential obstacles to effective contraceptive use. In addition, providers should ask about STD risks — whether the client, or his or her partner, is at risk. Instead of saying, “I want to tell you about family planning,” a provider might ask:

“What do you know about family planning methods?” or “How do you feel about using these methods?”

“The key is finding out what clients know, what clients understand, and their reasons for making the choices they have,” says Tabbutt-Henry of AVSC. “Find out what the clients perceive as their reproductive needs. What do they understand about the method they have chosen? Why have they chosen a specific method? Then information from the provider can be tailored to correct misconceptions or fill in the gaps.

Clients have limited time, as do providers. Counseling is the most efficient way to deliver quality services.”

Providers should address clients' questions by explaining that there are different types of available contraceptives: reversible and permanent methods, methods that provide long-term pregnancy protection and those that are short-term, and methods that do or do not protect against STDs.

Providers also should explain that some methods may be medically inappropriate for certain clients. For example, the IUD is

## INFORMED CONSENT NEEDED FOR STERILIZATION OR RESEARCH

Informed choice is a process in which family planning clients base their decisions about contraceptive use on adequate information. Informed consent is a process in which clients give their permission to undergo a procedure, take a medication or participate in a study after being fully informed.

"Informed consent is consent given by a competent individual who has received the necessary information; who has adequately understood the information; and who, after considering the information, has arrived at a decision without having been subjected to coercion, undue influence or inducement or intimidation," according to World Health Organization guidelines. "Informed consent protects the individual's freedom of choice and respects the individual's autonomy."<sup>1</sup>

Informed consent is important in both family planning programs and reproductive health research.

Informed choice should always be available to clients seeking health services. While written informed consent is not needed for most reproductive health services, it should be obtained from women and men who undergo sterilization, since this involves surgery and is considered permanent. Ideally, couples should be counseled together and informed about available reversible options. However, from a medical perspective, only the person undergoing the procedure needs give his or her informed consent. There is no medical reason to require a spouse's permission.

inappropriate for a woman who currently has an STD, since IUD insertion may increase the risk of pelvic inflammatory disease in these women. For a client who is uncertain as to which method to choose, a provider should make sure the client has all information needed to make an informed choice and help the client decide, without actually making the decision for the client.

After a client has selected a method, the provider should ask what the client knows about the method. If the client has limited correct information, the provider can offer a

The U.S. Department of Health and Human Services has listed seven basic elements of informed consent for sterilization. The first letters of key words in the list spell the English word "BRAIDED." Clients should be told about the "benefits" of the method; "risks" of the method, including major and minor risks and possible method failure; and "alternatives" to the method. In addition, they should know that they can make "inquiries" about their rights and responsibility; "decide" not to use the method without penalty; and receive an "explanation" of the method in ways that they understand. Finally, the provider should obtain "documentation" that the client has understood the other points. Usually, providers ask clients to sign a form, and the form is placed with the client's medical records.

### FULLY INFORMED

Volunteers who participate in contraceptive studies must be fully informed of the risks and benefits of any new drugs or devices they receive. They should understand the potential effects of methods not only on their physical health, but also on other aspects of their lives, including emotional well-being and privacy. Ethical reviews before research begins are essential to ensure protection of study participants.

To ensure that study participants fully understand the purpose of the research and personal consequences of their participation, FHI researchers have used several tools to measure the "readability" of informed consent documents. In the early 1990s, FHI

detailed explanation of how the method works, how to use it, possible side effects and how to cope with them, and problems that could indicate a need to return to the clinic. The provider should ask the client questions to determine if the client understands the information; for example, asking the client to repeat instructions on use or what to do if there is a problem. If the client selects a method that is not available at the clinic, the provider should refer the man or woman to another clinic that does offer the method.

evaluated informed consent documents for nine clinical trial studies using a variety of measurements.<sup>2</sup> Researchers found that the documents contained many words that, while familiar to researchers, were likely to be unfamiliar to clients. Researchers recommended that complex sentences be replaced by several shorter sentences. In addition, they recommended that medical terms be translated into common, everyday language. For example, a form could say "high blood pressure" instead of "hypertension."

Even with attempts to simplify language, researchers must still work to ensure that clients understand what they have been told. An FHI study of 70 women who participated in four clinical trials for barrier contraceptive methods asked the women to recall information up to 41 weeks after admission to the trials. Almost all participants correctly recalled the number and frequency of follow-up visits, tests and examinations. Few participants, however, correctly recalled the risks of pregnancy associated with contraceptive use.<sup>3</sup>

— Barbara Barnett

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Providers should explain that women and men have the right to change their minds about the method they have chosen. If the client decides not to use the method — if the client cannot tolerate side effects or simply is dissatisfied with her or his choice — providers should make another method available.

Providers should ask clients who are returning for services about their experiences with their current method. If there are

problems, the provider should explain possible ways to resolve them. The client should decide whether to continue the current method or switch to a new method. Providers should also ask if clients' reproductive goals have changed, if there have been changes in their breastfeeding status, or if their STD risks have changed.

Dr. Huezo of IPPF recommends that providers focus on information that is essential to help the client make a choice and use the method correctly. This means providers must consider the time available to spend with the client in order to cover vital information, and the tailoring of counseling to meet each individual's needs.

