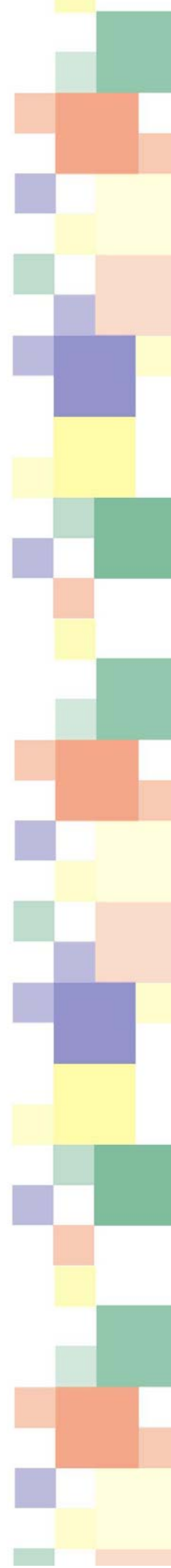

Provider Checklists for Reproductive Health Services

Reference Guide

Family Health International (FHI) is a nonprofit research and technical assistance organization dedicated to contraceptive development, family planning, reproductive health and AIDS prevention around the world.

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Provider Checklists for Reproductive Health Services

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Provider Checklists for
Reproductive Health Services

Reference Guide

To promote better reproductive health services for women and men, Family Health International (FHI) has developed and validated three checklists for health care providers. Based on standard medical criteria developed by the World Health Organization (WHO) and the U.S. Agency for International Development (USAID), **the checklists are designed to assist health workers in their efforts to help family planning clients make informed choices about safe and effective use of contraception**.

The first checklist, "How to be Reasonably Sure a Client is Not Pregnant," uses six simple questions to help health workers rule out pregnancy among women seeking contraception. This checklist could eliminate the widespread requirement that women must be menstruating before they can receive contraceptive methods — an unnecessary obstacle to contraceptive use. The checklist was designed for use in clinics but can also be used by health care providers in non-clinical settings, such as pharmacists, community-based workers, or nursing staff at health posts.

The remaining two checklists, "Checklists for Clients Who Want to Initiate Combined Oral Contraceptives (COCs)" and "Checklists for Clients Who Want to Initiate DMPA (or NET-EN)," focus on criteria for use of combined oral contraceptives (COCs) and the injectable contraceptive, depot-medroxyprogesterone acetate (DMPA). These checklists help **determine whether clients can safely initiate the use of their chosen method or whether clients might have medical conditions** that would prevent method use or would require further screening. While designed initially for use by community-based workers, other health care providers in both clinical and non-clinical settings, such as pharmacists, nurses at remote health posts, and those working in resource-poor settings, will find these checklists useful.

This package is intended to act as a reference guide for checklist users. Individual checklists are also available; however, it is important that people using checklists read the instructions for proper use and familiarize themselves with the explanations provided in this reference guide.

Making sure clinical and CBS practices are based on the most current scientific information is a critical element of quality services. These checklists can be a useful screening tool for health workers as they provide contraceptive services to their clients. Please share these materials with health workers, family planning program managers, and health policy-makers in your community.

If you have questions about the materials enclosed, contact FHI staff at *checklists@fhi.org*. Please note that any of the materials in this packet may be reproduced without permission. Appropriate credit should be given to Family Health International. Also, materials are posted on FHI's web site at *www.fhi.org*; go to the *Easy Links* menu and select *Checklists*.

Table of Contents

Provider Tools

How to be Reasonably Sure a Client is Not Pregnant – Checklist 3

Explanation of Checklist to Rule out Pregnancy 4

Checklist for Clients Who Want to Initiate COCs 5

Explanation of COC Checklist Questions 7

Checklist for Clients Who Want to Initiate DMPA (or NET-EN) 9

Explanation of DMPA Checklist Questions 11

Application of Checklists

Guide for Applying or Adapting COC and DMPA Checklists 13

Some Suggestions for Using the Checklists in Reproductive Health Programs and Policies 15

Questions and Answers 17

Annotated Bibliography 21

Information Resources

Combined Oral Contraceptives (COCs) – Fact Sheet 25

Progestin-Only Injectables – Fact Sheet 27

Using Checklists to Rule out Pregnancy – Research Brief 29

Using Contraceptive Checklists in Community-Based Programs – Research Brief 31

Medical Barriers Often Unnecessary – Article from FHI's *Network* 33

PROVIDER TOOLS

How to be Reasonably Sure a Client is Not Pregnant

If the client answers YES to any question, proceed to the first box directly below the YES column.

NO		YES
	1. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, *and* had no menstrual period since then?	
	2. Have you abstained from sexual intercourse since your last menstrual period?	
	3. Have you had a baby in the last 4 weeks?	
	4. Did your last menstrual period start within the past 7 days?	
	5. Have you had a miscarriage or abortion in the last 7 days?	
	6. Have you been using a reliable contraceptive method consistently and correctly?	

Client answered NO to *all* of the questions.

↓

Pregnancy cannot be ruled out.

↓

Client should await menses or use pregnancy test.

Client answered YES to *at least one* question.

↓

Client is free of signs or symptoms of pregnancy.

↓

Provide client with desired method.

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Explanation of Checklist to Rule Out Pregnancy

Goal of the Checklist Tool

Family planning providers should always rule out pregnancy when providing hormonal methods or intrauterine devices (IUDs). However, pregnancy tests may not be available in all clinics or affordable for all clients. In such cases, this checklist serves as an easy-to-use tool for providers to help non-menstruating clients safely initiate their method of choice. The checklist is based on criteria for ruling out pregnancy recognized by the World Health Organization (WHO).[1] Tests of the checklist's effectiveness in family planning clinics showed that the tool was more than 99 percent effective at ruling out pregnancy.[2]

Using the Checklist

The checklist is used to rule out pregnancy if no pregnancy tests are available. The provider simply asks the client each of the six questions (or includes them in history-taking). If the client answers "Yes" to *any* one question, and has no signs or symptoms of pregnancy, then she can safely be provided with her method of choice. It is very important that the provider trust what the client says. For example, if the client says her menstrual period started within the past seven days, the provider should accept the client's word.

Pregnancy cannot always be ruled out. In these cases, the woman may go for a pregnancy test elsewhere, or use a temporary barrier method while awaiting her menstrual period. If a pill client chooses to wait for her menstrual period, she should be given the option of carrying home a cycle of pills to initiate when her menstrual period returns.

Adapting the Checklist

Some programs may choose to adapt the checklist to their own unique situations. For example, since a provider does not need to continue asking questions once a client answers "yes," a program can re-order the checklist questions to reflect locally common reasons that exclude pregnancy. However, programs should take care to ensure that the meaning of the original questions remains unchanged when adapting or translating the checklist.

