# Decision-Making Tool for Family Planning Clients and Providers

## Technical adaptation guide

World Health Organization

**Acknowledgements**

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# About this adaptation guide

This guide is designed to assist programme managers and policy-makers in adapting WHO's *Decision-Making Tool for Family Planning Clients and Providers* at the national or sub-national level.

The *Decision-Making Tool* has been developed as a **generic tool** that can potentially be used in all countries. Adaptation means making changes to the tool so that it is suited to the national or local context, or integrated into existing national or local programmes. This guide assists with this adaptation process.

**Section 1** gives an overview of the tool and the principles of counselling and evidence-based care on which it is based and explains the rationale for its design. Understanding this rationale will help programme managers to make decisions about changes to the tool.

**Section 2** gives an introduction to the adaptation process and some key tips on introduction of the tool within national programmes.

**Section 3** gives detailed guidance on *recommended* adaptations to make the tool context-specific.

**Section 4** outlines further *possible* adaptations that can be made to the tool.

The **annexes** contain additional information that may be helpful during the adaptation process.

Section
1

# Introduction to the tool

## Background

The *Decision-Making Tool for Family Planning Clients and Providers* was developed by the Department of Reproductive Health and Research at the World Health Organization (WHO), in partnership with the INFO Project at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP).

The tool is designed for use by family planning providers to help their clients make informed choices about contraceptive methods and to give clients the information and help they need to use their chosen method successfully. It is an interactive tool that helps providers engage their clients in the family planning consultation, and it promotes clients' participation in the contraceptive decision-making process.

The tool was developed by experts in reproductive health education and communication at the WHO and JHU/CCP. Input has also been given by other health communication experts, in particular from counselling specialists at IntraHealth. The tool is evidence-based (see page 2) and has been reviewed by family planning experts from around the world. It has been tested with family planning providers and clients in several countries (see Annex 1).

**A focus on quality:** The tool was developed to improve the quality of family planning care in primary and secondary level health services. By improving the quality of services, the tool can help increase client satisfaction, client use of services, and the safe and effective use of contraceptive methods.

**A focus on rights:** Every woman and man has the right to decide the number, spacing and timing of their children, and the means through which they will achieve this desired family size. This tool aims to empower clients to choose a method according to their expressed needs and situation. By enabling providers to serve their clients well, and by supplying both providers and clients with correct and appropriate information, the tool should help women and men to carry out their reproductive intentions successfully.

## Key principles and attributes

The *Decision-Making Tool* is not simply a family planning flipchart designed to provide facts. It is a tool with various purposes and uses. It translates principles of good counselling and informed decision-making into a practical but tailored process that providers and clients can follow. Thus it is based on certain objectives and principles that are outlined below. As a background to adaptation, this section also explains how the tool.

The tool aims to meet the following ***three objectives***:

1) To engage clients fully in family planning decision-making so that they make a healthy contraceptive choice suited to their needs.

2) To improve the quality of technical information offered by providers by giving them a user-friendly resource containing accurate technical information and guidance on contraceptive use and other reproductive health topics.

3) To improve the counselling and communication skills of providers so that they can better interact positively with their clients and offer them high quality family planning services.

## A multi-purpose tool

The tool has been designed with several different uses in mind:

- **A decision-making tool:** The first function of the tool is to aid clients' decision-making regarding contraceptive method. The tool leads providers and clients through a step-by-step decision-making process to ensure that clients make the decision best suited to their needs and situation. It acts as both a *job aid* for the provider to assist in this process, as well as a *communication tool* to engage the client's participation in the family planning consultation.

- **A problem-solving tool:** In most countries the majority of family planning clients are returning clients who are already using a contraceptive method. Some of these clients may experience problems with their method and need counselling or else support to switch methods. One section of the tool has been designed to help providers counsel returning clients (see page 6 for more information).

- **A reference material for providers:** As well as assisting clients in their decision-making process, the tool serves as an informational resource for providers, offering them guidance on the appropriate provision of contraceptive methods. The tool contains the essential information providers need about each method. Providers can therefore assist clients both to *choose* and to correctly *use* a suitable family planning method.

- **A training reinforcement tool:** Often, health care training lacks adequate follow-up and reinforcement on the job. Trainers and educators can use the *Decision-Making Tool* to teach students the essentials of high quality family planning service provision, and later their students can refer to the tool while counselling and for reference. Providers can use it for self-study, as a reference material, and also as a job aid during counselling sessions.

## An evidence-based tool

The content of the *Decision-Making Tool* is based on the latest available evidence from medical, health communication and social science research:


- The technical information on contraceptive use is taken from WHO's two evidence-based family planning guidelines, the *Medical Eligibility Criteria for Contraceptive Use* (WHO, 3rd edition, 2004), and the *Selected Practice Recommendations for Contraceptive Use* (WHO, 2nd edition, 2005).

- Additional technical information on contraception and other reproductive health topics has been derived from other evidence-based guides, including the family planning handbook, the *Essentials of Contraceptive Technology,* (JHU/CCP, 2003) and other WHO reproductive health guidelines, including WHO guidance on emergency contraception and sexually transmitted infections.

- The counselling process in the tool is based on a normative model of decision-making, developed by WHO and JHU/CCP, and applies the findings of research on health communication and counselling.

A listing of evidence-based practices contained in the tool, together with relevant references, is contained in Annex 4.

## Promoting client-centred care

To improve client satisfaction with both services and selected methods, the *Decision-Making Tool* promotes a model of client-provider communication and interaction based on the following principles:

- **Client-driven consultations**

  In a conventional provider-centred consultation, it is the provider who determines the flow, direction and content of the consultation. Clients are not encouraged to participate or ask questions. The *Decision-Making Tool* has been designed to promote client-centred consultations: the provider must depend on input and answers from the client before proceeding to the next step in the tool. The tool also encourages the provider to ask questions, check understanding, and listen actively to the client.

- **Shared decision-making and problem-solving between two experts**

  The tool encourages a model of care in which decision-making and problem-solving are shared between two experts: the provider is the expert on contraceptive methods, and the client is the expert on her or his situation and needs. As they work together in an ***equal partnership***, the provider can help the client decide which method best suits her or his situation and needs or how best to solve any problems she or he has with method use.

- **Empowering clients and providers**

  Through the use of illustrations and easy-to-read text, the tool helps engage clients in the consultation. The tool acts as a point of focus for the provider and client to use together. Clients may see words or pictures that prompt questions or concerns or that reassure them. As the provider allows the client to direct the consultation through their answers and questions, the client becomes empowered to participate in their health care decision-making.

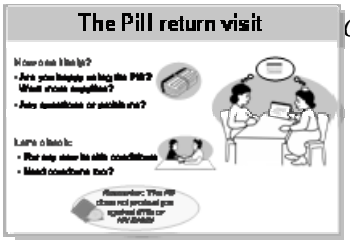
  The tool can also increase a client's confidence in the provider's ability. Often, providers are reluctant to use reference materials during consultations, thinking that clients may question their knowledge and skills. If the vital information is contained in a job aid, however, the provider needs only to glance at the technical points to be reminded of the correct practice or information. Use of the tool can also increase providers' self-confidence, because the tool helps reassure them that they are doing the right thing.

## Promoting counselling skills

### *An interactive client and provider material*

The *Decision-Making Tool* is an interactive job aid designed as a double-sided flipchart, with one side presenting pictures and basic information for clients, and the other containing technical information and more detailed guidance for providers.

Providers can use the "client side" together with their clients to discuss the key bullet points and demonstrate points using the illustrations. In this way, they will actively draw the client into the consultation, making them feel that their involvement and input are important. When needed, the providers can refer to the extra technical points on the "provider side".




*One side for clients…*


*…and one side for providers*

### *Cues for good counselling and communication behaviours*

The *Decision-Making Tool* focuses not only on technical information but also on ***HOW*** the information is transmitted.

In order to achieve the client-centred care outlined above, the provider must become a counsellor, not just a provider. The client's perception of good quality care is often related to the way care is provided, the way information is given, and the way the health care provider interacts with her or his client.

The tool is based on the following key principles:

**1.** The client makes the decisions.

**2.** The provider helps the client consider and make decisions that best suit that client.

**3.** The client's wishes are respected whenever possible.

**4.** The provider *responds* to the client's statements, questions, and needs.

**5.** The provider *listens* to what the client says in order to know what to do next.

The tool promotes positive counselling behaviours among providers and positive communication behaviours among clients (see box 1 below). It does so in the following ways:

- by giving cues and prompts to clients (which the provider will also see) (see figure 1).
- by giving providers suggested questions in their additional blue reference boxes, for example *"If these side-effects happened to you, what would you think or feel about it?"*
- by reminding providers of when it is important for the client to make a decision through use of the "decision-making icon" (shown in figure 1).
- by giving providers reminder **counselling icons** to remind them of good behaviours (see figure 2).

