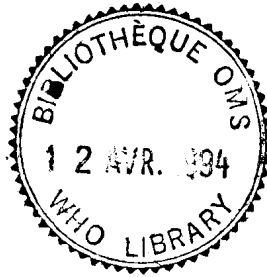


PROVIDING AN APPROPRIATE CONTRACEPTIVE METHOD CHOICE

What Health Workers Need to Know



World Health Organization
Family Planning and Population
Division of Family Health
Avenue Appia, 1211 Geneva 27
Switzerland
1993

Acknowledgement

The World Health Organization wishes to acknowledge the assistance of the Programme for Appropriate Technology in Health (PATH) in the preparation of this document. The Organization is grateful to the United Nations Population Fund (UNFPA) for its continued support in the production and publication of this document and other materials on contraceptive technologies.

© World Health Organization

This document is not issued to the general public, and all rights are reserved by the World Health Organization (WHO). The document may not be reviewed, abstracted, quoted, reproduced or translated, in part or in whole, without the prior written permission of WHO. No part of this document may be stored in a retrieval system or transmitted in any form or by any means - electronic, mechanical or other - without the prior written permission of WHO.

The views expressed in documents by named authors are solely the responsibility of those authors.

CONTENTS

| | |
|-----------------------------------------------------------------------------------------------|----|
| Introduction | 1 |
| What is an appropriate contraceptive method mix? | 3 |
| What factors affect a couple's choice of contraceptives? | 5 |
| What contraceptive methods can usually be offered to couples? | 7 |
| • male voluntary sterilization (vasectomy) | |
| • female voluntary sterilization (tubal ligation) . . | |
| • implants | |
| • combined oral contraceptives | |
| • progestin-only minipills | |
| • injectables | |
| • intrauterine devices | |
| • condoms | |
| • vaginal barrier methods | |
| • natural family planning | |
| • withdrawal | |
| Helping clients identify appropriate methods | 33 |
| Postcoital methods | 34 |
| Why is counselling important in providing an appropriate method mix? | 35 |
| How can providers counsel effectively? | 36 |
| What method-specific information do couples need to make an informed choice? | 37 |
| What advice should be given to clients at risk of STDs, including HIV infection? | 41 |
| What programmatic functions are important in ensuring appropriate client choice? | 42 |
| References | 43 |

Introduction

Family planning providers have a crucial role in helping clients to select an appropriate method from the contraceptive method mix supplied by a programme. Providing a variety of contraceptive methods and good quality care, including effective counselling, benefits both the client and the programme.

Clients benefit from being offered a choice of methods because they are more likely to find a method that meets their needs.¹ In addition, when clients are given complete information and counselled about their method, they will be better able to use it effectively and feel confident of its safety. Furthermore, by giving clients appropriate choices, providers help to guarantee each couple's right to freely determine the number and spacing of their children.

Programmes benefit from providing an appropriate method mix because, in general, when a variety of methods is offered more people will use contraceptives.² Clients who receive good quality counselling and assistance in selecting an appropriate method are more likely to continue using the method than clients who do not.^{3,4} Increased acceptance and higher continuation rates contribute to higher contraceptive prevalence and lower fertility.⁵ Another benefit to programmes is that clients who receive information about the correct use of methods are better able to use their chosen method effectively and less likely to need unanticipated follow-up care. Having a variety of methods available also makes it easier for clients to switch methods if their current method is no longer acceptable.

Using the information presented in this booklet in combination with their own knowledge and experience, providers can help their clients to make appropriate, informed contraceptive choices. This booklet uses a question and answer format to provide practical information about the different contraceptive methods available and the factors that influence a client's choice of method. Counselling techniques also are discussed, including a realistic approach to counselling couples about their

contraceptive options. For a more comprehensive discussion of method mix see the WHO publication *Contraceptive Method Mix: Guidelines for Policy and Service Delivery*.⁶

What is an appropriate contraceptive method mix?

The term "contraceptive method mix" refers to the variety of contraceptives available to clients through a family planning programme. The most appropriate contraceptive method mix for a given programme depends on the needs of the clients and the resources of the programme. A method mix that is appropriate for one programme may not be appropriate for another.

Most programmes serve a variety of clients who have different family planning needs. For example, clients in a typical family planning programme could include young women who want to delay childbearing, couples who want to space births, and couples who want to end childbearing. Furthermore, programmes may serve clients - both women and men - from a variety of cultural and religious backgrounds and with varied health needs. A good method mix is one that includes a variety of methods to meet the different needs of these clients.

Yet a method mix is only appropriate when the distribution and provision of methods are supported by adequate services. These services include the availability of trained providers, medical backup if complications occur, and a consistent source of supply of high quality contraceptives. In general, it is better to offer a limited method mix supported by good quality care and services than to offer many methods without adequate resources to support the safe and consistent use. When only a limited method mix can be provided, however, care should be taken to include different types of methods (for example, hormonal and non-hormonal, permanent and reversible, etc.) to meet the varied needs of users.



Fig. 1. By offering a variety of appropriate methods, programmes can meet the needs of different groups of users.

What factors affect a couple's choice of contraceptives?

Factors important to couples choosing a contraceptive method include whether or not the method:

- is permanent or reversible
- is effective
- is inexpensive
- is perceived to be safe
- is easy to obtain
- is easy to use and discontinue
- has frequent or undesirable side effects
- can be used while breast-feeding
- protects against sexually transmitted diseases (STDs)
- requires partner cooperation
- must be used each time the couple have sexual intercourse.