Sources: [1]Technical Guidance/Competence Working Group (TG/CWG). *Recommendations for Updating Selected Practices in Contraceptive Use: Volume II.* Washington: U.S. Agency for International Development, 1997.
[2]Stanback J, Qureshi Z, Sekadde-Kigondu C, Gonzalez B, Nutley T. Checklist For Ruling Out Pregnancy Among Family-Planning Clients in Primary Care. *Lancet* August 14, 1999;354(9178):566.

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Checklist for Clients Who Want to Initiate Combined Oral Contraceptives (COCs)

Please ask the client all of these questions and check the correct box.

NO		YES
	1. **Is your menstrual period late *and* do you think you could be pregnant now?**	
	2. **Are you currently breastfeeding a baby under 6 months of age?**	
	3. **Do you smoke cigarettes *and* are you over 35 years of age?**	
	4. **Do you have repeated severe head pain, often on one side or pulsating, causing nausea and made worse by light, noise, or moving about?**	
	5. **Do you have high blood pressure?**	
	6. **Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?**	
	7. **Do you have diabetes (sugar in your blood)?**	
	8. **Do you have or have you had breast cancer?**	
	9. **Do you have a serious liver disease or jaundice (yellow skin or eyes)?**	
	10. **Do you regularly take any pills for tuberculosis (TB), fungal infections or seizures (fits)?**	

If the client answers NO to all the questions, she can use COCs, *but to find out when she can start*, continue with question 11.

If the client answers YES to any of the above questions, *refer her to a clinic/physician*, and give her condoms to use in the meantime.

11. Has it been more than 5 days since the beginning of your last menstrual period?

NO. If the client began her last menstrual period *within the past 5 days*, she can be given COCs now.

YES. If the client began her last menstrual period *more than 5 days ago*, and if:

- **She *has been using an effective method of contraception* (including abstinence), give her COCs, instruct her to begin taking them now, but instruct her that she must use condoms or abstain from sex for the next 7 days. Give her condoms.**

OR

- **She *has not been using an effective method of contraception* (including abstinence), give her the COCs but instruct her to start using them on the first day or during the first 5 days of her next menstrual period. Give her condoms to use in the meantime.**

Source: Stang A, Schwingl P, Rivera R. New contraceptive eligibility checklists for provision of combined oral contraceptives and depot-medroxyprogesterone acetate in community-based programmes. *Bull World Health Organ* 2000;78(8):1015-23.

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Explanation of COC Checklist Questions

1

Is your menstrual period late and do you think you could be pregnant now?

This question has two parts — both of which should be asked together, and the answer "yes" must apply to both parts of the question. One or more missed periods **in combination** with the woman's own report that she is or might be pregnant is required before a woman should be referred to a higher-level health care provider.

2

Are you currently breastfeeding a baby under 6 months of age?

This question is intended to identify women who are breastfeeding babies under 6 months of age. A breastfeeding woman can begin COCs 6 months after her baby is born. However, if a client does not plan to continue breastfeeding, she may be an eligible candidate for COCs even before the baby reaches 6 months of age.

3

Do you smoke cigarettes and are you over 35 years of age?

This is a two-part question — and both parts need to be asked together and the answer "yes" must apply to both parts of the question. A woman less than 35 years of age who smokes as well as a woman over the age of 35 years who is a nonsmoker are not at risk for problems associated with the combination of smoking and older age. The answer "no" to one or both parts of this question means a client may be eligible for COC use.

4

Do you have repeated severe head pain, often on one side or pulsating, causing nausea and made worse by light, noise, or moving about?

This question is intended to identify women with migraines, a particular type of headache that may be problematic for COC users. The use of the words "severe frequent pulsating pain" and the occurrence of other problems during the headache are essential parts of this question. These words help the client distinguish between those types of headaches that make her ineligible for COC use (such as migraines) and the less severe (more common), mild headaches for which COCs may still be used.

5

Do you have high blood pressure?

The question is intended to identify women who have ever been told that they have high blood pressure, since women with this condition should be referred for further evaluation before receiving COCs.

6

Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?

This question is intended to identify women with already known serious vascular disease, not to determine whether women might have an undiagnosed condition. Women who have had any of these conditions will often have been told that they have had this condition and will answer "yes," if appropriate.

7 Do you have diabetes (sugar in your blood)?

The intention of this question is to identify women who know that they have diabetes, not to assess whether they may have an undiagnosed condition.

8 Do you have or have you had breast cancer?

The intention of this question is to identify women who know they have had or currently have breast cancer.

9 Do you have a serious liver disease or jaundice (yellow skin or eyes)?

The intention of this question is to identify women who know that they currently have a serious liver disease and to distinguish between current severe liver disease (such as severe cirrhosis or liver tumors) and past liver problems (such as treated hepatitis).

10 Do you regularly take any pills for tuberculosis (TB), fungal infections or seizures (fits)?

The following medications make COCs less effective:

- rifampicin (for tuberculosis)
- griseofulvin (an antifungal medication)
- phenytoin (for epilepsy/seizures)
- carbamezapine (for epilepsy/seizures)
- barbiturates (for epilepsy/seizures)

11 Has it been more than 5 days since the beginning of your last menstrual period?

The intention of this question is to determine when the client should start COCs. If she has just started her menstrual cycle and is within days 1 to 5 of the first day of bleeding, she can start the method immediately. If it is more than 5 days since her first day of bleeding, there are two options:

- If she has been using an effective method of contraception (correctly and consistently) that can help a provider rule out pregnancy, she can start taking the pill immediately but use a back-up method for 7 days.

- If she has **not** been using any effective method of contraception (including abstinence), in order to insure she is not pregnant, she needs to wait until her next menstrual period begins before starting COCs and be given condoms to use in the meantime.

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Checklist for Clients Who Want to Initiate DMPA (or NET-EN)

Please ask the client all of these questions and check the correct box.

NO		YES
	1. Is your menstrual period late *and* do you think you could be pregnant now?	
	2. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?	
	3. Do you have diabetes (sugar in your blood)?	
	4. Do you have or have you had breast cancer?	
	5. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	

If the client answers NO to all the above questions, continue with question 6.

If the client answers YES to any of the above questions, *refer her to a clinic/physician*, and give her condoms to use in the meantime.

6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?

If the client answers NO to all the questions, she can use DMPA, *but to find out when she can start,* continue with question 7.

If the client answers YES, she can be given DMPA now, *but refer her to clinic/physician for further evaluation of the bleeding.* Continue with question 7.