In a study of more than 11,000 clients in Guatemala, Trinidad and Tobago, Kenya, Jordan, Nepal and Hong Kong, Dr. Huezo and his colleagues found that counseling can cover too many topics or irrelevant ones. Women who received too much information or confusing information were more likely to discontinue contraception than those who received high-quality counseling and obtained the method they wanted.<sup>10</sup>

"The emphasis should be on quality of information, not quantity," says Dr. Huezo. "We need to provide in a clear way as much information as is relevant concerning the method the client has decided to use. Information on side effects should be sufficient for the client to make a clear assessment of risks. We need to convey messages clearly, but not rush over issues just because we have a long list to cover."

"Since providers can discuss and clients can absorb only a limited amount of information in a single session, providers must be selective in the information they offer, focusing on the most important issues for the client," writes Young Mi Kim of Johns Hopkins University, who has done extensive research on client-provider interactions. In Kenya, clients said they wanted to say more but were afraid to interrupt the provider. "She looked like she was in a hurry," one client said. Clients were also concerned they might irritate or anger providers.<sup>11</sup>

#### BARRIERS AND SOLUTIONS

Informed choice can be helped or hindered by cultural norms, service delivery systems or health policies.

Cultural norms that encourage large families or discourage women from playing a role outside the home may be a barrier to informed choice. Norms that place the responsibility for contraceptive use solely on women may discourage men from seeking family planning or STD services.

At the policy level, health programs may be dependent on donor support, so supplies are limited to those provided by donors. Or health policy-makers may not yet have adopted standardized national guidelines for provision of health services. Health policies may also emphasize demographic targets or number of contraceptive acceptors.

In family planning programs, informed choice can be limited by insufficient supplies, provider bias, or policies that unnecessarily restrict contraceptives for certain groups. For example, programs may not provide contraception to adolescents or to unmarried women and men, although there are no medical reasons to refuse them. Programs may refuse sterilization to women who do not have sons or to women with fewer than three children. In addition, providers may lack training in communication skills or up-to-date information on contraceptive technology. Individuals may lack access to family planning services because they do not have the money for health care or for the specific method they want.

FHI training sessions for physicians and nurses, recently held in Guatemala and El Salvador, have tried to help counselors see contraceptive choice from the client's perspective. In these sessions, FHI staff asked family planning counselors to name their three favorite contraceptive methods and explain their reasons for choosing these methods, plus their three least favorite methods. Then, to help providers understand that clients often do not make decisions based solely on method efficacy, trainers ask counselors to answer several questions from their own perspectives: Are you currently using a method? If so, what method and why did you choose it? If not, why not? For current users, have you ever used a different method? Why did you stop? For non-users, have you ever used a method? Why did you choose that particular method? What factors or decisions influenced your decisions?

The purpose of the exercise, says Kevin Young, a senior training officer at FHI, is to help providers realize that contraceptive

choice is not just a matter of assessing biomedical facts. "Counseling requires focusing on the circumstances, values and needs that affect the client's decision about fertility," says Young. "The factors that affect the method a person uses are more complex than just the various characteristics of that method."

— Barbara Barnett

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# Training Involves Many Factors

Assessing needs, evaluating the outcomes and maintaining skills are among important considerations.

**T**he effectiveness of training to improve provider practices depends upon many factors: who is trained and where, what providers are learning and how the information is taught, whether training is reinforced, and how training results are measured.

Training should begin with a thorough understanding of providers' abilities, needs and the settings in which they work. How skills acquired during training can be sustained is important to consider during this early planning.

What are the community's reproductive health needs? What knowledge, skills, experience and attitudes do providers already have? What do providers further need and want? Who should receive training? Answering these questions, formally called a "needs assessment," is essential.

Needs assessments can identify obstacles to successful training, which may be as simple as a lack of adequate supplies or facilities. Training providers to administer a certain contraceptive method, for example, is useless if the contraceptives themselves are unavailable.

Assessing existing provider knowledge and skills is also vital. "An important aspect of training is getting providers to unlearn wrong information, especially when it can lead to faulty practices that can harm patients," says Dr. Pouru Bhiwandi, an obstetrician and gynecologist in private practice in the United States and former FHI medical director and director of international programs. "Often, this must be done before

teaching providers what is right to do." For example, she says, incorrect technique for assuring sterile conditions when inserting an IUD could expose the client to infection, which could lead to pelvic inflammatory disease.

## WHOM TO TRAIN, AND WHERE?

Training may involve a few designated individuals, a team or an entire staff. One model developed by New York-based AVSC International (AVSC) emphasizes the value of training everyone who works at the same location. "Ideally, everyone at the site — including gardeners, secretaries and cleaners — is involved in evaluating site performance" during the needs assessment planning stage, says Dr. Pamela Lynam, manager of AVSC's Reproductive Health Linkages Program. "Teams make recommendations for improvement and, because they made the suggestions, they usually carry them out."

This way of motivating staff members to identify their own training needs is called the Client-Oriented, Provider-Efficient (COPE) approach. Each staff member completes an assessment questionnaire. "We believe that COPE is absolutely key in motivating people to want to improve services," she says.

Under the COPE system, training is usually done at the work site rather than taking staff to another location. There are advantages, however, to training away from the work place and its interruptions. "Medical professionals who are offered the chance

## INTERACTIVE TECHNIQUES ENHANCE TRAINING

People learn more easily when they build upon experience. Interactive training approaches, such as role plays and small group discussions, are among ways to enhance trainees' personal experience.

IRINA YACOBSON/FHI



FHI TRAINING IN TAJIKISTAN INVOLVES AN INTERACTIVE GAME.

- Interactive sessions should focus on behaviors or ideas that are vitally important to change. Reading materials or lectures can address other behaviors or ideas that are not as essential.

- Allow participants to practice new behaviors, give them feedback and then have them practice again. Allow them to handle products, such as contraceptive supplies.

