New contraceptive eligibility checklists for provision of combined oral contraceptives and depot-medroxyprogesterone acetate in community-based programmes

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Community-based services (CBS) have long used checklists to determine eligibility for contraceptive method use, in particular for combined oral contraceptives (COCs) and the 3-month injectable contraceptive depot-medroxyprogesterone acetate (DMPA). As safety information changes, however, checklists can quickly become outdated. Inconsistent checklists and eligibility criteria often cause uneven access to contraceptives. In 1996, WHO produced updated eligibility criteria for the use of all contraceptive methods. Based on these criteria, new checklists for COCs and DMPA were developed. This article describes the new checklists and their development. Several rounds of expert review produced checklists that were correct, comprehensible and consistent with the eligibility requirements. Nevertheless, field-testing of the checklists revealed that approximately half (48%) of the respondents felt that one or more questions still needed greater comprehensibility. These findings indicated the need for a checklist guide.

In March 2000, WHO convened a meeting of experts to review the medical eligibility criteria for contraceptive use. The article reflects also the resulting updated checklist.

Keywords: community health services; contraceptives, oral, combined, contraindications; drug incompatibility; eligibility determination standards; guidelines; medroxyprogesterone 17-acetate, contraindications.

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Introduction

To expand family planning services outside the traditional setting of the clinic, many reproductive health care programmes have employed a system of community-based family planning services (CBS). These programmes identify women who can safely use hormonal methods of contraception. Among the most important tools used in these services are simple checklists. These checklists commonly contain questions in a "yes/no" format that identify conditions (such as breastfeeding or a history of stroke) which make clients unsuitable for hormonal contraception without medical evaluation. The use of checklists is especially important in remote areas where medically trained providers are not available. Community health workers who administer eligibility checklists are generally non-health care professionals who receive basic training in the provision of family planning services. The advantages of CBS systems include the reduction of possible social differences between provider and consumer and lower costs of contraceptive distribution compared to clinics and hospitals (*1*).

Throughout the world, checklists have been used to deliver combined oral contraceptives (COCs) and injectables such as depot-medroxyprogesterone acetate (DMPA) effectively and safely. However, problems may arise when community-based workers use outdated and inaccurate checklists. These may contain outdated eligibility criteria that do not reflect current information on the safety of different contraceptive methods, thus excluding an eligible woman from using the contraceptive of her choice, or permitting the use of a contraceptive method that is medically unsafe for her. To address this problem, we present the following new checklists to assess eligibility for COC and DMPA use through CBS programmes (see Fig. 1 and Fig. 2).

In the early 1990s, US family planning researchers documented that women in many countries were being denied contraceptives on the basis of outmoded eligibility criteria. Situation analyses showed major discrepancies between existing access and contraceptive needs in a number of developing countries (*2*). An inventory of family planning service delivery guidelines was therefore compiled (*3*) to document the pervasiveness of outmoded and inconsistent eligibility criteria at both

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Fig. 1. **Checklist for clients who want to initiate combined oral contraceptives (COCs) in community-based services (CBS)**

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

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

If the client answers NO to all the questions, she can use COCs, *but to find out when she can start, ask:*

11. How many days ago did you start your last menstrual period?

_____ days

If the client began her last menstrual period within the past 7 days, she can be given COCs now.

If the client started her last menstrual period more than 7 days ago, and if:

- **she has being using an effective method of contraception (including abstinence), give her COCs, instruct her to begin taking them now, and instruct her that she must use condoms and/or spermicides or abstinence for the next 7 days. Give her condoms and/or spermicides.**
- **she has not been using an effective method of contraception (including abstinence), give her COCs but instruct her to start using them on the first day or during the first 7 days of her next menstrual period. Give her condoms and/or spermicides to use in the meantime.**

national and international levels. As long as CBS programmes were basing service delivery decisions on outdated criteria, access to contraception and quality of service would be compromised.