7. Are you currently breastfeeding?

If client answers NO, go to question 9.	**If the client answers YES, go to question 8.**

8. Is your baby less than 6 weeks old?

NO. If client is breastfeeding a baby *6 weeks old or older and her menstrual periods have not returned,* she can be given DMPA now. If her menstrual periods have returned, go to question 9.	**YES. If client is breastfeeding a baby less than *6 weeks old*, instruct her to return for DMPA as soon as possible after the baby is 6 weeks old.**

9. Has it been more than 7 days since the beginning of your last menstrual period?

NO. If the client began her last menstrual period *within the past 7 days*, she can be given DMPA now.	**YES. If the client started her last menstrual period *more than 7 days ago*, and if:**

- ❖ **She *has been using an effective method of contraception* (including abstinence), she can be given DMPA now, but instruct her that she must use condoms or abstain from sex for the next 7 days. Give her condoms.**

OR

- ❖ **She *has not been using an effective method of contraception* (including abstinence), she must wait until her next period to be given DMPA. Give her condoms to use in the meantime.**

Source: Stang A, Schwingl P, Rivera R. New contraceptive eligibility checklists for provision of combined oral contraceptives and depot-medroxyprogesterone acetate in community-based programmes. *Bull World Health Organ* 2000;78(8):1015-23.

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Explanation of DMPA Checklist Questions

1

Is your menstrual period late and do you think you could be pregnant now?

This question has two parts — both of which should be asked together, and the answer "yes" must apply to both parts of the question. One or more missed periods **in combination** with the woman's own report that she is or might be pregnant is required before a woman should be referred to a higher-level health care provider.

2

Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?

This question is intended to identify women with already known serious vascular disease, not to determine whether women might have an undiagnosed condition. Women who have had any of these conditions will commonly have been told that they have had this condition and will answer "yes," if appropriate.

3

Do you have diabetes (sugar in your blood)?

The intention of this question is to identify women who know that they have diabetes, not to assess whether they may have an undiagnosed condition.

4

Do you have or have you had breast cancer?

The intention of this question is to identify women who know they have had or currently have breast cancer.

5

Do you have a serious liver disease or jaundice (yellow skin or eyes)?

The intention of this question is to identify women who know that they currently have a serious liver disease and to distinguish between current severe liver disease (such as severe cirrhosis or liver tumors) and past liver problems (such as treated hepatitis).

6

Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?

The intention of this question is to distinguish between normal bleeding changes (such as those associated with the use of another contraceptive method), and those that are different or unusual for the client, and to identify postcoital bleeding (since bleeding after intercourse may indicate an abnormality). The use of DMPA does not make these conditions worse but may change the bleeding pattern. Unusual bleeding changes can underlie a serious condition that should be evaluated by a higher-level health care provider, but DMPA use need not be delayed.

7 and 8

Are you currently breastfeeding?

Is your baby less than 6 weeks old?

These questions are intended to identify women who are breastfeeding babies under 6 weeks of age. A breastfeeding woman can initiate DMPA 6 weeks after her baby is born.

9

Has it been more than 7 days since the beginning of your last menstrual period?

The intention of this question is to determine when the client should start DMPA. If she has just started her menstrual cycle and is within days 1 to 7 of the first day of bleeding, she can start the method immediately. If it is more than 7 days since her first day of bleeding, she will need to wait until her next menstrual period begins before she can be given DMPA. Give her condoms to use in the meantime.

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APPLICATION OF CHECKLISTS

Guide for Applying or Adapting COC and DMPA Checklists

Goal

These checklists provide an easy-to-use screening tool for various levels of health care providers, including physicians in resource-poor settings, pharmacists, or staff stationed at health posts or in other non-clinical settings. These checklists will be especially useful for community-based services (CBS) workers who may have limited medical training, and it was for this purpose that they were originally designed. The following information and guidelines address primarily the CBS context. The checklists are based on the guidance provided in the 1996 WHO document *Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use*, revised in March 2000. **Similar to the WHO recommendations, the checklists should be adapted to meet local needs.**

Purpose

The checklists allow health care providers to identify women who can safely initiate use of combined oral contraceptives and DMPA. This is done through a series of simple yes/no questions with further guidance and directions based on client responses. The checklists are not intended to identify or to newly diagnose conditions that may be "contraindications" for the method. Instead, the questions are intended to verify whether a client has or has had a known condition or disease. Women with either active conditions or a history of particular conditions will need further evaluation by a higher-level health care provider before the method is initiated.

*The following section of this guide is meant to assist **PROGRAM MANAGERS, POLICY-MAKERS, ADMINISTRATORS and TRAINERS**.*

1. The DMPA checklist is intended to be used to determine eligibility only for *three- or two-month progestin-only injectables*. Similarly, the COC checklist is intended to be used to determine eligibility *only for low-dose, combined estrogen-progestin oral contraceptives*.

2. Adapt both the language and style to meet the cultural and linguistic needs of your clients.

3. As you make the adaptations, please be careful that you do not inadvertently change the intent of the question. Explanations of the intent of each question are provided with each checklist to help with these adaptations. The following is an example of a poorly adapted checklist question:

Original COC checklist question:	Do you smoke **and** are you over age 35 years?
Poorly adapted question:	Do you smoke? Are you over age 35 years?

   This adaptation has separated the original question into two different parts. By doing so, the most important aspect of the original question could be misinterpreted: that only women who both smoke **and** who are over 35 years old have an increased risk of cardiovascular disease. This poor adaptation could prevent an eligible woman who desires COCs from receiving them. (See explanation of the COC checklist.)

4. The purpose of the questions is to verify whether a client has a known condition or disease that needs to be further evaluated before she can receive COCs or DMPA. The purpose is **not** for health care providers to make a diagnosis about conditions or diseases.
5. Health care providers and clients may not recognize the generic names of certain drugs. The following question requires that programs supply the locally available names for particular drugs:

   "Do you regularly take any pills for tuberculosis (TB), fungal infections or seizures (fits)?"
   (Only these particular drugs interact with COCs.)
   - rifampicin (for tuberculosis)
   - griseofulvin (an antifungal medication)
   - phenytoin (for epilepsy/seizures)
   - carbamezapine (for epilepsy/seizures)
   - barbiturates (for epilepsy/seizures)

6. The WHO medical eligibility criteria classifies history of hypertension where blood pressure cannot be evaluated (such as CBS programs), and known mild-to-moderate hypertension as conditions where DMPA may generally be used (Category 2). However, DMPA is not usually recommended for women with known severe hypertension (≥180 mmHg systolic/≥110 mmHg diastolic), or with vascular disease unless other more appropriate methods are unavailable or unacceptable (Category 3).

7. Please keep in mind that the questions on the checklists are meant to identify women who should be seen by a higher-level provider prior to initiating the method; the conditions listed are not necessarily contraindications for use of the method.

The following section applies to both ***PROGRAM MANAGERS and PROVIDER TRAINERS****:*

1. The checklists are not meant to replace counseling. Providers should make sure the client makes an informed and voluntary choice to use either COCs or DMPA.

2. Once it has been determined that a client is eligible to initiate use of the method she has chosen, instruct her on how to use the method correctly and consistently, and how to manage side effects and identify warning signs of more serious complications.

