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Revitalizing family planning: Lessons learned on strengthening contraceptive provision

Frontiers in Reproductive Health

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Legacy Series:

REVITALIZING FAMILY PLANNING

This paper is part of a series of eight *Legacy Papers* synthesizing major lessons learned through research conducted under the Frontiers in Reproductive Health Program (FRONTIERS).

The full set of *Legacy Papers* includes:

- Capacity Building
- Family Planning
- Female Genital Mutilation/Cutting
- Gender
- Integration of Services
- Sustainability of Services
- Utilization of Research Findings
- Youth Reproductive Health

The complete reports referenced in these papers are available online:

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Lessons Learned on Strengthening Contraceptive Provision

Attention and resources have gradually shifted from family planning in the past decade, but globally need remains high, with an estimated 350 million couples lacking access to family planning. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.4 million infant lives, and preventing 505,000 children from losing their mothers.

FRONTIERS findings can help address this need by providing useful lessons on process and impact of improving quality of care in clinics, feasibility and effectiveness of community-based distribution, and proven ways to increase access to underutilized contraceptive methods. This evidence can serve two

important purposes. First, it can help strengthen programs; and second, it can be used for advocacy in revitalizing family planning efforts, particularly in sub-Saharan Africa where modern method contraceptive prevalence is only 16 percent.

Quality of Care in Clinics

Quality does matter to clients. Quality of care can be defined as how individuals and clients are treated by the system providing services. Approaches proven effective in improving client satisfaction in studies in Egypt, Guatemala, Peru, and Uganda include: assessing client need; providing appropriate methods; offering adequate and complete information for informed choice; and ensuring chosen method is always available (Nawar et al. 2004; León et al. 2003a; Okullo et al. 2003; RamaRao 2003; Sanogo 2003).

Perspectives on Quality of Care

This series of eight-page policy briefs highlights research findings on major aspects of quality of care in family planning. Co-authored by FRONTIERS and Population Reference Bureau's MEASURE Communication Project, the briefs define the concept of quality of care and examine various perspectives of high-quality care (providers, clients, and adolescents) and address cost of improving quality of care.

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Creel et al. 2002a; Creel et al. 2002b; Creel and Perry 2003; Lantis, Green, and Joyce 2002; Raney, Joyce, and Townsend 2003

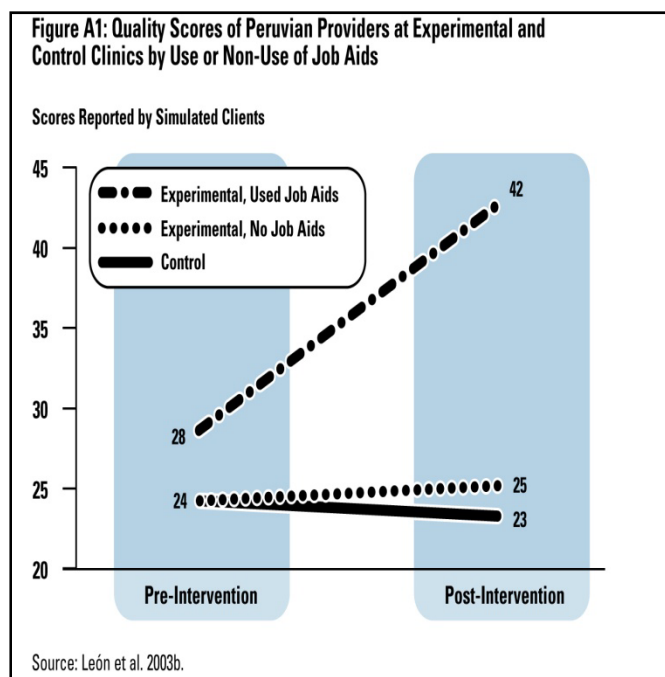
Sexuality training for providers leads to increased use of barrier methods

among clients. One of the key weaknesses in most FP services is client sexuality, and lack of discussion of client partner(s). A study in Egypt showed, however, training on issues of sexuality is both feasible and acceptable to FP providers. Moreover, such training led to positive changes in provider attitudes towards sexuality and discussion of barrier methods. Sexuality counseling is acceptable to clients as well; even after training, however, providers continued to feel embarrassed discussing sexual issues with clients. Clients counseled by trained providers were more likely to approve of and choose barrier methods than other clients (Abdel-Tawab et al. 2000).