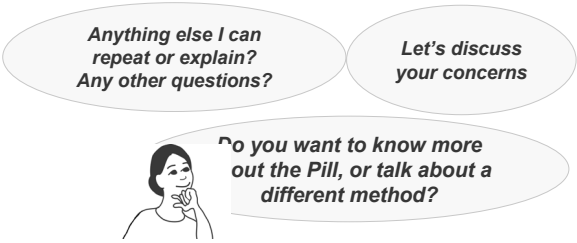



Fig. 1 Communication prompts for clients

**Box 1 : Communication behaviours promoted in the tool**

**For a provider:**

- Asks open ended questions
- Meets clients' statements with acceptance
- Listens actively to the client
- Avoids criticizing or blaming clients
- Checks the client's understanding of statements
- Asks if the client has questions

**For a client:**

- Tells the provider how they feel
- Asks questions
- Tells if information is unclear or if does not understand
- Feels comfortable to tell worries, fears, uncertainties
- Is honest about her/his personal situation
- Asks for instructions or other help

Figure 2: Counselling icons


## A structured decision-making and counselling process

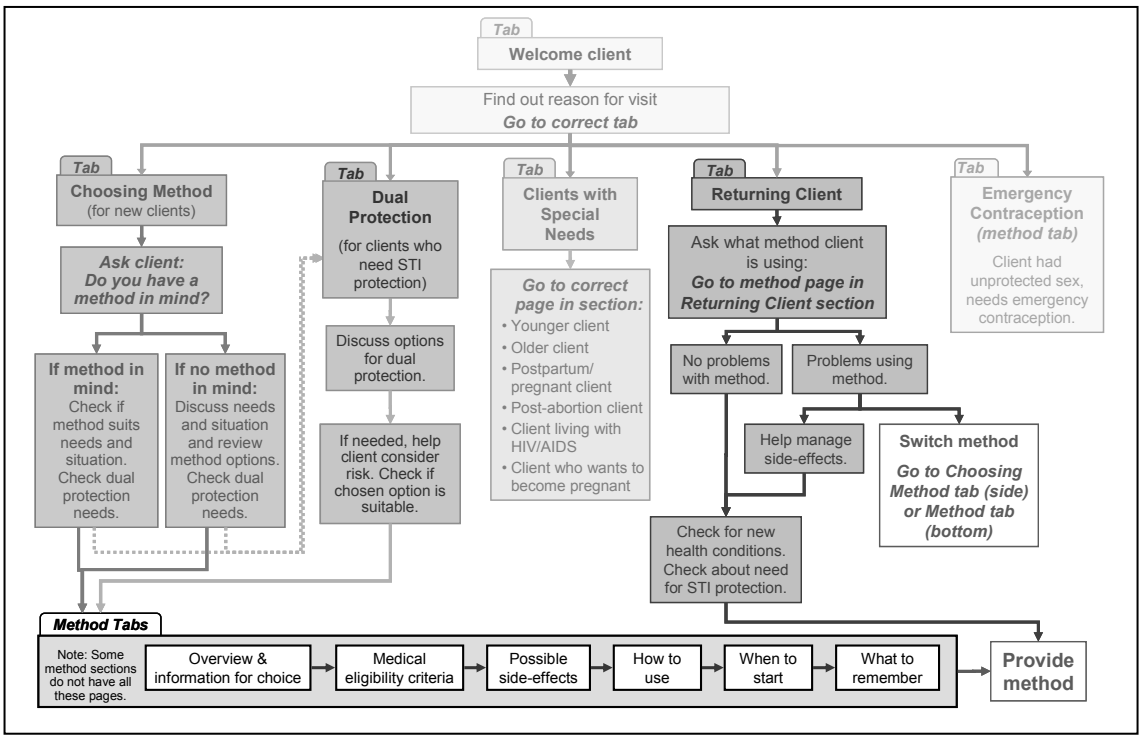
The *Decision-Making Tool* has been designed to lead providers and clients through a ***step-by-step counselling process*** of method selection and provision. It is composed of **three core sections**:

- ***The front section***, with tabs at the side, directs the provider along certain paths according to the client type or needs and is focused on decision-making for new clients and problem-solving for returning clients.
- ***The methods section***, with tabs along the bottom, contains detailed information about the different family planning methods (14 in total).
- ***The appendix section*** contains additional counselling materials for providers.

A summary of the tool's framework and flow is given in figure 3. It shows the tabbed sections and sub-sections of the tool that are discussed below.

The tool encourages the provider to solicit input from the client to make the next step in the decision-making or problem-solving process. The provider turns the pages, referring to the instructions at the bottom of the page if needed. (The next step is not always on the next page.) The step-by-step flow process contained in the tool is not prescriptive. It can teach providers the key information that they need to give to every client. Once providers learn these steps they can use the tool in consultations as they feel they need to. Some may find it helpful to go through each page with clients, others may prefer to use only certain pages, depending on the needs of the client.

Figure 3: The flow process contained in the tool



### 1) New clients choosing a method

The "Choosing Method" section contains the core decision-making process in the tool. It serves clients who have come to choose a method for the first time or who need to choose a new method after switching.

The decision-making process first focuses on **clients with a method in mind**. Often, family planning clients have heard about different methods from friends, family or the media. Many will arrive at a clinic with a method already in mind. Research has shown that clients are more satisfied if they can use their preferred method. Clients should receive this method if it suits their expressed needs and situation and they have no medical reason to avoid it. Thus, following the process in the tool, the provider first asks the clients if she/he has a method in mind before discussing method options.

For **clients with no method in mind**, the tool encourages the provider to solicit information on the needs and situation of the client before discussing method options. Provider and client consider together what the client's needs are (What are their previous experiences in family planning? What are their plans for having children? Does the client need STI/HIV/AIDS protection? What does her/his partner think? Etc.) Once the provider has heard the client's story, she/he can then help the client to consider options in light of these expressed needs. In this way, the time is used more efficiently, and the provider is discouraged from giving "information overload" about all the method options.

Once a client has made an initial selection of a method, the provider will flip to the method tabs to discuss the method in more detail.

### 2) Returning clients

Family planning clients not only need support in selecting a contraceptive method, but they may also need *continuing* support and reassurance to use that chosen method. Too often, clients leave with a method but without an offer of follow-up care and reassurance that they may return if they experience difficulties with their method.

The *Decision-Making Tool* focuses on the returning client with a special tab that offers guidance and counselling:

- It reminds the provider to check if the client is happy using their method, or if they would like to switch methods.
- It reminds providers of the particular follow-up issues for each method (e.g. resupply, late for injections, implant removal).
- It reminds providers to check for any new health conditions or problems that may affect method use.
- It gives guidance on how to counsel on side-effects and other problems the client may be experiencing. Through pictures and text on the client's pages, it makes the client feel more comfortable to raise any problems.
- It reminds providers to offer clients condoms and recheck their dual protection needs.

The tool therefore promotes critical continuity of care.

### 3) Dual Protection

Consideration of STI and HIV/AIDS prevention needs is a critical element of family planning decision-making, and the tool encourages *all clients* to consider their dual protection needs: **protection against both pregnancy and STIs/HIV/AIDS.**

The tool offers providers and clients an important entry point into the discussion of sexual issues and relationships. Job aids can help providers discuss STI risk and ensure that all relevant topics are covered. If information is contained in the tool, both the provider and client are more likely to see the discussion as a routine matter, rather than as a sensitive topic.

The tool also contains separate methods sections on condoms (male and female), with a detailed explanation and pictures of how to use them. The section underlines the important of correct and consistent condom use.

### 4) Clients with special needs

The tool contains a tabbed section for clients with special needs. It helps consider the family planning and other sexual and reproductive health needs of:

- Younger clients
- Older clients
- Post-partum clients
- Post-abortion clients
- Clients living with HIV/AIDS
- Clients who want to become pregnant

Providers can use these pages individually, or they may refer to them during the decision-making process with the client. They may also be used for reference, in training, and as reminders that offering specialised counselling to these clients is important.

### 5) Method information

Every client needs information about their method options, firstly to confirm that they have made a good choice, and secondly to know how to use their chosen method correctly. However, a client will only be able to take in or remember a certain amount of information during a consultation, Therefore the tool encourages providers to give clients only the key points about the method, but with enough information that they can use the method safely and successfully.

The tool contains a section on each family planning method, outlining the key points that the client needs to consider or know. Each method section consists of pages on:

- key characteristics and information about the method
- medical eligibility criteria
- side-effects
- how to use the method correctly
- what a client can expect during a procedure (e.g. IUD insertion)
- when to start
- when to come back
- what to remember (including signs that may indicate serious problems)

### 6) Appendices: additional counselling aids in family planning and sexual and reproductive health

The final section of the tool contains **appendices** presenting additional sexual and reproductive health counselling aids. Providers can refer to these pages during their usual family planning counselling or for reference:

1. *Questions to be reasonably sure a woman is not pregnant:* A checklist to help determine when a client can start a hormonal method or the IUD.
2. *Which methods meet the clients' needs?:* Helps compare methods during the decision-making process.
3. *Comparing effectiveness of methods:* Helps compare the effectiveness of methods as commonly used, and notes ways that the user can make the method as effective as possible.
4. *The female reproductive system:* A counselling tool to use with clients, particularly younger clients, to explain about their bodies. Also helpful for explaining how methods work.

5. *The menstrual cycle:* A counselling tool to use with clients, particularly younger clients, to explain about their menstrual cycle.
6. *The male reproductive system:* A counselling tool to use with clients, particularly younger clients, to explain about their bodies. Also helpful for explaining vasectomy.
7. *Starting a method:* Summarizes when during the menstrual cycle, after childbirth, or while breastfeeding, women can start using various methods.
8. *Facts about STIs/HIV/AIDS:* A reference for providers about STIs and HIV/AIDS.
9. *Promoting communication between partners:* A reference for providers to help counsel clients about partner communication, including suggested role plays, useful things to say, and advice on group counselling.
10. *Myths about contraception:* A reference for providers to help discuss common myths about contraception with clients.
11. *Sexual and reproductive health tips:* A reference for providers on different aspects of reproductive health which they should be aware of when discussing family planning (including facts about breast awareness, pap smears, the menopause, men's sexual and reproductive health needs, infertility and preparing for childbirth).
12. *Tips and hints for counselling:* A reference for providers containing advice on how to interact with clients. Includes tips on talking about sex.
13. *Supporting women living with violence:* Offers guidance to providers on how to counsel women who are victims of violence.