3. As mentioned above, the checklists identify clients eligible to **initiate** use of either COCs or DMPA under the supervision of the health care provider. However, they may be used or adapted to identify clients eligible to continue the use of these methods. It is not thought to be necessary to repeat each of the questions at each visit.

4. Establish an appropriate training system for use of the checklists to assure that health care providers use them in the correct way. Periodically evaluate the correct use of the checklists.

Be certain that a referral system to accessible clinics or private providers is established and that health care providers are familiar with the referral site and procedures.

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Some Suggestions for Using the Checklists in Reproductive Health Programs and Policies

Policy-Makers

- Distribute information about checklists to health care centers, family planning programs and nongovernmental organizations that provide contraceptives.
- Educate program managers and NGO representatives about the value of using checklists as a screening tool.
- Survey clinics, health posts, and community-based workers to learn how they have incorporated checklists into their service delivery practices.
- Present information on checklists to officials in the Ministry of Health.
- Encourage Ministry officials to incorporate checklists into national service delivery guidelines for family planning.
- Share checklist information with the media, who can be a valuable source of information for family planning clients and potential clients.
- Where community-based distribution of COCs and DMPA does not yet exist, use checklist materials as evidence to inform discussions.

Program Managers

- Hold a meeting to introduce checklists to staff.
- Hold training sessions for staff. Key points to cover are that:
  - Checklists are based on the most current scientific data available.
  - Checklists reflect criteria developed by international health organizations working with the World Health Organization and the U.S. Agency for International Development.
  - The pregnancy checklists are new and could eliminate the need for the menstruation requirement.
  - The COC and DMPA checklists are revisions of current ones staff may be using.
  - It is important that health providers ask the questions exactly as they are written. Subtle changes in wording can change the meaning of the questions.
  - The checklists are an important means to increase access to family planning services, while helping ensure client safety.

- Encourage providers to use new checklists and discard any old ones. New checklists contain the most current, up-to-date scientific information and will ensure that women are not denied contraceptives unnecessarily. Encourage providers to read the "Guide for Applying or Adapting COC and DMPA (NET-EN) Checklists," "Explanation of COC Checklists," and "Explanation of DMPA Checklists."

- Translate checklists into local languages. (Be sure to have someone who is familiar with checklists review the translations.)

- Monitor staff performance. Provide feedback on how health workers can best use checklists to deliver quality services.

- Monitor contraceptive initiation and discontinuation patterns to determine clients' satisfaction with the methods they have chosen. Evaluate whether pregnancy checklists have increased non-menstruating women's access to family planning. Evaluate whether COC and DMPA checklists have increased women's access to these specific methods.

Health Workers

- Review checklists to become familiar with the language.

- Review the rationale for questions in order to understand the need for specific questions and to be able to explain questions to clients.

- Provide feedback to program managers on whether checklists are easy to use and whether clients understand the questions.

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Questions and Answers

1. What are checklists?

Checklists are guides for use by health care workers. Typically presented as a list of questions that require a "yes" or "no" answer, checklists can be used as:

- screening tools for clients seeking services;
- monitoring tools to make sure protocols or procedures are followed in service delivery; or
- evaluation tools to make sure certain tasks were accomplished or projects were completed.

2. Why are checklists important?

The checklists in this packet are screening tools to help health workers provide prospective clients with contraceptives that are safe and effective. Contraceptive checklists can help:

- increase access to family planning by removing unnecessary medical barriers to contraceptive use;
- ensure safety by screening for conditions or health problems that might prevent use of a specific contraceptive method;
- promote quality of care for family planning clients.

3. What do the enclosed checklists address?

There are three checklists in this packet:

- "How to be Reasonably Sure a Client is Not Pregnant" checklist that screens for conditions that preclude pregnancy;
- "Checklist for Clients Who Want to Initiate Combined Oral Contraceptives (COCs) that screens for medical conditions that might preclude the safe use of combined oral contraceptives (COCs) — those that contain both the hormones estrogen and progestin.
- "Checklist for Clients Who Want to Initiate DMPA (or NET-EN)" that screens for medical conditions that might preclude the safe use of the injectable depot-medroxyprogesterone acetate (DMPA), or Depo-Provera, a progestin-only method that provides three months of protection against unplanned pregnancy.

The **Pregnancy** checklist is important because it can help eliminate an unnecessary obstacle to contraceptive use. In many countries, a woman must be menstruating before she can receive hormonal contraception, including pills, injectables, subdermal implants, or an intrauterine device. FHI review has found that unnecessary menstruation requirements are common in many countries. In Kenya, for example, researchers estimate that up to one-third of all new clients are sent home without a method

due to menstruation requirements. In Ghana, 76 percent of health providers said they would send non-menstruating family planning clients home to wait for the onset of menses. In Cameroon, 82 percent of menstruating clients, but only one-third of non-menstruating clients, received hormonal methods. In a simulated test case in Jamaica, 82 percent of clients were required to be menstruating or to have a negative pregnancy test before contraceptives were provided.

The menstruation requirement is a proxy for a pregnancy test, which can be expensive or unavailable. While the intention is good — to address the theoretical concern that hormonal methods can cause harm to the developing fetus or that the IUD might cause a spontaneous abortion — the reality is that many non-menstruating women could safely use these methods. However, they are sent home without the method they want and risk unplanned pregnancy.

The pregnancy checklist contains six simple questions. If a woman answers “yes” to any one question and is free from pregnancy symptoms, health workers can reasonably assume the woman is not pregnant and provide her with her contraceptive choice. If the woman answers “no” to all questions, providers should offer only barrier methods until a pregnancy test has been performed or the woman’s menstrual cycle begins.

The **COC and DMPA checklists** are important because they can provide guidance to health care providers, especially community-based health workers, as they counsel clients about appropriate and safe contraceptive use. They reflect the most up-to-date knowledge about contraceptive use. The checklists are a screening tool to help workers determine whether a client has any medical problem that might preclude initiation of contraceptive use or would require further evaluation by a physician or by clinic staff. However, the checklists were *not* designed to allow community health workers or other health care providers who lack the appropriate training, to diagnose diseases.

The COC checklist includes 10 questions on symptoms of health conditions or illness, such as pregnancy, headaches or diabetes, and health practices, including breastfeeding. If the client answers “yes” to any question, she should be referred to a clinic or physician for further evaluation and given condoms in the meantime. The final question on the checklist concerns the date of the woman’s last menstrual period. This can help health workers determine when the woman can start COCs.

The DMPA checklist can also be used as a screening tool for the injectable norethisterone enanthate (NET-EN), a progestin-only injectable that provides two months of contraceptive protection. This checklist contains five questions about health conditions, including diabetes and breast cancer. If the woman answers “yes” to any of the questions, the health care provider should refer her to a doctor or clinic for further evaluation and provide condoms as a back-up method. If she answers “no” to all questions, the health worker can proceed with questions about vaginal bleeding and breastfeeding. The final question concerns the date of the woman’s last menses, with instructions on when the woman may receive her injection.