Client characteristics, such as age, number and sex of living children, and frequency of sexual intercourse, may also influence a couple's method choice. The relative importance of these factors may change over time and, because of this, clients may eventually wish to switch to a different method.

Not all of these factors are equally important to all clients. For example, couples who do not want any more children might value method effectiveness more than ease of use. In contrast, a woman who wants to delay births may place more value on convenience and ease of use than on effectiveness.

A couple's method choice may also be influenced by information received from friends and relatives. This information is sometimes incorrect and misleading. Because of the strength of informal communications networks, providers should work with both clients and other influential sources of information in the community to change any misperceptions that exist about contraceptive use. It is important that couples base their

contraceptive decisions on accurate, up-to-date information about the different methods available.



Fig. 2. Many factors influence the decision to select a particular method. Advice from friends or family members can be an important determinant of method choice.

What contraceptive methods can usually be offered to couples?

Many contraceptive methods are available, including methods that are short- or long-acting, permanent or reversible, hormonal or nonhormonal, and for use by women or men. This section provides basic technical and service delivery information about all widely available methods:

- male voluntary sterilization (vasectomy)
- female voluntary sterilization (tubal ligation)
- implants
- combined oral contraceptives
- progestin-only minipills
- injectables
- intrauterine devices
- condoms
- vaginal barrier methods
- natural family planning
- withdrawal.

Not all of the methods mentioned here will be available in every programme. This section also provides a brief description of the contraceptive effect of breast-feeding and information on postcoital contraception.

Definition of terms

Some of the terms used in the method descriptions are defined below:

| | |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | How a method prevents pregnancy. |
| Typical first year failure rate: | Among typical couples in the United States of America who begin using a method, the percentage who experience an accidental pregnancy in the first year. The pregnancy rate for United States' couples using no method is 85%. |
| Resupply requirement: | How frequently the user must obtain the method. |
| Effect on STD risk: | Whether the method protects the user against sexually-transmitted diseases (STDs), increases the user's susceptibility to STDs, or has no effect. |
| Side effects: | Physical changes that result from use of a method but do not seriously threaten the user's health - for instance, mid-cycle menstrual bleeding, mild headaches, or weight gain. |
| Complications: | Conditions resulting from use of a method that can be harmful to the user's health - for instance, anaemia resulting from prolonged and/or heavy bleeding. |

Male voluntary sterilization (vasectomy)

| | |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | The vasectomy procedure involves minor outpatient surgery done under local anaesthesia. One or two small cuts are made in the scrotum and the vasa deferentia are cut and then tied or blocked to prevent the passage of sperm (a new procedure - the "no-scalpel" vasectomy method - reaches the vasa through a small puncture rather than cuts). |
| Typical first year failure rate: | 0.15% |
| Resupply requirement: | None. |
| Effect on STD risk: | Not protective. |
| Appropriate for breast-feeding women: | Yes. |
| Return to fertility after discontinuation: | Permanent method (reversal improbable). |
| Side effects: | Some users experience a minimum amount of pain during the procedure and minor swelling, pain, infection, and bruising following procedure. (Vasectomy does not affect a man's sexual potency.) |
| Complications: | Risk of serious complications extremely low. |

Service delivery considerations:

Providers should be trained in vasectomy technique and standard practice for surgical asepsis. Men who have had a vasectomy should be advised to limit strenuous activity for a few days after the procedure to minimize swelling and bleeding but can return to heavy work thereafter. Clients should be advised to use an additional contraceptive method for several months (until semen analysis is negative or ejaculation has occurred at least 20 times) to ensure that no sperm remain in the semen. Although reversal of sterilization may be possible in some cases, couples considering a vasectomy procedure should be thoroughly counselled about the permanence of the method. Clients must be sure they want no more children. Effective counselling will help to minimize the likelihood of regret.

Female voluntary sterilization (tubal ligation)

| | |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | In the female sterilization procedure a small cut is made in the abdomen and the woman's fallopian tubes are surgically blocked so that the egg and sperm cannot meet. It usually can be done under local anaesthesia. |
| Typical first year failure rate: | 0.4% |
| Resupply requirement: | None. |
| Effect on STD risk: | Not protective. |
| Appropriate for breast-feeding women: | Yes. |
| Return to fertility after discontinuation: | Permanent method (reversal improbable). |
| Side effects: | Some women experience a minimum amount of pain during the procedure and minor bleeding and wound infection following procedure. The procedure will not change the woman's monthly menstrual cycle. |
| Complications: | Improperly performed procedures may cause injury to other organs. There is an increased risk of complications if general anaesthesia is used. |

Service delivery considerations:

Providers should be trained in specific sterilization techniques, standard practice for surgical asepsis, administration of anaesthesia, and monitoring of vital signs. Medical back-up facilities should be available in case of emergency. Sterilized women should be told to return to the clinic one week after the procedure to ensure that no infection has occurred. Although reversal of sterilization may be possible in some cases, couples considering a female sterilization procedure should be thoroughly counselled about the permanence of the method. Clients must be sure they want no more children. Effective counselling will help to minimize the likelihood of regret.