- Be flexible. If one technique does not work, switch to another, recognizing that each training group has a unique personality.

- When possible, include respected professionals and opinion leaders in training sessions.

- Counseling training should put the client first. For example, role play gives providers a sense of what it is like to be asked personal questions.

—Kim Best

the site will have less impact on services. In addition, if several people from a site are trained, prospects are better for spreading the new information to others at the work site.

Training people in related jobs to provide family planning services can be a useful strategy. When family planning training was given in India to those who practice traditional methods of healing, such as the use of herbs, contraceptive use increased among the rural women who were served by the trained traditional healers.<sup>2</sup>

People with a variety of health-related experiences often "are responsible, respected members of the community and, as such, can influence expectations about health behavior," says Dr. Sharon Rudy of INTRAH, a reproductive health training program affiliated with the University of North Carolina School of Medicine in the U.S. INTRAH has worked extensively in developing countries to improve performance of family planning providers. "We have had a lot of success working with a variety of people — ranging from community-based distribution workers to midwives and traditional birth attendants."

Even people who simply use contraception can play an important role. In Sri Lanka, women who had used IUDs and oral contraceptives successfully were trained to help midwives motivate others to use these methods.<sup>3</sup>

to leave work settings filled with distractions and to meet with their peers for a short period of intensive learning, ideally in settings that are convenient and pleasant, tend to feel that they are participating in a cadre of excellence, that they are on the cutting edge," says Robert Rice, a training manager at FHI. "This is a powerful incentive for them to make sacrifices required to update their skills."

Dr. Lynam agrees that this approach, called centralized training, can be useful under certain circumstances, such as when a new contraceptive method is introduced and few or no local providers have experience with it. "Centralized training, however, is expensive, often excludes many key providers while training some people who will not use their new skills, and does not reflect the

reality of the local service delivery site," she says. "Providers who attend such centralized training events tend to return to their home sites only to find that no one else knows about the training and equipment. Drugs and supplies used or promoted during training may not be available. As a result, these newly-trained providers often just give up."

Training at the site allows specialized training for select people, while giving general training to orient everyone.<sup>1</sup> "As a result of this whole-site training, pharmacists order the right drugs, gatekeepers know about the new services, receptionists are informed and supportive," says Dr. Lynam.

Team training is another approach. If several professionals from a service delivery site are trained instead of only one or two, the absence of any one of those people from

### THE PROCESS

The process of training may be as important as the content. "Unless you pay equal attention to process, content is almost irrelevant," says INTRAH's Dr. Rudy. "The goal of the learning situation is to ensure that a particular skill will be performed, but many people who design instructional materials and do training are products of educational systems that rely on rote memorization of information. So there is a tendency to focus on knowledge as a learning goal, rather than changes in provider behavior."

Training techniques vary, but those considered most effective generally recognize that adults learn best when they build on personal experience. Interactive

approaches, such as role plays, case studies and small group discussions, are other ways to make training more dynamic. Using anatomic models and coaching to teach clinical procedures, and regularly assessing how well trainees perform a skill, are other techniques that seem to be successful.

"Because the interactive style of training is unfamiliar to most medical professionals, they feel silly at first doing it," says Dr. Irina Yacobson, an assistant medical director at FHI. "But after a couple of hours of participatory training, they like it because it is fun. When I am doing technical training, I break presentations into 15-minute sessions, then reinforce what I've presented with a game or case study or small group discussion. Then I give another session of technical information."

Dr. Erwin Conrado Curán Padilla, a Guatemalan obstetrician and gynecologist who conducts training, recently participated in an FHI-sponsored workshop to help trainers enhance their skills. After making a presentation about IUDs that was designed to include interaction with the audience, he commented that "not everyone shared my ideas. But I liked that. I also liked knowing that lively discussion would lessen misunderstanding of what I was teaching."

Training with an interactive approach is very useful in helping providers to evaluate important personal viewpoints or values, both a client's and the provider's own, a particularly important aspect of effective counseling. Called "values clarification," this exercise was part of FHI provider training in Senegal, where research showed that services for adolescent clients were being compromised by stigmatization and discrimination by some providers who did not believe young people should receive contraceptives.

"In this circumstance, if providers do not change their approach to clients, their own values and viewpoints become barriers to service," says Dr. Yacobson. A conventional way to train people for this problem might include more technical information, justifying why contraception for adolescents is important. In the Senegal training, however, FHI led providers through a values clarification exercise, showing participants how their personal opinions could affect counseling, and encouraged them to modify personal attitudes that may hinder services.

Illustrating how people have different values can be enlightening, she says. "Often providers think they know each other well. After all, they have worked and even socialized together. Yet during values clarification exercises, they discover that there are many things they do not know about each other. Still, they like each other and finally realize that, while they might disagree, each is entitled to his or her own values and views."

The training process can be modified for self-study. JHPIEGO Corp., an international reproductive health training organization affiliated with Johns Hopkins University in the U.S., has developed a self-paced, on-the-job learning package, says Dr. Rick Sullivan, director of JHPIEGO's Learning and Performance Support office. In field tests in Zimbabwe and Kenya, this form of self-study, working with a job coach, has been well received, he says.

Computer technology, adds Dr. Sullivan, may offer new ways to provide self-education, especially at large work sites. Computers allow participants to control the pace and flow of their learning. In a field test in rural Zimbabwe, "the response from people who had never seen a computer before was very positive," he says. "Like training at the job site, computer-assisted learning places the power to learn in the hands of the trainee. Computer technology also frees trainers from making rote presentations, giving them more time to engage in valuable activities such as doing role plays or training on models."

