

**REPRODUCTIVE HEALTH APPROACH  
TO FAMILY PLANNING**

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**FAMILY PLANNING**

Presentations from a panel  
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The Population Council is an international, nonprofit, nongovernmental institution that seeks to improve the wellbeing and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.

The Council's Robert H. Ebert Program on Critical Issues in Reproductive Health, established in 1988, responds to an awareness that many important reproductive health problems—and the ways women experience them—have been neglected by policymakers, program planners, and practitioners. Currently the Program focuses on several areas that merit special attention: improving the quality of services in reproductive health programs, managing unwanted pregnancy and preventing the consequences of unsafe abortion, devising new approaches to postpartum care to meet the health needs of the mother and child, and designing programs that address sexually transmitted diseases, including AIDS, within the larger context of women's reproductive health.

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**Introduction**  
**Implications of Reproductive Health for  
the Design of Family Planning Services**

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This panel has been designed to review key reproductive health elements that relate to family planning. In the presentations that follow, each of the following areas will be explored in greater detail:

- reproductive tract infections (RTIs) and sexually transmitted diseases (STDs), including AIDS;
- the prevention and treatment of unsafe abortion;
- pregnancy, labor, and delivery care; and
- postpartum care.

The definition of family planning that includes reproductive health has been developed by my colleagues Anrudh Jain and Judith Bruce: "to help individuals to achieve their reproductive intentions in a healthful manner" (Jain and Bruce, 1993). According to this definition, the view of the individual—the client who visits a family planning facility—is paramount. It is the individual who defines her own specific reproductive intentions. It is the responsibility of the family planning program to provide appropriate services to satisfy the individual's reproductive intentions, but to do so in a manner that is mindful of the individual's overall health—which implies that the service rendered will do no harm, and that the reproductive health concerns of the client will be identified and, if possible, resolved.

Family planning programs need to support voluntary fertility reduction, along with reproductive health, as their combined goal. If family planning programs are to respond to individual needs, they cannot be expected to be evaluated on the basis of demographic objectives. Such objectives may be the purview of the government of a given country, but they necessarily encompass development activities that go far beyond the purview of a family planning program, including improved education (especially for girls), empowerment of women, improved health services, and higher standards of living.

Obviously, family planning programs cannot deal with all reproductive health conditions in a given setting. At the very least, however, they should be responsible for those reproductive health needs that are directly related to fertility regulation—the four broad areas mentioned earlier. And it is those subjects on which we will focus our panel presentations.

### **Reproductive Health and Family Planning**

As defined by Adrienne Germain, a comprehensive reproductive health program should focus on sexual health beyond pregnancy, contraception, and abortion. It should include the treatment of RTIs, gynecological services, and child health care. Reproductive health should encompass services for women of all ages. The ultimate goal is "to achieve mutually caring, respectful, and responsible sexual relationships" (Germain, et al., 1994).

Far from being concerned with reproductive health per se, the initial motivations of national family planning programs were focused on achieving demographic objectives to slow rapid population growth through fertility reduction. Many people have increasingly felt, over the years, that this underlying objective of family planning programs is too narrowly focused, and in many instances can result in program efforts that do not take into account individual needs. If family planning is to focus on individual needs, demographic objectives need to be de-emphasized.

The onset of the AIDS pandemic in the early 1980s has forced a reconsideration of sexually transmitted diseases in general. These neglected diseases are inextricably linked with family planning. Indeed, family planning interventions should not increase the risk of sexually transmitted diseases through the use of certain contraceptives or medical interventions.

A third important change that has occurred in the past several years is that women's health advocates have focused attention on reproductive rights, and the problems of female genital mutilation, violence to women, and broader gender disparities.

All of these concerns have required those of us in the family planning field to broaden our vision to incorporate reproductive health as a crucial and fundamental element of family planning.

The current international debate has further heightened our need to rethink our programs. The preparations for the 1994 International Conference on Population and Development (ICPD) in Cairo repeatedly called for a greater attention to reproductive health and reproductive rights. At the same time, the U.S. government, with a new

administration, has also taken up the concern about individual rights and reproductive health.

Finally, a series of declarations by women's health advocates has brought this issue to center stage in international family planning and population meetings.

### **Unanswered Questions**

While there is increasing international consensus that family planning should be broadened to include reproductive health care, it is far from clear as to how this should be done, and which elements should be incorporated. This panel will explore some of these questions, including the following:

- Which reproductive health elements should be incorporated into national family planning programs?
- How should this be determined?
- How should decisions be implemented to ensure good quality of all services?
- What are the cost considerations?

We look forward to a stimulating discussion on these crucial elements, which will undoubtedly shape our future agenda in family planning, reproductive health, and broader population considerations at the ICPD and throughout the remainder of this century.

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## **A Puzzle of Will: Responding to Reproductive Tract Infections in the Context of Family Planning Programs\***

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For many years there has been considerable discussion of the prospects for integrating family planning efforts with other health programs—including maternal–child health, primary health care, other categorical programs (such as the Expanded Program for Immunization), and, more recently, programs for the prevention and control of sexually transmitted disease, including AIDS. The rapid emergence of the global epidemic of HIV infection, with the associated morbidity, mortality, and economic devastation of AIDS, and an increasing awareness of the impact of this epidemic on women's health, has brought a renewed sense of urgency to this debate. Unfortunately, the debate has often proceeded primarily on ideological grounds and has been marked by a paucity of data reflecting the actual experiences of field-based programs. I would like to examine some of the pieces of this puzzle and suggest some steps for moving forward in the name of action. I will draw, where possible, from the limited sources describing actual field-based programs.

I would like to explicitly avoid the usual discussion of how already existing vertical programs for family planning and STD control can be formally integrated. In political jargon, this issue is often a "non-starter" because of the extreme difficulty of combining the budgets and bureaucracies of existing programs under different lines of administrative authority. Family planning and STD control programs are often in different divisions of a ministry and, in some countries, in completely separate ministries. As a consequence, any discussion of formal program integration often quickly becomes a debate over administrative jurisdiction and budgetary control—a debate that is totally disengaged from the reproductive health needs of the clients of either program.

Instead, I will make the argument that responding to the problem of reproductive tract infections is a worthwhile—and long overdue—challenge to be taken up within the context of existing family planning programs. Infections of the reproductive tract—including the common STDs and HIV infection—are of central concern to the providers of family planning services, as these infections

\* Presentation based on a paper by Christopher Elias, Ann Leonard, and Jessica Thompson, 1993.

influence the safety and quality of our service programs and impact on the demand for fertility regulation and the utilization of contraceptive methods. The puzzle to be solved, therefore, is not how to integrate two separate government departments, but rather how to expand existing family planning services to more adequately and comprehensively meet the reproductive health needs of clients. As I will discuss, there are very few examples of how this has been successfully done, especially in sub-Saharan Africa. We have much to learn about the operational details of such programmatic expansion. Therefore—appropriate to the theme of this conference—I will end with a detailed agenda for operations research. It is, however, very much a puzzle of will. We will not identify successful service models unless we make this topic one of our primary concerns and invest the requisite time and effort to answer the outstanding questions.

### **Reproductive Tract Infections**

Let us first turn to the problem of reproductive tract infections, or RTIs. Through the advocacy of the International Women's Health Coalition and other concerned organizations, increased attention has been brought in the past several years to this largely neglected issue. Reproductive tract infections are of three general types: (1) sexually transmitted diseases, including gonorrhea, chlamydia, and HIV infection; (2) endogenous infections, caused by overgrowth of organisms normally present in the vagina, such as yeast and bacterial vaginosis; and (3) iatrogenic infections that are associated with medical procedures, such as abortion or IUD insertion.

A broader concern for RTIs, as opposed to a more narrow focus on STDs, is preferable because it more accurately reflects women's need for reproductive health services. When symptomatic, women present with specific syndromic complaints—for example, vaginal discharge or lower abdominal pain—that may or may not be sexually transmitted, and that may be the consequence of medical intervention, as well as sexual behavior. In any regard, all three types of RTIs are a significant source of morbidity and mortality for both the women and their children.

RTIs are extremely common. In a recent exhaustive review of the available prevalence data for lower reproductive tract infections among non-

prostitute populations—mostly gathered from antenatal and family planning clinic samples—Dr. Judith Wasserheit drew the following conclusions:

- First, RTIs are common in almost all of the developing countries in which they have been investigated, even among asymptomatic populations.
- Second, the prevalence of infection is greater in African populations than in Asian or Latin American populations.
- Finally, there are no consistent prevalence patterns across countries (even within the same continent) to indicate which groups of women are likely to be most in need of services.

Wasserheit summarizes the median prevalence of lower RTIs among non-prostitute, non-STD clinic populations of women by continent and by causative organism. Where data are available, the prevalence in Africa is generally higher and, in all areas, the range of prevalence is quite broad. Illustrative of the magnitude of these infections was Dr. Wasserheit's finding that "in seven of the eight asymptomatic, non-STD populations examined, at least 5 percent of women had gonorrhea, and in four of these studies, a prevalence of at least 10 percent was documented" (Wasserheit, 1989, p. 153).

But, these are clinic-based data. What about the prevalence of RTIs in the community? In the Population Council's Cairo office, Dr. Huda Zurayk and colleagues have conducted a community study of gynecological and related morbidities among women in two villages in rural Egypt (Younis, et al., 1993). Table 1 summarizes their findings for the prevalence of lower reproductive tract infections. These investigators randomly sampled 509 women from households in two communities in rural Giza.

**TABLE 1**  
**Gynecological Morbidity**  
**in Rural Egypt**

<u>Lower Reproductive Tract Infections</u>	<u>Percentage</u>
<b>VAGINITIS:</b>	
Laboratory diagnosis	44.2
Bacterial Vaginosis	21.9
Trichomonas	18.3
Candida	11.0
<b>CERVICITIS:</b>	
Clinically diagnosed	9.7
Chlamydia	8.6
Gonorrhea	0
Nonspecific Mucopurulent Cervicitis	9.2
<b>Source:</b> N. Younis, et al., "A Community Study of Gynecological and Related Morbidities in Rural Egypt," <i>Studies in Family Planning</i> 24, 3 (1993): 175-86.	

Because of an uncommon investment of time in sensitive recruitment and counseling of women, only 8.6 percent of their sample refused participation in the study. (Previous studies of this kind have been characterized by extremely high refusal rates that limit the generalizability of the study findings.) They found that a significant percentage of the women had vaginitis, or cervicitis, or both. Overall, 52 percent of the sample was found to have at least one reproductive tract infection.

In summary, data from both clinic and community studies indicate that a significant proportion of reproductive-age women currently have RTIs. Studies also indicate that a large portion of these infections are totally asymptomatic.

### Consequences of RTIs

There are many consequences of RTIs, several of which are potentially fatal. There are significant associations between various reproductive tract infections and fetal wastage, low birth-weight, and congenital infection. These outcomes contribute in turn to high neonatal and infant mortality rates and are also the cause of significant morbidity. Congenital gonococcal infection, for example, represents an important cause of preventable blindness. Cervical cancer is another important consequence of lower RTI, having been epidemiologically associated with several strains of the Human Papilloma Virus. Recent evidence also suggests that the risk of HIV transmission is increased at least three- to five-fold in the presence of other RTIs, qualifying the acquisition of this fatal infection as a consequence of unrecognized and untreated RTI.

Another complication of lower RTI that leads to a range of complications is infection of the upper reproductive tract, or pelvic inflammatory disease. Infertility, ectopic pregnancy, and chronic pelvic pain are common and serious results of such infection. Selecting just one of these outcomes for illustration, Table 2 indicates the estimated proportion of infertility attributable to RTIs by region. Note that, in keeping with the overall higher prevalence of RTIs observed in sub-Saharan Africa, the proportion of infertility

**TABLE 2**  
**Proportion of Infertility Attributable to Reproductive Tract Infections**

<u>Region</u>	<u>Percentage</u>
Sub-Saharan Africa	50–80
Asia	15–40
Latin America	30
Industrialized Countries	10–35

**Source:** J.N. Wasserheit, "The Significance and Scope of Reproductive Tract Infections Among Third World Women," *International Journal of Gynecology and Obstetrics*, Supplement 3 (1989):145-68.

attributable to these infections is higher and, indeed, represents the major cause of infertility in this region.

### ***Impact on Family Planning Programs***

The role RTIs play in causing infertility is important to keep in mind when considering their impact on family planning programs. By compromising fertility, pregnancy outcome, and child survival, RTIs may decrease the demand for contraception. In a more direct manner, when perceived as "side-effects" of contraceptive methods, RTIs may result in discontinuation of methods. Finally, real or perceived associations between RTIs and particular contraceptive methods may result in client or provider "bias" against these methods. "Bias," in fact, may be too strong a term in many settings where a reasonable suspicion of high RTI prevalence, combined with a lack of any facility for RTI screening, leads providers or appropriately counseled clients to use certain methods, such as the IUD, only with extreme caution.

So, what does all this mean for family planning providers and program managers? The prevalence and consequences of RTI form an important dimension in an expanded concept of unmet need. In a recent essay, Ruth Dixon-Mueller and Adrienne Germain (Germain and Dixon-Mueller, 1992) define a broader scope of unmet need. Such an expanded concept of unmet need would include recognizing the need among nonusers at risk of unwanted pregnancy for any method of contraception, as well as the need among some users for a more effective, satisfactory, or safer method; the need among both users and nonusers for treatment of contraceptive failure (or nonuse) through safe and accessible abortion services; and the need for related reproductive health services, such as the prevention and treatment of RTIs.

### **The Legacy of Categorical Programs**

Lack of sufficient recognition of the significance and scope of reproductive tract infection is not, however, the only ill we bear. We also bear the legacy of categorical programs that have historically been primarily, and sometimes too exclusively, focused on the control of fertility and population growth. An emphasis on "births averted" has led to both formal and informal program dynamics that discourage the embrace of a broader scope of unmet need.

One area where this dynamic is reflected is in the evaluation and reward of program effort. Consider, for example, the widespread use of couple-years of

protection (CYP) as the principal measure of family planning program success. As Jim Shelton discusses in his commentary entitled "What's Wrong with CYP?", the secondary benefit of condoms and spermicides in preventing AIDS and other STDs is "difficult, if not impossible,...to be addressed by CYP per se" (Shelton, 1991). And yet, because other evaluation techniques are often not routinely used in family planning programs, CYP or other methods of program success exclusively focused on fertility reduction remain the norm.

Such a dynamic in program evaluation and reward readily becomes reflected in provider attitudes that consider one method of contraception "better" than another solely because it has a greater perceived contraceptive effectiveness. As discussed in the quality-of-care literature, a narrow focus on this single, albeit extremely important, dimension of contraceptive methods underplays other important dimensions, such as client satisfaction and the need for other reproductive health services, including RTI screening and treatment. Such attitudes obviously affect the content of information and counseling providers give to clients and, ultimately, the client's choice of methods.

Similar concerns are also raised by the recent discourse on "medical barriers." While the removal of unnecessary obstacles to contraceptive accessibility is obviously a laudable goal, there is a danger that "STD screening" could become broadly conceived as a barrier to contraceptive access and, hence, reduce the interest of program managers in pursuing its appropriate application. Routine screening of potential IUD acceptors for RTIs prior to insertion is a reasonable goal and currently the standard of care in resource-rich environments. Its feasibility in resource-poor environments is currently limited by available diagnostic technologies, facility infrastructure, staff training, and financial resources. It would be inappropriate, however, to stop trying to overcome these difficulties because such screening became broadly signified by the somewhat pejorative term "barrier." We must remember that for many women throughout the world, maternal-child health (MCH) and family planning programs may represent their only contact with a health facility; hence, such encounters are an important opportunity to provide needed preventative and curative service. The challenge—and, as I see it, the responsibility—of operations research (OR) is to determine how such opportunities can be realized without detriment to existing services.

Another aspect of the legacy of categorical programs relates to client perceptions and health-seeking behavior. As discussed above, clients have a

range of reproductive health needs. They are also keenly sensitive to the intent of programs and readily perceive when providers are only interested in or capable of addressing their need for fertility regulation. The available literature on client–provider interactions in family planning services suggests that women in developing countries often view such categorical programs with considerable suspicion. Services that met a broader range of women's needs could expect to be viewed more positively, provided that such services were of adequate quality.

A final issue relates to health-seeking behavior and the "culture of silence" that surrounds women's reproductive tract infection and morbidity. While many RTIs are asymptomatic, most categorical programs have been poorly prepared to deal with those infections that are either symptomatic or detected during clinical examination. Several studies have shown that many women bear silently the symptoms and signs of RTI without seeking any health care. While some of their behavior reflects lack of an awareness of reproductive physiology and expectations that such problems are part of "woman's lot in life," it also surely reflects the reality that in many places there is simply no health care to seek, especially for symptoms that tempt the stigma of "venereal disease."

### **The Limitations of Current Technologies**

The final ill we bear is the limitation of our current technologies. We are in an unfortunate position where our most effective contraceptive technologies have either no protective effect on STD and AIDS transmission or potentially augment risk, and where the most effective means for avoiding STDs—condoms and spermicides—have a relatively poor track record regarding their use-effectiveness as contraceptives. Urgently needed are improved vaginal contraceptive methods that provide adequate protection against both unwanted pregnancy and sexually transmitted disease.

In the case of RTI screening, we face a further limitation in the available diagnostic technology for reliably identifying these infections. Urgently needed are simple, low-cost RTI diagnostics that would allow prompt identification of infections without requiring elaborate and difficult-to-sustain laboratory facilities. To that end, a consortium of donor organizations has recently created the STD Diagnostics Initiative to pursue the development of affordable diagnostic technologies for resource-poor environments. The Rockefeller Foundation has also recently announced its intention to offer a sizeable cash prize for the development of appropriate diagnostics for the developing world.