In addition, sexual and reproductive health concerns are integrated into the guidance and counselling process throughout the tool.

Section 2

# About adaptation

## Why adapt?

The *Decision-Making Tool* has been created as a generic tool that can be used by family planning providers in the majority of primary and secondary health facilities. The tool contains illustrations that are not specific to any particular region or country, and the technical and scientific terms in the tool have been kept as simple as possible. The generic tool also applies WHO's and others' global standards and best practices in family planning counselling.

Some countries may find that this *generic* tool is usable within their own programmes. If resources are short, providers may still be able to use the generic tool, even if there are differences in terminology or method mix. If resources are available, however, adaptation can make the tool more acceptable, usable and effective.

Every country has its own particular context within which family planning services are provided. Before national programme managers or policy-makers decide to introduce the tool, they will want to consider whether their own particular context necessitates adaptation of the generic tool. Varying degrees of adaptation could be applied to the tool, and decisions regarding possible changes will depend on the country's programmatic needs and the resources available for adaptation.

## What to adapt?

Adaptation can be divided into two different types of changes: recommended adaptations and possible adaptations. These are discussed in detail in the next two sections of the guide.

**Recommended adaptations** are changes recommended by WHO and the INFO Project to make the tool more usable by both providers and clients in a specific context. No changes are considered essential, but adaptation of the following key programme elements is recommended:

- Method selection
- Adapting method types
- Local terminology
- Consistency with national/sub-national standards and procedures
- Referrals
- Clinical capacity

**Possible adaptations** are those changes that countries feel are necessary given programmatic needs and available resources. These adaptation processes may take more time or may involve significantly adapting certain sections or components of tool. Some or all of the following key elements of the tool might be changed:

- Appendices
- Dual protection
- Legal issues
- Special clients
- Illustrations
- Adapting to different client groups
- Combining with existing checklists
- Production issues
- Training additions
- Harmonizing the tool with other national strategies

## The adaptation process

Any adaptation process must be considered as part of a broader process to introduce and implement the tool within a national programme. Adapting the tool offers an opportunity to bring various groups together to discuss the content and agree on the changes needed for effective use by family planning providers.

WHO has developed a guide that outlines the principles and process to introduce its guidelines and tools within national programmes: *Introducing WHO's Guidance in Reproductive Health into National Programmes: Principles and Process of Adaptation and Implementation.* This guide is available on the Implementation Guide CD-ROM. It can help programme managers plan a process to systematically introduce the tool into a programme so that it achieves its intended objectives.

Key points to consider when adapting and implementing the *Decision-Making Tool* include:

- **Use, intended audience, and objectives of the tool:** As described in section one, the *Decision-Making Tool* can be used for various purposes, including both as a job aid and a training tool. The adaptation process offers the opportunity to determine the objectives of introduction of the tool and how it can best be utilized with the national programme.

- **Available resources:** The tool can be a relatively expensive material to reproduce and the team planning introduction of the tool must take available resources into consideration. Training, discussed below, is also important, but may also be costly. The team can consider making adaptations to reduce costs, but if resources are limited, they must plan for resource mobilization to ensure that it can be implemented successfully. In all instances, the costs involved in full-scale implementation must be considered from the beginning.

- **Advocacy:** In order for a national programme to support introduction of the tool, it will be necessary to introduce it to policy-makers and decision-makers, and advocate for its implementation. Positive fieldtesting or pilot testing results can be used to demonstrate impact. Fieldtesting results of the generic version are discussed in Annex 1. WHO has also prepared some introductory presentations (downloadable from the training section of the Implementation Guide CD-ROM) can that can be adapted for local use when introducing the tool.

- **Training:** The *Decision-Making Tool* is a large resource containing both a counselling process and detailed technical information. For the tool to achieve its desired objectives, family planning providers will usually need updated training. This can include:
  - Basic training on use of the tool
  - Training on counselling and communication skills
  - Contraceptive technology update

  WHO has developed a training guide (available on the Implementation Guide CD-ROM) that contains training modules covering these three areas. Training on the tool can be integrated into ongoing training programmes within a country, or a new training programme may need to be developed.

- **On-the-job reinforcement:** Providers who have attended training on the *Decision-Making Tool* need to be supported in their work environment to ensure that new skills learned are applied in practice. The *Decision-Making Tool* itself supports providers on the job, but other supporting strategies may also be helpful. These include self-assessment checklists, supplementary materials for clients (e.g., flyers or posters), peer discussion groups, supervisory visits and mentorship from other trained providers.

- **Programme management:** For the tool to be introduced successfully, changes may need to be made within the programme itself. These can include relatively simple changes, such as updating job descriptions to reflect client-centred care or revised performance feedback processes. Often, however, structural changes may be needed, such as reorganization of patient flow to allow more time for counselling and to reduce waiting times; creation of private counselling areas; revision of provider payment or incentive structures (not only to ensure that there are is no underlying provider bias in method provision, but also to reward client-centred quality care); or review of logistics management to ensure that there are always supplies available of the full range of contraceptive methods.

- **Integration with other programmes and strategies:** In every country there will be ongoing initiatives, programmes and strategies related to family planning, directed either by the national Ministry of Health or Population, or by other partner agencies. Integrating work on the tool with these programmes is important, not only to ensure consistency in approaches and messages, but also as an opportunity to combine resources.

- **Translation:** The implementing team may need to consider whether multiple translations of the tool are needed. The tool is designed for both clients and providers and therefore should be made available in a language understandable to both. Sub-national languages may be needed.

- **Production:** The tool is a relatively complex material to produce. The generic version has been printed in full-colour with tabs, and with a custom-made binder that converts into a flipchart stand (printing specifications are shown in Annex 3). Production is likely to vary country-by-country. Key issues to consider are discussed on page 23.

Section
3

# Recommended adaptations

Recommended adaptations are changes that are recommended by WHO and the INFO Project to make the tool more effective and usable in the national or sub-national setting.

Different countries and regions have various characteristics that make them distinctive: they will almost certainly have diverse languages, dialects or terminology; they may have differing reproductive health or family planning standards and guidelines; their programmes may offer various different contraceptive methods; health system structures will involve different referral procedures; they will have their own laws and policies relating to the provision of contraception and other reproductive health services; and they will have diverse population groups with their own needs.

The following sections outline the recommended adaptations that may be considered by an adaptation team.

## a) Method selection

WHO's generic tool contains detailed information on 14 family planning methods (see box 3).

The first step in adaptation will be for countries to decide which methods the tool should cover. The complete tool is large (125 double-sided pages) and production costs will be reduced through the removal of unavailable methods.

***Key considerations:***

- Which methods are currently available through the national programme?
- If the tool is also to be used by private sector, are there additional methods available?
- Is the government currently considering the procurement of any additional methods?
- Are any currently used methods to be phased out in the near future?

**Box 3 : Methods contained in the generic WHO tool**

- Emergency contraception (ECPs and/or emergency IUD)
- Copper-bearing IUD
- Combined oral contraceptives (the pill)
- Progestogen-only pill (mini-pill)
- Progestogen-only injectable (long-acting injectable, DMPA or NET-EN)
- Combined injectable (monthly injectable)
- Norplant implants
- Vasectomy
- Female sterilization
- Male condoms
- Female condoms
- Vaginal methods (diaphragm and spermicides)
- Lactational Amenorrhoea Method (LAM)
- Fertility-awareness-based methods

When considering the methods, the adaptation team may determine that certain methods are very uncommon, and therefore providers do not need detailed technical information on these methods. They may instead prefer to give the providers some summary information about these less commonly used methods. In these instances, they could create a new tabbed section or annex on additional methods. These basic pages could be created/adapted from the first page of the method sections in the generic version.

Once the method sections have been decided upon, unwanted sections can be removed. Since the electronic files have been set up for double-sided printing, these files will have to be altered carefully (see Annex 2).

The team will also need to remove the pages of unwanted methods in the **returning client** section. They may also need to adapt the contents page of this returning client section in order to update the page references.

In addition, the team may also want to remove reference to unwanted methods in other sections of the tool. References to various contraceptive methods are given in the following pages:

- Page ii (flow chart): reference to emergency contraception
- Page iv (example page): page taken from "The pill" section
- Page W2: reference to EC method tab
- Page CM1: reference to pills and injectables
- Page CM3: client side has pictures of many methods on it
- Page CM3: provider side picture, plus reference to methods in the text
- Page DP1: client side has pictures of many methods on it
- Page DP2: reference to IUD
- Pages SN2-SN7 (Special Needs): references to various methods throughout
- Appendix1: Client side includes picture of various methods
- Appendices 2, 3 and 7: Charts include information on all methods
- Appendix 10: Reference to various methods

## b) Adapting method types

Once the team has chosen the methods it wants to include, it can then adapt the method sections to be more specific as to the exact type or brand of contraceptives offered in their country. Depending on what commodities are available, this not only allows the correct name to be used, but also more specific illustrations can be used. Also, this may allow more concise guidance about the method in the tool.

***ECPs: levonorgestrel-only pills vs combined estrogen-progestogen pills***

- ***Current focus:*** Levonorgestrel-only pills (with some points included on combined estrogen-progestogen pills)
- ***Rationale:*** WHO recommends levonorgestrel-only pills due to evidence that they are more effective and cause less nausea than combined estrogen-progestogen ECPs.
- ***Possible adaptations:*** The country programme may want to consider the tool as an opportunity to introduce levonorgestrel-only pills, or it may prefer to adapt the tool and focus its guidance on combined pills if these are most commonly used. Alternatively, if only levonorgestrel pills are available, the adaptation team could remove the reference to combined pills currently on page EC2.
- ***Other adaptations:*** The team may also want to include guidance on use of the standard daily pill (COCs or POPs) as emergency pills, if this is usual practice in their country. Other emergency contraceptive methods could also be added, if available, such as mifepristone.