Several international organizations sought to address this issue by initiating a global programme (Maximizing Access and Quality). This strategy was designed to improve access to higher quality contraceptive services. As part of this initiative, scientifically validated guidelines for provision of contraception that could be used by policy-makers and providers were prepared. USAID's Technical Guidance/ Competence Working Group (TG/CWG) assigned Family Health International the task of creating COC and DMPA checklists for use in the CBS programme.[a]

WHO convened family planning and reproductive health experts from around the world to review existing knowledge on the safety of contraceptive methods. This review produced the WHO document *Improving access to quality care in family planning: medical eligibility criteria for contraceptive use* (*4*).[b]

Four categories of eligibility for each contraceptive method are described:

Category 1 — conditions with no restriction on the use of the contraceptive method;

Category 2 — conditions where the advantages of the method generally outweigh the theoretical or proven risks;

Category 3 — conditions where the theoretical or proven risks usually outweigh the advantages;

Category 4 — conditions which present an unacceptable health risk if the contraceptive method is used.

The experts who created this classification scheme proposed that "where clinical judgement resources are limited", such as in community-based services, the four-category framework can be simplified into two categories. In such a situation, women in WHO categories 1 and 2 are eligible to use COC and DMPA methods of contraception and women in WHO categories 3 and 4 are not.

Methods and Results

Beginning with a mandate to develop new, updated checklists, we created a multi-tiered, iterative review process. This process solicited review from experts

[a] Checklists are generally not required for condoms or spermicides, which have no associated serious risks, nor are they required for Norplant or intrauterine devices, which require insertion by trained personnel.

[b] These criteria were established as a result of collaboration between WHO and a large number of international agencies active in the field of family planning.

Fig. 2. **Checklist for clients who want to initiate DMPA in community-based services (CBS)**

Please ask the client all these questions:	**Check the correct box:**	
1. Is your menstrual period late **and** do you think you could be pregnant now?	❑ Yes	❑ No
2. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?	❑ Yes	❑ No
3. Do you have diabetes (sugar in your blood)?	❑ Yes	❑ No
4. Do you have or have you had breast cancer?	❑ Yes	❑ No
5 Do you have a serious liver disease or jaundice (yellow skin or eyes)?	❑ Yes	❑ No
If the client answers YES to any of the above questions, *refer her to the clinic/physician,* and give her condoms and/or spermicides to use in the meantime. If the client answers NO to all the above questions, continue with the questions below.		
6. Do you have bleeding between menstrual periods which is **unusual** for you, or bleeding after intercourse (sex)?	❑ Yes	❑ No
(If the client answers YES, she can be given DMPA now, but *refer her to the clinic/physician for further evaluation of bleeding.* Continue with question 7.)		
If the client answers NO to all the questions, she can use DMPA, *but to find out when she can start, ask:*		
7. Are you currently breastfeeding?	❑ Yes	❑ No
If the client answers YES, go to question 8.		
If client answers NO, go to question 9.		
8. Is the baby less than 6 weeks old?	❑ Yes	❑ No
If client is breastfeeding a baby [*less than 6 weeks old*], instruct her to return for DMPA as soon as possible after baby is 6 weeks old.		
If client is breastfeeding a baby *6 weeks old or older and her menstrual periods have not returned*, she can be given DMPA now.		
If her menstrual periods *have returned*, go to question 9.		
9. How many days ago did you start your last menstrual period? _____ days		
If the client began her last menstrual period within the past 7 days, she can be given DMPA now.		
If the client started her last menstrual period more than 7 days ago, and if:		
• **she has been using an effective method of contraception (including abstinence), she can be given DMPA now, but instruct her that she must use condoms and/or spermicides or abstinence for the next 7 days. Give her condoms and/or spermicides.**		
• **she has not been using an effective method of contraception (including abstinence), she must wait until her next period to be given DMPA. Give her condoms and/or spermicides to use in the meantime.**		

from a variety of backgrounds including government, universities and family planning organizations, as well those who use the checklists (CBS workers, trainers, and clients). Our aim was to employ a broad consensus process to move us from the present to the future.

Evaluation of currently used checklists against eligibility criteria

Our starting point was the checklists already in use. Drafts of the WHO eligibility criteria were available in 1995 and the document was finalized in early 1996. During the summer of 1995, we collected checklists from 33 African, Asian and Latin American family planning programmes. We translated the checklists, evaluated how consistent the questions were with the current WHO eligibility criteria, and gathered this information into the *Checklist reference document*. This comparison revealed several differences. To assess these differences, we divided the checklist questions into the following categories.

