



Improving Provision of Hormonal Contraceptives

Practices

- Use a simple checklist to be reasonably sure a woman is not pregnant.
- Use simple eligibility checklists to eliminate the need for women to have medical exams and laboratory tests prior to initiating hormonal methods.
- Start women on oral contraceptives (OCs) anytime during the client's menstrual cycle.
- Provide OCs in advance, for later initiation.
- Promote new WHO instructions on missed pills.
- Institute a depot-medroxyprogesterone acetate (DMPA) grace period.

Summary: Hormonal contraceptives are a significant proportion of the contraceptive method mix in most countries. In sub-Saharan Africa, over half of all women using reversible contraceptives choose hormonal methods. Combined oral contraceptive pills (COCs) are the most frequently used hormonal method, with over 100 million women using them worldwide. However, medical barriers such as menstrual requirements and unnecessary exams often restrict or deny access to hormonal methods for eligible women who desire these methods. In order to ensure efficient, accessible, and high-quality family planning services, programs should implement the most up-to-date and evidence-based practices related to the provision of hormonal contraceptive methods.

Use a simple checklist to be reasonably sure a woman is not pregnant.

Before initiating a hormonal method, providers should rule out the likelihood of pregnancy. When pregnancy tests are unavailable or unaffordable, nonmenstruating women need not wait for the onset of their menses to initiate their method of choice. Providers can use a six-question checklist that offers an effective and inexpensive alternative to laboratory tests and increases women's access to essential family planning services.

Suggested Resources:

Pregnancy Checklist. FHI, 2006. <http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/pregnancy/index.htm>

Training and Reference Guides for Family Planning Screening Checklists. FHI, 2008. <http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/Guides.htm>

Use simple eligibility checklists to eliminate the need for women to have medical exams and laboratory tests prior to initiating hormonal methods.

Physical examinations and laboratory tests such as breast and pelvic exams, as well as routine laboratory tests, do not contribute substantially to safe and effective use of hormonal methods, including oral contraceptives (OCs), depot-medroxyprogesterone acetate (DMPA), and implants.¹ For women with a known medical or other special condition, a self-reported

medical history using simple checklists is all that is needed to determine if a woman is medically eligible to use a hormonal method. Clinicians and paraprofessionals, such as community-based distributors and pharmacists, can effectively use these checklists to initiate OCs and DMPA.

Suggested Resource:

COC and DMPA Checklists. FHI, 2006. <http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/cocchecklists/index.htm>; <http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/dmpachecklists/index.htm>

Start women on OCs anytime during the client's menstrual cycle.

Providers often delay initiating OCs among nonmenstruating women until the first day of their menstrual cycle for two reasons: fear that a woman may already be pregnant (and that the OCs may harm the fetus) and the perception that beginning OCs on that day maintains the appearance of a regular cycle. The former is outdated because inadvertent exposure to OCs early in pregnancy is not harmful.

Providers can confidently initiate use of OCs anytime during a woman's menstrual cycle. This practice, commonly known as "Quick Start," has been shown to improve short-term OC continuation rates without increasing menstrual side effects, particularly if the first pill is taken at the clinic.^{2,3,4}

To help programs improve the provision of hormonal contraception, FHI can provide:

- (1) background safety and effectiveness data on hormonal contraception
- (2) technical assistance on updating clinical protocols and training curricula
- (3) provider training on hormonal methods

FHI is also interested in formative or operations research on innovative approaches to implementing these evidence-based practices.

Provide OCs in advance, for later initiation.

When pregnancy cannot be ruled out, or when a woman wishes to wait until her next menses to begin taking OCs, providers should not send the client home without her method of choice. Many women often face high costs or extensive travel time to return for supplies. In these situations, providers can safely provide the client with multiple OC packs for later initiation and use. This practice, known as “Advance Provision” has been shown to be safe and feasible, and can reduce unwanted pregnancies while saving time and resources for both clients and providers. If supplies allow, the World Health Organization (WHO) recommends up to 13 packs be provided in advance.

Promote new WHO instructions on missed pills.

Women are often confused by instructions for missed OC pills. Because many OC failures can be linked to missed pills and incorrect use, it is essential that clients clearly understand what to do in case of missed pills. In 2004, WHO simplified recommendations to women who miss pills. The recommendations include what to do if three or more hormonal pills in a row are missed. Counseling clients on missed pill instructions may help decrease OC failure rates.

Suggested Resource:

Selected Practice Recommendations for Contraceptive Use. Second Edition. WHO, 2004. Missed pill instructions: recommendations 17, 18. <http://www.who.int/reproductive-health/publications/spr/index.htm>

Institute a DMPA grace period.

Clients arriving late for reinjections of DMPA are sometimes refused the method, leading to

unintentional discontinuation. Research has shown that a woman may present herself for DMPA reinjection up to four weeks late without an increased risk of pregnancy.⁵ Based on this evidence, WHO has updated its practice recommendations and suggests that a woman presenting for reinjection either two weeks early or up to four weeks late is still eligible to receive a reinjection. Providers should give the reinjection if the woman presents during the grace period and the provider is reasonably certain she is not pregnant.

Suggested Resource:

Pregnancy Checklist. FHI, 2006. <http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/pregnancy/index.htm>

Additional Resource

Selected Practice Recommendations for Contraceptive Use. Second Edition. WHO, 2004. Reducing medical barriers for non-menstruating women: recommendations 1, 4, 33. “Advance Provision”: recommendation 31. <http://www.who.int/reproductive-health/publications/spr/index.htm>

References

- 1 World Health Organization/Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs/INFO Project (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore and Geneva: CCP and WHO, 2007.
- 2 Westhoff C, Heartwell H, Edwards S, et al. Initiation of oral contraceptives using a Quick Start compared with a conventional start. *Obstet Gynecol* 2007;109(6):1270–76.
- 3 Westhoff C, Kerns J, Morroni C, et al. Quick start: novel oral contraceptive initiation method. *Contraception* 2002;66(3):141–45.
- 4 Lara-Torre E, Schroeder B. Adolescent compliance and side effects with Quick Start initiation of oral contraceptive pills. *Contraception* 2002;66(2):81.
- 5 Steiner MJ, Kwok C, Stanback J, et al. Injectable contraception: what should be the longest interval for reinjection? *Contraception* 2008;77(6):410–14.



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