### *The IUD: Copper-bearing IUD vs Levonorgestrel-releasing IUD*

- ***Current focus:*** Copper-bearing IUDs.
- ***Rationale:*** This is the most commonly used IUD.
- ***Possible adaptations:*** If levonorgestrel-releasing (hormonal) IUDs are offered in the country programme, the team may want to add either a separate method section or else include additional information on the hormonal IUD in the current IUD section. It may be advisable to create a separate section on hormonal IUDs, as the generic descriptions of the method in the front decision-making section and in the appendices may no longer apply if they are combined. The Implementation CD-ROM contains a file prepared on the hormonal IUD.

  If the Copper T-380A is the standard IUD used in a country, then the team may want to clarify the language on the first page of the section about length of efficacy. "Depending on type" may be removed from both the client and provider sides.

### *The Pill (COCs): 28 pill pack vs 21 day pack*

- ***Current focus:*** Both 28 and 21 day packs.
- ***Possible adaptations:*** If only one type of pill pack is used, the team can remove references to the other type. This will simplify guidance on how to take pills and guidance on missed pills (pages P4 and P5). The team also could adapt the illustrations to make them more specific. If 24-pill packs, ultra low-dose pills, or triphasic pills are used, the team may want to adapt the tool accordingly.

### *Long-acting Injectables: DMPA vs NET-EN*

- ***Current focus:*** Both DMPA and NET-EN.
- ***Possible adaptations:*** The team may choose to be specific, depending on which type is available. This will allow more specific guidance on the return date on page LI5.

### *Implants: Norplant vs Jadelle vs Implanon*

- ***Current focus:*** Only Norplant implants
- ***Rationale:*** As of 2005, they were the most commonly available implants in developing countries.
- ***Possible adaptations:*** The team may need to adapt this section according to which type of implants are available. The Implementation CD-ROM contains files prepared on both Jadelle and Implanon implants. These implants have different guidance on removal dates (in both the method section, pages IM1, IM4 and IM6, and in the Returning Client section, page RC 12), as well as differing descriptions of side-effects in both the method section and the returning client section.

### *Vasectomy: Scapel vs No-scapel vasectomy*

- ***Current focus:*** Scapel vasectomy procedure, with incisions.
- ***Possible adaptations:*** If no-scapel vasectomy is the standard practice in the country, then page V4 could be adapted, with illustrations changed accordingly.

### *Vaginal methods: Diaphragm and/or spermicides; foam vs tablets vs film*

- ***Current focus:*** Information on spermicides and diaphragm; information on foam, tablets and film
- ***Possible adaptations:*** Can remove information on methods types not commonly available

***Fertility awareness-based methods: Standard Days Method vs others***

- ***Current focus:*** The Standard Days Method (SDM) (with "CycleBeads")
- ***Rationale:*** The SDM is an effective and easy-to-use fertility awareness-based method that requires minimal training in use. Use of most other effective fertility awareness-based methods requires significant training from specialized trainers. Use of the SDM is most often taught using CycleBeads: an aid in the form of a string of beads for clients to remember which day of the cycle they are on. These are currently being widely disseminated by the Institute of Reproductive Health at Georgetown University and through USAID (http://www.irh.org/).
- ***Possible adaptations:***
  - The team may determine that it wants to focus on the Standard Days Method. It may choose to do this through training providers on the use of the CycleBeads. If the CycleBeads are currently part of, or soon to be introduced into the national programme, no changes need to be made to the tool. The team may also choose to remove references to other FAB methods.
  - SDM can also be taught with a calendar alone. The section can then be adapted to remove reference to the CycleBeads.
  - Alternatively, the team may choose to focus on a different FAB method. In this case the chapter will need full adaptation.
  - The implementation CD-ROM contains a file prepared on the "TwoDay Method", a simple adaptation of the cervical mucous method.

## c) Local terminology

The first step in any implementation process will often be ***translation***. Some countries may be able to use the generic tool (at present available in English, French and Spanish). For others, the translation process will offer the first opportunity to adapt the tool to the local context. Even if many providers can understand a generic language versions, using local terms and language will make the tool significantly more comprehensible for both providers and clients.

Whether or not one of the generic tools is usable in a country, adaptation could involve substituting local terms for:

- methods
- side-effects
- biological terms
- health conditions, etc.

Countries and regions may have specific terms for many different words used in the tool.

In some cases, terms and words in the flipchart may also need to be *simplified*, depending on average education levels of both providers and clients. The tool has already been created using simple language, but the adaptation team must consider if the current language level used in the tool is suited to the provider and client populations (see box 4 for examples).

**Box 4: Language needing simplification?**

Will the average client or provider understand these words? Do other terms exist in your country?

- nausea
- menstrual cycle, menstrual bleeding, spotting, periods
- STIs
- the mini-pill, the pill, female sterilization, IUD, emergency contraception, long-acting injectables
- menopause
- migraine
- confidentiality, etc.

## d) Consistency with national standards and protocols

**Note about WHO recommendations:**

WHO guidance has been created based on the most complete available scientific evidence. The guidelines have been developed to allow access to safe and effective contraception for all women and men. They have been created to remove unnecessary medical barriers, such as unnecessary tests or follow-up visits, and to allow women and men to readily use family planning methods in a safe and effective manner. As such, programmes should have a valid rationale before adapting WHO technical recommendations.

The technical recommendations are available in WHO's *Medical Eligibility Criteria for Contraceptive Use* and *Selected Practice Recommendations for Contraceptive Use* (downloadable from the Implementation Guide CD-ROM).

The information on contraception and other reproductive health issues contained in the tool is *evidence-based guidance,* developed by WHO and other international health bodies. As such, the tool contains recommended evidence-based best practices which should be promoted in all countries.

After a review of the tool and comparison with national standards and guidelines, the team needs to review any differences between the current practices/standards and the WHO guidance. The team then must consider:

- *Is the national practice out of date? Should national practices be updated?*
  It is important for guidance in the tool to be consistent with national standards. Efforts should be made to update national standards or national guidelines if the programme wants to promote the evidence-based practices contained in the *Decision-Making Tool.*

- *Is the national practice more appropriate for and better adapted to the local context?*
  Some of the programmatic guidance contained in the tool consists of generic best practices that may not be suitable everywhere. For example, WHO does not require any routine follow-up for implant users, except if they have problems with side-effects or other concerns. In some settings, however, national programmes may require more frequent follow-up visits to monitor the reproductive health of the woman, both to check how she is progressing with her method and to combine with other regular reproductive health visits, such as pap smear tests.

- *Are WHO recommendations suited to the skills levels of providers and/or clients?*
  WHO recommendations on contraceptive use are made with developing country settings in mind. Guidance is designed to be as simple and easy-to-follow as possible. In some contexts, however, providers may not have the skill level necessary for accurate implementation of the guidance (see for example page P2, guidance on women with migraine headaches). In other contexts providers may be able to apply more clinical judgement in the provision of methods, or treatment of problems, and the tool may need to be adapted accordingly.

## e) Referrals

There are several referral issues that the team may need to consider:

- What are the **standard referral issues** or practices for providers in your country?
  Issues that routinely require referral are shown in box 5, together with the page number where they are mentioned in the tool.

- Are providers technically capable of dealing with **complications** in returning clients?

  If a client returns to the clinic with problems, the provider needs to assess this problem to see what further care may be required. In cases of serious problems, the provider may need to refer the client to the appropriate level of care. The adaptation team must assess the proficiency level of providers in dealing with such complications, and what the appropriate referral or treatment processes would be. This is particularly important in the following instances:

  - IUD, p RC 3: Guidance on PID, ectopic pregnancy, IUD expulsion, pregnancy with IUD.
  - Long-acting Injectables, p RC9: Very heavy bleeding and abnormal conditions.
  - Implants, p RC13: Very heavy bleeding treatments.
  - Vaginal methods, p RC18: possible urinary tract infections.

**Box 5: Suggestions for referral adaptations**

- ***STI/HIV diagnosis or treatment*** (p. DP2, SN6, SN7 and Appendix 8): A note could be added for referral to the appropriate service in your country (e.g. specialized STI services, hospital out-patient clinics, family doctors etc.), and for HIV Counselling and Testing services if available.
- ***Post-exposure prophylaxis*** (p. EC1, MC3 and FC3): Appropriate referral points can be added.
- ***Youth services*** (p. SN2): If youth-friendly services are available in your country, a note can be added here for providers to refer clients to these services.
- ***Post-abortion care*** (p. SN5): If provider suspects infection, referral to appropriate service can be added.
- ***Supporting women living with violence*** (Appendix 13): Appropriate referral points can be added.

## f) Clinical capacity

Different services have varying capacities to undertake clinical procedures and treatments. Depending on the intended users of the tool, the adaptation team may consider it necessary to make the tool more specific to the clinical context:

- **Clinical procedures:** The tool gives basic descriptions of IUD insertion (page IUD4), implant insertion and removal (page IM4), and provision of injections (pages LI5 and MI5). If the providers offer advanced clinical services, more technical information could be added to the tool if it would be helpful. For example:

  - If providers routinely conduct male or female sterilization procedures, additional information could be added to these sections.
  - STI treatment: If providers are trained to diagnose and treat STIs, additional information could be added.