## CLINICAL PROCEDURES TRAINING

When training providers to perform certain clinical procedures, use of anatomic models is helpful. For example, practicing Norplant insertions on arm models promotes consistent, well-placed insertions and helps prevent difficult removals. After adequate practice, performing these procedures with supervision on clients is an ideal part of training.

The same applies to IUD insertions. "At FHI, we usually do a day of training using the pelvic model," says Dr. Yacobson, "with a provider inserting the device while talking to the model, anticipating that in real life this would be a woman who is hearing unfamiliar sounds made by metal tools, perhaps suggesting a major surgical procedure is about to take place."

In a study in Thailand, 150 midwives received IUD insertion training using a pelvic model. They became competent to perform the procedure more quickly than 150 midwives receiving traditional IUD insertion training. For the first group of midwives—who received clinical guidelines, a week of classroom training using the pelvic model and a week of practice on patients—the mean number of insertions to achieve competency was 1.6, compared with 6.5 for those midwives who received two weeks of classroom training with no model and four weeks of clinical practice.<sup>4</sup>

SARAH JOHNSON/FHI



TRAINING PARTICIPANTS PRACTICE GIVING INJECTIONS.

Similarly, a study in Indonesia showed that 151 physicians, nurses and midwives receiving model arm training for Norplant insertion achieved competency in insertion procedures sooner than 151 such professionals not receiving model arm training. Furthermore, more of the participants trained with the model arm achieved removal competency than did participants with no model arm training.<sup>5</sup>

## EVALUATING TRAINING

It is difficult to evaluate how training improves provider practices in terms of measuring client satisfaction, method continuation, and similar goals. Some contraceptive

number of new clients rose dramatically. New acceptors of oral contraceptives, condoms, and depot-medroxyprogesterone acetate (DMPA) rose in 34 health clinics staffed by trained nurses' aides.<sup>6</sup>

In a training program introduced by the Egyptian Ministry of Health, development of family planning nurses' counseling skills was stressed. A study sponsored by FHI in collaboration with the National Population Council found that this improved training was associated with positive changes in family planning knowledge, attitudes, and behavior among women attending study clinics. Favorable attitudes about oral contraceptives and condoms also became more common and, in one governorate, IUD use increased.<sup>7</sup>

IRINA YACOBSON/FHI



PRACTICING IUD INSERTION DURING FHI TRAINING IN UZBEKISTAN.

use and service delivery data are only available years after training has taken place. Also, training evaluations can be very costly.

Instead, the most common means of evaluating training include measuring the participants' skills before and during training; asking them whether they were satisfied with workshops; and assessing their skills during actual performance, through client interviews, observations and other ways.

However, greater acceptance of contraceptive methods due to provider training has been demonstrated in a number of studies and settings. In Uganda, after INTRAH and the Ministry of Health of Uganda trained 136 nurse's aides from nine districts to counsel about the benefits of family planning, the

Also in Egypt, training providers on IUD insertion and counseling was so successful that the IUD became the most prevalent method in the country. In contrast, failure to emphasize counseling and education during the promotion of oral contraceptives during the 1960s and 1970s resulted in considerable noncompliance.<sup>8</sup>

In a 1992 Nigerian study, three days of counseling training for certified nurses significantly improved the quality of care they provided compared with certified nurses who did not receive such training.

Client return visits, highly correlated with continuation rates, also increased.<sup>9</sup>

## MAINTAINING SKILLS

Training must be repeated to produce lasting changes in behavior. "We often want to train too many people too quickly in too many things simultaneously," says Dr. Roberto Rivera, FHI corporate director of international medical affairs. "But most educational goals have to be achieved through consecutive steps. The truth is that training not only takes resources and time, but requires follow-up, assessment and retraining — it is a continuing cycle."

Refresher courses after several months are valuable, adds FHI's Dr. Yacobson. "They allow providers to discuss how their new knowledge or skills worked in practice, identify what problems arose, and correct misinformation."

In a study in India, retraining workshops for medical and paramedical providers working with IUD and oral contraceptive users contributed to improved continuation rates. The retraining addressed counseling and motivational skills, management of side effects and follow-up care.<sup>10</sup>

Unfortunately, training often occurs only once. Thus, it is imperative that newly trained providers have colleagues who can supervise their skills.

AVSC has found that its "whole-site" training approach that includes supervisors helps programs sustain improvements. Says Maj-Britt Dohlie, AVSC program manager of quality improvement: "Supervisors not only support newly trained staff as they apply their new skills and knowledge. They also are in an excellent position to determine later whether training has met expectations and remains of good quality."

Supervision of providers trained to perform clinical procedures such as IUD or Norplant insertions and removals is especially important. Yet a study in Senegal of women's experiences with Norplant removal showed that, regardless of the type of training given, few providers said they had removed many implants under supervision, generally recognized as more difficult than insertion.<sup>11</sup> Using newly acquired skills is important. In a Kenyan study, skill retention depended more on providers' use of skills than on time elapsed since training.<sup>12</sup>

"In terms of sustaining skills, it is also essential that you have someone locally who can understand how to deliver services with limited resources," says Dr. Bhiwandi, the former FHI medical director. Dr. Rivera agrees. "It is absolutely necessary for an organization like ours to help support local institutions in their efforts to create their own training structures," he says. "An international training organization will only be successful when it has created local resources and structures to support and continue the training we do. There is no other way."