4. Our health workers already use checklists. Why do we need these new ones?

Medical technology changes continually. New research findings can affect the types of contraceptives available or refine and improve existing contraceptive methods. In addition, research findings can help improve service delivery and can change health policies. For example, in recent years, research has

provided valuable new information about the relationship between chronic diseases and contraceptive safety and the effect of contraceptive use on sexually transmitted infections (STIs).

The checklists enclosed in this packet reflect the most current, accurate scientific research on safe contraceptive use. While the pregnancy checklist is new, the COC and DMPA checklists include subtle but important changes in the wording of questions. Health workers should discard out-of-date checklists and use the newer ones.

5. How effective are these checklists?

FHI tested the pregnancy checklist in Kenya, screening 1,852 non-menstruating women at seven family planning clinics countrywide.

The checklist indicated that 88 percent of the women were not pregnant. For the remaining 12 percent, the checklist indicated that pregnancy was possible. All 1,852 study participants were given a dipstick urine pregnancy test. Only one percent of the women were actually pregnant among the 233 who could have been pregnant according to the checklist, and among the 1,629 for whom the checklist ruled out pregnancy, eight were pregnant.

The checklist had a sensitivity of 64 percent, a specificity of 89 percent, a positive predictive value of 6 percent, and a negative predictive value of greater than 99 percent. Negative predictive value is the relevant statistic because it implies that a provider can be more than 99 percent certain that the checklist is correct when it indicates a woman is not pregnant.

The COC and DMPA checklists were evaluated differently. First, FHI collected checklists used by community-based workers in 33 African, Asian and Latin American programs. The checklists were translated, reviewed and evaluated for how well they reflected WHO guidelines.

FHI staff then developed its own checklists based on WHO criteria. The questions were targeted to identify conditions in Category 3 (method not recommended) and Category 4 (method not to be used). In addition, FHI developed a one-page guide, explaining how the checklists should be used. Health workers, program managers and scientists reviewed the new checklists, which were then sent to community-based trainers, workers and clients in Jamaica, Mexico, Bolivia and Paraguay.

Among the 339 people who responded, 52 percent said the checklists were easy to understand and did not suggest changes. However, many individuals suggested changes in wording. While the intent was to simplify questions, some of the suggestions would have changed their meaning. As a result, FHI developed a detailed explanation of the rationale for the wording of each question, also included in this packet.

6. How should health providers use the checklists?

FHI recommends that program managers train health workers in how to use the checklists correctly and effectively. Those using the pregnancy checklist should understand that the checklist is a reliable indicator of whether a woman is pregnant, that lab tests for pregnancy may not be necessary, and that the woman does not have to wait for the onset of menses to begin using her chosen contraceptive method — even hormonal methods or intrauterine devices. Workers using the COC and DMPA checklists should understand the differences between the old and new checklists and note that there may be subtle yet critical changes in wording of questions. The checklists are a useful tool but are not intended to be used as clinical records or case forms in and of themselves. Clinical recording of the use of checklists with a client should be noted and adapted according to local policies and procedures.

Training should also include information on referral. The checklists are designed to be used only as a screening tool, not a diagnostic tool. Health workers who have questions about client eligibility to use contraception should refer the client to a physician or clinic.

All three checklists are available in English, French, and Spanish. The pregnancy checklist is also available in Kiswahili and Haitian Creole. However, program managers may wish to translate checklists into other languages. Because even small changes in wording can cause significant changes in meaning, FHI recommends that any such changes be reviewed by someone with expertise and knowledge of the medical basis for checklists.

7. Where did the new checklists come from?

These checklists were developed from international guidelines written by WHO and USAID. WHO's *Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use* (second edition) and their *Selected Practice Recommendations for Contraceptive Use* (in press, 2002), and USAID's *Recommendations for Updating Selected Practices in Contraceptive Use: Volumes I and II* were the guidelines upon which these checklists were based. Please see the Annotated Bibliography for more details.

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Annotated Bibliography

The following articles and reports provide information on checklists and standardized guidelines, which may be helpful to family planning program managers and health workers.

***Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use. Second Edition.* Geneva: World Health Organization, 2000.**

Since modern contraceptives were introduced more than 30 years ago, numerous studies have been conducted to assess and improve safety, and research has continued to refine methods and expand family planning choices. However, many women and men still lack access to contraception. One reason is that provider practices are often based on out-of-date medical information, theoretical concerns that have not been proven, studies on methods that are no longer in use, and provider biases. To improve quality of services, a committee developed international standards for contraceptive use. The committee lists various types of contraceptives along with health conditions that might affect a client's eligibility to use the method. Category 1 is a condition for which there are no restrictions. In Category 2, the advantages of using the method generally outweigh the risks. For Category 3, the risks generally outweigh the advantages. And for Category 4, the condition presents an unacceptable health risk if contraceptives are used.

Rai C, Thapa S, Day J, Bhattarai L, McMullen S, Jha R, Shrestha S, Bastola S, Rivera R. Conditions in rural Nepal for which DMPA initiation is not recommended: implications for community-based service delivery. *Contraception* 1999 Jul;60(1):31-37.

In Nepal, a survey was conducted at five rural health posts to determine the prevalence of health conditions that might affect use of DMPA. More than 300 women, ages 15 to 44, were interviewed as they sought contraception for the first time. Nearly half the women did not want any more children, but only 25 percent were using family planning. Each woman was interviewed about her current health status by a non-physician, then interviewed by a gynecologist who took a formal medical history and performed general, pelvic and breast exams. Researchers compared women's health reports with WHO medical eligibility for contraceptive use, looking specifically for conditions in Category 3 (use of a particular method not recommended) and Category 4 (method should not be used). The prevalence of Categories 3 and 4 conditions was very low. There were nine possible pregnancies among the group and one case of abnormal uterine bleeding. In addition, there were five cases of cardiovascular disease. These conditions could easily have been identified by a non-physician using a checklist developed by FHI. Study findings indicate that village health workers could safely provide DMPA without physician intervention.

Shelton J, Angle M, Jacobstein R. Medical barriers to access to family planning. *Lancet* 1992; 340:1334-35.

While well-intentioned and based partly on medical rationale, some service delivery practices are unnecessary and can prevent access to family planning services for women and men who could safely use methods. There are six types of medical barriers: inappropriate or out-of-date contraindications; too-stringent eligibility criteria; unnecessary physical exams and laboratory tests; provider biases; limiting contraception provision to physicians only; and government regulations that limit the types of contraceptives available. To reduce medical barriers, providers must work as a group to assess all service delivery practices, to determine whether they are essential to provision of contraception. The medical community should develop standard guidelines on contraceptive use. Family planning should be viewed as less medical: Women and men should be seen as clients not patients, and increased emphasis should be placed on delivery of methods through community-based, over-the-counter and social marketing outlets. Additional research should be conducted to assess contraceptive risks and benefits, to evaluate ways to reduce unnecessary restrictions and to understand clients' perceptions of family planning methods and services.