- **Drugs:** Certain drugs may be prescribed for treatment of method-related side-effects or problems. Some drugs are mentioned in the tool (any such treatments recommended are evidence-based and taken from *Selected Practice Recommendations for Contraceptive Use,* WHO, 2nd edition 2005), but the team may wish to adapt these, add more treatments, or make them more specific:
  - Page RC 3 (IUD): medication to reduce bleeding
  - Pages RC 5, 7, 9, 11, 13 (all hormonal methods): medication for headaches
  - Page RC 13 (implants): medication to reduce bleeding; antibiotics for infection
  - Page RC 15 (sterilization and vasectomy): antibiotics for infection

- Page RC 18 (diaphragm): antibiotics for infection
- Page EC2 (emergency contraception): anti-nausea medicine

- **Pill supplies:** The tool contains the WHO recommendation that clients should be given a year's supply of pills (pages P6, MP5, RC4, RC5, RC6, RC7). However, the national programme may not have the capacity to give this many pills at one time. It may be necessary to give alternate guidance for supply of pill packets.

- **Follow-up:** The tool contains WHO recommendations on appropriate follow-up visits after initial method provision. If countries determine that more frequent follow-up procedures are necessary than those suggested in the tool, they may wish to adapt. They should bear in mind, however, that WHO has determined that the follow-up schedules described in the tool are medically appropriate and safe.
  - Pills: initial 3 month visit (page P7 and MP6), then yearly follow-up (see above).
  - IUD: Follow-up recommended 3-6 weeks after insertion (or after 1st menstrual period), with no additional visits required (no new visits mentioned on page RC2).
  - Implants: Come back after 4-7 years, depending on her weight (if no problems) (page IM6).

Section
4

# Possible adaptations

Having made basic adaptations to the tool, some countries may have the need and resources to adapt the tool even further to make it more acceptable within their services.

The following sections outline possible advanced adaptations to the tool.

## a) Appendices

The generic tool contains 13 appendices that give additional guidance on a variety of family planning and other reproductive health topics.

The adaptation team can review these appendices to assess how useful they would be for providers in their country. The team must also weigh the additional production costs of these extra pages against the benefit that providers may gain from them. Possible considerations:

- Providers may already be using other materials on some of the topics, such as "Facts about STIs/HIV/AIDS"; information on male and female reproductive systems and menstruation; promoting communication skills; guidance on violence against women; or other sexual and reproductive health topics. If so, such pages could be removed.

- The team can review the charts, or fieldtest them, to check that providers understand them. Appendices 2, 3 and 7 contain charts that may be complicated for some providers. It may also be important to check that clients understand diagrams and anatomical drawings (e.g., "The Menstrual Cycle" in Appendix 5).

- The adaptation team may feel it important to focus on other reproductive health issues. The sexual and reproductive health appendix (11a and 11b) gives a brief overview of several topics. The team may want to give more guidance on these topics, or on other issues. For example providers may routinely do pap smear tests, and more information may be needed.

Some appendices may also require adaptation within them. Specifically, the team may wish to adapt:

- *Facts about STIs/HIV/AIDS (Appendix 8):* The Appendix currently outlines general facts on STIs/HIV/AIDS. The team can choose to insert country-specific data and information instead, such as information on common STIs in the country, on HIV prevalence levels, on HIV testing and counselling services, on availability of anti-retroviral drugs, or on availability of PMTCT services.

- *Promoting communication between partners (Appendix 9):* This appendix includes suggested strategies for providers to help them counsel clients and suggested phrases to help clients communicate with partners better. The suggested strategies could be adapted to what would be appropriate or possible strategies in the country. The suggested phrases could be adapted to make them more realistic or colloquial. Ideally, they should be based on women's own experience within their culture.

- *Myths about contraception (Appendix 10):* The myths included in the generic version are common myths about contraception in many countries. The team can assess whether they are common in their country, or if there are other local myths that should be added.

  Also, the tool addresses some method-specific myths within each method section. If other method-specific myths exist, these could be either added to the appendix or addressed in the method sections.

- *Sexual and reproductive health tips (Appendix 11):* The section on infertility could be adapted to reflect the services available (the generic tool assumes that no infertility treatment services are widely available). The section on pap smears can be adapted to give guidance on how often women should be tested, if testing is available, and where they must go.

## b) Dual Protection

The team may need to assess this section to successfully promote its use among providers and clients. It is important for the team to consider the prevalence of STIs and HIV/AIDS as well as the cultural context within which the programme operates.

**Where STIs and HIV/AIDS are highly prevalent**, it may be important to expand the information given on this topic. The dual protection section could be expanded to give more detailed guidance on STI risk assessment. It may also be important to give more counselling about protective behaviours, in particular issues related to condom use and/or negotiation. Appendix 9 includes some information on partner communication: this could be incorporated into an expanded dual protection section.

Further information may also be needed on HIV testing, counselling and treatment in high prevalence areas/countries, especially if the family planning provider can offer these services too. More information on the contraceptive options for HIV-positive women could be added to the Special Needs section (pages SN6 and SN7).

***Note:*** WHO recommends that dual protection remain as a separate section at the front of the flipchart, for this highlights its importance as a key topic of discussion and decision-making.

## c) Special Needs

The adaptation team will need to assess the family planning clientele in their country to decide which "special clients" they need to keep or add. At present, the tool addresses the needs of:

- Younger clients
- Older clients
- Post-partum clients
- Post-abortion clients
- Clients living with HIV/AIDS
- Clients who want to become pregnant

It may be that these clients are served by other specialist clinics (youth clinics, maternal health clinics, STI/HIV clinics etc.); or that such services are not available (e.g. post-abortion services). There may also be other pages that could be added, e.g., clients with disabilities.

## d) Legal issues

Some countries may have laws and policies that would necessitate adaptations in the decision-making tool.

- **Abortion/Termination of pregnancy**: If this service is legal and routinely available in family planning clinics, the tool could be adapted to include a special section on abortion services. The page in the Special Needs section on post-abortion family planning services could be moved to this section.

- **Informed Consent:** Clients should give their informed consent before undergoing sterilization or vasectomy. The appropriate national or programme-specific informed consent procedures could be added to the tool as a reminder and help for providers.

## e) Illustrations

The current illustrations are generic. They have proved to be understandable in fieldtests with providers and clients in parts of Africa, Asia, Latin America and the Caribbean. Still, it may be important to fieldtest illustrations locally for comprehensibility and acceptability. Countries may want to insert region- or country-specific illustrations to make them more acceptable and recognizable to clients.

Other illustrations that may need to be adapted are those that show the "nurse" to represent the provider. This picture may not be appropriate in some settings and if so may be off-putting to either the clients or the providers.

The team may also want to consider whether the tool's counselling icons are appropriate to the local context. Locally designed icons may better represent the intended counselling concepts.

If the team plans to alter any of the existing drawings, they are available electronically on the Implementation CD-ROM.

## f) Adapting to different service delivery settings

The tool has been designed for use in clinical settings by primary or secondary level providers. It has also been designed for literate or semi-literate clients. Adapting to different users may require significant alterations to the tool:

- ***For use in community-based distribution:*** Technical information on clinical methods (IUD, implants, sterilization, vasectomy) can be simplified or removed. Still, it may be important to include basic information about these methods to help the client choose and to inform them of all their options. Language may need further simplification, depending on the skills levels of providers.

- ***For use by group counsellors:*** The tool is currently designed for the single client (and her/his partner). Its structure would need to be changed for use in group counselling sessions, though much of the information would still be important. For example, the following aspects could be adapted:
  - *Make the tool bigger:* Both the page size and text size could be enlarged.

- *Removing the provider sides:* To give a brief overview of the methods, it may be enough for the group counsellor to use just the client sides. This may save printing costs.
- *Remove the returning client section*
- *Remove the sort page:* "How can I help you today?"
- *Removing method provision information:* Some technical information could be removed, including medical eligibility criteria (page 2 of each method), details on how to use the method, when to start, and what to remember (this would be more appropriately provided in a one-on-one meeting with a provider). Or, to simplify further, only the front pages of each method section could be used. These give an overview of the method.
- *Direct questions:* Some of the language may be adapted so that it is more applicable to groups, for example in the front section, instead of "Do you have a method in mind?", it may be more appropriate to say "If you have a method in mind…", or "If you don't have a method in mind…" .

- ***For use by physicians/doctors:*** The tool is designed for primary and secondary health care workers. Programmes may wish to adapt it for use by higher level doctors to help with counselling. To make the tool more acceptable, the language level on the provider's side could be adapted so that more technical terms are used. More clinical guidance could also be given about procedures, such as sterilization or post-partum IUD insertion, and management of side-effects or complications.

- ***For use with illiterate clients:*** If most clients are illiterate, it may be appropriate to reduce, or remove completely, the text on the client sides. It must be considered, however, that the providers often like to use the client side *together* with the client, and so it may be useful to keep some of the text and train providers to explain its meaning carefully to clients. Pilot testing will help guide the approach.

- ***For use in youth clinics:*** All the technical information contained in the tool can apply to younger clients. However, the way the information is transmitted may be adapted for a younger audience to make the tool more attractive. For examples, illustrations could be adapted so that they portray younger clients. The style of drawings may also need to be adapted. Counselling messages could also be adapted for younger clients, including:
  - *Counselling on dual protection:* More emphasis could be put on the importance of delaying sexual debut and emphasising condom use. Also, greater explanation of "other forms of intimacy'" may be helpful.
  - *Counselling on basic biology:* At present, the tool contains three appendices related to reproductive biology. It may be helpful to develop a special counselling section on these topics, discussing them in more detail. Also, more information could be added on pregnancy, including the risks and signs of pregnancy.
  - *Counselling on permanent methods:* The fact that younger people are more likely to regret sterilization or vasectomy could be emphasized in these sections.