— Kim Best

*Continued on page 26*

# Guidelines Require Comprehensive Steps

Effective use of national family planning guidelines includes dissemination and regular updating.

In recent years, nearly 50 developing countries have begun developing new or revised national guidelines on family planning services. Writing guidelines is a collaborative process, involving providers, government officials, technical experts and others. But writing them is only the first step.

Disseminating the guidelines, including training providers about how and why to use them, is essential. Also, guidelines must be updated regularly, since new scientific findings about contraception or other reproductive health issues may influence procedures and other policies. Making clients aware of their rights under guidelines is also vital.

"We have to take a comprehensive approach to implementing the guidelines, involving training, educating, policy-making, empowering clients and addressing cultural values," says Sandra de Castro Buffington of the U.S. Agency for International Development (USAID). Previously, when working for JHPIEGO Corp., a U.S.-based technical assistance organization specializing in reproductive health, Buffington helped develop guidelines in Brazil, Bolivia, Peru and Guatemala.

"We need to institutionalize the guidelines into the training at schools of medicine, nursing and pharmacy," she says. "We have to communicate to potential clients so they will demand that providers answer their questions and respect their right to make an informed choice. And we have to affect the supervisory and management system, both from the top down and the bottom up."

These important steps can take years to accomplish. Consequently, evaluating the full impact of recent family planning guidelines on service practices is not well documented. "Determining how much national guidelines themselves result in changes in provider practices is very difficult to determine," says Susan Palmore, who guides policy and research utilization at FHI. "Many factors affect these practices. Our research at FHI has sought to sort out the various factors."

## INTERNATIONAL RECOMMENDATIONS

In developing guidelines for contraception, many national health officials have relied extensively on recommendations developed by the World Health Organization (WHO)<sup>1</sup> and USAID.<sup>2</sup> These recommendations are designed to make services more accessible, more uniform and of higher quality.

Developing new national guidelines would be more difficult without the USAID and WHO recommendations, says Dr. Roberto Rivera, FHI's director of international medical affairs, who was a participant in developing the WHO and USAID documents. The recommendations have become a primary resource for updating national guidelines. "They represent the consensus of international experts, based on the latest scientific information available," says Dr. Rivera, who has advised health officials in

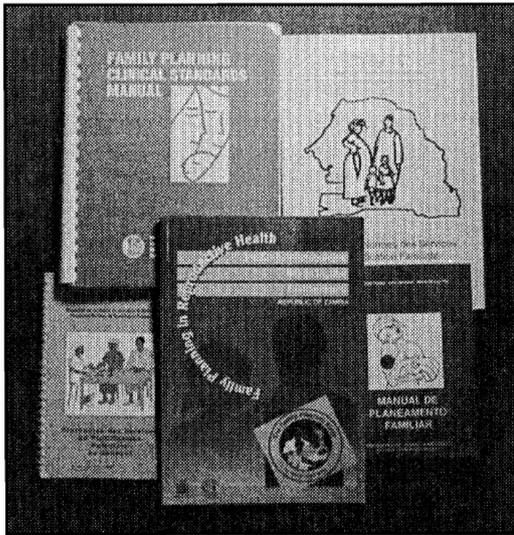
Mexico, Paraguay, Costa Rica, Jamaica and El Salvador as they have developed national family planning guidelines.

WHO uses a four-tier rating system for how a medical condition or other aspect of a client's circumstances should affect the use of specific contraceptive methods. If a condition does not interfere with method use, it is "category 1," while "category 2" means a person with the condition can generally use the method. For example, concerning a client's age, any woman from menarche to 40 years old falls into a category 1 for using low-dose oral contraceptives (OCs), while women 40 or older are a category 2.

However, if a woman is 35 or older and a light smoker, these conditions make OC use a category 3: a method not usually recommended unless other more appropriate methods are not available or not acceptable. If a woman 35 or older is a heavy smoker (20 or more cigarettes a day), the method should not be used (category 4).

USAID recommendations outline answers to common questions about each method, giving the scientific rationale

NASH HERNDON/FHI



NATIONAL GUIDELINES FROM SEVERAL COUNTRIES.

involved. They also classify various medical procedures with regard to contraceptive use. Procedures that are essential, mandatory or important are in one of four designated categories. Other categories include procedures that are rational in some circumstances but may not always be appropriate, those that may be good preventive health

measures but are not materially related to contraceptive use, and procedures that are not only unnecessary but also irrelevant to the safe use of the method.

For example, a pelvic exam, an appropriate medical procedure for some purposes, is not necessary to ensure safe OC use, placing it in the category of procedures that may be appropriate for good preventive health, but not related to safe use of the method. Certain laboratory tests, such as determining cholesterol levels, are in the category of "not only unnecessary but irrelevant" to safe OC use.

Many national guidelines are incorporating recommendations made by WHO and USAID, according to a study of guideline revisions in Bolivia, Guatemala, Peru and two states in Brazil between 1992 and 1996. The study focused on nine key categories with 400 indicators of program changes that would affect barriers to access and quality services. "We found a sharp reduction in the number of medical procedures and restrictive medical eligibility guidelines in the new sets of guidelines," says Jennifer Macías of JHPIEGO. While most of the guidelines are virtually in agreement with the WHO guidelines now, she emphasizes that such a desk review of documents does not provide information about changes in provider practices.<sup>3</sup>

A recent analysis based on interviews with more than 2,000 providers in five African countries compared national service guidelines and provider practices. "Providers impose a considerably different, and much more restrictive, pattern of barriers on clients than that required by policy," write Kate Miller and her colleagues at the Population Council.