## **The Experience of Field-Based Programs**

Let us now turn to the experience of field-based programs. Unfortunately, the literature is extremely scant regarding the incorporation of RTI, STD, or AIDS efforts within family planning programs. This situation reflects not so much a lack of experience, as a lack of well-designed, implemented, and evaluated program interventions that could be written up in either the published or the fugitive literature of population science. In other words, given that clients, providers, and managers of family planning programs struggle every day with the issues discussed earlier, I believe that even though such program experience does not exist in Popline or Medline, it does exist in this audience, and I am hoping this review of the inadequate information on this subject will be a "call to arms."

Let us first consider some of the hesitations family planning program managers, policymakers, and donors have had regarding the incorporation of RTI, STD, or AIDS efforts into programs. Some of the more common concerns are that:

- Attention to STDs and AIDS will stigmatize family planning and harm program performance.
- Comprehensive reproductive health services are simply too expensive to even consider in resource-poor environments.
- Family planning services are already overburdened and cannot accommodate expanded service obligations.
- Family planning clients are healthy people who will not appreciate being asked about or screened for diseases such as STDs or AIDS.

Some of the limited research to date has addressed these concerns. In Latin America, Population Council staff assisted in a number of operations research projects through INOPAL (Investigación Operativa y Cooperación Técnica en Planificación Familiar para América Latina y el Caribe), the regional Operations Research/Technical Assistance (OR/TA) Project. For example, in Colombia two operations research projects demonstrated that AIDS-prevention activities, including information/education/communication (IEC) and condom distribution, could be successfully incorporated into the services offered by PROFAMILIA, the country's family planning association, without any harm and,

indeed, with considerable benefit to the program. These projects involved a controlled assessment of adding AIDS-prevention responsibilities to the assignments of community marketing field workers and the assessment of an AIDS-prevention radio campaign. In the experimental group, the field workers were instructed to dedicate 20 percent of their time to STD- and AIDS-prevention activities, while in the control group the workers simply responded to spontaneous demands for STD and AIDS information.

The principal findings of these studies were (Vernon, et al., 1990):

- There was a large demand for AIDS information among regular family planning audiences.
- Family planning field workers were able to reach target groups of high-risk persons for AIDS information.
- Field workers who programmed a fixed proportion of their time to AIDS activities were more likely to give a larger number of talks to a larger variety of target groups than the field workers who mostly responded to requests for information.
- The field workers were able to establish condom distribution posts in meeting places of target groups and sell condoms through them.
- Workers who devoted 20 percent of their time to STD/AIDS-related activities established more condom distribution posts at a larger variety of places and sold more condoms through them than did control-group workers.
- Carrying out AIDS-related activities did not cause the workers' contraceptive sales to decline.
- Results of the radio campaign assessment revealed no negative effects on PROFAMILIA's image.

In another Latin American operations research study, researchers in Peru evaluated the feasibility of establishing comprehensive reproductive health services for a high-risk group of commercial sex workers (San Marcos University, 1990). This intervention was targeted to the over 600 commercial sex workers in Callao and involved the provision of STD and HIV education, HIV and STD

testing, free condoms, and reproductive health services, including family planning.

Project evaluation focused on the utilization of services and changes over time among health center users regarding their frequency of condom use, HIV knowledge and attitudes, and the incidence of RTIs. Over 96 percent of the registered prostitutes attended at least one educational session. Over 1.1 million condoms were distributed over one year, and reported condom use increased greatly among the women. In addition, the annual incidence of gonorrhea decreased from 20 percent to 3 percent. A total of 69 percent of the women made use of the family planning services offered. This project demonstrated the feasibility, as well as the potential benefits, of establishing an integrated service structure. Indeed, for this group of high-risk women, the STD services may have been the primary attraction, providing an additional entry for contraceptive counseling.

The results of these and other OR studies from Latin America suggest that many of the initial hesitations about the potential harm of integrating STD- and AIDS-related activities into family planning programs were not warranted. They also suggest the potential for mutual benefits from a more comprehensive approach for the reduction of both unwanted pregnancy and RTIs.

But, what is the experience in Africa? Very little documentation is available on efforts to address reproductive tract infections within family planning programs in sub-Saharan Africa. This is particularly unfortunate given the generally higher prevalence of both RTIs and infertility observed in this region. Within the scope of the Africa OR/TA Project, a number of sub-projects dealt with diagnostic studies or technical assistance related to STDs or AIDS— notably in Zambia, Burkina Faso, Gambia, and Senegal, as well as Nigeria.

While there is little documented program experience at the country level in Africa, program managers, providers, and, in some cases, governments have already begun to respond to pressure from their communities to take action. Awareness of AIDS throughout the region is high and people's concern is great. A recent study by POPTECH of the potential for integrating AIDS prevention and family planning programs in sub-Saharan Africa found that a number of countries, notably Botswana and Zimbabwe, had begun to integrate STD and HIV into their family planning curricula. They noted that "the demand for this additional training comes mainly from the clients who want information about STDs and AIDS" (Population Technical Assistance Project, 1993). With growing

concern and little experience, we face a unique opportunity today, as we look forward to the next five years of operations research. The time has come to seize this opportunity and to design, evaluate, document, and disseminate the results of program interventions in this important area.

### **The Name of Action**

I would like to close with a description of steps forward. As I see it, there are three types of steps to take: first, immediate opportunities—these are things we can do today, based on the limited experience in other regions and the demand for information; second, operations research—a series of specific OR questions that I believe are a priority for future work; and, finally, some discussion of opportunities to explore new service paradigms that might be of mutual benefit to family planning and RTI prevention programs.

### ***Immediate Opportunities***

Family planning programs can do much right now to respond to their clients' and staff's concerns about RTIs, STDs, and AIDS. For example:

- All clinic staff need to be well-informed about HIV/AIDS in order to be able to protect themselves and their clients from infection and to answer their clients' basic questions. In this respect, it is important that staff be helped to work through any fears they themselves may have about AIDS, or judgmental attitudes they may harbor toward people with STDs, so that they can respond accurately and with sensitivity to those who may be infected, or at risk of becoming infected.
- Clinic staff also should be aware of the basic symptoms of RTIs, so that even if diagnosis and treatment are not available on-site, this knowledge can be taken into account when considering the method of family planning most appropriate for each client.
- Family planning programs should also take into consideration the possibility that clients may have or be at significant risk of exposure to RTIs in determining protocols for providing various contraceptive methods. Barrier methods, particularly condoms, should become more prominent options for some clients despite being considered "less effective" methods in terms of calculating CYP. In other words, for some clients the secondary benefits of RTI prevention may be as salient as the primary benefit of contraception.

- Programs should be sure to have on hand good quality IEC materials dealing with RTIs, STDs, and AIDS for use by both staff and clients. Specifically, programs should have available simple, pictorial instructions on how to correctly use and dispose of condoms.
- Programs should also make the effort to find out what testing and treatment services for RTIs, STDs, and AIDS are available in their area and establish mechanisms to refer clients to these services as appropriate.
- Clinics should also make sure that they have ample supplies of condoms on hand at all times and that clients can be resupplied as quickly, efficiently, and unobtrusively as possible.

### ***An Operations Research Agenda***

I will now turn to the question of operations research and outline a research agenda that begins to address the many unanswered questions concerned with responding to RTIs within the context of family planning programs.

#### Choice of Methods

- Is it feasible for clients to adopt and use dual protection—that is, condoms plus a "more effective" contraceptive method—to achieve protection from infection, as well as unwanted pregnancy? If so, what are the implications of this strategy in terms of counseling, acceptability, compliance, and measurement of effectiveness?
- How can we use existing family planning services to more effectively promote condoms for the primary prevention of RTIs—especially among men and youth?
- What are the associations between different contraceptive methods and the incidence and consequences of RTIs?
- What are the dimensions of acceptability of female-controlled methods such as the female condom and vaginal spermicides?

#### Counseling

- How do we best add RTI, STD, and AIDS information to contraceptive counseling? How does this vary by setting? What are the training and supervisory requirements?

- What is the appropriate content of counseling for people who are at risk of RTIs within family planning programs? What is the role of risk assessment? And should such assessment be made primarily by providers or clients?
- Recent work suggests that voluntary counseling and testing for HIV may be a useful strategy for behavior change. Are family planning clinics a feasible site to provide such services?
- How do we ensure the confidentiality of client information in the era of AIDS, with its associated discrimination?

### Service Delivery

- What are some of the obstacles to clients'—both male and female—use of family planning services for RTI information, counseling, or, where available, treatment?
- What is the relative cost-effectiveness, acceptability, and quality of categorical versus integrated approaches to providing service for RTIs and family planning?
- What would be the effect of comprehensive services on service dynamics, such as patient load, waiting times, provider–client ratios, and specific outcomes such as safer sex, RTI prevalence, unplanned pregnancy, and method continuation?
- What is the role of syndromic diagnosis (that is, the stratagem of diagnosis and treating clients on the basis of groups of symptoms rather than specific laboratory diagnoses) and the use of treatment algorithms for the management of RTIs, and how are these best incorporated into existing services?

### Information, Education, and Communication

- What IEC strategies are most effective in improving accurate knowledge regarding condom use and disposal?
- What are the pros and cons of combining messages for unwanted pregnancy and RTI prevention in IEC programs? Is this a useful strategy for social marketing?
- What is the role of target audiences? Does such targeting lead to stigmatization?

- How can we elicit more client participation in the design of IEC materials? Will such participation have an impact on the client's willingness to seek information and services?

### Cost-Effectiveness and Referrals

- What would be the cost to family planning programs of providing condoms for the primary prevention of RTIs?
- How would inclusion of screening and referral for RTIs affect cost? Against what measure of effectiveness do we balance the increased cost?
- What is the cost-effectiveness of syndromic management of RTIs?
- Once established, how effective are referral networks between family planning services and programs offering testing and treatment services for RTIs, including HIV? How can these be monitored and evaluated?

### Community Outreach

- Can traditional healers, traditional birth attendants (TBAs), and other community practitioners effectively disseminate AIDS information, distribute condoms, offer syndromic diagnosis and management of RTIs, or provide referrals for testing and treatment?
- Can dissemination of RTI/STD/AIDS information and condoms be effectively conducted by community-based distributors (CBDs) or other family planning outreach workers?
- Would male motivators be more effective in reaching men about both RTIs and family planning?
- How can peer counselors be most effectively used to reach young people with information about both RTIs and family planning?

### Indicators/Evaluation

- What would constitute effective performance indicators for integrated programs?
- What are some practical methodological approaches to evaluation of integrated family planning and RTI activities?

- How can programs effectively assess the use of proper clinical procedures, the extent of provider knowledge, and the effect of provider bias toward specific contraceptive methods?
- What are cost-effective quality-assurance procedures for RTI diagnosis, including laboratory procedures?

### ***Exploring New Service Paradigms***

In addition to operations research that begins with existing family planning programs and explores an expansion of activity, there are a number of areas where attention to RTIs, STDs, and AIDS may actually provide a catalyst for expanding the reach of family planning programs.

One area that family planning and AIDS-control programs have both inadequately explored to date is the challenge of involving men, whether it be in planning parenthood, assuming responsibility for support of children, or avoiding sexually transmitted infection. Developing models of reproductive health services that identify and address male involvement may present an important opportunity for improving the impact of both family planning and RTI- control efforts.

A similar opportunity exists in meeting the reproductive health needs of youth—a group at significant risk of sexually transmitted infection and often left out of traditional family planning services.

Finally, we must recognize the tremendous opportunity made available through cooperation with community-based organizations. As the devastation of the AIDS epidemic proceeds, one of the lessons we have learned concerns the relatively low cost and high effectiveness of community-based efforts in such areas as the provision of home care and support for orphans. These organizations are well placed to mobilize community resources, as well as articulate perceived needs. Communities rarely demand categorical service. Exploring the expansion of services through cooperation with community-based organizations will require a willingness to be flexible in program design and goals, but may provide an important avenue for reaching more people in need of family planning and RTI prevention information.

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## **What Family Planning Services Can Do To Reduce Unsafe Abortion**

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International Projects Assistance Services

Throughout the Cooperating Agency meeting we have been encouraged to look beyond just the things that are do-able now—to have a vision of what we should and could be doing in the future, to stretch ourselves to achieve bigger goals than we may have previously had in mind. In this presentation, I am interested in having us stretch ourselves beyond what we currently are able or willing to do in family planning programs around the world.

We have heard a lot in the past few days about the problems women experience when they are forced to seek an unsafe abortion. We know that many of these women suffer serious side effects and that some of them die. We know that hundreds of thousands of them enter the health-care system seeking treatment for those complications. We also know that very few of them leave that system with any information about family planning and fewer yet leave with an acceptable method or access to future services.

Why is it that women must risk their lives to be able to regulate their fertility, and that we continue to ignore this cry for help? Why is it that our ability to organize and conduct high-quality family planning programs stops at the door of the abortion ward? We cannot allow this pattern to continue; as professionals committed to women's reproductive health, we must recognize our ethical responsibility to maximize access to and quality of comprehensive reproductive services.

But, clearly, it has not been just in the past few days that these issues have been raised. For example, in 1993, IPAS (International Projects Assistance Services) convened, in collaboration with the Population Council, the International Planned Parenthood Federation (IPPF), and South-to-South Cooperation in Reproductive Health, a meeting to address specifically the needs of women post-abortion. The meeting was designed to discuss the gaps between abortion and family planning services and to find concrete solutions to addressing those problems. Participants included family planning and abortion

\* Presenter

providers, policymakers, women's health advocates and donors. Some were internationally known and renowned in the areas of policy and programs as well as strong front-line providers whose perspectives on services and client needs infused our discussions with an important dose of reality.

As a result of that meeting, a set of recommendations was made that speaks to the responsibilities of a range of providers, policymakers, and researchers. Based on these recommendations, today I would like to specifically address the responsibilities of the family planning community in reducing unsafe abortion.

### **Recommendations for Providers' Responsibilities**

For at least a decade, and perhaps longer, the family planning community has felt itself to be largely separate from the issues surrounding unwanted pregnancy and abortion care. This attitude has created a terrible gap for women who need guidance with an unwanted pregnancy, assistance with abortion care, or family planning services post-abortion. We have largely left these women to their own devices, with disastrous results.

#### **RECOMMENDATION 1**

**Managers and staff of family planning programs have an ethical responsibility to make contraceptive services available to women who have undergone abortion. Therefore, family planning programs must provide functional ties with providers of abortion care.**

First, the family planning community must recognize their ethical responsibility to reach women who have undergone abortion, and to offer them family planning services. It is the responsibility of the family planning community to seek out these links and to create mechanisms to provide that care. This must be an active process. It will not happen passively.

It may mean going beyond the boundaries of the family planning clinic to find the places where women are seeking abortion care. These places may be in the hospital or they may be in the community. Family planners must understand and link up with these services.

## RECOMMENDATION 2

**All family planning programs should serve women who do not want to become pregnant as well as those who are pregnant and do not wish to be, through direct provision of or referral to safe abortion services.**

**Personnel should be trained in the provision of abortion services, post-abortion counseling, contraceptive methods, and referral.**

Contraceptives fail. This is not news to anyone in this room. Yet in the family planning community, we have not acknowledged our responsibility to address the needs of our clients who experience contraceptive failure. Any program that delivers family planning services *must* address the needs of its clients who experience an unwanted pregnancy. These issues cannot be separated. A family planning program cannot claim to be of high

quality when it abandons a client whose method has failed.

Each family planning group will have to address how it intends to work with these women. The decisions will be influenced by local attitudes, resources, laws, and needs. But it is not adequate for a family planning group to refuse to acknowledge the needs of these clients. No matter what the legal context of abortion, the family planning community must address this issue. Our responsibility is to the woman.

## RECOMMENDATION 3

**Family planning nongovernmental organizations (NGOs) should provide menstrual regulation services, induced abortion services, and treatment of incomplete abortion to the fullest limits of local law and practice.**

It is essential that family planning agencies look to deliver direct menstrual regulation (MR), induced abortion, or treatment of incomplete abortion services. This is a new activity for some groups, but we cannot consider ourselves professionals, dedicated to working with women to help them achieve their fertility goals, if we do not assist them, to the extent possible, with

access to safe abortion-care services. Can we be comfortable with ourselves when we know that our clients who experience unwanted pregnancy will be pushed to seek potentially deadly services because we refuse to help them ourselves? Can we feel proud of our stance when our clients die for their efforts or are permanently injured, leaving their families to live with the consequences? I do not believe that is how we intend to treat our clients.

Family planning groups also must look to the future to be prepared for the coming of new technologies. Advancing technologies offer increased opportunities for expanding access to high-quality care. In particular, the advent of post-coital methods

and the potential for anti-progestin medicinal agents could greatly expand the range of activities of current family planning groups.

This recommendation seems simple enough, yet the combination of abortion care and family planning counseling is virtually nonexistent. Many hospitals that deliver abortion care that do not offer any post-abortion

family planning. Hospital services for

abortion care and family planning tend to be physically and administratively separate, which hinders women receiving care during their stay. Sometimes women may receive abortion care in any one of several locations in a hospital, including the emergency room or the obstetrics/gynecology ward. Usually neither of these locations has the capacity to deliver family planning services. This capacity must be developed at each hospital delivering abortion care

#### RECOMMENDATION 5

**Family planning programs, including hospital-based family planning units, should initiate joint programs with emergency abortion services, such as cross-training staff and implementing mechanisms to reach abortion patients with counseling and services.**

arrangement, a sustainable mechanism for reaching these women with high-quality services is essential.