- ***For use in pharmacies:*** The tool could be adapted as for community-based distribution section to remove the detail in clinical method sections (while still providing basic information on methods that are available in clinical services).

## g) Combining with existing checklists

Some programmes may already provide certain family planning checklists for providers. This may mean that some of the technical content of the tool could be removed. For example, often programmes will provide history forms for providers to assess medical eligibility criteria. These pages (usually page 2 of each method section) could then be removed from the tool, and a reference added to refer providers to consult these forms instead.

## h) Production issues

- ***Graphic design and colours:*** Various adaptations of the graphic design are possible:
  - If method sections are removed during adaptation, this may alter the current colour scheme. Method sections currently alternate in four colours, to ensure that different sections are easily found.
  - The adaptation team could also make the book a two-colour product which would reduce printing costs (although this would detract from the utility of the colour-coded tabs). As an alternative, it may also be possible to print the different sections on different coloured paper.
  - The current colour scheme and design may be changed if countries have their own existing graphic designs and colours that are specific to their family planning programme. This would help make the tool consistent with existing communication materials.

- ***Section order:*** The adaptation team may decide that the current order of sections within the tool is not as helpful as it could be. Specifically they could:
  - Reorder the method sections, according to most used methods
  - Move the Special Needs section from the front, and include this information as an appendix.

- ***Page numbering:*** Pages in the generic tool are numbered section-by-section, to facilitate section removal and other adaptations (see box 6). Once a country has determined which methods to keep in the tool, the team may prefer a continuous page numbering system, but they should consider whether more method sections might be added later.

- ***Removable pages:*** The generic tool has been designed as a complete and finished manual, which may be reprinted as guidance is up-dated. The current binding allows users to insert and remove pages easily, for example to adapt to changes in recommendations. This feature could also be useful for country programmes. Nonetheless, countries may wish to consider different binding systems.

- ***Accompanying materials:*** The team may determine that certain accompanying materials may add value to the tool and be helpful for clients, including:
  - *"Take-home pages" for clients:* Take-home materials help clients remember the essential information they need. An easy adaptation would be to make copies of all the "What to remember" pages in each method section (last page of each section). These pages give some basic information, but they also be adapted to include more detailed information. It may also be helpful to copy some other key pages, in particular the "What to do if you miss pills" page in the pill section.
  - *Posters:* Accompanying posters could reinforce messages from the tool, for example posters with basic information on each method (possible adaptation of JHU/CCP's *"Do you know your family planning choices?"* poster, available on the Implementation CD-ROM); posters encouraging clients to share information with providers and ask questions; posters outlining

**Box 6: Current page numbering System**

**W:** Welcome
**CM:** Choosing Method
**DP:** Dual Protection
**SN:** Special Needs
**RC:** Returning Client
**EC:** Emergency Contraception
**IUD:** IUD
**P:** The Pill
**MP:** Mini-pill
**LI:** Long-acting Injectable
**MI:** Monthly Injectable
**IM:** Implants
**V:** Vasectomy
**S:** Sterilization
**MC:** Male condom
**FC:** Female Condom
**VM:** Vaginal Methods
**L:** LAM
**FA:** Fertility awareness-based methods
**AP:** Appendices

clients' rights during a family planning visit; or posters displaying dual protection messages. The style could be designed to match the tool, to help with continuity of messages.

## i) Training additions

The introductory pages of the tool (p. i-iv) give a brief overview and instructions on how to use it. If training capacities in the programme are limited, the team may wish to add more instructional content to teach providers more thoroughly how to use the tool.

## j) Harmonizing the tool with other health strategies

Country programmes may have certain health messages or campaigns that could be easily incorporated into the tool. It is important that the tool does not operate on its own, but that it links to and is supported by other programme materials.

Such programme messages could be related to family planning and reproductive health, for example by adding national quality assurance logos to the tool. Or they could be broader health promotion messages; for example linking to infection prevention campaigns.

# Annex 1: Fieldtesting and Evaluation Results

Fieldtesting of the *Decision-Making Tool* was conducted in five countries by a team from Johns Hopkins University/Center for Communication Programs and WHO, in partnership with several organizations working to support family planning programmes in these countries. Fieldtesting was conducted in two stages which are outlined below. The draft tool was revised based on the fieldtesting results and on the recommendations of providers, clients and family planning experts in the countries.

**Phase 1: Provider Feedback**

Focus group workshops were held in three countries:

- South Africa: in collaboration with Reproductive Health Research Unit, Durban.
- Trinidad and Tobago: in collaboration with the Family Planning Association of Trinidad and Tobago and the Western Hemisphere Regional Office of the International Planned Parenthood Federation.
- Indonesia: in collaboration with the STARH Program of Johns Hopkins Bloomberg School of Public Health.

The aims of the workshop were to:

1) obtain provider's recommendations on making the tool more usable, understandable and readable;
2) obtain provider's suggestions on what should be included in a package of tools and materials for clients and providers;
3) discuss how the tool could be implemented and used in each country.

Each workshop lasted three days, attended by 10 to15 family planning providers. The providers were mainly working in primary health care facilities or family planning clinics. In Indonesia, the tool was translated into bahasa Indonesia. After a brief introduction to the tool, and on counselling and communication in family planning, providers were given exercises to become familiar with the tool. They were then asked for feedback in focus group discussion sessions, and also through an interactive group work exercise, in which they were asked to "redesign" the tool in the way that was best suited to their needs. They were also given a questionnaire for their anonymous feedback. A discussion was also held on how the tool could be successfully introduced into national programmes in each country.

**Phase 2: Observational Research**

Observational studies were conducted in three countries:

- Indonesia (2nd visit): in collaboration with the STARH Program.
- Mexico: in collaboration with the Population Council.
- Nicaragua: in collaboration with the Centro para Programas de Comunicación, Family Health International and Institute for Reproductive Health of Georgetown University.

In the second phase of fieldtesting, researchers at Johns Hopkins University/Center for Communication Programs, in collaboration with partners, conducted observational studies to guage the usability and acceptability of the tool with family planning providers and clients. For Mexico and Nicaragua the tool was translated into Spanish, and the bahasa Indonesia version was used as in Phase 1. The studies used an innovative methodology to videotape providers and clients during counselling in order to monitor and analyse their communication. Providers in the three study sites included primary-level midwives and family planning providers, as well as physicians and hospital-based nurses.

After collection of baseline data (videotaped family planning counselling sessions and client exit interviews), the intervention included:

- a short training course for providers (2.5 days) to introduce the tool and the basic concepts of counselling and communication in family planning, and to teach participants how to use the tool;

- use of the tool by the providers in family planning counselling sessions for either 1 month (Mexico and Indonesia) or 4 months (Nicaragua);
- a follow-up visit by a supervisor to support providers in using the tool (except in Nicaragua);

The providers were then videotaped again at the end of the intervention period, and further client exit interviews were collected. Each provider was videotaped with about 8 clients, that is, 4 clients per round of data collection. Ideally, each set of 4 clients taped included one new client with a contraceptive method in mind, one new client without a method in mind, one returning client with a problem, and one returning client without a problem. After the videotapes had been collected and transcribed, providers were invited to a meeting for focus group discussions and in-depth interviews (where they were shown their video tapes and asked detailed questions on their use of the tool). They also were asked to fill in a questionnaire anonymously. Some clients were visited for further in-depth interviews to learn more about their experiences with the *Decision-Making Tool* and to obtain suggestions for improvement.

Overall, the assessment focused on the following areas:

- the comprehensibility, usability, and acceptability of the tool among providers and clients
- how the tool facilitates or hinders the family planning counseling process
- how the tool can help clients make appropriate decisions in choosing a method and/or to solve problems concerning family planning
- how providers integrate the tool into their daily work
- changes needed to increase the impact of the tool on the decision-making process and client-provider communication.

In addition to the qualitative data collected through the focus group discussions, interviews and questionnaire, quantitative data were captured through coding and analysis of the videotaped counselling sessions. The videotapes were coded for client-provider communication and eye contact, and decision-making behaviors were rated. The results of this analysis from the Mexico study have been published in *International Family Planning Perspectives (*Kim YM et al., Promoting informed choice: evaluating a decision-making tool for family planning clients and providers, *International Family Planning Perspectives,* 2005, 31(4):162–171), and the paper is downloadable on the Implementation CD-ROM.

**Summary of results from Phase 1 and 2**

- **Overall positive reaction to the tool:** In all countries visited, both providers and clients reacted very positively to the tool. Among providers, this included doctors, nurses, counsellors, midwives and psychologists. They felt it was an excellent job aid and would support them in their work. They suggested few substantive changes but instead had suggestions on design and production. Clients also appreciated the tool and the improved counselling that they felt they received.

- **"Practice makes perfect":** Most of the providers considered it very important to have sufficient practice with the tool before using it with clients. Providers also felt that using the tool became easier over time, as they became familiar with its content. Many providers felt that supportive follow-up was helpful to encourage use of the tool.

- **Improvements in client participation and satisfaction:** The tool helped engage clients in the counselling and decision-making process. Clients participated more in the counselling sessions and asked more questions. They reported greater satisfaction with the services and found the information they were being given more credible and trustworthy since it was shown on the tool. However, analysis of the videotapes showed that client participation could still improve further, in particular when confirming the choice of a method.

- **Provision of more structured and complete information by providers:** Providers gave more complete information on methods when using the tool, including discussions of side-effects and explanations of how to use the method. Using the tool also helped providers to give more structured information. Providers appreciated the classification according to "types" of clients (new clients, returning clients, special needs, etc.), since this was helpful to them in structuring the counselling session.