For example, while none of the guidelines in the five countries requires a spouse's consent except for sterilization, a substantial percentage of providers in all countries did require spousal consent for most methods. For OCs, almost a third of providers in Burkina Faso and nearly 10 percent in Kenya required spousal consent. In Botswana, 12 percent of providers required consent for injectables, and 25 percent of providers in Senegal required it for intrauterine devices (IUDs).

The study compared restrictions in service practices regarding marital status, spousal consent, parity requirements, and age requirements with what each country's guidelines say about these issues for six methods (OCs, condoms, IUDs, injectables, Norplant and female sterilization). "In all cases, providers are vastly overapplying restrictions to contraceptives above those required by protocol," the authors concluded.<sup>4</sup>

Anecdotal evidence indicates that some new guidelines have improved services. The injectable depot-medroxyprogesterone acetate (DMPA) was once kept locked at regional district medical offices in Tanzania, and providers would not give DMPA to a woman unless she had several children. "DMPA was thought to be a dangerous drug that should be prescribed by doctors only," says Dr. Catherine Sanga, deputy family planning program manager for Tanzania's Ministry of Health. Working with INTRAH, the ministry convened a group in Tanzania to draft new guidelines, followed by a year-long dissemination process. On the DMPA issue, the new document agreed with WHO and USAID recommendations that a woman with no children can use the method and any trained service provider can offer it.

"Officials have now taken the locks off the DMPA supply and made the method available to more women," says Dr. Sanga. The percentage of women of reproductive age in Tanzania using injectables went from 0.3 percent in 1991, before the new guidelines, to 3.7 percent in 1996, after the change, according to Demographic and Health Surveys data. Dissemination of the new guidelines was critical to the change. "In 1993, we held workshops in all 101 districts and went through the guidelines page by page to be sure everyone knew what they were saying," says Dr. Sanga.

## PROVIDER PRACTICES

Studies also indicate that guidelines affect provider practices. In a review of published evaluations of clinical guidelines, 55 of 59 studies found "significant improvement in the process of care after the introduction of guidelines." The reviewed guidelines covered such medical issues as

antenatal care, tetanus vaccinations and cesarean deliveries. "The successful introduction of clinical guidelines is dependent on many factors, including ... the methods of developing, disseminating and implementing these guidelines," the study concluded.<sup>5</sup>

At a recent meeting in Washington, USAID assembled more than 100 experts to assess the role of guidelines in affecting service quality in the international family planning field. The meeting described the process of developing and disseminating guidelines as a "road to maximizing access and quality." The overall goal is for providers to use the guidelines. Said Pauline Muhuhu of INTRAH, who has worked with developing guidelines in Africa for a decade: "The guidelines must come off the shelf. All of us in the reproductive health field have a responsibility for keeping the guidelines lively so they are used."

Establishing the need for guidelines and ensuring the commitment of government officials to the process is essential. Pre-testing an early draft with local providers helps assure that guidelines make sense to those who will actually be using them.

Well-organized dissemination and promotion efforts must follow. The guidelines must also be updated and, ideally, their use be evaluated. Each step can influence the success of the overall effort.

An FHI review of recent changes in family planning guidelines emphasizes the importance of appropriate strategies at each step in the process. "Adequate dissemination of new or revised guidelines is necessary, as well as training, close supervision and monitoring to ensure that practices actually change," conclude the authors. The authors also called for more research on how guidelines affect provider practices and service quality.<sup>6</sup>

A study in Cameroon, conducted by the Pan-African Association of Anthropologists and FHI, found that new national guidelines distributed in training workshops appeared to have little impact on changing provider practice regarding barriers to service. While the guidelines say that all women of reproductive age should have access to OCs and all, except adolescents, to injectables, they do not specifically say that providers should not use age and parity criteria to prescribe particular methods. Similarly, the guidelines do not say specifically that pelvic exams and

blood or urine tests, known as "process hurdles," should be the exception rather than the rule. "The material referring to eligibility criteria and process hurdles is difficult to find," the study noted.<sup>7</sup>

Preliminary results from a 1998 follow-up study provided mixed results, says John Stanback, an FHI health services researcher who is coordinating the study. There were few changes in most types of barriers to services. For example, even though the guidelines say that age and parity in general are not reasons to deny contraceptives, the proportion of clients younger than age 20 years old and without any children did not increase after the dissemination workshops in 1994.

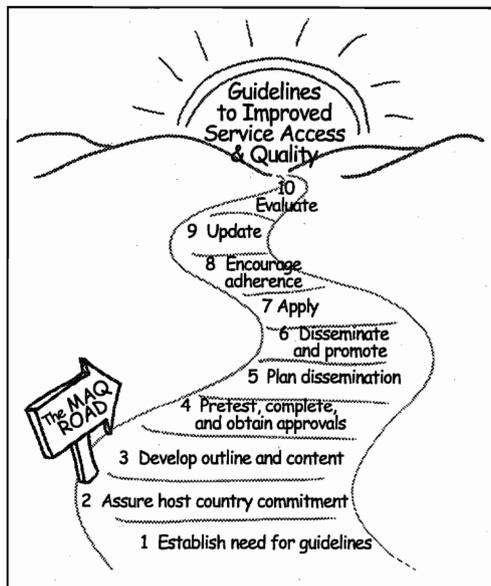


ILLUSTRATION FROM A USAID MEETING.

However, "new clients were more likely to have continued with their methods for both six months and a year, and continuation was even better in the clinics where providers said they had recently referred to guidelines," says Stanback. Also, after 1994, new clients were more likely to be unmarried, especially in clinics where at least half of the staff had been to the workshops and referred to the protocols. The study reviewed records on more than 5,000 women from 1992 to 1996 (300 clients in each of 18 clinics).