### Core Information

What is clear is that there are an incredible variety of settings in which women will receive abortion care and in which they will need access to family planning. It is obvious that not all these settings have the same capacity. The Bellagio group felt very strongly, however, that some essential "core information" should be made available to women post-abortion, no matter what the setting or circumstance.

This core information comprises the following three elements:

#### RECOMMENDATION 4

**All hospitals should have the capacity for post-abortion family planning counseling and services. Ideally, these services should be available through the emergency treatment area. An alternative is to ensure functional referral to the family planning unit.**

We must find concrete, effective mechanisms to link family planning and abortion care.

The family planning community has to reach out to those providing abortion services, to devise ways to provide those services together. This may mean cross-training staff, having scheduled rotations through the wards, or assigning family planning staff to the abortion care units. Whatever the

- The woman must understand that her return to fertility will be almost immediate; women will often ovulate within two weeks, and they can become pregnant again before the next menses. This situation is in contrast with the postpartum period, when women and providers understand the delayed return to fertility.
- Women must know that safe methods exist to prevent or delay pregnancy. Some women may not know that contraceptives are available that can safely prevent pregnancy. A woman may have sought an abortion because she felt the risks of contraception were greater than the risks of the abortion. We must assure that she knows about and understands safe options for contraception.
- Women need to know where they can get access to family planning services in their community. That is, the abortion-care provider must be able to identify those outlets. Often, hospital-based providers are not familiar with community services. This situation must be changed, so that women can obtain referral information for family planning services post-abortion—since, in all likelihood, they will not be coming back to the abortion-care site for their ongoing reproductive needs.

## Conclusion

Much remains to be done to assess how best to design and deliver these services. Research is needed on a range of issues to identify mechanisms to make this care effective, sustainable, and acceptable. For example, there are issues of quality and cost of services, identification of the issues that influence women's decisionmaking, provider attitudes that influence care, and women with special needs, including adolescents or those who are HIV-positive.

The need for research does not remove, however, the absolute need for immediate action. Policies that promote preventable deaths, disabilities, and injuries should no longer be tolerated. *We must act now to encourage links between abortion and family planning services.*

The recommendations of the Bellagio group represent a vision for the direction of the reproductive health field in the next decade. We are soon to be benefiting from the change in philosophy that was articulated at the Cairo ICPD meeting. We, as

## RESEARCH NEEDS

- Health-systems research
- Quality and cost effectiveness of post-abortion family planning services
- Women's perspectives
- Social issues that influence women's decisionmaking
- Provider issues that are obstacles to post-abortion family planning
- Current and new contraceptive methods
- Quality and accessibility for women with special needs

professionals in this field, must not act as barriers to the expanded view of reproductive health. We must work within our organizations to bring this expanded vision into action, to help women throughout the world find the access they need to safe, high-quality, comprehensive reproductive care. There is no time for delay.

## Post-abortion Services: Technology and Quality of Care

*Forrest C. Greenslade, PhD\**; *Katie Early McLaurin*;  
*Ann H. Leonard, RN, MSPH*  
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In the decade in which many international organizations were greatly influenced by the United States' so-called Mexico City policy, an estimated two million women, mostly in developing countries, died from complications of unsafe abortion. Countless others suffered serious, long-term disabilities. Apart from these individual tragedies, unsafe abortion must be considered by reproductive health and family planning organizations as the ultimate indicator of the unmet need for safe fertility regulation. It is estimated, for example, that more than 120 million women in developing countries who want to practice family planning lack the means to do so. This drives many women to seek abortion, even when their only recourse is to illicit abortion, carried out by untrained practitioners under dangerous conditions.

I obviously do not have to remind organizations funded by USAID that the abortion issue is controversial. It has been controversial throughout history and will likely remain controversial. However, women have experienced abortion throughout history and will clearly do so in the future. As

reproductive health professionals, we must accept our responsibilities. We must understand that "regardless of the ethical, moral or legal constraints placed on abortion, women who have experienced abortion—especially unsafe abortion—must have access to high-quality post-abortion care" (Greenslade, et al., 1994).

I want to discuss two technical issues related to the quality of post-abortion care. The first is the use of the IPAS (International Projects Assistance Services) manual vacuum aspiration (MVA) instruments in the treatment of incomplete abortion. The second is a new perspective in the post-abortion provision of contraceptive technologies.

**Women who have experienced abortion— especially unsafe abortion— must have access to high-quality post-abortion care.**

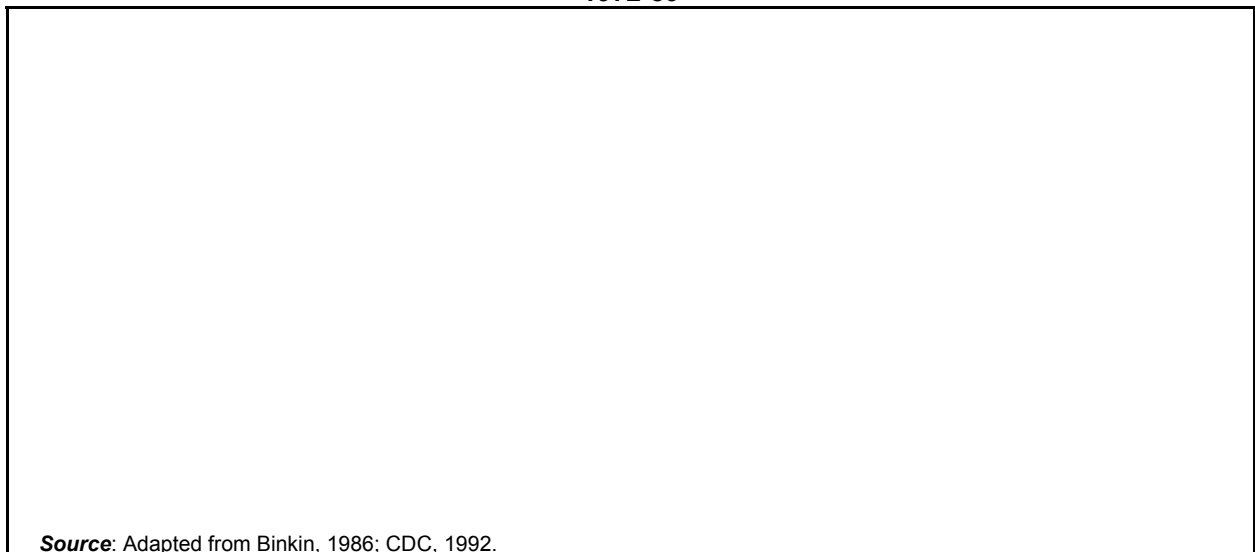
\* Presenter

## Emergency Treatment of Incomplete Abortion: Technical Approaches

I want to start my discussion of emergency treatment of incomplete abortion with a close-up view of two technical approaches to uterine evacuation: sharp curettage (also called "dilation and curettage," or D&C) and vacuum aspiration (also sometimes called "suction curettage"). Sharp curettage involves scraping the uterine lining with a sharp rigid instrument, whereas vacuum aspiration removes the uterine contents and/or lining through a cannula by vacuum.

A recently completed comprehensive review of the clinical and programmatic experience with vacuum aspiration, focusing on IPAS MVA instruments, included over 80 studies involving over 500,000 women (Greenslade, et al., 1993). A major proportion of the clinical experience was gained in developed countries on induced abortion, such as the data presented in Figure 1, from the major U.S. Joint Program for the Study of Abortion (JPSA) study conducted by the Population Council and the Centers for Disease Control (CDC). After its introduction in the early 1970s, vacuum aspiration increasingly became the preferred technology for uterine evacuation, while sharp curettage declined.

**FIGURE 1**  
**Trends in Abortion Care Technology in the U.S.**  
**1972-89**



By 1989, nearly 96 percent of all induced abortions in the United States were done using electric-pump vacuum aspiration. Unfortunately, in many developing countries, sharp curettage is still the predominant technology used for uterine evacuation. Accordingly, sharp curettage is used far too often for treatment of incomplete abortion.

## Vacuum Aspiration

During the late 1960s and early 1970s, the need to make vacuum aspiration available in a wider range of clinical settings led to refinements in the technologies that used a manual vacuum source rather than an electric pump. In 1971, USAID funded Battelle Laboratories to undertake this task, but in 1973, the Helms Amendment blocked funding of abortion-related activities, and IPAS was created to complete development and undertake worldwide introduction of the MVA technology.

The IPAS MVA system for uterine evacuation comprises a vacuum syringe, a range of flexible cannulae, and a set of training and informational "software" to support provider expertise and patient counseling.

MVA acts via vacuum extraction of the uterine contents through the cannula. The cannula is attached to the syringe, which has been previously charged and locked to produce a vacuum. Little or no cervical dilation is required because the cannula is slender and of uniform width. (Remember the "spoon" shape of the sharp curette.) When the syringe's locking valve is released, the vacuum is transferred to the uterine cavity, aspirating the contents of the uterus into the syringe.

As shown in Figure 2, a vacuum of 26 inches of mercury, the same as that produced by an electric pump, is generated by the IPAS vacuum syringe. Incidentally, every single syringe that leaves the IPAS production facility in North Carolina is tested and must maintain this level of vacuum.

**FIGURE 2**  
**Vacuum in IPAS Syringe**

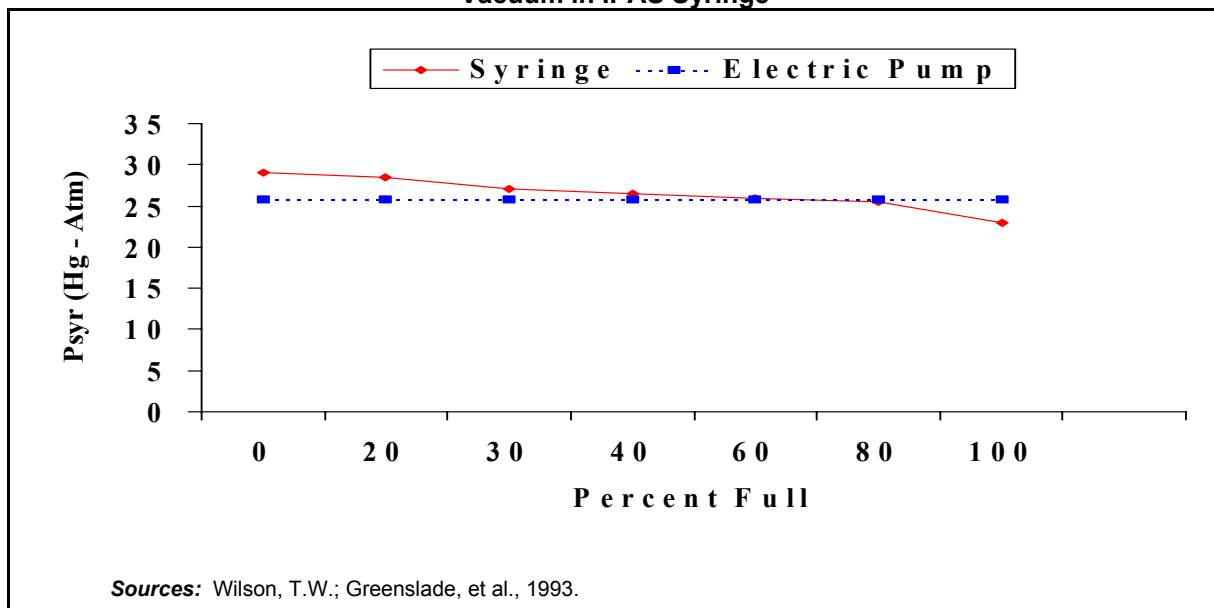


Table 1 is witness to the effectiveness of vacuum aspiration in uterine evacuation. It summarizes 30 years of data and documents showing that, for both induced abortion and for treatment of incomplete abortion, vacuum aspiration (including MVA) is highly effective in evacuating the uterus. In fact, in the studies in which MVA was used, the effectiveness rate generally exceeded 98 percent.

**TABLE 1**  
**Summary of Studies on the Effectiveness\* of Vacuum Aspiration**

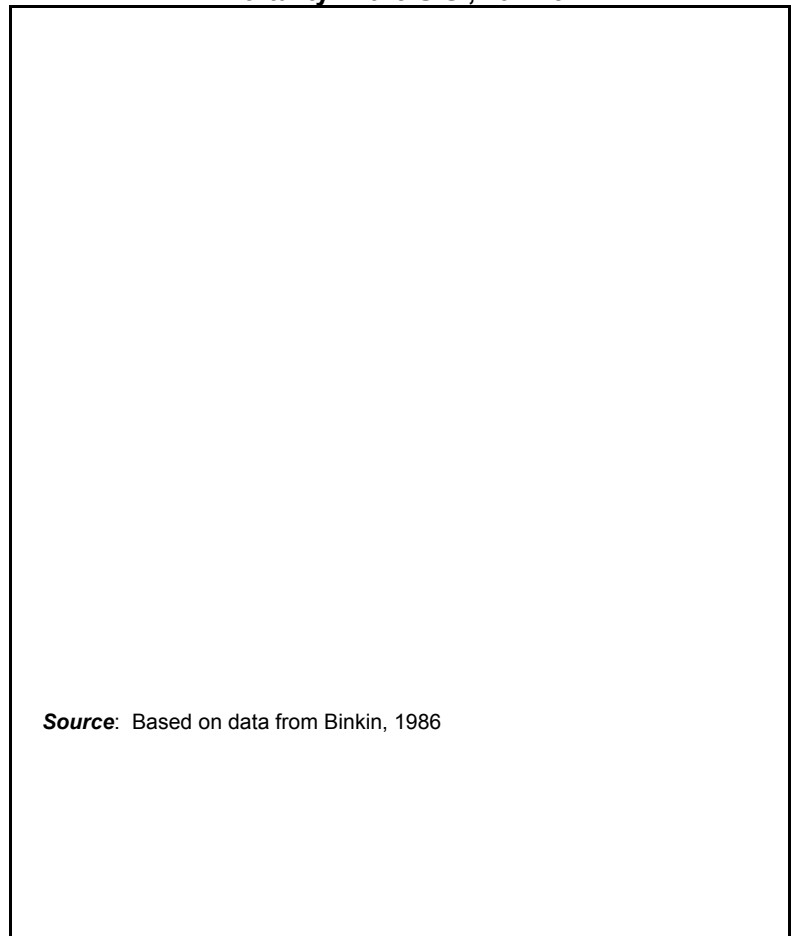
	Number of:		Percent Complete
	Studies	Patients	
Induced Abortion	46 (MVA: 9)	>400,000 (MVA >15,000)	~98%
Incomplete Abortion	19 (MVA: 4)	>5,000 (MVA 1,400)	~98%

\*Defined as complete evacuation *Source:* Adapted from Greenslade, et al., 1993

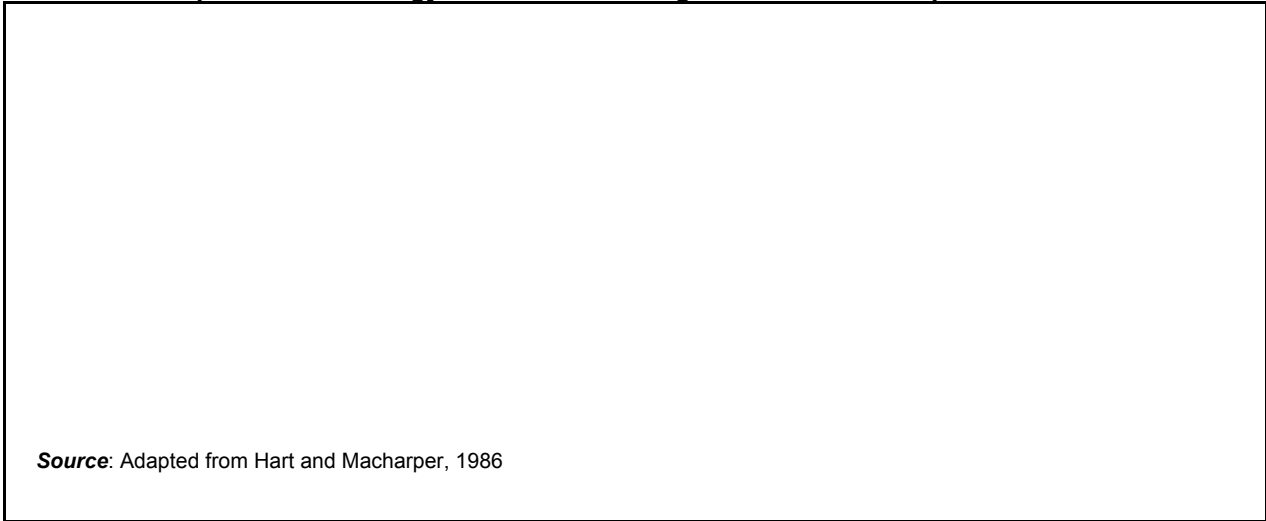
The JPSA study provides important safety information. The top panel in Figure 3 shows the increasing use of vacuum aspiration in the United States. The center panel reveals a trend in performing uterine evacuation (in this case, for induced abortion) earlier in gestation. The bottom panel demonstrates that over the period of the analysis abortion-related mortality decreased four-fold. There are a number of reasons for this improvement in safety, but critical is the use of vacuum aspiration early in gestation.

This safety record is confirmed in another large study done in Australia (Figure 4), which showed that the overall

**FIGURE 3**  
**Trends in Abortion Care and Mortality in the U.S., 1972-81**



**FIGURE 4**  
**Impact of Technology and Gestational Age on Abortion Complication Rate**



*Source:* Adapted from Hart and Macharper, 1986

complication rate is lower for vacuum aspiration than for sharp curettage at each of three time periods in gestation (Hart and Macharper, 1986).