- The question adequately reflected the WHO criteria.
- The checklist question was too general or vague. For example, in reference to migraines, several checklist questions asked: "Do you have severe headaches?" However, only headaches that are severe, recurrent and accompanied by focal neurological symptoms fall into category 4 — where the risk of use outweighs the benefit.
- The checklist question was not relevant. Several checklists asked the question, "Do you have seizures or convulsions or epilepsy?" Epilepsy is considered a category 1 condition with no restrictions on use.
- The checklist did not have an equivalent question related to a WHO category 3 or 4 condition.

Comparison of existing checklist questions and the current WHO eligibility criteria provided a measure of the suitability of existing questions to determine COC and DMPA eligibility in CBS programmes. It highlighted the need for a new and consistent set of questions based on the currently available safety information.

Table 1. **Checklist review process**

Draft	Date	To	What	Requested
1	September 1995	Small expert TG/CWG[a]	Draft 1, CRD,[b] background	Open comment Additional checklists
2	November 1995	Full expert TG/CWG	Draft 2, CRD, explanation	Structured comment
3	February 1996	Full expert TG/CWG	Draft 3, Checklist Guide 1, explanations, thanks, explanations of why comments not addressed in Drafts	Comments on Checklist Guide 1 and Draft 3
4	May 1996	Full expert TG/CWG	Draft 4, Checklist Guide 2	Bring comments to in-person meeting
	May 1996	Meeting of TG/CWG in subgroups	Draft 4, Checklist Guide 2	Comments for small group discussion; and review discussion
5	June 1996 Fall 1996	TG/CWG leadership Field-test sites	Draft 5, Checklist Guide 3 Draft 5, Checklist Guide 3	Final approval Comments on all material

[a] TG/CWG = USAID Technical Guidance/Competence Working Group.

[b] CRD = Checklist Reference Document.

Checklist development, review and revision

Staff at Family Health International developed a first draft (draft 1) of a COC checklist and a DMPA checklist by late summer 1995. Only questions that corresponded to WHO categories 3 and 4 were included. The questions were formulated so that any woman who answered one of the questions positively would be identified as being in category 3 or 4. Such a client would not receive COC or DMPA from the CBS worker and would be referred to a qualified medical provider for more detailed evaluation.

Draft 1 was sent to a group of approximately 10 TG/CWG members for review (see Table 1). Their suggestions were incorporated into draft 2 of the checklists. From this initial review, we realized that reviewers needed an explanation of the purpose of the checklist questions and we therefore produced the *Checklist reference document* to provide explanation and more information about the source of our draft questions. This document accompanied draft 2 when it was sent to our second round of reviewers, including the entire TG/CWG membership (approximately 50 members). To ensure they understood the specific issues to be addressed the following questions accompanied the draft.

- Should only elements of questions rather than fully worded sentences be included so that CBS workers can phrase questions in their own way? If so, what kind of elements?
- Should all the questions remain in the checklist? If not, please explain.
- Should "public health messages" be included on the checklists?
  - "Encourage client to continue breastfeeding."
  - "Recommend that she quit smoking regardless of her age or amount currently smoked."
- The only condition which merits a WHO category 3 or 4 is severe hypertension ($\geqslant$180 mmHg systolic/$\geqslant$110 mmHg diastolic). However, how can instructions/questions be worded so that women with only mild hypertension are able to receive DMPA and those with severe hypertension be appropriately referred to a clinician? Is this possible, or should all women with a history of hypertension be referred? Could DMPA be provided to all those answering "yes" to this question, with the requirement that a visit to a provider for a blood pressure measurement occur before she can receive the next injection?

The responses received were very helpful and focused, enabling us to refine our expectations of the checklists. For example, we anticipated that each programme would modify the questions as appropriate for their clinic populations, and would phrase questions to facilitate a natural conversation with the client. However, following the continued misunderstandings about the use of the checklists, we drafted a one-page *Checklist guide* to clarify their goals. In mid-February 1996, we sent out a revised draft 3, the new *Checklist guide*, and a further reminder about the purpose of the checklists, especially that they were intended to be used only after a client had freely made an informed decision to use the method, and not to replace counselling.