Improvements in quality of care do not necessarily increase continuation rates.

Studies in Peru and Egypt followed women for 12 months after starting a contraceptive method. The studies found, on average, no significant difference in the average continuation rates between women who had received improved quality of care and those receiving standard quality of care (León et al. 2003c; Nawar et al. 2004). Most women in Egypt were using an IUD and so continuation rates tended to be higher (66-68%) than in Peru (44-48%), where most women used a hormonal method (pill or injectable). Similar studies from the Philippines and Senegal, which also found little difference on average, discovered within the group attending clinics at which a quality improvement intervention was implemented, those receiving better quality of care did have longer continuation rates than those receiving poorer quality (Sanogo et al. 2003; Costello, Sanogo, and Townsend 2002). Thus care needs to be taken when interpreting average continuation rates that may hide important differences.

Tools for Improving Quality of Care



Tools for improving quality: Identifying and responding to a client's FP needs—Balanced Counseling Strategy (BCS).

Developed and scaled-up in Peru, BCS has also been expanded nationally in Guatemala (AGMM 2004; León et al. 2003b). As the figure shows, providers using BCS with job aids scored significantly higher in quality of counseling compared with a control group and one without job aids (León 1999; León et al. 2003a; León et al. 2008).

BCS was also adapted for use in counseling for FP services in high HIV/STI settings. Balanced Counseling Strategy Plus (BCS+) incorporates additional screening, counseling and services for STIs and HIV, including HIV counseling and testing (C&T), into the standard BCS. Studies in Kenya and South Africa showed use of BCS+ significantly increased quality of counseling for FP clients, especially around FP-HIV interactions and dual protection (Liambila et al. 2008; Mullick et al. 2008a).

Balanced Counseling Strategy combines an algorithm for family planning counseling with a set of job aids—cards and pamphlets on available methods. Available in English, French, and Spanish from:

www.popcouncil.org/frontiers/bestpractices/BCSpage_082007.html

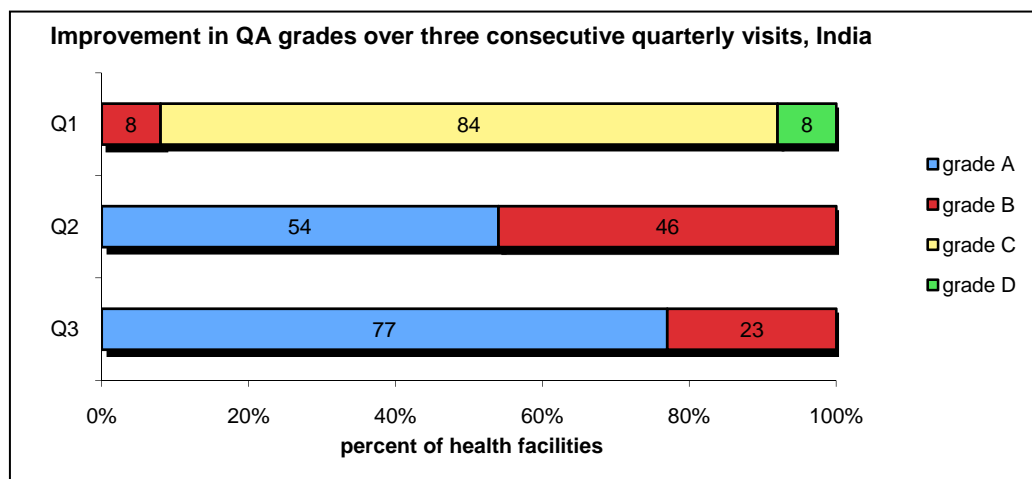
Balanced Counseling Strategy Plus expands the standard BCS algorithm to improve counseling on family planning and prevention, detection, and treatment of sexually transmitted infections (STIs) including HIV. Additional cards and pamphlets are available as job aids.