Furthermore, the complication rate for both technologies increases with length of gestation. Studies such as these are the basis for labeling MVA for use at 12 weeks LMP uterine size or earlier.

The clinical experience for MVA in the treatment of incomplete abortion, as compared with sharp curettage, is summarized in Table 2. Both technologies effectively evacuate the uterus. However, MVA is associated with lower complication rates. Because of its slim uniform size, the MVA cannula seldom requires cervical dilation. Accordingly, lower levels of pain control are generally needed.

**TABLE 2**  
**Comparison of MVA and Sharp Curettage (SC) for Incomplete Abortion: Clinical Issues**

	<b>MVA</b>	<b>SC</b>
Effectiveness in uterine evacuation	Highly effective	Highly effective
Complications	Lower rates	Higher rates
Cervical dilation	Occasionally needed	Often required
Pain control	Lower level needed	Higher level required

*Source:* Ipas

These clinical characteristics translate into some very important programmatic advantages for MVA, as shown in Table 3. Because general or high-level anesthesia is seldom required, MVA may be provided in a treatment room rather than in an operating room. That means that lower-level facilities, such as clinics and primary health care centers, can provide this service.

**TABLE 3**  
**Comparison of MVA and Sharp Curettage (SC) for Incomplete Abortion: Programmatic Issues**

Variable	MVA	SC
Facility Used	Treatment room	Operating room
Service Provider Skills	Similar to IUD insertion	Gynecologic surgery
Patient Stay	Less than one day	Often overnight

*Source:* Based on Johnson, et al., 1992

Providers specifically trained in MVA are required, but clinicians inform us that the procedure is more like IUD insertion than like gynecologic surgery. Our experience shows that patients do not have to remain in

the hospital as long with MVA as they do with sharp curettage. Our research in several countries has shown that such improvements in the quality of emergency treatment care are also accomplished with significant savings in resources, including financial, for the health system.

### Clinical Recommendations

A management tool just developed by IPAS's Ann Leonard and Professor Ladipo of the South-to-South Program can guide the choice of post-abortion contraceptive methods (Leonard and Ladipo, 1994). Their approach, rather than focusing on the characteristics of the contraceptive technologies, centers on women's special situations after they have experienced an abortion. Three general clinical recommendations are made:

- Given appropriate client screening and informed choice, all modern contraceptive methods can be used immediately post-abortion.
- Women should abstain from sexual intercourse until bleeding stops and complications are resolved.

- "Natural" family planning—withdrawal or rhythm—is not recommended until the regular menstrual pattern returns.

However, the real value of this approach in improving quality of care resides in the examination of the issues that each individual woman may face after experiencing abortion, especially an unsafe one. This approach considers the specific clinical and personal factors for the woman, as well as the family planning resources she has available to her to guide her contraceptive choice.

She may have special clinical issues which will clearly affect the appropriateness of different methods for this particular woman (Table 4).

She may also have personal factors that will impact on her choice. For instance, she may have been using a method when she became pregnant and the factors that contributed to the failure in use of that method may still be present post-abortion (Table 5).

Finally, women who have experienced abortion often have serious service delivery or community barriers to accessing contraceptives (Table 6).

The important issue in method selection post-abortion is a realistic assessment of each woman's personal situation in helping her select a method.

## Conclusion

Controversy must no longer divert attention from preventing death and injury caused by unsafe abortion. Adoption of a women's health initiative for abortion care, as shown here, offers the best opportunity to reduce maternal mortality and morbidity from unsafe abortion. The technologies for treating the complications of spontaneous or unsafely induced abortion and for post-abortion contraception are available today. The expertise for a coordinated effort to build developing-country institutions' capacity to provide high-quality, sustainable post-abortion care is present at this meeting of cooperating agencies. Only international cooperation can provide women around the world with the care that they deserve.

**The Elements of Post-Abortion Care**

- Emergency treatment services for complications of spontaneous or unsafely induced abortion
- Post-abortion family planning counseling and services
- Links between emergency abortion treatment services and comprehensive reproductive health care

**TABLE 4**  
**Clinical Issues in Post-Abortion Family Planning<sup>1</sup>**

Clinical Condition	Precautions	Recommendations
<p>No complications after incomplete abortion, spontaneous abortion, or induced abortion in the first trimester</p>	<p>Recommend abstaining from intercourse until bleeding stops and using an effective method as soon as intercourse is resumed.</p> <p>Natural Family Planning: do not recommend until a regular menstrual pattern returns.</p>	<p>Consider all methods:</p> <p>Female or male sterilization            NORPLANT® implants<sup>2</sup>            Injectables<sup>2</sup>            IUDs            Oral Contraceptives<sup>2</sup>            Condoms (male or female)            Diaphragm, cervical cap, sponge            Spermicidal foams, jellies, tablets or film</p>
<p>Confirmed or presumptive diagnosis of infection</p> <p>Signs of unsafe or unclean induced abortion, or signs and symptoms of sepsis or infection</p> <p>Unable to rule out infection</p>	<p>Female Sterilization: do not perform procedure until infection ruled out or infection fully resolved (appx. 3 months).</p> <p>IUD: do not insert until risk of infection ruled out or infection fully resolved (appx. 3 months).</p> <p>Diaphragm, cervical cap, sponge<sup>3</sup>: do not use until infection ruled out or resolved.</p>	<p>NORPLANT® implants: begin without delay</p> <p>Injectables: begin without delay</p> <p>Oral Contraceptives: begin immediately</p> <p>Condom (male/female): use when sexual activity is resumed</p> <p>Spermicidal foams, jellies, tablets, or film: can be used when sexual activity is resumed</p>
<p>Trauma to Genital Tract</p> <p>Uterine perforation</p> <p>Serious vaginal or cervical trauma</p> <p>Chemical burns</p>	<p>Female sterilization: do not perform procedure until serious trauma healed.</p> <p>IUD: do not insert until serious trauma healed.</p> <p>Diaphragm, cervical cap and sponge: do not use until vaginal or cervical trauma healed.</p> <p>Spermicidal foams, jellies, tablets or film: do not use until vaginal or cervical trauma healed.</p>	<p>NORPLANT® implants: begin without delay</p> <p>Injectables: begin without delay</p> <p>Oral Contraceptives: begin immediately</p> <p>Condom (male/female): use when sexual activity is resumed</p> <p>Diaphragm, cervical cap, sponge: can be used with uncomplicated uterine perforation</p> <p>Spermicidal foams, jellies, tablets or film: can be used with uncomplicated uterine perforation</p>

**TABLE 4, cont.**  
**Clinical Issues in Post-Abortion Family Planning<sup>1</sup>**

<b>Clinical Condition</b>	<b>Precautions</b>	<b>Recommendations</b>
Hemorrhage and Severe Anemia	<p>Female sterilization: do not perform procedure until hemorrhage or anemia resolved.</p> <p>NORPLANT® implants<sup>4</sup>: not advised until severe anemia resolved.</p> <p>Injectables<sup>4</sup>: not advised until severe anemia resolved.</p> <p>IUD (inert or copper bearing)<sup>4</sup>: not advised until hemorrhage resolved and until severe anemia resolved.</p> <p>Diaphragm, cervical cap and sponge: do not use until hemorrhage resolved.</p>	<p>Progestin-releasing IUD: can be used with severe anemia (decreases menstrual blood loss)</p> <p>Oral Contraceptives: begin immediately (beneficial when hemoglobin is low)</p> <p>Diaphragm, cervical cap and sponge: can be used with severe anemia</p> <p>Condom (male/ female): use when sexual activity is resumed</p> <p>Spermicidal foams, jellies, tablets or film: can be used when sexual activity is resumed</p>
Second-Trimester Abortion	<p>Female sterilization: advisable to delay procedure 4-6 weeks for uterine involution to occur; if this is not possible, use minilap technique.</p> <p>IUD: size of uterus requires skilled, experienced provider for correct fundal placement; if this is not possible, delay insertion for 6 weeks.</p> <p>Diaphragm, cervical cap and sponge: do not use until bleeding stops and uterine involution is complete (4-6 weeks).</p> <p>History or current indications of excessive clotting, as may be seen with missed abortion, contraindicate oral contraceptives containing estrogen, and female sterilization.</p>	<p>NORPLANT® implants: begin without delay</p> <p>Injectables: begin without delay</p> <p>Oral Contraceptives: begin immediately</p> <p>Condom (male/ female): begin when sexual activity is resumed</p> <p>Spermicidal foams, jellies, tablets or film: can be used when sexual activity is resumed</p> <p>Hypercoagulability of pregnancy is not a significant clinical consideration until the third trimester.</p>

<sup>1</sup> In this chart methods are listed in order from most effective to least effective. The most effective methods are also those that require the most provider involvement for use and discontinuation. Sterilization, because it must be considered permanent, requires special counseling and is only appropriate when no additional children are wanted.

<sup>2</sup> Hormonal methods (NORPLANT® implants, injectables, and oral contraceptives) should be started within one week in order to become effective early enough in the menstrual cycle to block ovulation.

<sup>3</sup> The recommendation for delaying use of the diaphragm, cervical cap, and sponge is based on the presumption of potential increased risk of toxic shock syndrome. No definitive data are available on this issue after abortion.

<sup>4</sup> These methods may increase or prolong bleeding.

**TABLE 5**  
**Social Issues in Post-Abortion Family Planning**

If the woman:	Issues to Consider	Recommendations
Does not want to become pregnant soon	<p>Induced abortion, whether legal or clandestine, strongly suggests that the woman does not want to be pregnant.</p> <p>Screen adequately for contraindications to any method considered.</p>	<p>Consider all methods.</p> <p>Assist the woman in making an informed decision.</p>
Is under stress, in pain, or not prepared to make a long-term decision	<p>Stress and pain interfere with making informed, voluntary decision.</p> <p>The time of treatment for complications may not be a good time for a woman to make a long-term or permanent decision.</p>	<p>Do not encourage use of permanent, long-acting or provider-dependent methods.</p> <p>Consider temporary methods.</p> <p>Provide referral for more long-term approach to contraception.</p>
Was using a contraceptive method when she became pregnant; or had stopped using a method	<p>Method failure, unacceptability, ineffective use or lack of access to supplies may have led to unwanted pregnancy.</p> <p>These same factors may still be present.</p>	<p>Assess why contraception failed and existing obstacles to effective contraception.</p> <p>Help woman select a method of her choice that she will be able to use effectively.</p> <p>Make sure she understands how to: use the method, get follow-up care and resupply, discontinue use and change methods.</p>
Has a partner who is unwilling to use condoms or will prevent use of another method	<p>Do not recommend methods that the woman will not be able to use effectively.</p>	<p>If the woman wishes, include her partner in counseling.</p> <p>If the woman is at risk for STDs, tell her about methods that offer some protection.</p> <p>Protect the woman's confidentiality even if she does not involve her partner.</p>
Wants to become pregnant soon	<p>Do not try to persuade her to accept a method.</p>	<p>Provide information or referral for reproductive health services.</p>

Source: Leonard and Ladipo, 1994.

**TABLE 6**  
**Local Capability to Deliver Services**

<b>Facility, Provider, and Community Capability</b>	<b>Issues to Consider</b>	<b>Recommendations</b>
Opportunity, space, and private environment for counseling and informed decisionmaking	<p>Emergency-care settings may be too crowded and hectic to ensure privacy and informed choice.</p> <p>Do not give permanent or long-acting methods without adequate counseling.</p>	<p>Arrange space and time for private counseling.</p> <p>If adequate counseling is impossible: Offer temporary methods (oral contraceptives, condoms, spermicides, female barriers or injectables), AND Provide referrals for further counseling regarding other methods.</p>
Choice of contraceptive methods	Do not limit the range of methods offered. Limiting the availability of methods will deny some women access to the most appropriate methods or to their preferred methods.	Make a range of methods available. Reduce provider bias for or against particular methods by educating providers about appropriate use of all methods.
Links with family planning resources in the community	Consider the woman's access to follow-up care and resupply in recommending methods.	<p>Make sure counselors and providers know about family planning resources throughout the area served.</p> <p>Establish referral links among family planning resources or between abortion-care and family planning services.</p>

Source: Leonard and Ladipo, 1994.

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## **Pregnancy, Labor, and Delivery Care: Life-Saving Skills and Family Planning Programs**

*Margaret Marshall, DNM, EdD, MPH, FACNM, American College of Nurse-Midwives*

We have been hearing exciting news about USAID's commitment to move toward an integration of reproductive health services and the acknowledgment that providing quality maternal and child health services, including the prevention and treatment of STDs, promotes the population agenda. As we look toward a time of broadened family planning programs, we must ask ourselves several questions.

### ***How do we move away from vertical programming?***

First, we must seek some attitude changes and management changes regarding the way in which services are offered. If we are currently offering family planning services one day, STD services another, tetanus toxoid services only in conjunction with "under-fives" clinics, and antenatal services another day, integration of care cannot succeed. Usually we offer services during daylight hours convenient to the provider, with little regard to the scheduling needs of the consumer.

As we seek to create a multipurpose, integrated reproductive health worker, care must be taken to avoid a cheap, quick fix. Placing 30 workers in a classroom for several weeks to "update" their knowledge is not sufficient continuing education. Acquisition of new skills or refreshing old skills requires sound clinical practice in a training center with a high volume of clients.

### ***Who is this integrated multipurpose worker who can be called a reproductive health worker?***

As we look at the ingredients needed for this broad-based health worker, we note that this individual must be able to:

- do complex thinking,
- have a problem-solving attitude,
- be available widely at the grassroots community level, and
- be able to handle family planning needs; STDs (including HIV); routine obstetrical care including treatment of obstetrical emergencies for stabilization, treatment, and/or referral; and treatment of children under the age of five.

### ***Is this person a TBA?***

Some disadvantages of placing such a high level of responsibility with a traditional birth attendant (TBA) are:

- She is the least educated worker in the health care system, often having as little as three weeks of training.
- Because clinic staff are unable to travel or communicate with the field, the TBA receives little or no supervision, and her practice cannot be monitored for quality.
- As a private practitioner, she is often not linked with the formal public-sector health system.
- The TBA frequently does not enjoy the respect or support of the modern health care system.

On the other hand, the TBA is located at the furthest points of the periphery and is therefore, easily available in the middle of the night or at other times, speaks the client's language, and performs religious rituals related to birthing that are appropriate to the community. Moslem women may be unable to leave their compound to seek delivery assistance. Conservative Christian women may want to deliver within their church, often at the altar. Some women may require fetishes to provide protection during these vulnerable hours of labor, or they might need herbs to drink as infusions or to apply to the abdomen or vagina.

### ***Is this person a midwife?***

Midwives have a number of advantages in assuming the role of integrated reproductive health worker.

- They are available in both private- and public-sector institutions in many countries and may be dispersed better geographically than Ministry of Health facilities.
- They usually have the language skills to serve their local communities.
- They have basic clinical skills, as well as interviewing and counseling skills, in the areas of maternity and child care. Depending on when they graduated, they might have acquired family planning and STD skills through continuing education training programs.

### ***Is this person an obstetrician?***

In many countries there are one to two obstetricians per million population. They rarely care for healthy women, and they see a very small percentage of the population. They generally are reserved for women with complications, surgery, consultation, and teaching. Routine counseling and services for healthy women is a poor utilization of scarce resources.

However, regardless of the providers' preparation or the sophistication of their education and background, everyone becomes TBAs if basic service inputs are not available. A board-certified obstetrician can do little if no blood, no anesthesia, no anticonvulsant drugs, no IVs, no suture, no electricity, or no clean water is available. The provision of sound integrated reproductive health services requires functioning systems as well as the deployment of properly prepared health workers.

Clearly, the health workers that are best equipped to provide appropriate integrated reproductive health services in most countries are the professional midwives.

### ***What should be in the obstetrical component of practice of this newly integrated reproductive health worker?***

Given that more than half a million women die in childbirth annually and more than 3.5 million suffer from maternity-related morbidity, it is critical that health workers focus on those skills and services that directly attack maternal mortality and morbidity. It is important that training programs contain a tight integration of theory and clinical practice, with an emphasis on competency-based assessment. In order to determine what service gaps exist in the delivery of quality maternity care, the American College of Nurse-Midwives started by looking at the causes of and contributing factors to maternal mortality.

In 1989, with funding from Carnegie Corporation of New York, two maternal mortality studies were conducted in the Greater Accra Region of Ghana. One was a retrospective review of mortality records from the three large public institutions with maternity services (Antwi and Marshall, unpublished). The other study was a qualitative analysis of the service and cultural contributors to maternal mortality as perceived by the private-sector midwives of the region (Marshall, unpublished).

Additionally, a risk assessment/intervention tool was developed for use by midwives. The tool addressed the management of pregnancy-induced hypertension (PIH) and the prevention and treatment of anemias—the major killers of pregnant women in Ghana—which can be addressed by improved antenatal care. As a result of findings from that project, it became clear that there is a great need for continuing

education or updating of midwifery knowledge and skills to reflect the current needs in Ghanaian society. Therefore, a follow-on project was designed to address this critical need for continuing education for midwives.

During the first project year, a manual entitled *Life Saving Skills for Midwives* was developed. A site was located to pilot-test the training. Trainers were hired, taught the new skills, and allowed to practice clinically for three months prior to training participants. Four training courses were conducted. The training site was enhanced by the provision of some equipment and supplies for the labor and delivery suite, and by the purchase of models and charts for the teaching activities. Models not available commercially were created by the training staff.