In the letter that accompanied draft 3, we explained why some issues that had been raised by TG/CWG members had not been incorporated into either the checklists or the *Checklist guide*. We believe that our attention to the concerns raised by TG/CWG members and our feedback about the usefulness of their comments created a very dynamic process in which all were encouraged to participate.

After receiving comments on draft 3 and on the *Checklist guide,* we incorporated suggestions into draft 4 and a second draft of the guide. These drafts served as the basis for discussion at a meeting of the TG/CWG, convened to review the development of USAID's *Recommendations for updating selected practices in contraceptive use, volume II* (*5*). This document was to include the draft checklists and the *Checklist guide* as just one part of several recommendations for updated practices in family planning. Approximately two weeks prior to the meeting, we sent draft 4 and the second draft of the guide to TG/CWG members, explaining this would be the basis of discussion at the 1996 meeting.

At this meeting, eight groups of approximately ten TG/CWG members convened to review the remaining unresolved issues. For each group, a convenor and a rapporteur were appointed who were in charge of recording the discussion and relaying major points to the larger group at the end of the day. The meeting provided us with the valuable opinions of many experts after lengthy discussion.

The iterative consensus process proved valuable in developing acceptable and accurate wording for the questions. An example of this process involved the question assessing whether a woman had hypertension or not. Since moderately high blood pressure (140–159 mmHg systolic/90–99 mmHg diastolic) is not necessarily an exclusion criterion, a client's blood pressure should be measured to evaluate more precisely her eligibility for COCs. However, as several experts pointed out, the availability of blood pressure monitoring equipment in many poorly served areas is low. Thus, the basic question "Do you have high blood pressure?" was included in the COC checklist. The rationale was that a woman with high blood pressure is likely to have been told she has it. In these circumstances, her own knowledge of her condition (or lack thereof) would be an adequate proxy measure. Other experts added that stroke and myocardial infarction (MI) resulting from contraindicated COC use are rare in developing countries among women of childbearing age. By canvassing a broad group of experts, we were able to include a realistic assessment question about hypertension.

Based on the comments from this meeting, draft 5 was produced. Within two weeks, it was given final approval by the leadership of the TG/CWG and was ready for field-testing.

Field-testing

Developing new checklists required that we examine current practices of CBS workers in the field. Since in many cases, CBS workers have received no post-secondary school education and are not well acquainted with general medical practices, we avoided constructing the checklists as diagnostic or educational tools. Rather, they were designed strictly to determine whether the client of a CBS worker is eligible to initiate the use of COCs or DMPA or whether the client needs to see a higher level provider.

Field-test sites in Bolivia, Jamaica, Mexico (two sites), and Paraguay were identified. We wanted the CBS *workers* (who pose the questions), CBS *trainers* (those who might adapt the questions and train workers) and CBS *clients* (who would be asked the questions) to field-test the checklists. A total of 334 workers in five field sites (including one English and four Spanish speaking sites) reviewed the checklists. Input from users at every level helped us identify difficulties with semantics, adaptation and general user-friendliness.

Of the 334 forms returned, slightly more than half (52%) of the respondents felt the questions were intelligible and did not suggest any changes. However, the remainder (48%) made suggestions for changing or adapting one or more questions. Closer examination of the response forms showed that many of the changes proposed related to the use of standard Spanish in the translation as opposed to the local vernacular Spanish. Some of the suggestions offered by CBS workers and clients would have changed the meaning of the question and rendered a medically eligible client ineligible to receive COCs or DMPA. For example, one suggestion was to split Question 3 on the COCs checklist, "Do you smoke cigarettes and are you over 35 years of age?", into two questions. However, the intention of the question is to identify women who are both smokers and over the age of 35 years, since such women are at particular risk of thromboembolism. Young women (aged $\leqslant$35 years) who smoke or non-smokers over the age of 35 years are eligible to use COC by WHO contraceptive eligibility (categories 2 and 1, respectively). An example of problems with the DMPA checklist arose when one group of workers administered the field test to clients who were taking Cyclofem. DMPA is a three-month progestin-only injectable contraceptive and Cyclofem is a monthly combined estrogen–progestin injectable contraceptive. Most of the questions on the DMPA checklist are irrelevant to Cyclofem use. However, mistaken use of the lists for potential Cyclofem acceptors was important information in labelling the final checklists and the guide.