- **Greater promotion of dual protection:** The studies found that discussions of dual protection increased significantly with the tool. All providers felt the tool was helpful in raising this sensitive subject. However, providers did not often

use the tool to help clients assess their risk, and very few checked if clients were going to be able to use condoms consistently and correctly if the client selected them.

- **Not focusing on clients with a method in mind:** When clients had a method in mind, providers still did not focus in on this method, but instead often tried to inform clients of all the other available methods. They rarely used the "method in mind" tab (part of the fieldtest draft of the tool) to help check if a pre-selected method was appropriate. The tool was revised to address this problem (see below).

- **Problems narrowing down choices:** For new clients with no method in mind, the providers were not efficiently narrowing down choices. They often continued to explain about all available methods, rather than focusing in on the clients' needs and situation. The tool was revised to address this problem (see below).

- **Appendices and special needs sections used infrequently, but providers requested more:** Although the observational studies showed that providers were rarely using the special needs section and appendices (especially in Mexico), provider said that they liked these sections and wanted more information in them. In particular, many providers asked for more information on other sexual and reproductive health topics.

- **Returning client pages incorrectly used:** In the first fieldtest draft the returning client pages were placed as the last page of each method section. Providers were failing to use these pages with returning clients and instead were using them with new clients. The tool was revised to address this problem (see below).

- **Improvements in providers' interpersonal communication and counselling skills:** Providers perceived, and the researchers observed, improvements in their counselling skills. Providers were more attentive to their clients and felt more confident, especially in Indonesia. Providers asked their clients to participate more and checked their understanding more. They offered more emotional support and more frequently discussed their clients' feelings.

- **Providers keen to have the tool disseminated in programmes:** All providers felt keen that the tool should be disseminated fully in their programmes. Some providers had even started training others in its use.

- **Length of counselling sessions increased, but so did quality:** The average length of counselling sessions increased with use of the tool. For example, in Mexico average counselling sessions increased by 6 minutes (from 5 to 11 minutes), and in Indonesia by 9 minutes (from 6 to 15 minutes). Some providers felt that this may make use of the tool harder to accommodate within their programmes, indicating a need to plan a systematic introduction of the tool to give more time to counselling. They agreed that more time for counselling would be a positive development and would lead to higher quality of care.

**Client:** ***"It reassured me that the method I am using is safe."***

**Client:** ***"You have to follow using the flipchart, its really helpful, because sometimes I go in nervous, and it relaxes me to see it, the explanations and diagrams."***

**Provider:** ***"The flipchart brought a positive change…Now my clients are making the decisions instead of me."***

**Provider:** ***"I think this is an excellent job aid. Everybody should know it and use it."***

**Provider:** ***"The flipchart is an important support for family planning counselling. Users leave satisfied and so do providers."***

## Revisions

Based on these fieldtesting results, changes were made to the tool to make it more usable and effective. The following is a brief summary of these revisions:

- **Illustrations added:** Many more pictures were added throughout the tool

- **Returning client section revised:** This section was fully revised, with all advice for returning clients brought up into the front section (and removed from method sections). Information for returning clients was made specific for each method.

- **Revised decision-making process:** The original "method in mind" and "no method in mind tabs" were combined into one "choosing method" section. The method information page (displaying all available methods) was moved back so as not to encourage providers to discuss all methods at the beginning of a counselling session. Instead, they are now encouraged to draw out clients' needs first.

- **Revised dual protection:** The dual protection section was revised to include a new page to encourage clients to consider their own risk. This page also now includes information on STI symptoms that were previously included as an appendix.

- **New appendices:** More guidance on sexual and reproductive health has been added to the appendices, including information on violence, and more sexual and reproductive health tips, including information on infertility. More counselling tips and hints were added.

- **Revised introduction:** The introductory pages of the tool were revised, and a new 'flow chart' was added to provide an overview of the flow processes and sections of the tool.

- **More decision-making tips:** More tips and hints to encourage shared decision-making were added, particularly through the use of the "decision-making icon".

# Annex 2: Working with the electronic files of the Decision-Making Tool

### Using the files

- The tool has been designed in Microsoft PowerPoint to make it easy to translate and adapt. There are 21 separate PowerPoint files containing the different sections.
- Each page of the flipchart consists of a CLIENT SIDE and the corresponding PROVIDER SIDE. The provider's side repeats the text from the client side, plus it offers reference information, suggested steps, and helpful wording for counselling. See p. iv of the introduction for standard features of the provider's pages. In the electronic files the client's side and the provider's side alternate. The client's side usually has pictures. The provider's side usually does not have pictures.

### Printing instructions

- You can print the tool from the PowerPoint files.
- The *Decision-Making Tool* is a FLIPCHART, with two sides to each page. To make your own tool correctly (double-sided/recto-verso), you must use a printer that is set for 2-sided printing AND select SHORT-EDGE binding. Then bind the flipchart across the tops of the pages.
- Each PowerPoint file is linked to the previous and next sections through its first and last pages. Each section starts with the PROVIDER's side and finishes with the first CLIENT's page of the *following* section. This is not a mistake; it permits you to print the entire *Decision-Making Tool* easily.

### Removing or adding sections of the tool

- Since the tool is set up to print correctly, the first client-side page of each section is positioned in the previous electronic file. This means that if you decide to remove method sections for an adaptation, you must switch in the correct last page in each electronic file to be the first client page from the section that will follow.

### Tips on mass-production of an adapted Decision-Making Tool

- The English-language generic tool was printed by converting the PowerPoint files into PDF files. The printers may require the original illustration files to convert the files (available on the Implementation CD-ROM).
- For mass production some printers may insist that the PowerPoint files be converted into a graphic design programme.
- In the PowerPoint files pages intended to have tabs have a box showing the tab mark. Once tabs have been made, or individual tab pages designed at the printers, you can remove these boxes that indicate the tab placement.
- The credits pages and the introductory pages are pages that are designed for the provider only. For printing the generic version of the tool, the first three client-side pages (inside front cover, page i, and page iii) were all rotated so that the provider can read them with the pages laid flat.

**For advice on printing, please contact the INFO Project at** orders@jhuccp.org.

# Annex 3: Printing specifications of the generic tool

The printing specifications of the generic tool are shown below. The tool can be produced in other ways, according to the needs and resources of the country, but these specifications will serve as a guide.

| | |
|---|---|
| 1. Number of Pages: | 244 |
| 2. Size of pages/paper: | 8.5 inches x 11 (204 pages) (normal pages)<br>9 x 11(28 pages) (pages tabbed at bottom)<br>8.5 x 11.5 (12 pages) (pages tabbed at side) |
| 3. Thickness of Paper: | 130 GSM (204 pages), Matt finish<br>220 GSM (28 pages), Matt<br>220 GSM (12 pages), Matt |
| 4. No. of colours: | 4 colour |
| 5. Binding/packing: | 20 oz mill board x 2 pieces on top & bottom, die cut for index, Die making, Punching 3 holes with drill, gathering, shrink wrap etc. |

***Specifications for the Binder***

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|---|---|
| 1. Measurement: | Height – 12.64 inches<br>Width – 10.70 inches<br>Spine width – 2.20 inches |
| 2. Color: | Pantone 2945C |
| 3. Ring: | one and a half inch |
| 4. Printing on Binder: | Matter to be printed / silk screened on the front, back and spine of the binder. |
| 5. Thickness of Binder sheet: | 2.5 mm |

# Annex 4: Evidence-based practices

**Evidence-based practices on contraceptive use**

The ***technical guidance*** on contraceptive use in the *Decision-Making Tool* is derived primarily from the following key evidence-based guidelines:

> *Medical Eligibility Criteria for Contraceptive Use, 3rd edition.* 2005. World Health Organization.
>
> *Selected Practice Recommendations for Contraceptive Use, 2nd edition.* 2005. World Health Organization.
>
> *Essentials of Contraceptive Technology.* 1997. Johns Hopkins Bloomberg School of Public Health, Population Information Program, 1997. Fifth Printing 2005.
>
> And its successor *Family Planning: A Global Handbook for Providers.* 2007. World Health Organization and Johns Hopkins Bloomberg School of Public Health.

(All these materials are downloadable from the Implementation Guide CD-ROM.)

In addition, further information on specific topics was derived from the following references:

> *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines, 2nd edition.* 2004. International Consortium for Emergency Contraception.
>
> *Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice.* 2003. World Health Organization.
>
> *Sexually transmitted and other reproductive tract infections - A guide to essential practice.* 2005. World Health Organization.
>
> *Standard Days Method of Family Planning: Reference Guide for Counseling Clients.* 2002. Institute for Reproductive Health. Georgetown University.
>
> *Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services, 3rd edition.* 2004. International Planned Parenthood Federation.
>
> *Post-abortion Family Planning: a Practical Guide for Programme Managers*. 1997. World Health Organization.
>
> *HIV in Pregnancy: A Review.* 1999. World Health Organization.