Implants (NORPLANT®)

| | |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | NORPLANT® consists of six small capsules that slowly release progestin after being implanted under the skin of a woman's upper arm in a minor surgical procedure. The procedure is generally performed using local anaesthesia. The progestin prevents pregnancy by temporarily stopping ovulation and thickening the cervical mucus. |
| Typical first year failure rate: | 0.4% |
| Resupply requirement: | At least once every five years. |
| Effect on STD risk: | Unknown. |
| Appropriate for breast-feeding women: | Implants are not the preferred choice for lactating women. If they are selected, however, use should not be initiated before six weeks postpartum. |
| Return to fertility after discontinuation: | Immediate. |
| Side effects: | Users may experience a minimal amount of pain on insertion and removal and infection at the insertion/removal site. Users may experience weight gain, headache and irregular menstrual bleeding (longer bleeding episodes, amenorrhoea, or spotting) following insertion. |

Complications:

Studies to date have shown no long-term complications.

Service delivery considerations:

With training and practice, providers can learn proper surgical insertion and removal techniques for NORPLANT®. To ensure that a woman is not already pregnant at the time of insertion, NORPLANT® should be inserted within seven days of the beginning of menstruation. It is important that providers know how to counsel clients about possible changes in menstrual bleeding patterns, a common side effect. NORPLANT® is effective for up to five years but can be discontinued at any time with assistance from a trained provider. Clients must have the implants removed after five years of use. Removal should be available on request.

Combined oral contraceptives (pills)

| | |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | Combined oral contraceptives (OCs) contain oestrogen and progestin and prevent pregnancy by temporarily stopping ovulation and thickening the cervical mucus. |
| Typical first year failure rate: | 1-8% |
| Resupply requirement: | Monthly or less frequently if several cycles can be obtained at once. |
| Effect on STD risk: | May protect against some forms of pelvic inflammatory disease (PID). May increase risk of infection with some STDs. |
| Appropriate for breast-feeding women: | Not earlier than six months postpartum. |
| Return to fertility after discontinuation: | May be delayed for several months. |
| Side effects: | Although some side effects of OC use have been reduced with low-dose pills, some women still experience nausea, weight gain, headaches, skin colour changes, and other side effects that may go away after several months or continue as long as OCs are taken. |
| Complications: | Increased risk of cardiovascular disease in women over 35 years old who smoke, and increased risk of hypertension; possible increased risk |

of cervical cancer; risk of breast cancer unclear.

Service delivery considerations:

Providers do not need specialized technical skills to distribute OCs, but should know how to prescribe them properly. Providers should make sure that clients know where to obtain more OCs, how and when to take the pills, what to do when pills are missed, and that common side effects - such as irregular bleeding and nausea - often go away after several months or can be managed by switching to a different brand or dosage of OC. Providers also should tell clients about potential danger signs and where to go for assistance.

Progestin-only minipills

| | |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | Progestin-only minipills prevent pregnancy by temporarily thickening the cervical mucus and often stop ovulation. |
| Typical first year failure rate: | 3-10% |
| Resupply requirement: | Monthly or less frequently if several cycles can be obtained at once. |
| Effect on STD risk: | Unknown. |
| Appropriate for breast-feeding women: | Hormonal methods are not the preferred choice for lactating women. If minipills are selected, however, use should not be initiated before six weeks postpartum. |
| Return to fertility after discontinuation: | Immediate or after slight delay. |
| Side effects: | Users may experience irregular menstrual bleeding (longer bleeding episodes, amenorrhoea, or spotting). |
| Complications: | Studies to date have shown no long-term complications. |

Service delivery considerations:

Providers should follow the same service delivery guidelines for minipills as for combined OCs. It is very important to take minipills at the same time each day to ensure effectiveness. Providers should instruct clients who are three or more hours late taking a pill to use a back-up method for two days. Providers should also counsel clients about changes in bleeding patterns that may occur.

Injectables

Currently available injectable contraceptives include those that contain both oestrogen and progestin (Cyclofem and Mesigyna) and those that contain only progestin (DMPA, NET-EN).

| | Progestin/oestrogen | Progestin-only |
|--------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | Injectables work by temporarily stopping ovulation and thickening the cervical mucus. | Injectables work by temporarily stopping ovulation and thickening the cervical mucus. |
| Typical first year failure rate: | 0.2% | 0.4%. |
| Resupply requirement: | Monthly. | DMPA: every 3 months. NET-EN: every 2 months. |
| Effect on STD risk: | Not protective. | Unknown. |
| Appropriate for breast-feeding women: | No. | Hormonal methods are not the preferred choice for lactating women. If progestin only injectables are selected, however, use should not be initiated before six weeks postpartum. |
| Return to fertility after discontinuation: | Immediate or after slight delay. | Immediate or after slight delay. |

| | Progestin/oestrogen | Progestin-only |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| Side effects: | Some users may experience nausea, weight gain, headaches, and other side effects that may go away after several months or continue as long as injectables are used. | Users may experience weight gain and irregular menstrual bleeding (longer bleeding episodes, amenorrhoea, or spotting). |
| Complications: | Studies to date have shown no long-term complications. | Studies to date have shown no long-term complications. |
| Service delivery considerations: | With proper training, providers can learn how to screen clients and give injections. It is important for providers to counsel women carefully about possible changes in menstrual bleeding - such as amenorrhoea - that can accompany injectable use. Providers also should remind clients when to return for their next injection. The first injection should be given during the first five days of the menstrual cycle. | |

The Contraceptive Effect of Breast-feeding

In addition to providing an ideal food for the infant and protecting the infant against disease (including diarrhoea), breast-feeding can have an important contraceptive effect during the early postpartum months. For a breast-feeding woman who (1) does not feed the baby foods other than breast milk, (2) is not yet menstruating, and (3) is less than six months postpartum, breast-feeding is about 98% effective in preventing pregnancy. The chance of pregnancy increases over time and as mothers breast-feed less often and begin giving the infant supplemental foods.