As a result of these and other similar potential misinterpretations, we have added an *Explanation of checklist questions for trainers* for both the COC and DMPA checklists. This explains the rationale behind the framing of each question (see Annex 2 at www.who.int/bulletin). Based on our field experience, we recommend that *Explanation of checklist questions for trainers* be used with CBS workers when they are being trained in the use of the checklists, and periodically when there are questions about any item. The *Checklist guide* (see Annex 1 at www.who.int/bulletin) was also added to the checklist material along with the question explanations. This guide includes general instructions for using the checklists, and special instructions for making the guide specific to a particular locality. For example, workers could

add the names of locally available barbiturates to the question, "Do you regularly take any pills for tuberculosis, fungal infections or seizures, such as_____ ?"

On 8–10 March 2000, WHO convened a meeting of experts to review the medical eligibility criteria for contraceptive use on which these checklists were based (*6*). In this meeting, one of the conditions that represents an important risk for COCs use in CBS was redefined in the light of recent safety information. Also, one of the conditions that affected the use of COCs in CBS was eliminated, based on new assessment of safety information. This article reflects the updated proposed checklists.

Discussion

The first checklists and accompanying materials were disseminated as part of *Recommendations for updating selected techniques in contraceptive use,* vol. II (*5*). This has been translated into Spanish and French and approximately 1700 copies distributed in 41 countries. Family Health International is widely distributing the recently reviewed checklists, including all the recipients of vol. II of the *Recommendations***.** It is hoped that as these checklists become more widely reviewed, they will be incorporated into CBS programmes or used as a basis for updating the checklists currently in use.

The use of a multi-tiered consensus process to develop health care guidelines and materials such as the CBS checklists is important in developing a usable, scientifically based, updated tool that ensures safety and maximizes access to contraception. This approach provided valuable insights into the importance of a participatory and consensus-building process involving both providers and trainers. The collaboration of experts from a variety of backgrounds, including government, universities and research organizations, many of whom had extensive field experience, provided the final product with broader credibility. In face-to-face discussion these experts came to consensus over every detail of the checklists. However, the final field-testing was perhaps one of the most important steps in creating documents that could be effectively and correctly used.

Our field-test experience shows that adapting and translating scientific or technical information into languages other than English is difficult. We recognized the importance of translation and adaptation being both culturally and technically correct. Even seemingly minor changes to the checklist questions can create obstacles to contraceptive access. Therefore, we suggest that changes to simplify and customize the checklist questions be reviewed, prior to dissemination, by an individual with relevant expertise in the medical basis of the checklists. Though we did not have the funding to test whether the final version of the documents was being used effectively and correctly, we strongly recommend this be done as more institutions begin to incorporate the documents into their CBS programmes.

Our field-testing also revealed the need for training in the use of "new" checklists that may vary from those that have been in place for many years. Training should focus on how these checklists differ from the old ones, since in some cases there may only be a subtle, yet critical, change in wording. For example, workers may be accustomed to asking the question: "Do you have severe headaches?" However, the corresponding question in the new checklist is: "Do you have severe frequent pulsating pain in one side of the head, with nausea and made worse by light, noise, or moving about?". Eligibility criteria single out women with certain types of migraines, not all women who have severe headaches.

Using provider/client role-play and other training techniques, CBS workers can practise asking the questions in a simulated environment where "client responses" can challenge assumptions that workers may make, especially those who have used the same checklists for many years. The guide and explanations are meant primarily to be used by CBS trainers. However, users with a formal medical background may also benefit from the information.

Given that use of the checklists by CBS workers occurs within a health care structure, it is also recommended that some attention be paid during training to the referral system in a given area. Without a referral structure in place, CBS workers may make diagnoses, provide methods to women who should not receive them, or exclude others from use of contraceptive methods. Poor screening can contribute to unintended pregnancies or method-related morbidity or mortality. Any training should emphasize that the checklists are a preliminary screening tool and should be used as a referral mechanism to allow adequately trained health care providers to make final assessments when necessary.