Stanback J, Nutley T, Gitonga J, Qureshi Z. Menstruation requirements as a barrier to contraceptive access in Kenya. *East African Medical Journal* 1999;76(3):124-26.

A study was conducted in Kenya in 1996 to determine whether menstruation requirements pose a barrier to new clients seeking family planning services. Data were collected from eight public-sector health centers and one hospital in two provinces. Health providers tracked the menstrual status of women using a simple tally sheet. Forty-five percent of the women seeking services were not menstruating. Of the 345 non-menstruating women, 51 percent were breastfeeding and amenorrheic, while 49 percent were between menstrual periods. Providers considered non-menstruating women pregnant unless they were within six weeks postpartum. Women were told to go home and await the onset of menses or to have a pregnancy test at another facility. Researchers estimated that 78 percent of non-menstruating women were sent home without their chosen method, and that up to one-third of all women were turned away. In most cases, pregnancy could have been ruled out with a simple checklist. Policy-makers should consider adopting national guidelines that do away with the unnecessary menstruation requirement.

Stanback J, Qureshi Z, Sekadde-Kigondu C, Gonzalez B, Nutley T. Checklist for ruling out pregnancy among family planning clients in primary care. *Lancet* 1999 Aug 14;354(9178):566.

Where pregnancy tests are unavailable, health providers, fearing possible harm to fetuses, often deny contraception to non-menstruating clients. In Kenya, a trial (n=1,852) of a simple checklist to exclude pregnancy showed a negative predictive value of over 99 percent. Use of this simple tool could improve access to services and reduce unwanted pregnancies and their sequelae.

Stanback J, Thompson A, Hardee K, Janowitz B. Menstruation requirements: a significant barrier to contraceptive access in developing countries. ***Studies in Family Planning*** **1997; 28(3):245-50.**

Some family planning clinics require women seeking hormonal contraception or intrauterine devices (IUDs) to be menstruating before they can receive their chosen method. Studies in Ghana, Kenya, Cameroon, Senegal and Jamaica have found that menstruation requirements negatively affect access to services for clients who could safely use contraceptive. As many as one-fourth or one-half of new clients seeking contraceptive services are sent home to await the onset in menses. These clients risk an unplanned pregnancy, and many are unable to return due to time and money constraints. Because pregnancy is a contraindication for contraceptive use, health providers have used menstruation as a proxy for expensive pregnancy tests. Another rationale for menstruation requirements is timing — hormonal methods are usually initiated and IUDs typically inserted during menses. In addition, some providers believe pregnant women may use contraceptives to induce abortion. While many providers believe that women know about menstruation requirements, data from Kenya and Cameroon show that clients do not. Denial of contraceptive methods to non-menstruating women is a serious obstacle to services, which could be reduced by using a simple checklist for pregnancy.

Stang A, Schwingl P, Rivera R. New contraceptive eligibility checklists for provision of combined oral contraceptives and depot-medroxyprogesterone acetate in community-based programs. ***Bull World Health Organ*** **2000;78(8):1015-23.**

Checklists are an important tool for community-based health workers who provide contraceptives. Checklists have long been used to determine a woman's eligibility for specific contraceptive methods. Family Health International developed new checklists for combined oral contraceptives and DMPA, based on criteria from the World Health Organization. FHI staff compared checklists in use in 33 different African, Asian and Latin America countries with WHO criteria and found that none completely reflected current WHO recommendations. FHI field-tested its new checklists and received suggestions for wording changes, to make the meanings clearer. However, even subtle word or phrase changes modified the intent of checklist questions. To aid health workers, FHI subsequently developed a guide on how to use checklists and a list of rationales for each question.

Technical Guidance Working Group. ***Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting. Volume I.*** **Eds: Curtis KM, Bright PL. Washington, DC: U.S. Agency for International Development, 1994.**

Guidelines for the provision of family planning methods and services are often inconsistent and conflicting. In some cases, out-of-date and inaccurate guidelines limit women's and men's access to services. The Technical Guidance Working Group, comprised of international experts on family planning, examined the necessity of performing various procedures, such as blood pressure exams and Pap smears, before prescribing contraception. Procedures are categorized into four groups: Class A means the procedure is essential; Class B means the procedure is acceptable in some circumstances but may not be appropriate in all circumstances; Class C means the procedure is recommended for good reproductive health care but is not necessary for contraceptive use; and Class D indicates the procedure is not medically necessary or a good routine preventive practice. The publication categorizes procedures for four methods — combined oral contraceptives, progestin-only injectables, subdermal

implants and copper intrauterine devices — and explains the rationale for performing or not performing the procedure. Guidelines explaining how to determine if a woman is pregnant also are included.

Technical Guidance/Competence Working Group. *Recommendations for Updating Selected Practices in Contraceptive Use.Volume II.* Ed. Gaines M. Washington, DC: U.S. Agency for International Development, 1997.

The delivery of family planning services should be based on accurate, up-to-date information about contraceptive risks and benefits. In 1997, the World Health Organization published standardized criteria for contraceptive eligibility. The Technical Guidance/Competence Working Group explains the implications of these new criteria for family planning programs through a series of questions and answers. Contraceptive methods covered are: male and female sterilization, combined injectable contraceptives, the levenorgestrel-releasing intrauterine device, the Lactational Amenorrhea Method, natural family planning, withdrawal, progestin-only pills, barrier methods, and emergency contraceptive. Special sections on client-provider interaction, contraceptive effectiveness, risk assessment for sexually transmitted disease, dual method use and cervical cancer prevention are also included.

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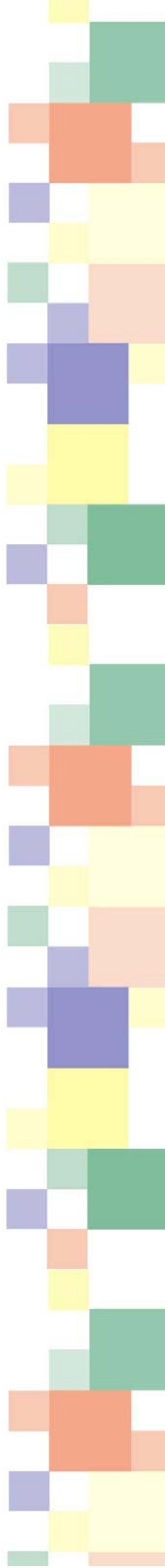
INFORMATION RESOURCES



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COMBINED ORAL CONTRACEPTIVES (COCs)

WHAT ARE COMBINED ORAL CONTRACEPTIVES?

Combined oral contraceptives (COCs) are pills that are taken once a day to prevent pregnancy. They contain the hormones estrogen and progestin.