During the second year, 11 more training courses were conducted. A second edition of *Life Saving Skills for Midwives* was completed, based upon review by outside experts, trainers, and trainees. A project evaluation was conducted and monies were sought for the continuation of this highly successful program. The training program has been shared at several international fora, has been replicated in both Nigeria and Uganda through MotherCare/USAID funding, and is starting in Vietnam with Population Council/ World Bank monies.

The Life-Saving Skills (LSS) training is a competency-based training program conducted at high-volume hospitals, which are used as training centers. The training focuses on the five major maternal killers—hemorrhage, sepsis, pregnancy-induced hypertension, obstructed labor, and unsafe abortion. Skills taught address prevention, treatment, and/or stabilization and referral. Universal precautions against HIV infection to protect both provider and client are also stressed.

Some of the skills that are taught include infant and adult cardio-pulmonary resuscitation; suturing of lacerations and episiotomies; labor management with the partograph; control and/or prevention of hemorrhage through active management of third-stage, bimanual compression of the uterus; manual removal of the placenta; and digital removal of products of conception. Training always includes as many midwifery tutors as possible to facilitate moving the LSS training into the midwifery pre-service curricula.

It is very clear from our experience with Life-Saving Skills training in Ghana, Nigeria, and Uganda that:

- Midwives can play a crucial role, particularly at first-level referral, in treating moribund women received from the TBA or home.

- Technically, midwives can perform many advanced midwifery skills in a highly competent manner, even those skills that are not taught during their pre-service training.
- A critical ingredient in saving women's lives is a referral center equipped with essential inputs, including physicians and midwives who have received updated training.

In summary, the professional midwife is an ideal candidate to be trained as an integrated reproductive health worker. She has ties with the community, enjoys the trust of women, and is usually eager to update and expand her scope of practice to better serve women and their families.

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## **Postpartum Care and Family Planning Services**

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This discussion deals with postpartum care and family planning services. While we have a fair idea of what "family planning services" means, the meaning of "postpartum care" is less apparent. Although the term "postpartum" seems self-explanatory, meaning "after birth" in its translation from Latin, it is not, in fact, clear what the content or timing of "postpartum" services is or should be.

With respect to timing, suggestions include provision of services at the time the placenta is delivered (in other words, "immediate post-placental services" become "postpartum services") or, with an administrative view of the locus of services, all in-hospital services after a birth but before discharge are considered to be "postpartum services." Others, following the definition in medical texts, use "postpartum" to mean anything that occurs during the time it takes for the uterus to involute to its pre-pregnancy shape and size. Thus, any service that is delivered within 42 days of a birth is considered to be a "postpartum service." The term is also used in a functional sense, in which "postpartum" means sometime during the time the woman is intimately involved with her baby in a special way, both immediately after birth and during breastfeeding. There is some resonance for this definition: although it represents a somewhat less-defined period than the others, it does point to a period of time when mothers and babies have special needs and there are special norms for contraceptive advice.

### **Western Versus Non-Western Models of Care**

The orientation and content of postpartum services are also not clearly defined. The western model of medical care focuses on discrete technology-based interventions. The model assumes that "postpartum" is a specific period following childbirth, not a vague notion, and that in this defined period care should be the same whether the birth is the first, second, third, or fourth. The concept does not take into account the experience that mothers may have with childbirth, infant feeding, and infant care in general. Medical care is segmented according to the separate physical needs of the mother and baby. In other words, the pediatrics staff sets the norms for and monitors the care of the baby, and the obstetrics and gynecology staff does the same for the mother. Care for one is not necessarily given in conjunction with care for the other, as

the two individuals, mother and baby, are seen as separate. They are thus served independently as well. Consideration of the stresses on the new mother—psychological, biological, social, or economic—is not incorporated into the medical care offered. Finally, no specific provision is made for family or community support to the woman in this period, as the care is centered mostly on physical needs.

The western model of care contrasts with the traditional, non-western model of caring for women in the postpartum period, which does not assume the content of care to be mostly medical. The special situation of the mother is viewed as part of a continuum from the beginning of pregnancy through the end of breastfeeding. In most cultures, the first birth is treated very differently from subsequent ones. It is acknowledged that primiparous women have special needs, beginning with the fact that they have not experienced delivery previously, that they are maternal "novices" and, therefore, are perhaps awkward and less successful at breastfeeding and infant care. In traditional circumstances, care and advice are provided to the mother and infant as a dyad: both are usually considered together. The mother is provided with special care, and a large content of that care consists of family and community support. These two models of postpartum care create quite different environments for women. Providers of contraception who enter the system only as purveyors of a technology may fit with difficulty into a model of care that is based on more traditional practices, which tend to treat women's needs more comprehensively.

### **The Timing of Contraceptive Initiation**

Why has there been a particular emphasis on contraception in discussions of postpartum care? Indeed, in some locations, there has been a clear preference for offering contraception at the place of delivery, and often post-placentally. Three assumptions generally underlie this orientation, some of which have been examined more rigorously than others.

The first assumption is that if one is interested in reducing population growth, it is best to reach mothers as early as possible in the postpartum period to prevent any "unintended" pregnancies. It is not clear, however, that immediate postpartum contraception is the optimal strategy for producing the longest birth intervals, particularly in areas characterized by prolonged breastfeeding and high contraceptive discontinuation rates. In rural Bangladesh, for example, women who accepted oral contraceptives during lactational amenorrhea had shorter birth intervals than did nonusers, because they ceased using those contraceptives before the resumption of menses (Bhatia and Kim, 1984; Bhatia, et al., 1987). In Zimbabwe, extensive overlap

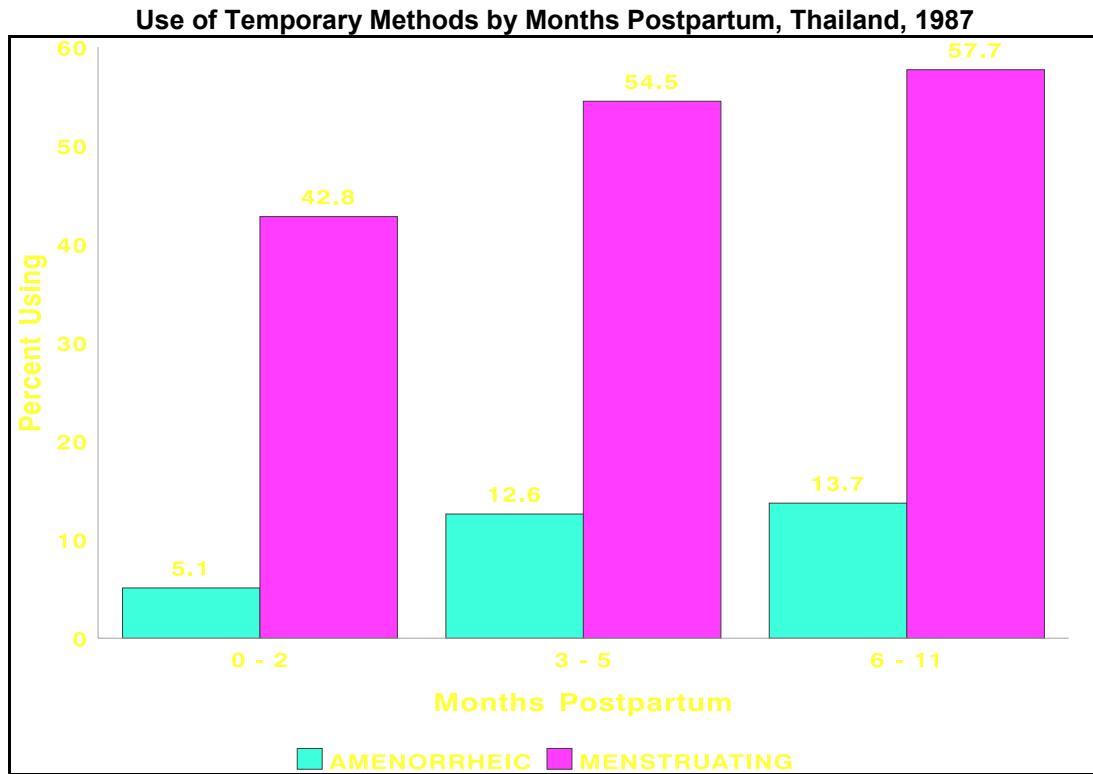
between contraceptive use and amenorrhea provided one explanation for the finding that both contraceptive prevalence and fertility were high (Adamchak and Mbizo, 1990). Assuming that the total duration of contraceptive use is not affected by the timing of initiation, reducing the duplication of protection by starting contraception closer to the end of lactational amenorrhea would result in lower fertility than earlier initiation of use.

A simulation study of the effect of the timing of contraceptive initiation postpartum on pregnancy intervals provides further evidence: as the incidence of breastfeeding increases, increasingly higher levels of contraceptive continuation rates are required to ensure that an immediate postpartum family planning strategy is optimal in demographic terms. Since contraceptive continuation rates are likely to be lowest where the incidence and duration of breastfeeding are highest, such a strategy is unlikely to be optimal on these grounds. In addition, in the case of IUDs, immediate postpartum insertion seems to have a direct impact on continuation rates: a comparison of discontinuation rates in the International Postpartum Program found that earlier acceptors were more likely than delayed acceptors to have discontinued use at a specified time post-insertion, due to a greater proportion of expulsions (Sivin, 1974).

Second, it is assumed that maximum maternal motivation for family planning exists immediately after a birth. Childbirth is thought to have been an unpleasant experience, making women averse to repeating it in the near future. Moreover, women immediately postpartum are felt to be so conscious of their responsibilities to the new child that they would naturally think of delaying the next one. Very little systematic work has been done on the subject of maternal motivation, however, and we are just beginning to see papers that address the issue of what women want and when they want it. There is some indirect evidence that suggests that women are interested in family planning and spacing births, particularly at a point when they feel vulnerable to pregnancy.

However, one of the strongest indicators to women that they are vulnerable to pregnancy, apparently, is the presence of menses, and not just the fact of having given birth. Data from Thailand on women's initiation of the use of temporary methods after childbirth show that menstruating women were much more likely to use methods at any time postpartum than the women who were still amenorrheic (Figure 1). This suggests that it is not merely time postpartum, but the fact of menstruation, that prompts women to seek contraception. If that is so, then, at least for some women, the time immediately after birth will not be as congruent with their own impulses for practicing contraception as will an option to adopt contraception at the time of weaning or at the time when menses returns.

FIGURE 1



Source: Adapted from Knodel and Kamnuansilpa, 1988.

A third, very commonly offered rationale for immediate postpartum contraceptive programs is that women will not return for services after discharge, and so it is better to "capture" them while they are available in an institution that provides medically oriented services. There is very little documentation regarding the likelihood that women will return for postpartum services. Some of the data that are available suggest that women will return when meaningful services exist. Table 1 demonstrates some of the variability in rates of return for postpartum care.

**Table 1  
Return for Postpartum Check**

<u>Place Return</u>	<u>N</u>	<u>Date</u>	<u>%</u>
Botswana <sup>1</sup>	3,177	1983-88	71
Tunisia <sup>2</sup>	9,240	1987	83
Honduras <sup>3</sup>	688	1987	75-80
Ecuador <sup>4</sup>	2,036	1982-87	38

**Sources:** 1. Lesetedi, et al. 1989; 2. Centro de Estudios de Población y Paternidad Responsable, et al., 1988; 3. de Chavez, et al., 1989; 4. Coeytaux, 1989.

## **Potential Problems with Immediate Postpartum Contraception**

While we are not absolutely certain about women's motivations for using family planning immediately after the birth of a child, we do have new information on the problems that may accompany the use of the immediate postpartum period as a vehicle for family planning services, without consideration of women's other reproductive health needs. These problems fall into three main categories:

1. the poor technical quality of family planning services,
2. the discordance between what women want and would find useful and the services being provided, and
3. the possibility of coercion.

No data are available on the issue of coercion. We know, however, that women in the immediate postpartum period are in a vulnerable state. They may be in pain or exhausted or perhaps feeling that they do not know what is good for them and should do whatever is suggested by medical personnel. The ground is laid for coercive interventions when providers (or policymakers) are convinced they know better than women what is "best" for them.

Since not all methods are available and/or appropriate to give to women immediately postpartum, providers who feel impelled to provide contraceptives to as many women as possible may push women toward methods that are available at the moment rather than allowing them to wait so they can have a real choice. From subtle "influence" on women's choices it is easy to progress to a "sequential offer" of choice: that is, the provider's preferred method is advocated before the woman is told about other possibilities.

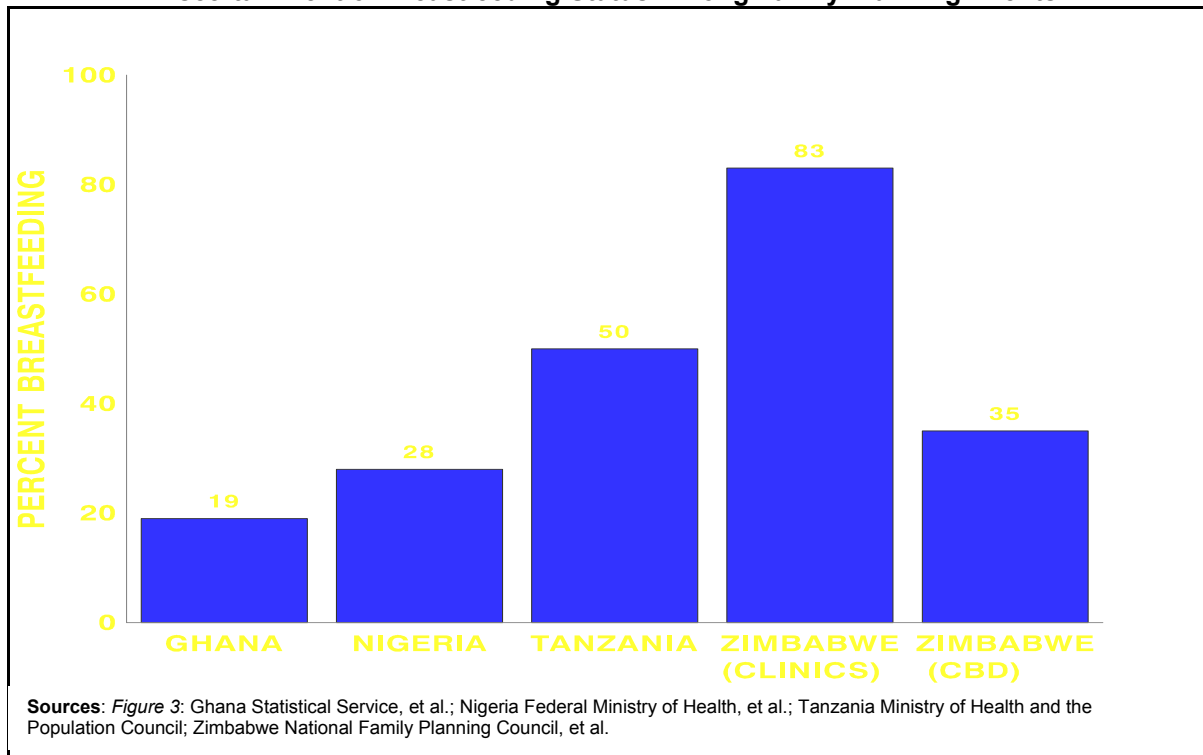
In addition, it is very easy to insert an IUD, for example, into the uterus of a woman who has just given birth without her knowledge; sadly, that has happened in many places, including in this country. There is anecdotal evidence that clinicians have been consulted by women who are involuntarily infertile, only to discover an IUD of which the woman was unaware! We need to be careful that the effort to promote postpartum contraception does not result in an over-enthusiastic response that jeopardizes women's autonomy and informed consent.

We do have some new information on the other two problem categories, technical quality and women's needs and preferences. There are two main concerns related to the technical quality of family planning programs. One is the issue of IUDs

and RTIs, discussed in another presentation, which is particularly problematic in the postpartum period. Immediately after childbirth, it is virtually impossible for women to report symptoms or for physicians to complete diagnosis of reproductive tract infection. In addition, some information suggests that women may be particularly vulnerable in the postpartum period in terms of their husbands' behaviors; that is, this may be a time when husbands are promiscuous, putting both themselves and their wives at a higher risk of contracting STDs (Brady and Winikoff, 1993). Thus, the provision of immediate postpartum IUD services, especially in low-resource, high-RTI prevalence communities, can pose special safety problems.

The second technical issue is whether adequate consideration is given to the appropriate advice to give breastfeeding women regarding postpartum contraception. Situation analyses completed by the Population Council's Operations Research Project have looked into whether family planning services even ask if a woman is breastfeeding before giving her contraceptive advice. Sadly, this is one of the most deficient indicators of quality of care that we have uncovered. That is, at many service delivery points, women are not asked whether they are breastfeeding (Figure 3). In addition, the content of the advice given to breastfeeding women in many places is clearly deficient

**FIGURE 3**  
**Ascertainment of Breastfeeding Status Among Family Planning Clients**



(Figure 4). About half the breastfeeding women at the Tanzania sites were advised to use birth control pills, which are generally acknowledged not to be a method of choice for nursing mothers.