Stanback is currently studying the impact of guidelines and dissemination workshops in Senegal. "The new Senegalese guidelines are very user-friendly, and the

pattern of dissemination should make the impact on service practices easier to determine," he says.

#### ENCOURAGING ADHERENCE

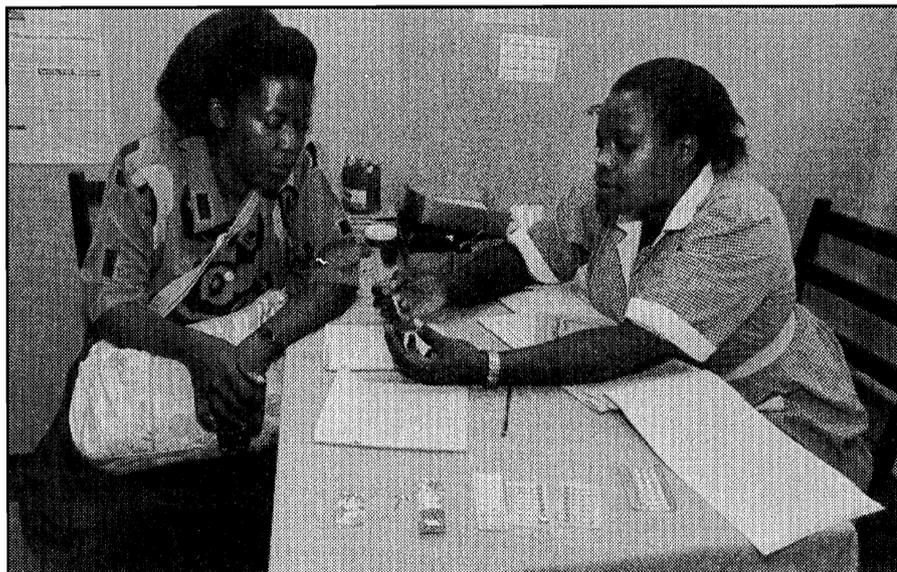
In 1996 and 1997, the Ministry of Health in Paraguay developed new national family planning guidelines and service delivery protocols. The guidelines address topics not yet widely contained in national documents, including emergency contraception, male sterilization and the lactational amenorrhea method (LAM). Following field testing, the new guidelines were revised. In 1998, the ministry held three dissemination workshops and follow-up training workshops, with FHI providing technical assistance.

FHI plans to study the effectiveness of three dissemination approaches: attending dissemination workshop only; attending the workshop and having a supervisor reinforce the central messages during site visits; and attending the workshop and receiving printed reminders of guidelines highlights.

Many potential obstacles exist to ensuring that providers actually follow the new guidelines. In areas with scarce resources, the full vision of developing, disseminating, and using new guidelines is ambitious, says Dr. Robert Leke of the University of Yaoundé in Cameroon. "How do we get the guidelines where they have to go at local sites? We do not even have the necessary logistics to put them into practice. At each step, it is a question of cost. How are we going to ensure there are resources for dissemination and for sustaining the new practices?"

National guidelines must be revised periodically to reflect new scientific information, which is also expensive. Informing clients about new national policies, and how these affect services, is a difficult task. Still another concern is the scope of guidelines. Many of them are more than 200 pages long, making them cumbersome and intimidating to providers.

Despite such challenges, progress has been made in standardizing national policies that have the potential to improve access and quality. Still more progress can be made if dissemination focuses on the guidelines' most essential elements. "The three biggest



A WOMAN CONSIDERS METHOD CHOICES  
AT A CLINIC IN KAMPALA, UGANDA.

service limitations on access and quality are age, parity and when to start different methods," says Dr. Rivera. "If you want to change provider practices, start with the most important. That way, you are more likely to have the highest impact."

— William R. Finger

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## NETWORK WINS GLOBAL MEDIA AWARD

Family Health International's quarterly bulletin, *Network*, has been named "best population journal" in the 1998 Global Media Awards for Excellence in Population Reporting. The awards, sponsored by the Washington-based Population Institute, were presented in a November ceremony in San José, Costa Rica.

During the year, one of *Network's* theme issues explored men's reproductive health concerns. For example, scientific surveys from several regions of the world showed that men are more interested in family planning than most people think, contradicting widespread views that most men know little about contraception, do not want their partners to use it, and are not interested in planning their families. Other theme issues were on female and male sterilization, and the many facets involved in the allocation of scarce resources in family planning programs.

Other 1998 winners include the Ugandan weekly radio program "Choices," which features information on family planning; *Asia Pacific Population & Policy*, published by the East-West Center

Program on Population in Hawaii; and *The Washington Post* as "best major daily newspaper" and the newspaper's Judy Mann as "best columnist."

Atlanta-based Turner Broadcasting Systems won for its "People Count" documentaries; *The San Francisco Chronicle* won for best editorial support; Eleanor Mill of Mill News Art Syndicate in Hartford, CT, USA, received the best editorial cartoonist award; and Melissa Fletcher Stoeltje of *The Houston Chronicle* in Houston, TX, USA, won for articles on high-yield farming.