Women should be encouraged to breast-feed and instructed in proper breast-feeding technique. Providers should remind clients that they will need to use a contraceptive when they (1) have begun giving the infant foods other than breast milk, (2) have resumed menstruation, or (3) are more than six months postpartum. Breast-feeding women who need additional protection from pregnancy should choose a method that is appropriate for use while breast-feeding (see Fig. 6).

Intrauterine devices

| | |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | The intrauterine device (IUD) prevents pregnancy primarily by causing temporary changes in the uterus and fallopian tubes which prevent fertilization. ⁷ |
| Typical first year failure rate: | 3% |
| Resupply requirement: | At least once every 3-8 years, depending on device. |
| Effect on STD risk: | Increased risk of PID in women at risk of STDs. |
| Appropriate for breast-feeding women: | Yes; providers should follow instructions for postpartum insertion. |
| Return to fertility after discontinuation: | Immediate after removal by trained provider (assuming no infections have occurred). |
| Side effects: | Users may experience pain on insertion and increased menstrual bleeding and cramping. |
| Complications: | Increased risk of anaemia if heavy bleeding occurs; perforation (rare); increased risk of PID, especially within four months of insertion and in women at risk of STDs (PID may lead to infertility). Nulliparous |

women have greater likelihood of expulsion.

Service delivery considerations:

IUDs must be inserted by properly trained providers. IUDs can be inserted immediately postpartum or after six weeks postpartum. Careful client screening and good provider technique are important for the achievement of high effectiveness and low complication rates. IUD users should have access to a health facility for follow-up care and removal when necessary. Providers should tell clients that they may experience changes in menstrual bleeding patterns, what the signs of infection are, how to check their IUD string, and when to return for follow-up visits.

Condoms

| | |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | The condom is a thin latex rubber sheath that is worn over the erect penis throughout sexual intercourse. It prevents semen from entering the vagina and uterus. |
| Typical first year failure rate: | 12% |
| Resupply requirement: | Frequent. |
| Effect on STD risk: | Protective. |
| Appropriate for breast-feeding women: | Yes. |
| Return to fertility after discontinuation: | Immediate. |
| Side effects: | Some users experience sensitivity to latex rubber or lubricants. |
| Complications: | None. |
| Service delivery considerations: | Providers should give clients clear instructions for condom use and remind them that condoms can be very effective if used with spermicides. Only water-based lubricants should be used. It is important that no oil-based lubricants (such as Vaseline, mineral oil, and cooking oil) are used because these products break down latex rubber. A new condom must |

be used every time the couple has sexual intercourse. Because condom quality is affected by environmental conditions, condoms should be stored away from heat and light. Providers should periodically monitor condom supplies for signs of deterioration, such as damaged packaging, colour changes, and texture changes (dry or sticky).

Vaginal spermicides

| | |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | Vaginal spermicides (foam, cream, jelly, suppositories, film, and foaming tablets) are placed in the vagina before sexual intercourse and prevent pregnancy both by killing sperm and by forming a barrier over the cervix so that sperm cannot enter the uterus. |
| Typical first year failure rate: | 21% |
| Resupply requirement: | Frequent. |
| Effect on STD risk: | Protective against some diseases. |
| Appropriate for breast-feeding women: | Yes. |
| Return to fertility after discontinuation: | Immediate. |
| Side effects: | Some users experience sensitivity to spermicides. |
| Complications: | None. |
| Service delivery considerations: | Providers should give clients clear instructions for spermicide use. It is important that spermicides are inserted into the vagina before a couple has sexual intercourse and reapplied each time they have intercourse. Spermicidal suppositories and tablets must be |

placed in the vagina at least 10-15 minutes before intercourse to be effective. Providers should remind clients that spermicides can be more effective if used with another barrier method, such as the condom or diaphragm. Clients must also be informed about where and how to obtain further supplies.

Other vaginal barrier methods (diaphragm, cap, sponge)

| | |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | The diaphragm, cervical cap, and contraceptive sponge prevent pregnancy by blocking the opening to the uterus and holding spermicide around the cervix. |
| Typical first year failure rate: | 18-28% |
| Resupply requirement: | Sponges and spermicides (which are used with diaphragms and caps) require frequent resupply. Diaphragms and caps must be replaced every few years or when torn or damaged. |
| Effect on STD risk: | Protective against some diseases. |
| Appropriate for breast-feeding women: | Yes. |
| Return to fertility after discontinuation: | Immediate. |
| Side effects: | Some users experience sensitivity to latex rubber and/or spermicides; some diaphragm users experience increased frequency of urinary tract infection. |
| Complications: | None. |

considerations:

Providers must be trained to fit diaphragms and cervical caps, explain how the methods are used, and help clients practise inserting and removing them. Clients should be informed that diaphragms must be used with spermicide and both diaphragms and caps must be cleaned after every use. Clients should be instructed to leave vaginal barrier methods in the vagina for at least six hours after intercourse. Women who have had a baby or a weight change of over 10 pounds should have their diaphragm or cap size checked by a trained provider. Clients must also be informed about how and where to obtain further supplies.