Our experience also shows how checklists need to be regularly updated. After this paper had been submitted for publication, WHO convened a new meeting of experts in March 2000 to review the existing medical eligibility criteria for contraceptive use (*6*). The revised criteria modified the definition of headaches for COCs use, which required rewording one of the original questions (*4*). Also, one condition that placed a limitation on COCs use in CBS was eliminated, which simplified the COCs checklist since the corresponding question was dropped. This version of the article reflects these changes.

Ultimately, the purpose of developing, refining, testing and disseminating these checklists is to empower local providers to offer the best possible services to the greatest number of women in poorly served areas. It is our hope that the checklists and the methods used to develop them can be integrated into CBS programmes worldwide, to increase the quality of services and care and increase women's access to contraceptives. ■

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Résumé

Nouveaux questionnaires de contrôle pour la fourniture des contraceptifs oraux associés et de l'acétate de médroxyprogestérone-retard (AMPR) par les programmes communautaires

Pour multiplier les services de planification familiale en dehors des dispensaires traditionnels, les programmes de soins de santé génésiques ont employé des services communautaires de planification familiale permettant de recenser les femmes susceptibles d'utiliser des méthodes hormonales de contraception en toute sécurité (plus précisément, des contraceptifs oraux et injectables). L'un des outils les plus importants de ces services est le questionnaire de contrôle. Celui-ci consiste en général en une série de questions auxquelles il faut répondre « par oui ou par non », permettant d'identifier certaines contre-indications (par exemple l'allaitement au sein ou des antécédents d'accident vasculaire cérébral) qui empêchent les clientes d'utiliser des contraceptifs hormonaux sans évaluation médicale. Ils sont surtout très utiles dans les régions reculées ou dans les endroits où il n'y a pas de personnel ayant une formation médicale.

Toutefois, des problèmes peuvent se poser lorsque ces questionnaires de contrôle sont basés sur des critères dépassés ou inexacts, ne reflétant plus les connaissances actuelles que l'on a de l'innocuité des méthodes. Par exemple, un agent des services communautaires de planification familiale peut, pour cette raison, ne pas donner à une femme qui pourrait le prendre le contraceptif de son choix ou, à l'inverse, lui offrir une méthode contraceptive qui n'est pas sans danger pour elle sur le plan médical.

Pour résoudre ce problème, de nouveaux questionnaires de contrôle ont été mis au point afin de déterminer si les clientes peuvent ou non prendre les contraceptifs oraux associés et l'acétate de médroxyprogestérone-retard (AMPR) offerts par ces programmes communautaires. Ils sont basés sur l'ensemble des critères qui figurent dans un document de l'OMS de 1996 intitulé *Pour un meilleur accès à des soins de qualité en matière de planification familiale. Critères de recevabilité médicale pour l'adoption et l'utilisation continue de méthodes contraceptives*. On y trouve le détail des conditions requises pour pouvoir utiliser des méthodes contraceptives, qui sont le fruit d'une analyse étendue et d'un consensus auxquels sont parvenus des experts internationaux.

Dans le cadre de l'élaboration de ces questionnaires de contrôle, Family Health International a rassemblé les questionnaires actuellement utilisés par ces services communautaires dans 33 programmes de planification familiale d'Afrique, d'Amérique latine et d'Asie et. Ils ont été traduits, analysés et évalués de façon à déterminer dans quelle mesure ils reflétaient les directives de l'OMS en la matière. On a élaboré une série de projets de questionnaires concernant les contraceptifs oraux associés et l'AMPR, de façon à les faire correspondre à chacune des affections figurant dans les catégories 3 et 4 de l'OMS, ce qui permet d'identifier les femmes à qui il ne faut pas qu'un agent de ces services communautaires propose ces méthodes. L'analyse approfondie de ces questionnaires s'est faite par un processus d'examen à trois niveaux. Ils ont été testés sur le terrain par des agents des services communautaires et leurs clientes dans cinq sites internationaux. Les résultats de ces tests de terrain ont indiqué la nécessité de joindre un mode d'emploi d'une page (Annexe 1) à ces questionnaires, afin de préciser leur objectif et de fournir une explication pour chacune des questions de la liste (Annexe 2).