**FIGURE 4**  
**Family Planning Advice Given to Breastfeeding Women**

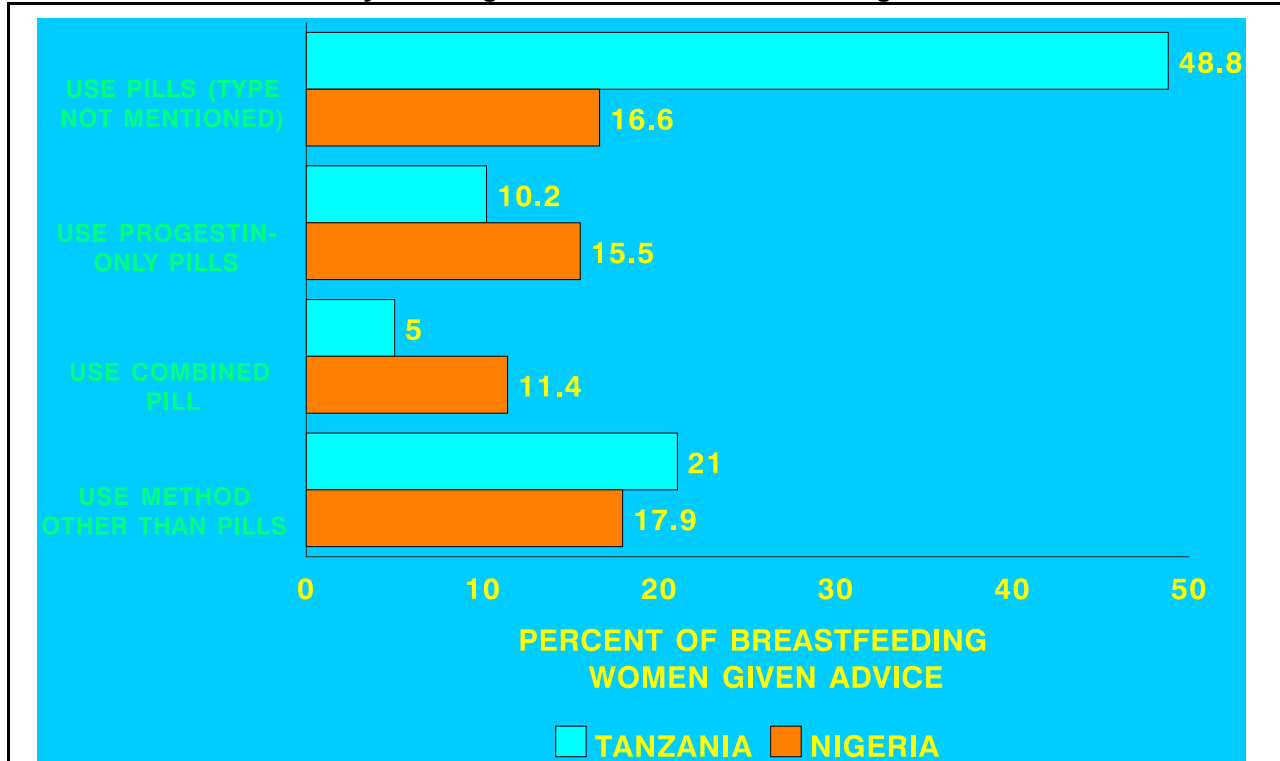
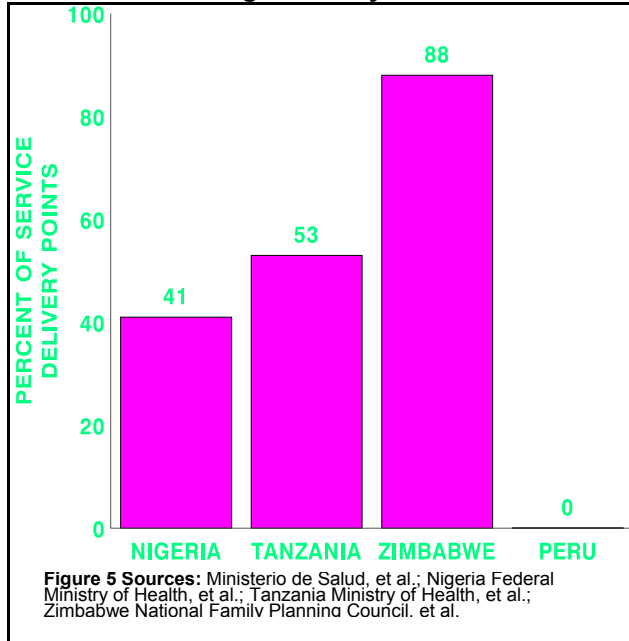


Figure 4: Nigeria Federal Ministry of Health, et al.; Tanzania Ministry of Health and the Population Council.

Finally, the situation analyses looked into the number of service delivery points that are prepared to provide the correct kind of pills (progestin-only) for breastfeeding women who choose oral contraceptives. With the exception of Zimbabwe, performance can only be regarded as dismal (Figure 5). In Peru, no service delivery points provided progestin-only pills, and in Nigeria and Tanzania very few did so.

Heavy promotion of contraception immediately postpartum seems to foster a lack of concordance between women's wishes and providers' views. Let us turn to what we know about women's needs and wishes in the postpartum period. In order to assess the adequacy of services to meet women's needs, we need to know something about the range and timing of services women desire. Types of services include contraception, postpartum health check for the mother, well-baby care for the child, and information about breastfeeding, infant care, and nutrition. When Turkish women were asked to describe the kind of information they wanted in the postpartum period, the

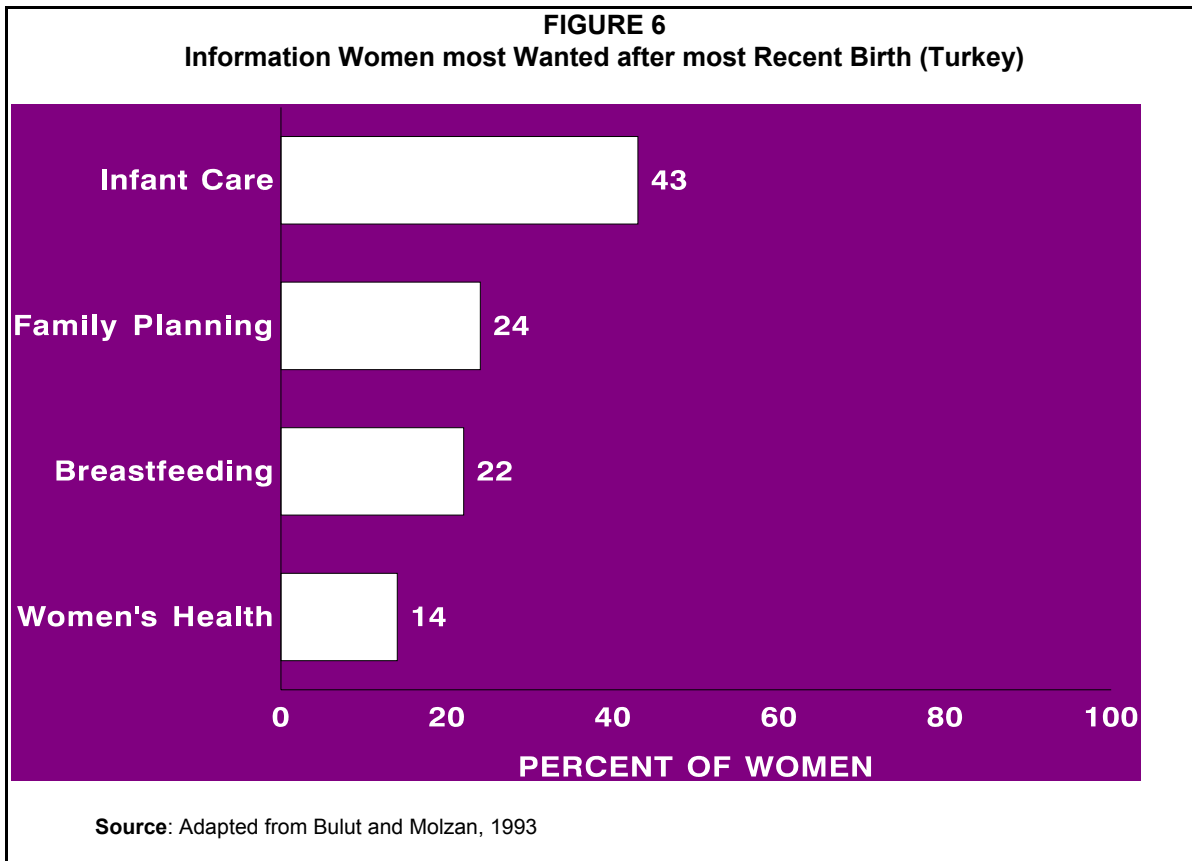
**FIGURE 5**  
**Percent of Service Points with Progestin-only Pills**



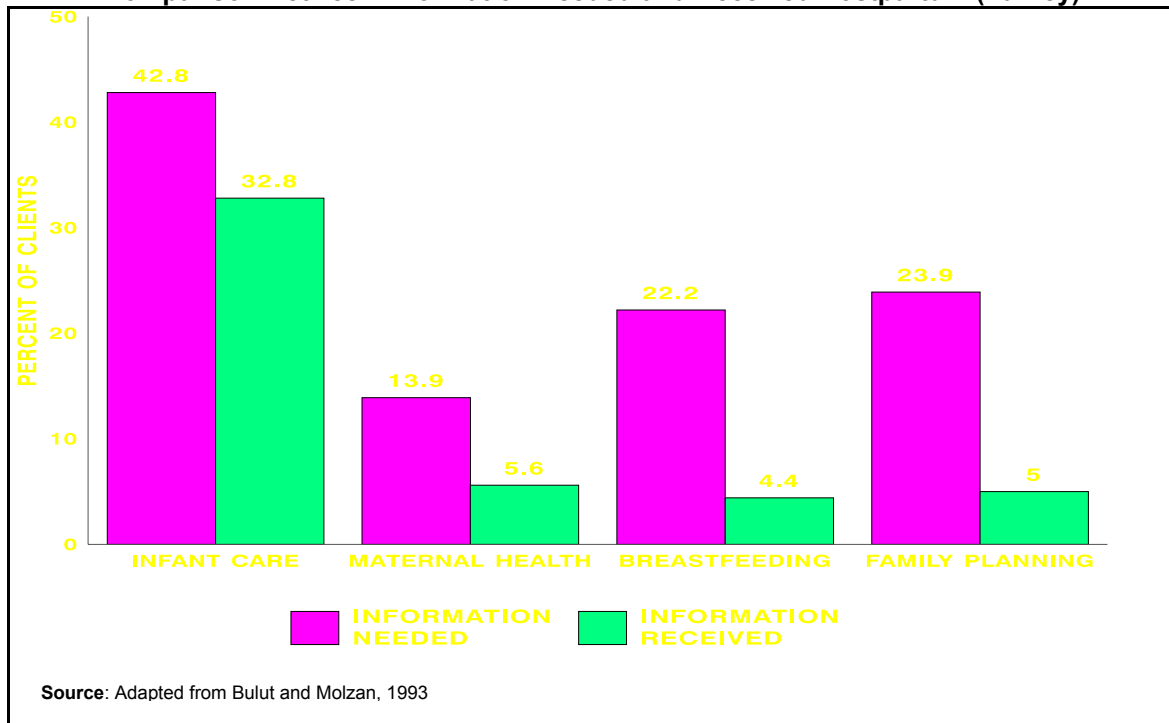
most common answer was information on infant care (Bulut and Molzan, 1993) (Figure 6). Also, substantial numbers of women wanted information on family planning and breastfeeding; slightly fewer desired to know about their own health. One can see, certainly, that family planning information alone will not satisfy the needs of a majority of women.

If we look, in the same population, at what women wanted and what they received, we see a fair amount of responsiveness in the area of infant care but a big gap between what was wanted and what was provided in the areas of

**FIGURE 6**  
**Information Women most Wanted after most Recent Birth (Turkey)**



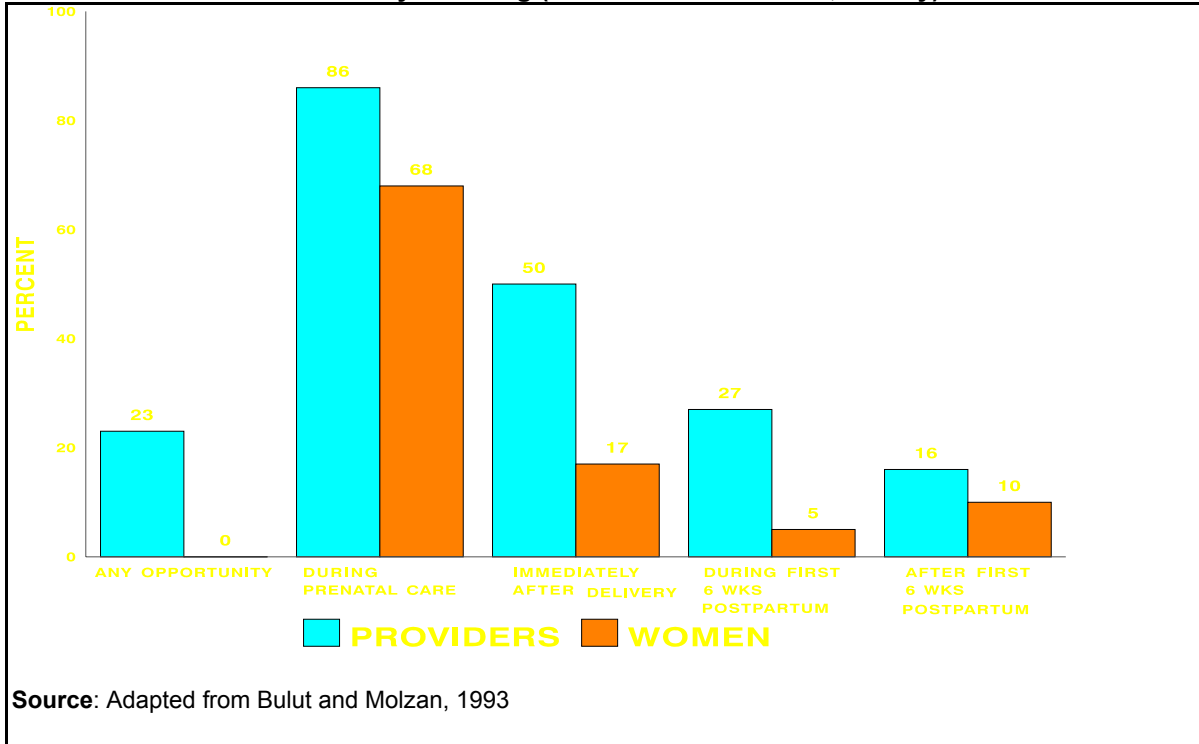
**FIGURE 7**  
**Comparison Between Information Needed and Received Postpartum (Turkey)**



breastfeeding and family planning (Figure 7). Identification of this gap is emphatically not a plea to withhold information about family planning, but rather to put it in the context of the total range and timing of services that women wish to have so they can make the best use of this information.

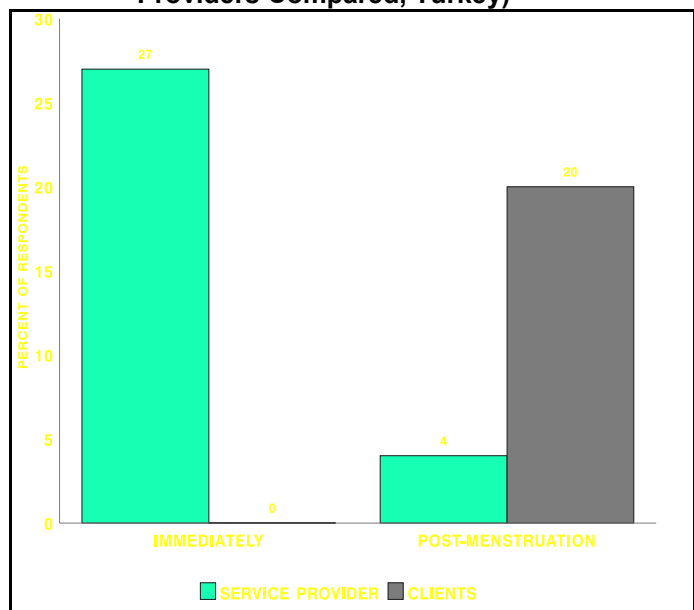
For example, women and providers shared some ideas about the need for information on family planning during prenatal care and after the first six weeks postpartum, but there was a major difference in their perceptions regarding the appropriateness of providing such information "immediately after delivery," at "any opportunity," or "during the first six weeks postpartum" (Figure 8). (Providers were much more enthusiastic than were women.) So, there is a great deal of concordance about the need for family planning information, but some difference in perception as to the most appropriate time to provide it.