Natural family planning

| | |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | Natural family planning (NFP) involves identifying the woman's fertile period and abstaining from intercourse during that time. Depending on the type of NFP used, the length of abstinence can range from 7 to 14 days each month. The woman's fertile period can be determined in several ways, including using a calendar, monitoring cervical mucus, and monitoring changes in body temperature. |
| Typical first year failure rate: | 20% |
| Resupply requirement: | None. |
| Effect on STD risk: | Not protective. |
| Appropriate for breast-feeding women: | No. |
| Return to fertility after discontinuation: | Immediate. |
| Side effects: | None. |
| Complications: | None. |

Service delivery considerations:

Providers must receive special training to teach NFP methods to their clients. Couples who use NFP must be highly motivated to monitor the woman's cycle and abstain from intercourse during fertile periods. It is important that NFP trainers maintain contact with their clients for the first few months of method use to help answer questions and monitor progress.

Withdrawal

| | |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mode of action: | Withdrawal involves removal of the penis from the vagina before ejaculation takes place, thus preventing sperm from entering the vagina. |
| Typical first year failure rate: | 18% |
| Resupply requirement: | None. |
| Effect on STD risk: | Not protective. |
| Appropriate for breast-feeding women: | Yes. |
| Return to fertility after discontinuation: | Immediate. |
| Side effects: | None. |
| Complications: | None. |
| Service delivery considerations: | Providers should tell clients how to use the withdrawal method correctly, emphasizing that some sperm may be released before ejaculation and that both partners must have self control for it to be an effective method. If clients cannot use other methods or temporarily do not have access to contraceptive supplies, using withdrawal is better than using no method at all. |

Helping clients to identify appropriate methods

Many people who seek contraceptive services have already decided upon a method. Unless a client requests a method that is medically contraindicated or unavailable, providers should attempt to honour the client's choice.

In some cases, clients will need assistance in selecting an appropriate method. With proper training, providers can use the decision trees illustrated here as tools to assist clients to identify methods that will best meet their contraceptive needs. Providers should use the decision tree shown in Fig. 4 for clients who desire more children or are uncertain of their fertility intentions and the decision tree shown in Fig. 5 for those who desire no more children. (Pregnant clients should be referred to antenatal or abortion services as appropriate and informed about future contraceptive options, including postpartum sterilization and IUD insertion.)

To use the decision trees, begin at the top and continue asking the questions outlined until an appropriate selection of contraceptive options has been identified. For example, a woman who desires to have more children eventually should be asked if she is breast-feeding (see Fig. 4). If she is breast-feeding, the provider should then determine whether or not the woman requires a complementary method of contraception. If the woman requires a complementary method and is six weeks or more postpartum, the provider should discuss the use of IUDs, barrier methods, implants, minipills, and progestin-only injectables (all of these methods may not be available in all programmes).

These decision trees are intended to be used as a guide for identifying appropriate choices. They should not substitute for the experience and good judgment of the provider.

Postcoital methods

In some areas, postcoital family planning methods may be available. Postcoital methods are intended for emergency use only and currently are not recommended for use as a regular family planning method. They are highly appropriate in cases of unplanned, unprotected intercourse; suspected contraceptive failure, for example, by a broken condom, dislodged diaphragm, or missed pill; and rape or incest. To reduce the need for repeated use of postcoital methods, providers should discuss other contraceptive options with their clients.

The most frequently used postcoital method involves administration of steroid hormones (oestrogens or oestrogen/progestin combinations) within 72 hours of unprotected intercourse. Hormonal treatment prevents implantation, probably by causing changes in the endometrium. A commonly used dose regimen consists of taking 0.1 mg of ethinyloestradiol and 0.5 mg of levonorgestrel as soon after exposure as possible and again 12 hours later. Most reported failure rates for the combined oestrogen/progestin treatment range from 0 to 2.0%. Although no serious complications or long-term effects of postcoital hormonal treatment have been reported, possible side effects include nausea and vomiting, irregular uterine bleeding, breast tenderness, and headache.

Insertion of a copper-containing IUD up to five days after intercourse can also be used to prevent implantation of a fertilized egg. Since 1976, over 1300 postcoital insertions have been reported with only one failure recorded. The side effects and contraindications described for general IUD use also apply to postcoital use.

Women receiving postcoital methods should return to the provider one month after administration to confirm the absence of pregnancy or receive counselling in the case of method failure. In the unlikely event that treatment fails, the possibility of ectopic pregnancy should be considered; postcoitally administered steroid hormones usually prevent uterine pregnancy but not ectopic implantation.

Why is counselling important in providing an appropriate method mix?

By providing accurate, appropriate information and sensitive counselling, providers can help ensure that couples make informed contraceptive choices and are satisfied with the method they select. Research has shown that clients who are given adequate information and counselling about their method choice are more likely to continue using the method than clients who are not appropriately counselled.^{3,4} Having thorough knowledge about the method selected, including information about possible side effects and complications, is also important for correct and safe use.

Illustration: Client (or couple) being counselled by a provider.



Fig. 3. Providing comprehensive, culturally appropriate counselling leads to increased user satisfaction, increased continuation, correct use, and fewer accidental pregnancies.

How can providers counsel effectively?