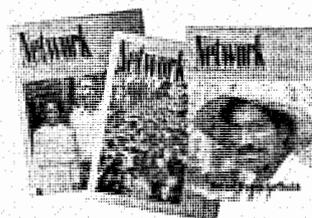
*Newsweek*, a U.S.-based magazine, won for articles on population overcrowding that threatens Amazon rain forests. ReachOut Foundation of the Philippines was honored for creating better public awareness of reproductive health issues through posters, brochures and other media. Also recognized were the Futures Group's Personal Choice advertising campaign in Kingston, Jamaica, which promotes contraceptive services; and Inter Press Service (IPS), an international news service, for its daily journal *Terra Viva*, produced at the United Nations in New York.

### A THANK YOU TO OUR READERS

More than 10,000 *Network* subscribers have written to us this summer, providing updated mailing address information. We appreciate your help making sure FHI publications are reaching health professionals who need them. If your address changes, please write or send us an e-mail ([publications@fhi.org](mailto:publications@fhi.org)), so that we can continue to send your subscription to the correct destination. A subscription order form for new subscribers is located below. Thank you!

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*Network* serves developing country health providers, educators, policy-makers and media, and is free of charge.

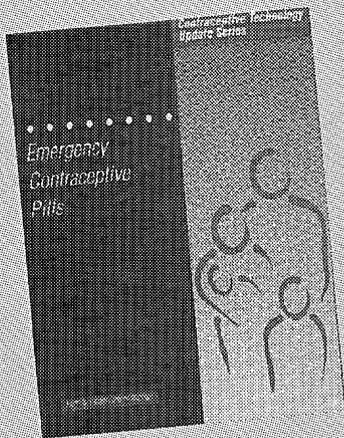
# Resources

## POPULATION REPORTS ON IMPROVING QUALITY

The November issue of *Population Reports*, Series J, Number 47, "Family Planning Programs: Improving Quality," describes how programs can satisfy clients' needs and strengthen the quality of care while using resources more efficiently. The report covers how systematic approaches to quality assurance are helping programs establish service guidelines and strengthen client care. Also, the December issue, Series J, Number 48, entitled "GATHER Guide to Counseling," updates a counseling guide used around the world for 10 years. To obtain free current or back copies, write: Population Information Program, Johns Hopkins University School of Public Health, 111 Market Place, Suite 310, Baltimore, MD 21202, USA. Full text is also available at <http://www.jhuiccp.org/poprpts.stm>.

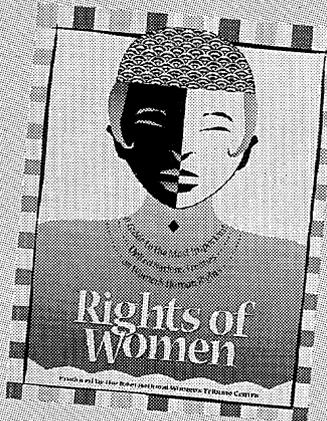
## FHI MODULE ON EMERGENCY CONTRACEPTIVE PILLS

Effective counseling, programmatic issues and procedures regarding the use of emergency contraceptive pills are discussed in a slide lecture module produced by



FHI, part of FHI's *Contraceptive Technology Update Series*. Presentations are designed for informing physicians, nurses, medical students, program managers and policy-makers

about specific contraceptive methods. The Emergency Contraceptive Pills module includes 35mm slides, a narrative, audience handouts and reprints of key scientific studies and other sources. The module is currently available in English, with translations in French and Spanish being prepared. A copy is free to developing country providers and trainers upon written explanation of need, and may be purchased by others. For pricing details or to obtain a copy, please contact: CTU Project Coordinator, Family Health International, P.O. 13950, Research Triangle Park, NC 27709, USA. Telephone: (919) 544-7040. Fax: (919) 544-7261.



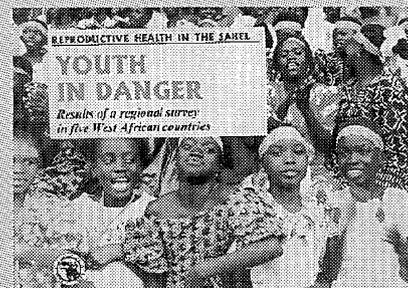
## WOMEN'S RIGHTS

*Rights of Women: A Guide to the Most Important United Nations Treaties on Women's Human Rights* discusses United Nations conventions relevant to the needs and concerns of women. The 148-page manual published by the International Women's Tribune Centre is designed to help readers understand the conventions and develop materials and campaigns to implement them. The book explains what the conventions are, how they work and why they are important to women. Also included

is information about efforts to recognize additional rights and a resources kit that includes charts and key documents. It is free to developing world people and can be purchased by others for U.S. \$15.95, plus a shipping fee (U.S. \$5 for the first book and U.S. \$2 for each additional copy). To obtain a copy, please contact: Women, Ink., 777 United Nations Plaza, New York, NY 10017, USA. Telephone: (212) 687-8633. Fax: (212) 661-2704.

## REPRODUCTIVE HEALTH YOUTH SURVEY

*Youth in Danger: Results of a Regional Survey in Five West African Countries* describes reproductive health problems faced by adolescents living in Burkina Faso, Gambia, Mali, Niger and Senegal. Edited by Le Centre D'Etudes et de Recherche sur la Population pour le Développement (CERPOD) in Bamako, Mali, the 48-page booklet contains information from focus groups with adolescents and parents, as well as from interviews with family planning service providers, religious leaders, village heads and teachers. Free English copies are available from the Academy for Educational



Development, The SARA Project, 1255 Twenty-third Street, NW, Suite 400, Washington, DC 20037, USA. Telephone: (202) 884-8700. To order a copy in French free of charge, contact CERPOD, B.P. 1530, Bamako, Mali. Telephone: (223) 22 30 43.