**FIGURE 8**  
**Most Appropriate Time to Provide Information on Postpartum Health and Family Planning (Women and Providers, Turkey)**

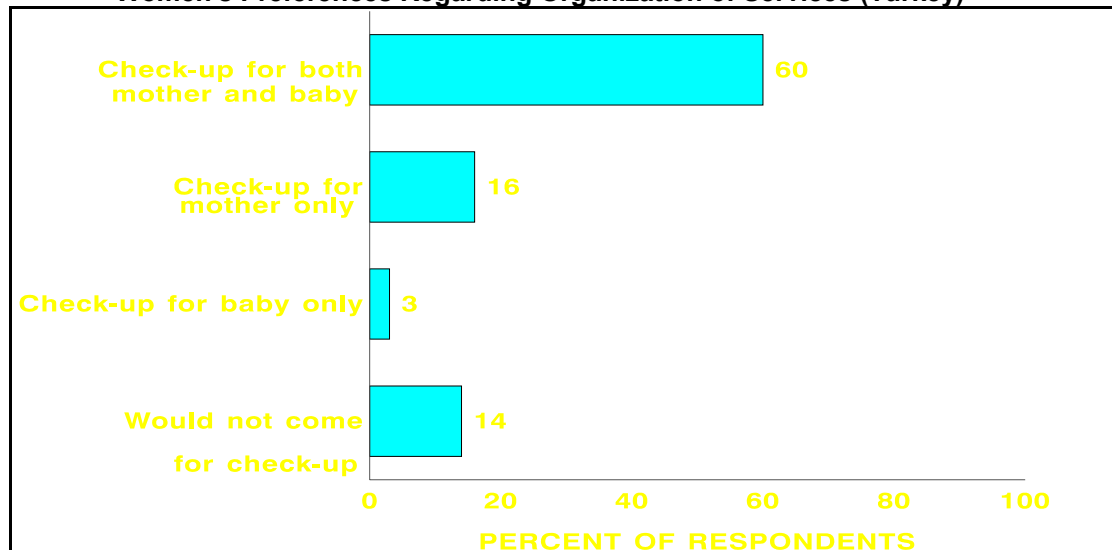


Providers and women seem to also have fairly different emphases with respect to the most appropriate time to adopt contraception (Figure 9). For example, when women and providers were asked to identify the most appropriate time for women to begin practicing contraception postpartum, many providers thought that "immediately" was a good idea, but none of the women did; on the other hand, many of the women identified "post-menstruation" as a good time to begin—a response that was much less popular with the providers. With regard to the overall content of services, it is clear that

**FIGURE 9**  
**Most Appropriate Time to Begin Using Contraception Postpartum (Women and Providers Compared, Turkey)**



**FIGURE 10**  
**Women's Preferences Regarding Organization of Services (Turkey)**



women prefer combined services to serve both themselves and their babies (Figure 10). Very few women indicated that they did not want to come back for any services or for a check-up for themselves.

### **Examples of Comprehensive, Women-Centered Postpartum Programs**

We have looked for examples of programs that do things differently, services that do not view the postpartum period only as a vehicle for providing family planning services but, instead, see family planning as part of a comprehensive set of health services that need to be offered to women in the postpartum period. One of these is the program developed by the Instituto Chileno de Medicina Reproductiva in Chile, which was replicated in a low-income community on the outskirts of Santiago with Council support.

Program components included:

- scheduled joint maternal–infant visits at 8, 20, 30, 40, 55, and 70 days postpartum and at monthly intervals for the rest of the year;
- joint maternal–infant files;
- training of all health workers in breastfeeding and contraception;
- education and counseling as key components of the program, beginning during pregnancy;

- contraceptive choices including only those that do not interfere with lactation;
- time of initiation of contraception determined by the woman; and
- evaluation of women's experience with contraceptives during subsequent visits.

The clinic that instituted this program in a poor urban area was compared with a control clinic offering only the usual services. Outcomes measured in both clinics show a substantial advantage for the study clinic (Alvarado, 1993; Diaz, 1993) (Table 11).

**Table 11**  
**Outcomes of Postpartum Program, ICIMER, Chile**

<u>Outcome</u>	<u>Study Clinic</u>	<u>Control Clinic</u>
Family planning initiated first year postpartum	90%	NA
Fully nursing, 1 mo.	100%	72%
Fully nursing, 6 mos.	76%	9%
Average weight, 1 year	10,088g	9,696g
Diarrhea, first year	2%	18%
Respiratory infection, first year	40%	61%

Source: Alvarado, 1993

The Population Council has also worked with the Postpartum Program of the Social Security Institute of Honduras. This program has modified its norms to include the following:

- a perinatal information system;
- a prenatal education program;
- family planning and reproductive health counseling;
- a 40-day postpartum clinic (with functional integration of maternal and infant care); and
- an increased range of contraceptive methods.

This program resulted in a substantial increase in the number of women returning for care and an increase in exclusive breastfeeding as well as in contraceptive use (Lundgren, 1993). (Figure 12).

**FIGURE 12**  
**Outcomes of Social Security Institute Postpartum Program (Honduras, 1991-92)**

<u>Outcome</u>	<u>Pre-Program</u>	<u>Post-Program</u>
Women delivering in hospital returning for postpartum care	15%	45%
Mean months exclusive breastfeeding	4.3	5.8
Contraceptive acceptance rates	9%	46%

Source: Lundgren, 1993

## Conclusions

The lesson that we draw from the above is that the postpartum period is a unique opportunity to provide meaningful services to women, but to do so, one has to design meaningful services. The principles of service design include the following:

- Women's autonomy should be respected.
- Postpartum care should be part of a continuum of services from the beginning of pregnancy through the end of breastfeeding.
- The range of services provided should be based on what women want and need.
- Women should be able to obtain information and services separately and at various times.
- The principles of informed contraceptive choice should be followed.
- The opportunity to provide integrated health services should not be missed.

Without these considerations, services run the risk of being irrelevant, unused, and possibly abusive to women.

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## **Postpartum Counseling for Optimal Breastfeeding and Use of Family Planning Methods**

*Judy Canahuati*

*Wellstart International*

When I ask a group of experienced mothers, who may be midwives or community-based distributors, whether spacing their pregnancies or breastfeeding their babies is more important to them, they are often confused. Finally, one usually realizes that both are equally important. Thus, we would hope that our family planning programs would incorporate breastfeeding counseling into their services, so that they could respond to the need of the immense majority of the world's mothers for support in achieving optimal breastfeeding and the use of appropriate family planning methods.

Supporting women in their wish to breastfeed optimally means assisting women to breastfeed exclusively during the first six months after birth, to continue breastfeeding with complementary foods until well into the second year, and to introduce appropriate child-spacing methods in a timely manner.

We know that women want to and are breastfeeding. In most of the world, the majority of women initiate breastfeeding and many women continue to breastfeed for well over a year. The challenge is that these women are not optimally breastfeeding and that they do not understand how breastfeeding relates to fertility.

### **Issues: Family Planning and Breastfeeding**

The issues that we must analyze in order to develop a programmatic response to these identified needs are women's *concerns about family planning* and its *compatibility with breastfeeding*.

With regard to family planning concerns, mothers want to space their pregnancies. They realize that babies need their attention. They know that they need time to recover from childbirth—but they question whether breastfeeding and family planning are compatible. Many women, especially in Latin America, have equated family planning with the combined birth control pill. This association comes out very clearly in focus-group discussions. The literature for these pills (and in some cases even for the progestin-only pill) says that they should not be used by breastfeeding women. If physicians discuss the subject at all with women contemplating a method of family planning, they usually tell them that they cannot breastfeed and use combined oral contraceptives at the same time.

The message that women may hear is that family planning—not just the pill—and breastfeeding are incompatible. In Honduras, a Social Security hospital began offering breastfeeding and family planning services and not only explained, but offered alternatives to the pill. The prevalence of exclusive breastfeeding in the intervention group almost doubled at four months postpartum, and continued breastfeeding at six months increased significantly (see Table 1). Over 45 percent of the women in that population were working in the formal sector (Chavez, 1990).

<b>TABLE 1</b> <b>Prevalence of Breastfeeding at the Hospital and at Home</b> <b>During the Six Months Postpartum</b>		
Indicator	Control	Experimental
Began breastfeeding in the hospital <sup>a</sup>	99.4%	99.7%
Continued to breastfeed at home <sup>a</sup>	98.2%	99.4%
Continued breastfeeding at four months <sup>b</sup>	71.6%	83.8%*
Continued breastfeeding at six months <sup>b</sup>	57.6%	72.4%*
Exclusive breastfeeding for four or more months <sup>b</sup>	12.1%	22.5%*
Median duration of exclusive breastfeeding	1 month	2 months

<sup>a</sup>Percent of total, 334. <sup>b</sup>Percent of those who initiated breastfeeding, 328. \*The differences between the experimental and control groups are statistically significant (z test) at  $p \leq .05$ .

There were significant increases both in the use of all contraceptive methods (Table 2) and the "fit" between the return of menstruation and the use of methods. In this study population, the control group received "routine" attention consisting of delayed rooming-in, breastfeeding brochures, and appointment at fifteen days postpartum at the growth and development clinic for the baby and a six-week postpartum check-up for the mother. The intervention consisted of "beefing up" the educational messages given to mothers prenatally and in the maternity wards, along with an appointment at the newly-opened breastfeeding clinic at seven days after birth. Along with this improvement in breastfeeding services, a family planning clinic was opened that offered method alternatives to the combined oral contraceptive.

<b>TABLE 2</b>		
<b>Contraceptive Prevalence at Six Months Postpartum, by Method</b>		
<b>Method</b>	<b>Percent Using Control (N=334)</b>	<b>Percent Using Experimental* (N=334)</b>
<b>Modern methods</b>	<b>53.9</b>	<b>67.8</b>
Orals	17.8	10.3
IUD	19.6	31.3
Sterilization	7.0	10.8
Condom	7.7	13.3
Spermicides	1.8	2.1
<b>Traditional methods</b>	<b>16.3</b>	<b>10.0</b>
Periodic abstinence	4.6	2.7
Withdrawal	8.0	4.3
Exclusive breastfeeding	3.7	3.0
<b>All methods</b>	<b>70.2</b>	<b>77.8</b>
<b>No method</b>	<b>29.8</b>	<b>22.2</b>

**Note:** Total percents might not add up due to rounding.

\*The difference between the experimental and control groups is statistically significant ( $X^2$  test) at  $p \leq .05$ .

How do we go from an algorithm to the mother? Approximately 35% of the women in the experimental group remained amenorrheic for six months. The lactational amenorrhea method (LAM) algorithm indicates that women who are exclusively breastfeeding, amenorrheic, and have children under six months are at least 98 percent protected. Although the women in the experimental group remained amenorrheic, they did not fulfill the other two conditions of the algorithm. How does one communicate with a mother in a way that will help her to understand that she is at risk of pregnancy when all three conditions are not fulfilled? At the same time, how does one communicate that continued amenorrhea during six months is a reliable sign when the mother is fulfilling the other two conditions of the algorithm, but it may not be reliable when one of the conditions (full breastfeeding) is not fulfilled, although the other two are? It has been our experience that counseling for both breastfeeding and family planning is one way to help to enhance the mothers' capacity to choose.

If we look at the mother's alternative choices and the risks derived from them it is clear that combining breastfeeding and family planning counseling and services will support the best possible choices by the mother.

## Risk

If we think in terms of maternal-child risk, then we can see the importance of combining breastfeeding and family planning counseling and services.

## Breastfeeding without Contraception

If women are breastfeeding and not practicing contraception, depending on the age of the baby, some risks may be increased and some decreased. Mothers will be at higher risk for pregnancy, but lower risk for premenopausal breast, ovarian, and uterine cancers, and postpartum anemia. Babies will be at risk for early weaning if the mother becomes pregnant, but will be protected as long as she is breastfeeding optimally.

## Not Breastfeeding and Not Practicing Contraception

There are no pluses here. This is increasingly happening all over the developing world for various reasons, placing both mother and baby at extremely high risk: mother for another pregnancy and at increased risk for breast, uterine, or ovarian cancer, and baby for diarrhea, acute respiratory infection, malnutrition, and death.

## Practicing Contraception and Not Breastfeeding

Baby is at risk for diarrhea, acute respiratory infection, malnutrition, and death, but has a lower risk of losing the focused attention of the mother, if she is conscious of the need for intimate, close interaction, early stimulation, and so on. Mother is at a lower risk for an early pregnancy, but she loses the protective effects of breastfeeding: physical effects of breastfeeding and she doesn't benefit from the "bonding" brought about by breastfeeding-induced hormones.

## Breastfeeding and Practicing Contraception

This is the only "win-win" situation. Risks are lowered for mother and baby, and everyone benefits, even society. Health care costs go down. Babies are raised in a "human" fashion. This is what we should all be promoting, along with support of "optimal" breastfeeding.

## **Breastfeeding Counseling within Family Planning Services**

Family planning and postpartum services should incorporate breastfeeding counseling for optimal breastfeeding because it:

- empowers women to take control of their lives and to better control the time of initiation of family planning method use,
- emphasizes individualized postpartum counseling,
- removes all possibility of coercion associated with immediate postpartum method provision, and
- reduces double coverage.

Breastfeeding counseling needs to be seen as a part of the normal preparation for childbirth, and it should be introduced in a nonauthoritative, non-manipulative fashion. It is not exhortation or obligation that will give women an incentive to breastfeed in a non-breastfeeding culture.

The sorry state of optimal breastfeeding practices suggests that women need support to achieve the "win-win" scenario of simultaneous breastfeeding and contraception. Counseling needs to begin no later than the onset of pregnancy, and perhaps even earlier. In fact, learning about breastfeeding should be a part of health education beginning in primary school. It would be most helpful if every prenatal clinic could have a regular discussion group in which pregnant women, especially primiparas, could talk with experienced, breastfeeding mothers, or if clinics could refer their clients to such groups. In any case, breastfeeding should be discussed at the latest during the second trimester of pregnancy, so that women have some time to absorb the information before they become preoccupied with the birth itself.

### Training and Selecting Breastfeeding Counselors

In the traditional biomedical model, the interaction between clients and service providers is hierarchical. The health professional is the authority and the mother is the passive recipient of whatever knowledge or instruction is imparted. Questioning is not encouraged and information is received in as much as it relates to the resolution of a "problem." Experiences are not shared and relationships are impersonal. The mother never knows whether she or her baby had a positive breastfeeding experience, or the basis for the information she receives. She respects that information simply because it comes from a health professional.

In contrast to this traditional biomedical model, training for support emphasizes sharing. Along with information, the provider offers an emotional connection, the chance for self-expression, listening, acceptance, and the opportunity to give emotional

support (Rosenberg and Lee, 1992). It is this type of training that the breastfeeding counselor needs.

Who would make an effective breastfeeding counselor? As in most family planning community programs, the "satisfied user" is a powerful communicator, and that characteristic is probably more important than her educational or professional training. We have had wonderful experiences with counselors who are non-literate but who are empowered with the knowledge that their successful breastfeeding and childraising experiences are important contributions to society.

It is not enough for a breastfeeding counselor to teach LAM. Women continue to breastfeed after six months and continue to need support. If family planning clinics have no mechanisms for dealing with counseling once a modern method has been accepted, they need to be in close contact with community breastfeeding groups, support them, and refer mothers to them. A counselor needs to have knowledge in all of the following areas, in order to be able to fully support mothers:

- prenatal support
- early breastfeeding
- frequent breastfeeding
- no other supplements or bottles
- correct positioning
- dealing with breastfeeding difficulties
- normal breastfeeding patterns and growth
- LAM and when and how to introduce family planning
- when to refer for medical support
- introduction of foods and continuation of breastfeeding
- breastfeeding and sexuality
- separation from the baby and breastfeeding

### **Support Groups**

Support groups can be hospital-, community-, or clinic-based. The important issue is to provide support in a place where the mother feels safe and can be at ease. If she is at a hospital or a clinic, she needs to feel comfortable, to be in a situation in which she feels free to speak out. Family planning clinics need to work with the community in identifying contexts where mothers feel safe, and in determining how to provide a nurturing atmosphere for them.

A health professional may facilitate the support group or discussion group, but that professional does not "own" the group. The group needs to belong to the women, or they will not feel comfortable expressing questions or doubts. When women come to

the clinic or hospital, they need to be able to bring their babies and their children with them, or they will be anxious. In one hospital, tubal ligation rates increased dramatically when postpartum women were able to bring their babies with them when they came to the hospital for the procedure.

### **Who Gains and Who Loses When Breastfeeding and Family Planning are Supported?**

When optimal breastfeeding is supported, there are losses to formula companies, pharmaceutical companies, and bottle and teat manufacturers.

Women are among the ones who gain, through improved relationships with health providers; through improved quality of care in pregnancy, birth, and delivery services; through an improved sense of self-confidence and personal control; and by learning a valued practice.

Children also stand to gain when optimal breastfeeding is supported, because breastfeeding enables them to receive a first food that will promote optimal brain development and health, to receive undivided attention from their mothers for a longer period of time, and to become socialized in a healthy way.

Finally, society benefits through decreased environmental stress; decreased health care costs; decreased export of scarce dollars for imported milks, medicines, and the like; decreased absenteeism in the workplace; increased worker satisfaction; and improved quality of the future workforce.

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## **WALKING THE WALK: REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAMS**

*Anrudh Jain, PhD*

*The Population Council*

There has been considerable talk about how to provide reproductive health services through family planning programs.<sup>1</sup> In order for this talk to materialize into effective action, we need to understand why these programs have not paid attention to health issues related to reproduction. After all, women had reproductive tract infections even before the invention of intra-uterine devices. One of the main reasons for the neglect of reproductive health issues by family planning programs is that the design and evaluation of these programs has been guided by an overriding interest in reducing fertility and population growth in developing countries. Moreover, there is no empirical evidence to show that the addition of reproductive health services is a cost-effective way to reduce fertility. The primary objective and the main evaluation criterion for these programs, therefore, must be revised in order for them to pay serious attention to reproductive health issues.

### **Background**

The establishment of family planning programs has been guided by multiple rationales, ranging from an individual's right to regulate his or her fertility, to a nation's interest in reducing its fertility and population growth, to the global interest in population stabilization. The overriding intent of governments and donors in allocating funds to these programs, however, has been to reduce total fertility and population growth. The success or failure of these programs, therefore, has been measured in terms of the reduction in total (wanted and unwanted) fertility and population growth.