By providing effective counselling providers can help to ensure that clients feel satisfied with their choice of contraceptive method and leave with the knowledge necessary to use that method safely and effectively. During a counselling session providers should:

- Establish open, two-way communication with their clients using language and concepts that clients can understand. It is important that clients feel at ease during the counselling session. Clients who feel comfortable interacting with their provider and asking questions are more likely to return for services or seek help if complications occur.
- Listen to and address client needs, concerns, and misperceptions. In order to make appropriate recommendations, providers need to know what their clients want and whether their clients have any misinformation or concerns about specific methods.
- Provide individual clients with clear, accurate, unbiased information about the methods that are appropriate for them to use (see box: Helping clients to identify appropriate methods). Clients cannot make informed decisions without sufficient information about the risks and benefits of these methods.

What method-specific information do couples need to make an informed choice?

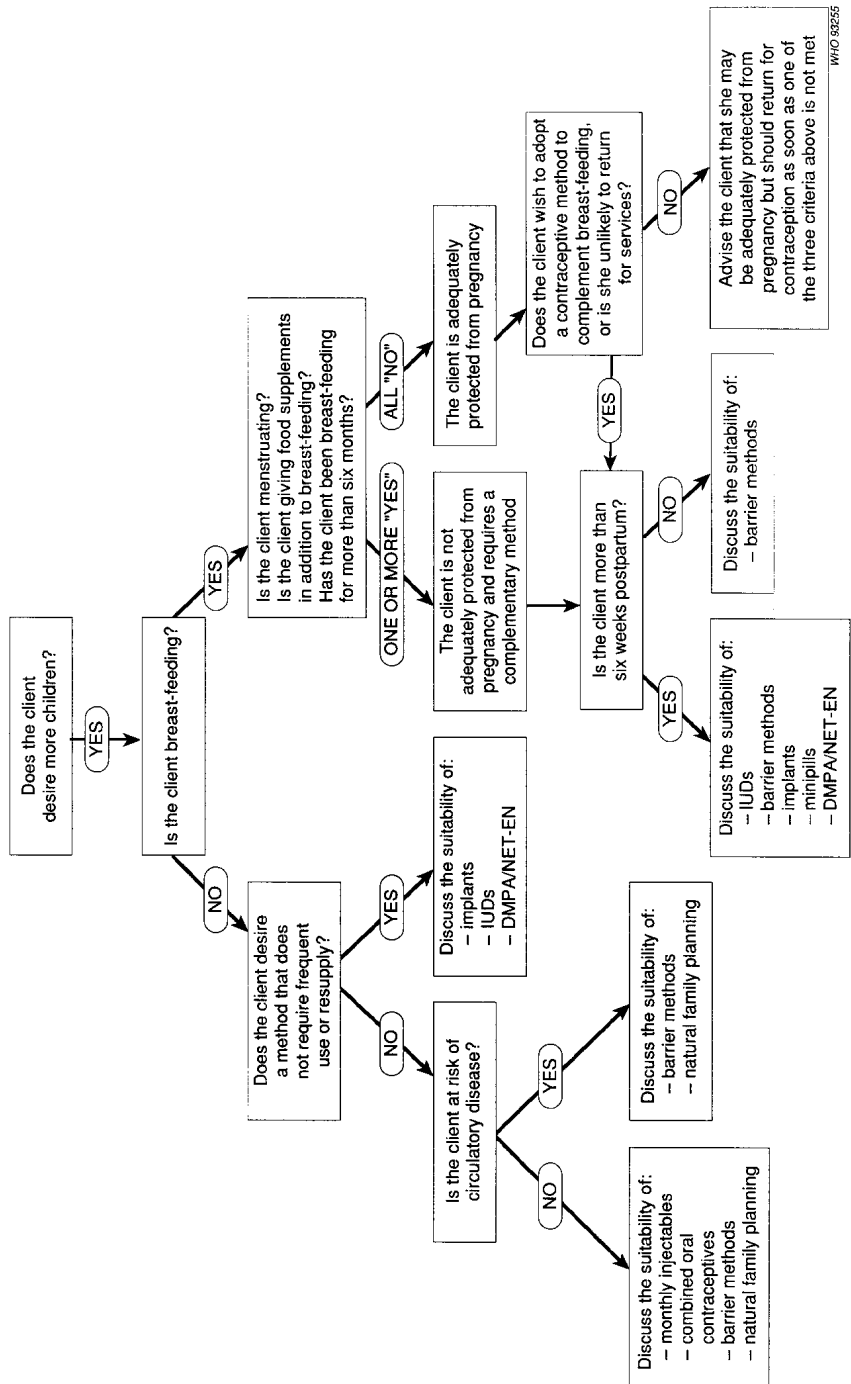
After providers have helped clients to identify several appropriate methods, more detailed information about each of these methods should be provided, including how the method works, effectiveness, advantages, and disadvantages. Although providers are responsible for informing clients about appropriate methods, it is ultimately the client who should make the decision about which method to accept, if any.

Once a client has selected a method, providers should check for medical contraindications and tell the client how to use the method properly, when and where to obtain additional supplies, possible side effects, danger signs, and where emergency care can be obtained, if necessary. Ideally, clients should be provided with appropriate instructional materials to take home.

Couples also need to know that they can return to the clinic at any time if they have questions or concerns about method use. Even clients who receive thorough counselling can experience unexpected side effects and may wish to switch methods. Providers should help clients switch methods and remind them that as they move through the reproductive life cycle their fertility intentions may change and they may wish to switch to a different, more appropriate method (see Fig. 6).

Fig. 4.