Available in English from:

www.popcouncil.org/frontiers/bestpractices/BCSPlus_102008.html

Monitoring and strengthening quality at health facilities: standard Quality

Assurance procedure. Members of a district health management team can be trained to conduct quarterly visits to each facility. During each two- to three-hour visit, the team uses a 65-item checklist to assess and grade each facility from A (excellent) to D (poor) in terms of infrastructure, staff training and technical competence, supplies, procedures, interactions with clients, and services delivered, including family planning, and maternal care. The team suggests measures to address any gaps identified and uses the same tool to assess improvements during subsequent visits.



Use of the tool in India demonstrated significant improvements in quality achieved over three quarterly visits. This tool has now been integrated into all 25 districts in Gujarat state, and is being introduced in an additional six states (Khan et al. 2008a).

Ensuring a gender perspective in FP

services: gender certification.

Organizations can introduce a gender perspective by following a certification strategy, in which a health facility needs to achieve quality of care and gender standards to be certified as “gender-sensitive”. The strategy includes a guidance tool with instructions to help facilities conduct self-assessments, identify their strengths and deficiencies in terms of gender-sensitive services, and develop action plans to improve gender-related services. Four manuals were developed (in Spanish) to support implementation:

- ✓ Certification overview and process
- ✓ Gender and QOC concepts for staff
- ✓ Data collection and evaluation tools
- ✓ Cost-assessment tools



In those clinics where the strategy was introduced, the proportion of married women of fertile age who did not want a pregnancy in the following two years or did not want more children, and who were not using a contraceptive method, although they would like to, decreased by nearly 35 percent as a result of certification (Palenque et al. 2004). The certification strategy has now been introduced in at least four Latin American countries (Palenque, Riveros and Vernon 2007). The Spanish manual is on the FRONTIERS website, and English and French will be available in 2009 (Riveros, Martin, and Vernon 2008).

Increasing number of services available for RH clients through Systematic

Screening. Systematic screening is a job aid to reduce unmet client health care need by increasing number of services provided per visit. Providers use a checklist or brief questionnaire to identify each client’s needs for RH services and then provide or refer these services. Many clients coming to a clinic for a particular service may also have an unmet need for FP or another RH service (León, 1998; Vernon and Foreit 1999; Foreit 2006; Vernon, Foreit, and Ottolenghi 2006). Use of a simple checklist during an RH consultation was shown to increase number of services received per client visit by between nine and 28 percent during studies in Bolivia, Honduras, India, Peru, and Senegal (Foreit, Vernon, and Hamel 2005; Vernon et al. 2005; Das et al. 2005; Sanogo et al. 2005). In addition, NGOs can increase revenues by using systematic screening methods to increase sales of related services and commodities. At the request of USAID Missions, the systematic screening tool has also been adopted in Madagascar, the Philippines, and Rwanda. USAID has identified the systematic screening tool as a priority best practice and plans its replication in other countries.

No. of services per visit: Screened vs. unscreened			
Study location	Not screened	Screened	Difference (%)
Bolivia	1.1	1.2	9
Honduras	1.1	1.3	18
India (large clinics)	1.6	2.0	25
India (small posts)	1.5	1.6	7
Peru	1.6	1.8	13
Senegal (urban)	1.2	1.4	17
Senegal (rural)	1.4	1.8	28

The Systematic Screening Manual is available in English, French and Spanish at: www.popcouncil.org/frontiers/projects_pubs/topics/SLR/SystematicScreeningManual.html.

Enhancing integration of FP with other

RH services: Assessing Integration Methodology (AIM).

For more than a decade, reproductive health programs have been struggling to determine how best to organize service delivery so FP services can be effectively and efficiently integrated or linked with other RH services. Efforts have focused on some of the most obvious linkages – with antenatal and postpartum services; with HIV and STI services; within postabortion care services – as well as less obvious combinations, e.g. post-rap care. FRONTIERS has undertaken more than 15 studies globally that have diagnosed, assessed and evaluated efforts to organize and provide integrated or linked RH services. This experience has been distilled into a standardized methodology for undertaking health facility assessments of integrated services, entitled the “Assessing Integration Methodology” (AIM) handbook. This handbook explains the basic principles of conducting studies using AIM; provides tips for data collection; and makes available data collection instruments validated in projects throughout the developing world.