HOW DO COCS WORK? (MECHANISM OF ACTION)

- Inhibit ovulation
- Thicken cervical mucus (make it hard for sperm to penetrate)
- Change endometrium (make implantation less likely)

WHO CAN USE COCs?

Women of any reproductive age or parity who:

- Want to use this method of contraception
- Have no contraindications

WHO SHOULD NOT USE COCs?

Women who have the following conditions (contraindications):

- Pregnancy
- Breastfeeding, during first six weeks postpartum (not a good method for women who want to continue breastfeeding)
- Unexplained vaginal bleeding (before evaluation)
- Current breast cancer
- Liver tumors, active hepatitis or severe cirrhosis
- Age 35 or older, who smoke heavily (20 cigarettes/day or more)
- Greatly increased risk of cardiovascular conditions: blood pressure of 180/110 and higher, diabetes with vascular complications, history or current deep venous thrombosis, stroke, ischemic heart disease, severe headache with focal neurologic symptoms

(For more information, see WHO eligibility criteria.)

ADVANTAGES

- Safe and 99 percent effective if used consistently and correctly
- Reversible, rapid fertility return
- Easy to discontinue use
- Pills do not interfere with intercourse
- Have beneficial non-contraceptive effects (menstrual improvements, protection from ovarian and endometrial cancer, protection from ectopic pregnancy and symptomatic PID requiring hospitalization, anemia, benign breast disease)

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Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709
USA
Telephone: (919) 544-7040
Fax: (919) 544-7262
URL: http://www.fhi.org

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COMBINED ORAL CONTRACEPTIVES (COCs)

DISADVANTAGES

- Require daily use
- Incorrect use is common (easy to miss the pill)
- Require re-supply
- Have common side effects (serious complications very rare)
- No protection against STIs/HIV

POSSIBLE SIDE EFFECTS

- Headaches
- Nausea
- Breakthrough bleeding
- Breast tenderness
- Mood changes
- Weight gain
- Dizziness
- Amenorrhea

PROVIDE FOLLOW-UP AND COUNSELING FOR:

- Any client concerns
- Any warning signs of complications (thrombosis/thrombembolism):
  - severe chest pain or shortness of breath
  - severe headache with vision problems
  - sharp pain in leg or abdomen
- Common side effects

DISPELLING MYTHS REGARDING COCs

Contraceptive pills do NOT:

- Cause birth defects
- Cause infertility
- Require a "rest" period
- Generally decrease sex drive
- Build up in a woman's body

This work is supported in part by the U.S. Agency for International Development (USAID). The contents do not necessarily reflect FHI or USAID policy.

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PROGESTIN-ONLY INJECTABLES

WHAT ARE PROGESTIN-ONLY INJECTABLES?

Progestin-only injectable contraceptives (e.g., Depo Provera, Noristerat) contain no estrogen. To prevent pregnancy, a shot is given every three or two months, depending on the type of injectable.

HOW DO THEY WORK? (MECHANISM OF ACTION)

- Prevent ovulation
- Thicken cervical mucus (make it hard for sperm to penetrate)
- Change endometrium (make it thin and probably not suitable for implantation)

WHO CAN USE PROGESTIN-ONLY INJECTABLES?

Women of any reproductive age or parity who:

- Want to use this method of contraception
- Have no contraindications

WHO SHOULD NOT USE PROGESTIN-ONLY INJECTABLES?

Women who have the following conditions (contraindications):

- Pregnancy
- Unexplained vaginal bleeding (before evaluation)
- Current breast cancer

(For more information, see WHO eligibility criteria.)

ADVANTAGES

- Highly effective
- Reversible (with delay in return to fertility)
- Easy to use
- Do not interfere with intercourse
- Private
- Do not affect breastfeeding
- Have beneficial non-contraceptive effects (protection from endometrial cancer, ectopic pregnancy and symptomatic PID). May reduce sickle crises in women with sickle cell anemia
- May prevent seizures in epileptics

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Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709
USA
Telephone: (919) 544-7040
Fax: (919) 544-7262
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PROGESTIN-ONLY INJECTABLES

DISADVANTAGES

- Delay return to fertility (by average of nine months after the last injection)
- Have common side effects
- No protection from STIs/HIV

POSSIBLE SIDE EFFECTS

- Irregular menstrual bleeding/spotting
- Amenorrhea
- Weight gain
- Headaches
- Nausea

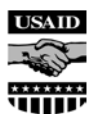
PROVIDE FOLLOW-UP AND COUNSELING FOR:

- Any client concerns
- Common side effects, especially irregular bleeding/spotting or amenorrhea
- Importance of timely injection

DISPELLING MYTHS REGARDING PROGESTIN-ONLY INJECTABLES

Injectables do NOT:

- Cause birth defects
- Cause permanent infertility



This work is supported in part by the U.S. Agency for International Development (USAID). The contents do not necessarily reflect FHI or USAID policy.

Using Checklists to Rule Out Pregnancy: Eliminating a Barrier to Contraceptive Use

Summary: Where pregnancy tests are unavailable, health providers, fearing possible harm to fetuses, often deny contraception to non-menstruating clients. In Kenya, a trial showed that a simple checklist ruled out pregnancy for 88 percent of new clients, with more than 99 percent accuracy. Using this checklist could improve access to service and reduce unwanted pregnancies.

Introduction

In many parts of the world, women must be menstruating in order to receive family planning methods and services. Family Health International (FHI) has analyzed data from family planning programs in Kenya, Ghana, Cameroon, Jamaica and Senegal and found that one-fourth to one-half of non-menstruating new clients are turned away from family planning clinics and sent home to await the onset of menses. Although the requirement is often viewed as an attempt to protect women's health — by ensuring that they do not begin use of hormonal contraceptives or intrauterine devices (IUDs) while pregnant — this requirement may actually harm women's health by putting women at risk for an unplanned pregnancy. The menstruation requirement presents an unnecessary obstacle for women seeking family planning and may discourage them from using contraception.

Study

In Kenya, up to one-third of all women seeking family planning services are refused because of the requirement that they must be menstruating, according to a 1996 FHI pilot study at seven health centers. However, nearly all of these women are not pregnant and could safely use contraception. FHI and the University of Nairobi recently conducted a study to determine the effectiveness of using a simple checklist, with six questions, to confirm or rule out pregnancy. The checklist was developed by FHI, based on criteria from the World Health Organization (WHO).

Questions include:

- ✓ Have you given birth in the last four weeks?
- ✓ Are you less than six months postpartum **and** fully breastfeeding **and** free from menstrual bleeding since your last child?
- ✓ Did your last menstrual period start within the past seven days?
- ✓ Have you had a miscarriage or abortion in the past seven days?
- ✓ Have you abstained from sexual intercourse since your last menses?
- ✓ Have you been using a reliable contraceptive method consistently and correctly?