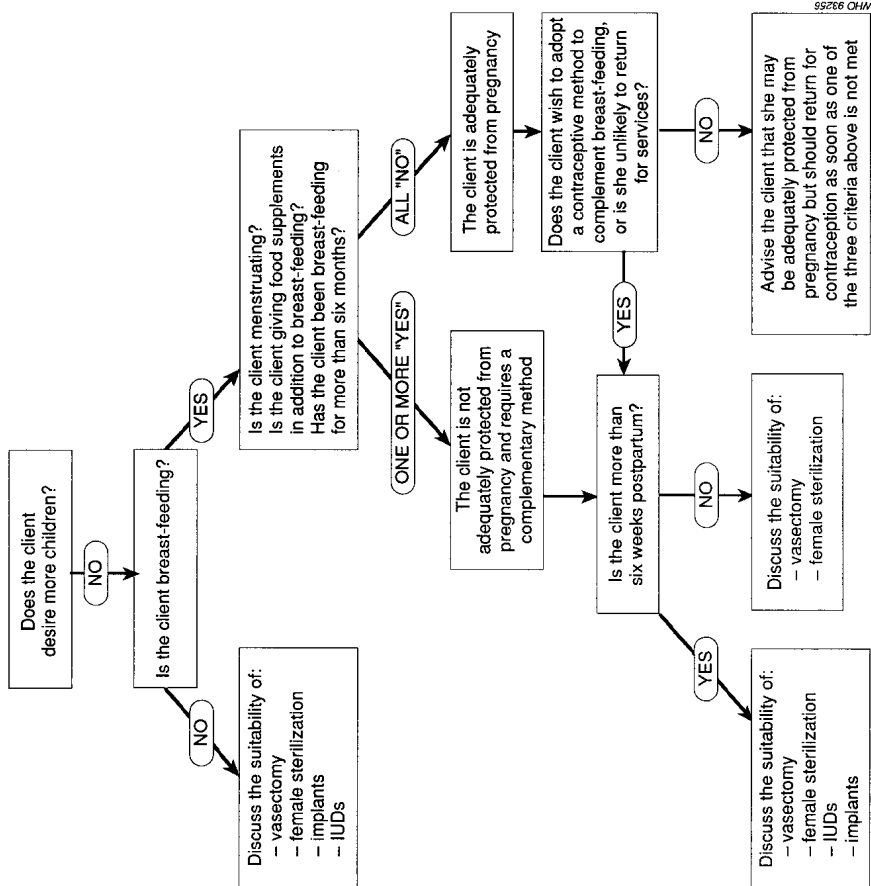
Contraceptive choice decision tree for clients who desire more children



WHO 98255

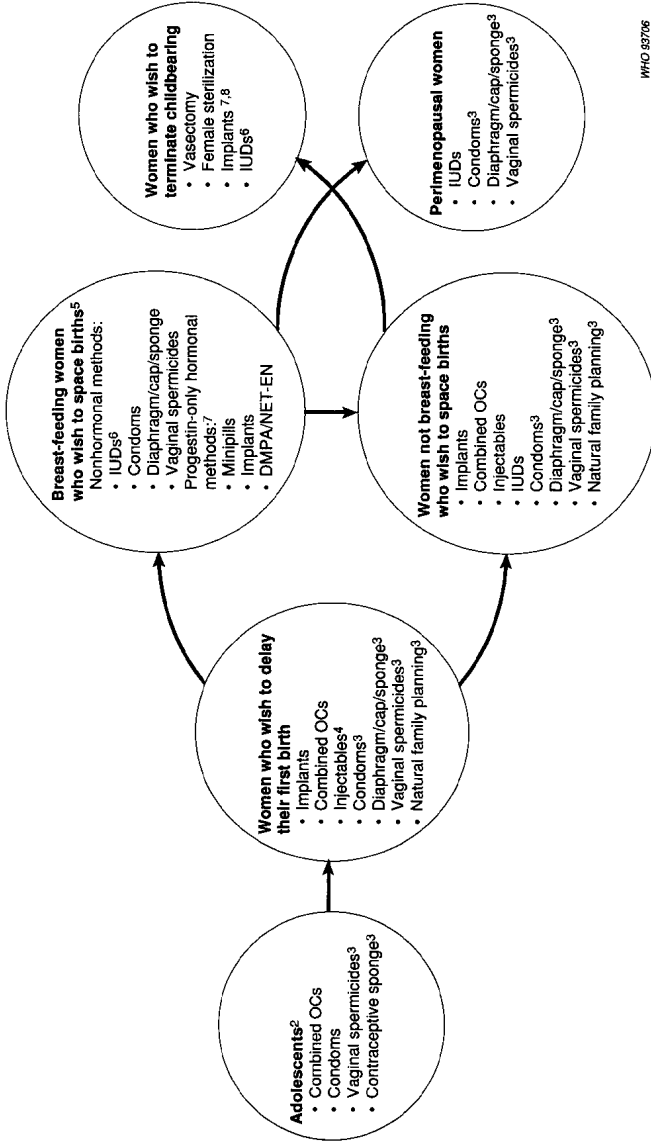
Fig. 5.

Contraceptive choice decision tree for clients who desire no more children



WH 93255

Particularly appropriate methods for different stages in a woman's reproductive life cycle



WHO 93796

1 This figure includes only modern, scientifically based methods of contraception. Individual and cultural acceptability of these methods may vary in different areas and may be based on factors such as frequency of intercourse, relationship with partner, and influence of family members. Although still widely practised in some areas, more traditional methods, such as withdrawal, are not included here owing to lower effectiveness. Each woman's needs must be assessed individually. Methods not listed in a particular grouping may still be appropriate for some women.