Community-based distribution

Research conducted by FRONTIERS provides additional evidence community-based distribution (CBD) of reproductive health services and products is feasible and acceptable for both providers and clients, especially in Africa. In addition, and most importantly, CBD substantially increases knowledge and use of contraceptives (Chege et al. 2000; Martin and Vernon 2004; Sanogo et al. 2003).

Successful CBD programs need periodic reviews and adjustments to adapt to changing circumstances and new challenges. Zimbabwe had one of the most successful CBD programs in Africa. An assessment by FRONTIERS found there are now many alternative sources for FP competing with CBD agents for clients, the proportion of women wanting to use injectables has increased, putting agents at a disadvantage to clinics, and average age of CBDs is over 40 years and many are finding it difficult to cover catchment areas effectively and reach younger clients (Maggwa et al. 2001). Results from this study were used to revise the program so CBDs had a broader range of responsibilities, such as seeking adolescents and men, condom promotion, education on STI/HIVs, including VCT, giving information on antenatal and postnatal care, referring for infertility counseling and post-abortion care.

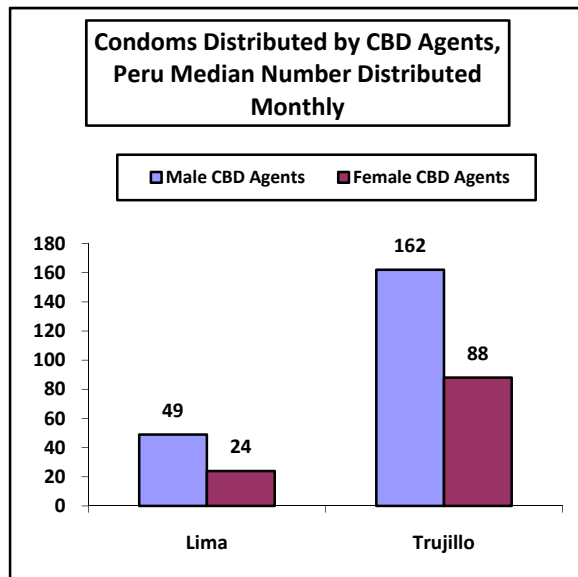
Record keeping and reporting are often weak components of CBD programs, making it difficult to assess performance. Simple and user-friendly reports have been developed in Senegal for literate and non-literate agents that can be adapted by other programs (Sanogo et al. 2004). In Ghana, even trained CBD agents with adequate knowledge of FP have problems remembering the pill's side effects and contraindications, and knowledge of STIs and HIV/AIDS tends to be limited, however most CBD agents give messages on dual protection of condoms. Moreover, many CBD agents have a negative attitude towards giving information and services to youth (Chege et al. 2000).

Both quality of CBD services and client characteristics affect contraceptive adoption and continuation. A study of Bangladesh's CBD program found quality of care provided by CBDs was significantly associated with adoption of contraception and more frequent worker visitation was associated with method adoption and lower discontinuation. Higher quality of care by CBDs was significantly related to lower discontinuation of any method. The quality of services from female CBDs played a significant role in adoption and continuation of a modern method by less educated women. Women with no or some primary school education were significantly more likely to adopt contraception when receiving high quality care from outreach workers, but quality of service was not associated with method adoption among women with secondary school education (Koenig, Ahmed, and Hossain 2003).

Increasing access to underutilized contraceptive methods

CONDOMS: Numerous opportunities exist for increasing access and use

- ✓ *Male CBD agents have proven very successful as distributors of male condoms.* Male agents usually serve more male clients than do female agents and distribute more male condoms. In Kenya, male volunteers distributed almost three times more



condoms than female volunteers (Green, Joyce, and Foreit 2002); and in Peru, male distributors sold significantly more male condoms per month than female distributors (Foreit et al. 1992).