At the global level, it has been asserted that we have come half-way toward achieving replacement-level fertility of about two births per woman: the total fertility rate (TFR), a measure of the number of children a woman would have during her reproductive period, declined from the pre-transition level of about six to about four births per woman in the mid-1980s. Prior to attributing credit for this achievement to

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<sup>1</sup> Some of the ideas included here are discussed in detail in Anrudh Jain and Judith Bruce, "A reproductive health approach to the objectives and assessment of family planning programs," in *Population Policies Reconsidered: Health, Empowerment, and Rights* Ed. Gita Sen, Adrienne Germain, and Lincoln Chen (Cambridge: Harvard University Press, 1994).

family planning programs, we should consider the scope and design of these programs. In some countries, these programs offer services and information about contraceptive methods, and engage in activities to promote the benefits of small families. In some, the choice of contraceptive methods is limited to reversible methods and in others, the programs emphasize long-acting methods, including sterilization. Some programs also offer incentives to providers and clients; others have implicit or explicit method-specific quotas; and a few have gone as far as to try coercion and compulsion. Unless the population field wants to endorse all these activities to reduce fertility in the future, some adjustment for not-so-desirable means should be made in considering the contribution of family planning programs to fertility decline. For example, if we exclude China from the global numbers, we can see that fertility has declined from six to five births per woman; that is, we have come only 25 percent of the way to achieving replacement-level fertility. In Africa and South Asia, fertility had declined from about 6.3 to 4.8 births per woman as of the early 1990s. That means that countries in those regions have quite a way to go in order to achieve replacement-level fertility.

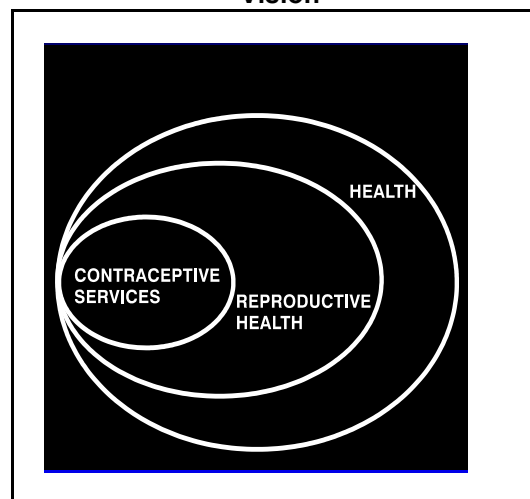
Should the design of services in such countries be guided by the objective of reducing fertility and population growth? Should the success or failure of family planning programs continue to be assessed in terms of a decline in fertility and population growth? If the answer is yes, would that adversely affect the design of those services? How does a focus on reproductive health and quality of care influence the answers to such questions?

The three aspects of family planning programs—objectives, design, and evaluation—are interconnected. Modification of one would require modification of the other two as well. Thus, one cannot simply change the design of services—that is, require these programs to add reproductive health services—without modifying their primary objective and the main criterion for evaluation of their success or failure.

### Proposed Revisions

It can be argued that it is unethical for family planning programs to neglect the reproductive health services that are beyond services for contraceptive methods. From this perspective, the vision (depicted in Figure 1), could be that

**FIGURE 1**  
**Vision**



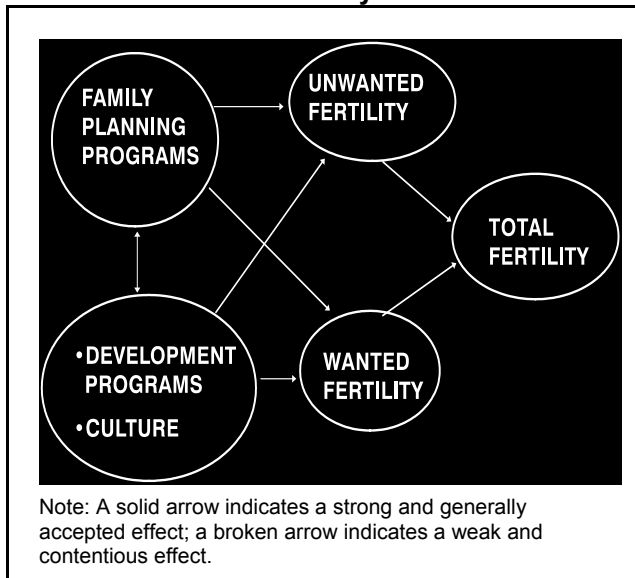
contraceptive services are subsumed within reproductive health, which in turn is subsumed within broader health services. The problem in achieving this objective is that both the contraceptive and health services have their constituencies and budget; reproductive health, on the other hand, has some constituency but no independent budget. Thus, the reproductive health advocates have to work with family planning programs and health programs to get reproductive health services delivered.

### Objective

The reproductive health approach focuses on individual rights and well-being. Because of the demands made by reproductive health advocates, family planning programs are being pulled in two different directions: to improve individual well-being and to reduce societal fertility. The managers and donors (internal as well as external) of these programs can be asked to add reproductive health services—that is, to divert funds from contraceptive to reproductive health services—under two conditions: if the reproductive health approach is demonstrated to be a cost-effective way to reduce total fertility or if the primary objective of family planning programs is redefined. A convergence of interests of reproductive health advocates and family planning program managers is easy as far as services for safe abortions are concerned, because the availability of those services would reduce fertility, expand choice, and reduce morbidity. However, there is no empirical evidence to support the cost-effectiveness of providing other reproductive health services in reducing fertility. Efforts to gather such evidence are unlikely to be productive. What if empirical research shows that this approach is not as cost-effective in reducing fertility as incentives to providers and clients? Moreover, the objective of offering reproductive health services is to improve the reproductive health of individuals and not to reduce fertility, and therefore, they cannot be judged on the basis of their impact on fertility reduction. For these reasons, the objective of the programs offering contraceptive and reproductive health services should be defined not in terms of reducing total fertility but in terms of providing individuals with the means—that is, information and services of good quality—so they can achieve their own reproductive intentions in a healthful manner.

The first part of this objective maintains the link with the current objective of fertility reduction by focusing on unplanned and unwanted childbearing, and the second part extends the link with reproductive health services.

**FIGURE 2**  
How Family Planning Programs Effect Fertility



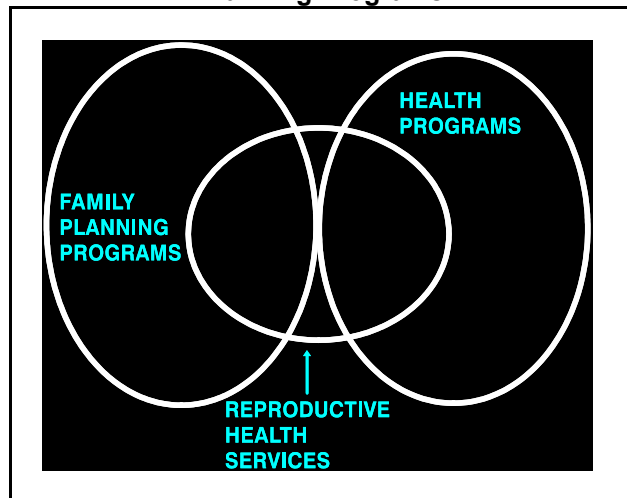
We know that total fertility is the sum of wanted and unwanted fertility (see Figure 2). We also know that there is very little evidence to support the premise that motivational messages propagated by family planning programs have any substantial effect on reducing the number of children wanted.<sup>2</sup> Moreover, a reduction in fertility desires would require much more than these motivational messages; it would require broader socioeconomic development sensitive to individual well-being. Therefore, why continue to burden service delivery programs with the objective of reducing

wanted fertility, and why continue to blame them for a lack of decline in total (wanted plus unwanted) fertility among populations with high fertility norms? The main effect of these programs, oriented to provide services and information, on fertility reduction will materialize by helping individuals to reduce unwanted childbearing.

Design

The use of the phrase "healthful manner" in the revised objective of family planning programs implies that individuals should not only be able to reduce unwanted childbearing, but in the process, they should not elevate their risk of morbidity. Thus, a practical strategy, depicted in Figure 3, would be to incorporate into family planning programs those reproductive health

**FIGURE 3**  
Practical Strategy for Incorporating Reproductive Health Services into Family Planning Programs



<sup>2</sup> This is the most contentious effect. The belief that family planning programs can reduce the wanted fertility has led these programs in many countries to go beyond these motivational messages and try means that are not so desirable, such as method-specific quotas, incentives for providers and clients, and coercion.

services that interact directly with the reduction of unwanted childbearing; that is, make them a part and parcel of the delivery of contraceptive services, while making other issues of reproductive health the responsibility of health programs.

One way to redesign services is to develop standards for screening, diagnosis, and treatment (including referral for treatment) of contraindications for each contraceptive method, to monitor compliance, and to explicitly incorporate reproductive-related morbidity in evaluations of these programs. Such an approach will also have implications for estimating the costs of providing a method. The cost of a method, in addition to the commodity cost, should include the cost of screening, diagnosis, and treatment of contraindications, as well as managing adverse reactions to or side effects of the method.

### Evaluation

If the objective of the family planning programs proposed above is accepted, the success or failure of those programs should be assessed in terms of the extent to which they assist or empower individuals in reducing unwanted childbearing in a healthful manner.

The assessment of the success or failure of a program from an individual's perspective is fairly easy. Suppose an individual does not want to have a child for two years. Then, from that person's perspective, the program is a success if she does not have a child for two years, without any increase in associated morbidity and mortality. Otherwise, the program is a failure. The challenge is how to collect and aggregate such information. A considerable degree of experimentation would be required.

Existing indicators, like the TFR, can be reported in terms of wanted and unwanted fertility. However, we know that information collected retrospectively about the "wantedness" of a child already born is biased. Women understandably are reluctant to report that a child already born was unplanned or unwanted.

A better link between reproductive intentions and subsequent fertility behavior can be established when the information is collected for the same woman through follow-up surveys of those who initiate the use of contraception or population-based panel studies in which both the users and nonusers of contraceptive methods are followed over time. In those studies, women are asked first about their reproductive intentions in terms of whether and when they want to have the next child; that information is then linked to their subsequent fertility behavior.

## **The HARI Index**

In my work on quality of care, I have followed the sound advice that Professor Ronald Freedman gave to those involved in the evaluation of the Taiwanese family planning program in the mid-1960s. When some of those involved in that effort were discouraged by the high discontinuation rates for IUDs, observed for the first time in a field program outside a clinic, Ron said, "Follow the women and not the method."

The same principle can be applied to assess the impact of family planning programs in terms of their combined outcome reflecting both the avoidance of unwanted and unplanned childbearing and reproductive health by an index called HARI, an acronym for Helping Individuals Achieve their Reproductive Intentions.

The definition of the HARI index should be linked to the type of services made available through the program. For example, if services for safe abortion are not available, the HARI index can be defined as being equal to 100 minus the percent of women who have an unplanned or unwanted pregnancy or who experience severe morbidity related to reproduction, during a specified period of observation. In programs that also provide services for safe abortion, the HARI index can be modified and estimated by 100 minus the percent of women who have an unplanned or unwanted birth or who experience severe morbidity related to reproduction, during a specified period of observation.

The HARI index has three elements: the percent of women who have an unwanted pregnancy (or birth), the percent of women who have an unplanned pregnancy (or birth), and the percent of women who experience severe morbidity related to reproduction. The index is not a substitute for input indicators, process indicators, or indicators of reproductive morbidity or fertility, but it provides a way to assess the overall impact of the service delivery programs from the clients' perspective.

The HARI index may be confused with the concept of unmet need, which includes women who state a desire to regulate their fertility but who are not practicing contraception. The magnitude of unmet need, however, is used to justify program expansion; it is not an indicator of program performance. The HARI index, in comparison, can be used to measure the impact of service delivery in fulfilling the unmet need. In the absence of panel or follow-up studies, we can not judge the accuracy or intensity of statements about reproductive intentions or the impact of services in eliminating unmet need.

The value of the HARI index would be 100 if no one wanted to regulate her fertility and everyone was having children without experiencing severe morbidity or mortality associated with childbearing. In this fashion, the program will not be penalized for the

prevalence of high fertility norms. However, in high-fertility societies, the index will not be 100 if morbidity and mortality associated with childbearing are taken into account. The value of the HARI index would also be 100 if all women wanted to regulate their fertility and all were able to do so effectively and safely.

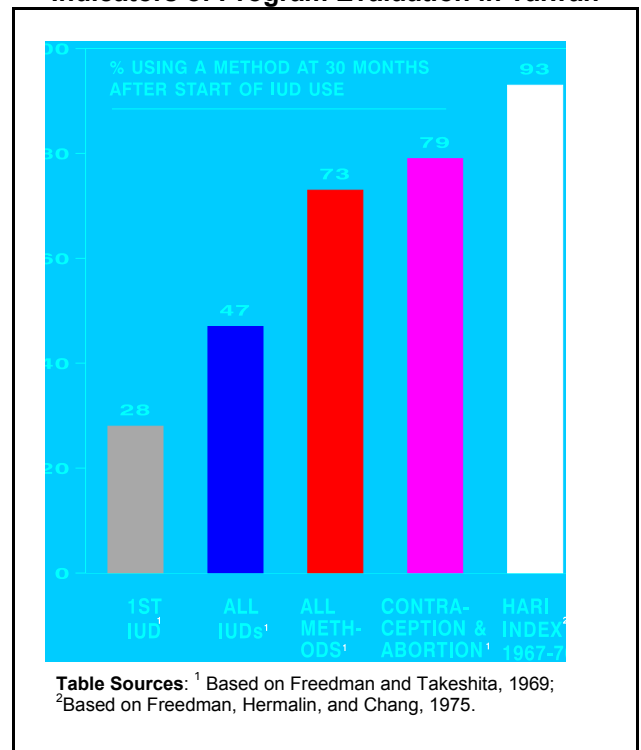
An analysis of the reasons for failure can shed light on the components of the program that need to be improved. We have identified five types of failure. Three of those types can occur among those who have an unplanned or unwanted pregnancy, and could be due (1) to the inadequacies of the methods (i.e., when continuous or compliant use of a method nonetheless leads to a pregnancy), (2) to poor quality of information exchanges (such as when a client is not informed about the possibility of switching methods or sources of supply), or (3) to inadequacies in outreach efforts (when a potential client does not get enough or appropriate information or access to a service facility).

The next two failures apply to all women, whether or not they had an unplanned or unwanted pregnancy during the observation period. They make the link with reproductive health issues: morbidity failure occurs when a client indicates that she has suffered undue morbidity due to the use of contraceptives or due to unsafe abortion. The next category of inappropriate methods includes the situation in which a client is given a method that is inappropriate for her reproductive intentions (for example, sterilization to those who want more children), for her health conditions (for example, IUDs to those suffering from RTIs and STDs), and for the health of her child (for example, combined hormonal contraception during breastfeeding).

There are no panel or follow-up studies that would allow us to estimate the value of the HARI index including all its elements. A reduced form of the index is calculated to demonstrate its utility. This index is based on whether or not women have an unwanted birth during the observation period.

The degree of success of the Taiwan program is demonstrated in Figure 4 by using different criteria. Focusing on first-method continuation would have led to quite a different

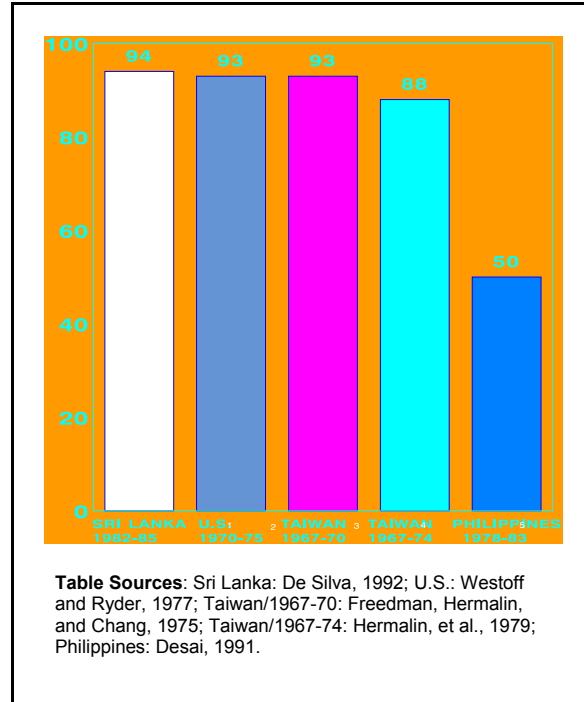
**FIGURE 4**  
**Indicators of Program Evaluation in Taiwan**



conclusion about the success of the Taiwanese program than focusing on all methods, including abortion. The program appears to be even more successful when it is not penalized for wanted childbearing.

The values of the HARI index based on panel studies are summarized in Figure 5. These results show that the degree to which stated fertility desires are implemented and the extent to which women are successful in avoiding unwanted childbearing reflect the environment of services (private and public) for multiple methods, including abortion. These studies did not collect information on the service environment, but the lower success rate in the Philippines study most likely points to some deficiencies in the services for contraceptive methods and abortion. For example, the outreach failure in the Philippines is estimated to be 33 percent of all women, in comparison with 6 percent in Taiwan. The switching and method failures in the Philippines are estimated to be 9 and 8 percent, respectively. In comparison, those two failure rates together in Taiwan come to 2 percent. Similar studies under different service environments are required to demonstrate the importance of services in reducing unwanted childbearing safely.

**Figure 5**  
**HARI Index for Selected Countries**



## Conclusion

In order for reproductive health and quality of care to become realities, the main objective of and the evaluation criterion for family planning programs need to be redefined so that they emphasize helping individuals to achieve their own reproductive intentions in a healthful manner. The continued evaluation of these programs in terms of fertility reduction—that is, reduction in both wanted and unwanted fertility—is likely to have an adverse effect on the design and scope of these programs, especially when the pace of fertility decline is slower than desired.

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