2 Special factors affecting adolescent contraceptive choice include possible high risk of exposure to STDs and frequent non-use of methods owing to impulsive sexual behaviour and/or possible alcohol and drug use. These factors should be taken into consideration when counselling an adolescent about method selection and use. For parous adolescents, implants and IUDs may also be appropriate.

3 Less than 90% effective.

4 Injectables are likely to delay return to fertility (average four to eight months).

5 Breast-feeding alone has a significant contraceptive effect; women who are fully breast-feeding, still amenorrhoeic, and less than six months postpartum are about 98% protected from pregnancy. Women who do not meet these criteria should use a complementary form of contraception.

6 IUDs are appropriate for breast-feeding women but should be inserted either within ten minutes of placental delivery or six weeks or more after delivery.

7 Standard practice is to initiate use no earlier than six weeks postpartum in breast-feeding women or after first menses.

8 May be inappropriate for perimenopausal women.

What advice should be given to clients at risk of STDs, including HIV infection?

Clients at risk of STDs, including human immunodeficiency virus (HIV) infection, need special counselling to help them avoid becoming infected or transmitting an infection to a partner. Counselling about STD transmission may be difficult because it involves frank discussions about sexual behaviour. Providers should be trained in culturally appropriate counselling techniques and should routinely ask questions to determine the client's risk status. When laboratory tests confirm that a client has an STD or a provider suspects that a client may be at risk of STDs, counselling should include:

- A discussion of the client's sexual behaviour to identify any risk-taking practices (for instance, having multiple sex partners or having a partner who has multiple sex partners). Providers should encourage clients to minimize risk of STD infection by limiting their number of partners and choosing partners who are at low risk of STDs.
- A discussion of contraceptive methods that help prevent the spread of STDs. Although no method is 100% effective, condoms provide the best protection against STDs, including HIV infection. Other barrier methods provide some protection against some diseases.
- Referrals for treatment. Clients who are already infected should be referred for treatment, if available, and counselled about how to prevent giving the disease to their partner(s). These clients also should be counselled about the possible long-term effects of STDs.

What programmatic functions are important in ensuring appropriate client choice?

In order for providers to serve family planning clients effectively, they must be supported by well-run programmes. An adequate budget along with efficient systems for training, supervision, referral, record-keeping, logistics, and evaluation are crucial to the provision to clients of an appropriate choice of methods.

- **Budget:** Programmes need adequate budgets to support the provision of a variety of methods and high quality care. It is important that consistent funding is available from year to year and that budgets include money for training and supervision of personnel.
- **Training:** Providers need to receive training about available methods. Training should include up-to-date information about the methods, technical skills for method administration, communications skills for counselling, and general administrative skills for record keeping and referral. Continuing education should occur on a regular basis to update providers and upgrade their skill levels when appropriate.
- **Supervision:** Proper supervision of family planning providers is necessary to ensure that medical and counselling protocols are being followed and that quality of care standards are maintained. Supervision should occur on a regular basis and should be aimed at helping providers do their jobs as effectively as possible.
- **Referral:** Local-level managers should establish and maintain referral and follow-up networks. Efficient referral systems give clients access to methods that are not supplied by their regular provider. Providers

should receive training in how to use the referral system and should be knowledgeable about the methods that are available from other sources.

- **Record keeping:** A good record-keeping system that includes accurate client records can help providers give clients consistent care at each visit. Accurate records also can help programmes estimate the number of commodities needed and facilitate continuous evaluation of the programme.
- **Logistics:** A good logistics system is as important as the technical services in a family planning programme. A logistics system must be able to provide a continuous supply of contraceptives - especially for methods that require frequent resupply - and ensure that product quality has not been affected by bad transportation or storage conditions. Continuous supply of other items necessary for the provision of some methods, such as surgical gloves and syringes, also is necessary to ensure high quality care. Elements of a good logistics system include accurate projections of supply needs, appropriate storage facilities, efficient distribution systems, and regular monitoring of product quality.
- **Evaluation:** Periodic evaluation of family planning programmes can help providers and programme managers identify successful service delivery strategies and areas for improvement. Knowledge of the impact of the programme on fertility rates, contraceptive prevalence, and women's reproductive health also is important in obtaining continued funding.

For further discussion of these functions, see the WHO publication *Contraceptive method mix: guidelines for policy and service delivery*.⁶

References

1. Jain, A.K. Fertility reduction and the quality of family planning services. *Studies in family planning*, 20(1):1-16 (1989)
2. Ross, J.A. et al. *Management strategies for family planning programs*. New York: Center for Population and Family Health, School of Public Health, Columbia University (1989)
3. Prabhavathi, K. & Sheshadri A. Pattern of IUD Use: A Follow-up of Acceptors in Mysore. *Journal of family welfare*, 35(1):14 (1988)
4. Zimmerman, M. et al. Assessing the acceptability of NORPLANT implants in four countries: findings from focus group research. *Studies in family planning*, 21(2):92-103 (1990)
5. Levels and trends of contraceptive use as assessed in 1988. *Population studies*. New York: United Nations; 110:1-129 (1989)
6. *Contraceptive method mix: guidelines for policy and service delivery*, Geneva: World Health Organization (in press)
7. Sivin, I. IUDs are contraceptives, not abortifacients: a comment on research and belief. *Studies in family planning*, 20(6):355-359 (1989)