Findings

Using the FHI checklist, family planning providers were able to rule out pregnancy among 88 percent of the study participants. A urine test was performed on all women to confirm pregnancy. Among the women for whom the checklist ruled out pregnancy, eight women were pregnant. Among the 233 women for whom the checklist did not rule out pregnancy, 14 were actually pregnant. In total, less than 1 percent of women were pregnant; 99 percent were eligible to use contraception.

Of the 1,852 non-menstruating women who participated in the study, 59 percent were experiencing postpartum amenorrhea, 37 percent were between menstrual periods and 4 percent were seeking services after an abortion. Seventy-nine percent of women seeking family planning services were breastfeeding. Sixty-nine

percent of breastfeeding clients were protected from pregnancy by the Lactational Amenorrhea Method (LAM), which requires that women be six months postpartum or less, that they be fully or nearly fully breastfeeding, and that their menstrual periods have not yet returned.

Providers were generally positive about the checklists and found them easy to use. However, they also were concerned that women would not tell the truth when answering questions about pregnancy symptoms. Providers held more favorable attitudes toward providing contraceptive methods to non-menstruating clients after learning about the checklists. Nonetheless, they remained reluctant to provide intrauterine devices (IUDs) for clients who were not menstruating.

This study was conducted by FHI and the University of Nairobi with funding from the U.S. Agency for International Development. The study was conducted at Kisii District Hospital, Homa Bay District Hospital and Rongo Health Center in South Nyanza Province; Othaya Health Center, Nyeri Provincial General Hospital and Mugeka Health Center in Central Province; and Kiambu District Hospital in Kiambu.

Source:

Stanback J, Qureshi Z, Nutley T, Sekadde-Kigondu C. Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet* 1999;354(August 14):566.

Observations/Implications

- The checklist is a valid way to rule out pregnancy, with a reasonable degree of certainty. For the majority of women, it offers an effective and inexpensive alternative to laboratory tests. Using the checklist could increase women's access to hormonal contraceptive methods, such as pills or depot-medroxyprogesterone acetate (DMPA), and their access to IUDs.
- The checklist can be used by clinic staff or community-based workers. However, training is essential for correct use of the checklist. Training should specifically address negative provider attitudes about offering hormonal methods and IUDs to clients who are not menstruating.
- The checklist should be tested in other service delivery settings where it has the potential to increase contraceptive use.

RB-02-07E

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Using Contraceptive Checklists in Community-Based Programs: Pills and Injectables

Summary: Community-based workers worldwide use checklists to determine whether women are medically eligible to use combined oral contraceptives (COCs) or depot-medroxyprogesterone acetate (DMPA). However, problems may arise when outdated and inaccurate checklists are used. With input from dozens of experts, Family Health International developed new checklists that are easily understandable and consistent with the World Health Organization's (WHO) medical eligibility requirements.

Background

Community-based health workers have long used checklists to determine whether women can safely initiate COCs, pills that contain both estrogen and progestin. As the injectable contraceptives depot-medroxyprogesterone acetate (DMPA or Depo-Provera) and norethindrone enanthate (NET-EN), become more widely available through community-based programs, workers have begun using checklists to determine women's eligibility to initiate these progestin-only methods as well.

Checklists offer guidance to workers with little or no medical background, as they identify health conditions that might preclude a woman's initiation of hormonal contraceptives. Checklists must be medically accurate and reflect the most up-to-date scientific information, but they must also be written in language that is simple and easily understood by both client and health worker.

Problems arise when community-based workers use outdated and inaccurate checklists that may not contain current information on the safety of contraceptive methods. Even minor changes in wording can exclude some women who may be healthy and could safely use hormonal methods, or include women whose health conditions warrant further evaluation and referral.

In 1996, and again in 2000, WHO produced new medical eligibility criteria and guidelines for contraceptive use. Family Health International (FHI) has developed new, updated checklists for COCs and DMPA use based on the WHO criteria to help community-based workers evaluate whether women can safely initiate oral contraceptives or injectables. The checklists were developed at the request of the U.S. Agency for International Development's Technical Guidance/ Competence Working Group, a group of international organizations with expertise in reproductive health.

Findings

Staff at FHI evaluated 36 checklists currently in use in 33 African, Asian, and Latin American countries. They found numerous inconsistencies. While some checklists reflected WHO criteria, others contained questions that were too vague or general to detect specific medical conditions. For example, some checklists included the question, "Do you have severe headaches?" However, according to WHO, only headaches that are severe, recurrent, and accompanied by visual disturbances would preclude DMPA and COC use. Other checklists asked irrelevant questions, such as whether the woman has varicose veins, a condition that does not restrict contraceptive use.

Working with researchers, physicians, and family planning program managers, FHI's new checklists contain questions to identify women with conditions that would represent an

unacceptable health risk if they used COCs or injectables, or health risks for which the disadvantages of use would outweigh the advantages.

The checklists consist of questions for women about conditions that might preclude DMPA or COC use, such as pregnancy or breast cancer. In addition, the checklists also have questions about breastfeeding practices to determine when clients can initiate pills or if they might be protected from pregnancy by the Lactational Amenorrhea Method (LAM).

The checklists were field tested in Bolivia, Jamaica, Paraguay, and two sites in Mexico. A total of 334 people were involved, including workers who would use the checklists, trainers who might adapt the questions and train workers to use the checklists, and clients who would be asked the questions. As a result of field-testing, an explanation of checklist questions was added to both the COCs and DMPA checklists, explaining the rationale behind each question. A checklist guide was also added to the checklist material. This included general instructions for checklist use and special instructions for adapting the guide to a particular locality.

This study was conducted by FHI, with funding from the U.S. Agency for International Development. Institutions participating in the field test included the Universidad Juárez del Estado in Durango, México; the Centro de Investigación Biomédica in Coahuila, México; the National Family Planning Association of Jamaica; the Ministerio de Salud Pública y Bienestar Social in Asunción, Paraguay; and Proyecto Integral de Salud in La Paz, Bolivia.

Source:

Stang A, Schwingl P, Rivera R. New contraceptive eligibility checklists for provision of combined oral contraceptives and depot-medroxyprogesterone acetate in community-based programmes. *Bull World Health Organ* 2000;78(8):1015-23.

Observations/Implications

- Health policymakers should work with program managers and providers to replace out-of-date checklists with the newer versions.
- Community-based workers need training on how to use new checklists properly. Training should include an explanation of why specific wording is important and should explain subtle but critical differences in wording between old and new checklists.
- It is important that checklists be culturally relevant and technically correct. However, even minor changes in wording can have significant changes in meaning. Therefore, any changes to simplify or customize the checklist should be reviewed by individuals with expertise and knowledge of the medical basis for checklists.
- Community-based workers should know when and where to refer clients. Checklists are a preliminary screening tool for contraceptive eligibility. Clients with possible health problems that might preclude hormonal method use should temporarily be given non-hormonal methods, such as condoms, and be referred to a trained health provider for further assessment.

RB-02-06E

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