**Best practices in family planning counselling and communication**

The *Decision-Making Tool* incorporates many best practices in family planning counselling and communication. These practices, together with a selection of key references, are listed in the following table.

| Best Practice | Key References |
|---|---|
| Providers should be respectful and responsive to the needs of the client, for example:<br>o assures privacy and confidentiality;<br>o listens and responds to the client's needs and concerns, including responding to rumours;<br>o uses a friendly tone of voice and attentive body language. | • Koenig MA, Hossain MB, Whittaker M. The influence of quality of care upon contraceptive use in rural Bangladesh. *Studies in Family Planning.* 1997, 28(4):278–89.<br>• Morris N. Respect: its meaning and measurement as an element of patient care. *Journal of Public Health Policy,* 1997, 18(2):133–54.<br>• Schuler SR, Bates LM, Islam MK. The persistence of a service delivery 'culture': findings from a qualitative study in Bangladesh. *International Family Planning Perspectives*, 2001, 27(4):194–200 |
| Providers must engage clients in active participation during counselling, for example:<br>o encourages client to ask questions;<br>o checks client's understanding;<br>o encourages client to tell their story;<br>o solicits information and asks what information the client wants to know. | • Brown LD et al. *Improving Patient-Provider Communication: Implications.* 1995. Bethesda. University Research Corporation.<br>• Kim et al. Client participation and provider communication in family planning counseling: transcript analysis in Kenya. *Health Communication,* 1999, 11(1):1–19.<br>• Kim YM et al. Client communication behaviors with health care providers in Indonesia. *Patient Education and Counseling,* 2001, 45: 59–68.<br>• Kim YM et al. Increasing patient participation in reproductive health consultations: an evaluation of "Smart Patient" coaching in Indonesia. *Patient Education and Counseling,* 2002, 50:113–122.<br>• Nathanson CA, Becker MH. The influence of client-provider relationships on teenage women's subsequent use of contraception. *American Journal of Public Health,* 1985, 75(1): 33–38.<br>• Roter D and Hall J. *Doctors Talking with Patients, Patients Talking with Doctors: Improving Communication in Medical Visits.* 1992. Westport. |
| Clients must be engaged in the counselling process, for example:<br>o tells providers of their personal circumstances;<br>o asks questions and elicits information;<br>o expresses concerns and fears;<br>o asks for instructions and help to carry out their decision | • Kim YM, Kols A, Mucheke S. Informed choice and decision-making in family planning counseling in Kenya. *International Family Planning Perspectives,* 1998, 30(1):4–11&42.<br>• Kim YM et al. Increasing patient participation in reproductive health consultations: an evaluation of "Smart Patient" coaching in Indonesia. *Patient Education and Counseling,* 2002, 50:113–122. |
| Providers promote shared decision-making, for example:<br>o advises client on the options and supports her/him to make a decision;<br>o promotes a organized decision-making process; | • Elwyn G, Edwards A, Kinnersley P. Shared decision-making in primary care: the neglected second half of the consultation. In *Shared Decision Making. Patient Involvement in Clinical Practice,* 2001, Nijmegen, WOK.<br>• EngenderHealth. *Choices in Family Planning: Informed and Voluntary Decision Making,* 2003. |

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| ○ encourages client to state her/his choice aloud;<br>○ recaps discussions and the client's decision(s);<br>○ helps clients plan how to carry out a decision. | • Gwyn R, Elwyn G. When is a shared decision not (quite) a shared decision? Negotiating preferences in a general practice encounter. *Social Science and Medicine,* 1999, 49(4):437–47.<br>• Ivey AE, Bradford Ivey M. *Intentional Interviewing and Counseling: Facilitating client Development in a Multicultural Society.* 1999. Pacific Grove: Brooks/Cole Pub.<br>• Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. *British Medical Journal.* 1999, 319:766–771. |
| Clients should receive their chosen "method in mind" when possible. | • Huezo C, Malhotra U. *Choice and user-continuation of methods of contraception: a multicentre study.* 1993. London: International Planned Parenthood Federation.<br>• Pariani S et al. Does contraceptive choice make a difference to contraceptive use? Evidence from East Java. *Studies in Family Planning,* 1991, 22(6):384–390. |
| Providers use best practices in information-giving, for example:<br>○ information is tailored to the needs and situation of the client;<br>○ information given is well-structured and concise;<br>○ providers assist clients to make a decision from a range of different methods. | • Bertakis K. The communication of information from physician to patient: a method for increasing patient retention and satisfaction. *Journal of Family Practice,* 1977, 32(2):175–81.<br>• Delbanco TL, Daley J. Through the patient's eyes: strategies toward more successful contraception. *Obstetrics and Gynecology,* 1996, 88(3 Suppl): 41S–47S.<br>• Huezo C, Malhotra U. *Choice and user-continuation of methods of contraception: a multicentre study.* 1993. London: International Planned Parenthood Federation.<br>• Kim YM, Kols A, Mucheke S. Informed choice and decision-making in family planning counseling in Kenya. *International Family Planning Perspectives,* 1998, 30(1):4–11&42.<br>• Leon FR et al. Length of counselling sessions and amount of relevant information exchanged: a study in Peruvian clinics. *International Family Planning Perspectives, 2001,* 27(1):28–33&46.<br>• Ley P. Satisfaction, compliance and communication. *British Journal of Clinical Psychology,* 1982, 21: 241–254.<br>• Soliman MH. Impact of antenatal counselling on couples' knowledge and practice of contraception in Mansoura, Egypt. *Eastern Mediterranean Health Journal,* 1999, 5(5): 1002–1013. |
| Counselling on dual protection from pregnancy and STIs/HIV/AIDS should be integrated into standard family planning counselling. | • Adeokun L; Mantell JE; Weiss E; Delano GE; Jagha T. Promoting dual protection in family planning clinics in Ibadan, Nigeria. *International Family Planning Perspectives,* 2002, 28(2):87–95.<br>• Cates, W. The "ABC to Z" Approach: Condoms are one element in a comprehensive approach to HIV/STI prevention. *Network*, 2003, 22(4).<br>• Cates, W; Steiner, M. Dual protection against pregnancy and sexually transmitted infections: What is the best contraceptive approach? *Sexually Transmitted Diseases,* 2002, 29(3):168–74.<br>• *Sexual and Reproductive Health of Women Living with HIV: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.* WHO and UNFPA, 2005 (forthcoming). |

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| Providers should counsel clients on possible side-effects and should address any problems with side-effects among returning clients. | • Ali M, Cleland J. Contraceptive discontinuation in six developing countries: a cause-specific analysis. *International Family Planning Perspectives*, 1995, 21(3):92–97.<br>• Cotton N et al. Early discontinuation of contraceptive use in Niger and the Gambia. *International Family Planning Perspectives,* 1992, 18(4):145–149.<br>• Lei Z et al. Effect of pretreatment counseling on discontinuation rates in Chinese women given depo-medroxyprogesterone acetate for contraception. *Contraception*, 1996, 53(6): 357–361.<br>• Rutenberg N, Watkins SC. The buzz outside the clinics: conversations and contraception in Nyanza province, Kenya. *Studies in Family Planning,* 1997, 28(4): 290–307. |
| Providers support switching methods if the client desires to. | • Ali M, Cleland J. Contraceptive discontinuation in six developing countries: a cause-specific analysis. *International Family Planning Perspectives*, 1995, 21(3):92–97.<br>• Grady WR, John OG, Klepinger B. Contraceptive Method Switching in the United States. *Perspectives on Sexual and Reproductive Health,* 2002, 34(3):135–145. |
| Providers and clients can use decision-making aids to promote client-centred care and informed decision-making. | • Edwards A, Elwyn G. The potential benefits of decision aids in clinical medicine. *Journal of the American Medical Association,* 1999, 282(8):779–280.<br>• McBride CM et al. A tailored intervention to aid decision-making about hormone replacement therapy. *American Journal of Public Health,* 2002, 92(7):1112–1114. |
| General references on client-provider interaction | • Abdel-Tawab N, Roter D. The relevance of client-centered communication to family planning settings in developing countries: Lessons from the Egyptian experience. *Social Science and Medicine,* 2002, 54(9):1357-1368.<br>• Gask L, Usherwood T. ABC of psychological medicine: The consultation. *British Medical Journal,* 2002, 324;1567-1569.<br>• Jennings V et al. Analyzing the organizational context for a positive client-provider interaction : a leadership challenge for reproductive health. *MAQ Papers,* 2000, 1(1). [http://www.maqweb.org/maqdoc/index.htm].<br>• Lipkin M Jr. Physician-patient interaction in reproductive counseling. *Obstetrics and Gynecology,* 1996, 88(3 Suppl):31S-40S.<br>• Murphy E, Steele C. Client-provider interactions in family planning services: guidance from research and program experience. *MAQ Papers,* 2000, 1(2). [http://www.maqweb.org/maqdoc/vol2.pdf]<br>• PATH. Improving interactions with clients: a key to high-quality services. *Outlook,* 1999, 17(2). [http://www.path.org/files/eol17_2.pdf]<br>• Rinehart W, Rudy S, Drennan M. GATHER guide to counseling. *Population Reports,* 1998, Series J(48). [http://www.infoforhealth.org/pr/j48edsum.shtml].<br>• Rudy S et al. Improving client-provider Interaction. *Population Reports,* 2003, Series Q(1). [http://www.infoforhealth.org/pr/q01/index.shtml] |

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| General references on patient-centred care | • Gerteis M et al. (eds). *Through the patient's eyes: understanding and promoting patient-centered care,* 1993. San Francisco: Jossey-Bass.<br>• *Preparing a health care workforce for the 21st century.* Geneva, World Health Organization, 2005.<br>• RamaRao S et al. The link between quality of care and contraceptive use. *International Family Planning Perspectives,* 2003, 28(2):76–83.<br>• Smith RC, Hoppe RB. The patient's story: integrating the patient- and physician-centered approaches to interviewing. *Annals of Internal Medicine,* 1991, 115(6):470–477.<br>• Stewart MA. Effective physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal,* 1995, 152(9):1423–33. |
| General references on informed choice | • Pariani S et al. Does contraceptive choice make a difference to contraceptive use? Evidence from East Java. *Studies in Family Planning,* 1991, 22(6):384–390.<br>• Upadhyay UD. Informed choice in family planning: Helping people decide. *Population Reports,* 2001, Series J(50). [http://www.infoforhealth.org/pr/j50edsum.shtml] |