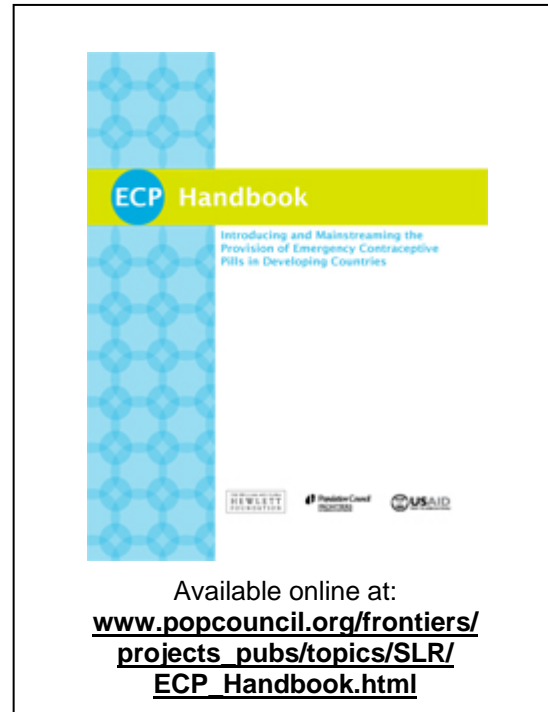
- ✓ *FP providers may be hesitant about discussing condoms, especially with married clients.* Experience from Kenya (Liambila et al. 2008) and South Africa (Mullick et al. 2008) showed condoms were rarely being mentioned, even though HIV is known to be prevalent in this population; after training in **BCS Plus** (see above), discussions around condoms and their use increased substantially (three-

fold in Kenya) and reported use of condoms at last sex, in the last month, and with another contraceptive method all increased significantly. Thus training in use of job aids helping structure discussions around condoms during FP consultations can definitely help providers to counsel clients on use, including dual protection.

- ✓ *It is possible to promote condoms at men's places of work.* In Bangladesh, rickshaw pullers form a large proportion of the poor population (over three million nationwide) and live and work in situations making them vulnerable to STIs— over half of those interviewed had extramarital sex. An intervention to reach them through workplace education sessions and training some to become workplace condom distributors proved successful, increasing current condom use from five to 18 percent and use in previous three months from 41 to 72 percent (Bhuiya et al. 2007).
- ✓ *Male condom users can provide relevant messages about condom use.* Successful male condom users in the Dominican Republic recommend talking with partners beforehand about condom use, using health and safety arguments, eroticizing condoms and carrying their own supply as effective strategies to motivate partners to use condoms (García and Goldman 2004).

EMERGENCY CONTRACEPTION: This method can be introduced, used, and scaled up nationwide, even in conservative settings

- ✓ *Emergency contraception (EC) remains a highly underutilized method, often because it is little known and has limited availability in many countries.* Even in traditionally conservative settings, however, EC access can be improved, increasing accessibility and use. A study in India demonstrated training and supporting paraprofessional health workers to offer it was not only feasible, but also led to levels of care equal to or greater than by physicians (Kumar et al. 2007). Based on these findings and advocacy efforts, the Indian Ministry of Health and Family Welfare introduced EC as over-the-counter medication, making it possible for paraprofessionals all over the country to provide EC pills. This supports findings from Guatemala that awareness training among medical staff increases knowledge about the method (Kestler and Ramirez 2004; Martin and Vernon 2004).
- ✓ *Prophylactic provision of EC pills and a brochure, rather than delivery on demand, appears more likely to lead to use.* In Bangladesh, women living in an area where this EC service was available in advance were five times more likely to report use than women living in areas where only available after unprotected intercourse (Khan, Sharif, and Rahman 2004).
- ✓ *Women using EC frequently ‘bridge’ to more effective contraception afterwards.* A study in Bangladesh showed 84 percent of women who used EC already used an FP method before unprotected intercourse; after using EC, 96 percent of these women went back to their previous method. Of the 16 percent of women without a method, 68 percent started one after EC. Moreover, the vast majority of EC users (91%) used EC only once during the nine month study period, refuting concerns EC may replace regular use of more effective contraceptives (Khan, Sharif, and Rahman 2004).
- ✓ *Scaling up EC introduction within a public sector program is possible.* In Bangladesh, FRONTIERS provided technical assistance to government-led activities over four years in three key areas: i) building system capacity to train staff about EC provision and monitor implementation; ii) implementing EC program at a national level; and iii) monitoring program implementation and undertaking special studies. Scaling up occurred in two phases: First, EC was introduced throughout Dhaka (pop. 41 million), and secondly in the other five divisions (population of 89 million in 48 districts). A three-tier training program was developed, with a total of 300 master trainers, 2,364 trainers and 44,774 service providers/field workers (Khan and Sharif 2008).



- ✓ Lessons learned from Bangladesh are now being replicated in India (Khan et al. 2008d), Nepal (Shrestha, Hossain, and Khan Forthcoming), and Pakistan (Khan et al. 2008c) to introduce and scale up provision of EC. Lessons learned during this process have been documented and are available in the *ECP Handbook*.

IUD AND VASECTOMY: Misunderstood and underused methods

- ✓ Studies conducted in Ghana (Gyapong et al. 2003; Osei et al. 2005), India (Khan et al. 2008b), and Guatemala (Brambila and Taracena 2003) to assess reasons for low IUD use found use is affected by a variety of factors:
 - Lack of equipment and trained staff to provide services;
 - Insufficient knowledge among providers;
 - Insufficient information given to potential users;
 - Several policy and programmatic barriers; and
 - Client lack of knowledge about IUDs (Vernon 2008).
- ✓ FRONTIERS tested two different practical training strategies:
 - **Training in high-volume clinics.** In Honduras, training was offered at clinics routinely undertaking a large number of IUD insertions. The model required trainees to stay in these clinics for up to one week to complete a minimum of five supervised insertions for achieving competency. Competency in removal used anatomical models. However, only 62 percent of the 183 nurse auxiliary trainees were able to complete training, mostly because of insufficient clients for IUD insertions. Furthermore, a large proportion of those who completed training did not insert IUDs on return to facilities, citing lack of confidence in skills and not conducting demand-generating activities (Villanueva et al. 2001).
 - **Training in provider facilities.** In Guatemala problems of low demand were addressed by conducting training at trainee's facility. Once trainees had identified potential IUD clients, they were trained in their facilities using a service delivery protocol checklist to assess competence in counseling and clinical procedures. Follow-up visits showed three-fourths of nurse auxiliaries who completed the training (42 of 56) were still conducting insertions up to 20 months afterwards; this training model seems to better institutionalize IUD provision than training in high-volume clinics. However, just over half (90 of 160) of the nurses and nurse auxiliaries who began training completed it, mainly because of job rotation or misunderstanding of time required for training (Montufar et al. 2005).

- ✓ *Paraprofessional providers can deliver safe and effective IUD services.* In Honduras, 60 nurse auxiliaries (6–9 years of basic education, 1–2 years of health training) and supervisors carried out 2,030 IUD insertions over a 12-month period with only three pregnancies and no perforations or other complications (Villanueva et al. 2001). In Guatemala, 45 trained nurse auxiliaries conducted a monthly mean of 1.2 insertions during a four-month period, with only one pregnancy and one perforation, which was appropriately handled (Montufar et al. 2005). In Ghana, 12 rural Community Health Officers (CHOs) conducted 33 IUD insertions in community health compounds (i.e. outside standard clinic setting) with no reported complications (Osei et al. 2008).
- ✓ *In areas where the IUD is little known or poorly understood, community outreach and clinic-based education are essential for enhancing interest and demand.* In Honduras, nurse auxiliaries at rural health centers gave daily 10-minute talks about new services, including IUDs, and asked each woman to distribute five leaflets to friends and neighbors. Following this intervention, the monthly number of new IUD users increased from 2.8 to 4.5 (Mendoza and Vernon 2001). A follow-on intervention to further increase awareness of IUD through community-level activities led to a doubling of IUD delivery in clinics serving intervention areas (Flores et al. 2007). In India, strengthening skills of 76 paraprofessionals and distributing leaflets and posters widely increased mean monthly number of insertions from 212 to 247 in urban areas and from 46 to 106 in rural areas (Khan et al. 2008b).
- ✓ *An innovative model for improving access to vasectomy information and services has been successfully tested and expanded in Guatemala.* The model involved on-site facility-based orientation in vasectomy for entire facility team (not just physicians), providing counseling and information for potential clients, especially partners of women immediately after delivery (i.e. as postpartum FP method), and on-site competency training for surgeons. The model has increased the number of vasectomies performed annually by the public sector in Guatemala from less than 10 in 2003 to over 200 in 2005 and has proved sustainable (de Rodriguez, Vernon, and Solórzano 2007; Vernon, Solórzano, and Muñoz 2008).