L'intérêt d'une approche à plusieurs niveaux pour élaborer des directives et des matériels tels que ces questionnaires de contrôle a été confirmé au cours de ce projet. Cette approche a fourni des indications précieuses sur l'importance d'un processus participatif et consensuel impliquant les prestateurs et les formateurs. La collaboration d'experts venus de divers horizons, notamment des instances gouvernementales, des universités et des organismes de recherche dont beaucoup ont une grande expérience du terrain, a donné une vision plus large au débat et rendu le produit final plus crédible. En confrontant leurs points de vue au cours de discussions, ces experts sont parvenus à un consensus sur chaque détail de ces questionnaires. Toutefois, la dernière étape, qui consistait à les tester sur le terrain, était peut-être l'une des plus importantes pour créer des documents qui puissent être utilisés correctement et avec efficacité. Nous espérons que ces outils et la méthode utilisée pour les élaborer pourront servir de mécanisme permettant de délivrer des contraceptifs en toute sécurité à des populations mal desservies, par l'entremise des services communautaires de planification familiale partout dans le monde.

En fin de compte, en élaborant, en affinant, en testant et en diffusant ces questionnaires de contrôle, le but est de donner aux prestateurs locaux la possibilité d'offrir les meilleurs services au plus grand nombre

possible de femmes dans les régions mal desservies. Nous espérons que ces questionnaires de contrôle pourront être intégrés partout dans le monde dans les programmes communautaires, qu'ils pourront accroître la qualité des services et des soins et permettront à davantage de femmes d'avoir accès aux contraceptifs.

Resumen

Uso de nuevas listas de comprobación de los requisitos para el empleo de anticonceptivos en el contexto del suministro de anticonceptivos orales combinados (AOC) y de acetato de medroxiprogesterona de liberación retardada (DMPA) en programas comunitarios

A fin de ampliar los servicios de planificación familiar fuera del ámbito clínico tradicional, los programas de salud reproductiva han empleado un sistema de servicios de planificación familiar de base comunitaria (SBC) que identifica a las mujeres que pueden empezar a utilizar de forma inocua métodos hormonales de anticoncepción (concretamente anticonceptivos orales e inyectables). Uno de los instrumentos más importantes empleados en esos servicios es la lista de comprobación. Estas listas consisten por lo general en preguntas de disyuntiva «sí/no» que permiten identificar determinadas situaciones y afecciones (como el amamantamiento o los antecedentes de ictus) que obligan a considerar contraindicados para las usuarias determinados tratamientos anticonceptivos hormonales si no van precedidos de una evaluación por parte de un dispensador de atención médica. Su uso es especialmente aconsejable en zonas remotas o en lugares en donde no se dispone de dispensadores de atención con formación médica.

Sin embargo, pueden surgir problemas cuando se usan listas de comprobación basadas en criterios de selección obsoletos o imprecisos, que no reflejan los últimos conocimientos sobre la inocuidad de los métodos. Por ejemplo, un trabajador del SBC puede negar a una mujer apta el anticonceptivo de su elección o, a la inversa, la usuaria puede recibir un método anticonceptivo peligroso desde el punto de vista médico.

Para afrontar ese problema, se han elaborado nuevas listas de comprobación al objeto de evaluar la pertinencia del uso de los anticonceptivos orales combinados (AOC) y del inyectable de acetato de medroxiprogesterona de liberación retardada (DMPA) en los programas de SBC. Dichas listas están basadas en un sistema de requisitos descrito en un documento de 1996 de la OMS titulado *Improving access to quality care in family planning: medical eligibility criteria for contraceptive use*. En él se describen con detalle los requisitos que para el uso de métodos anticonceptivos establecieron, tras un exhaustivo proceso de revisión y consenso, diversos expertos internacionales.

Como parte del proceso de desarrollo de listas de comprobación, Family Health International (FHI) reunió las listas empleadas por los SBC en 33 programas de planificación familiar de África, Asia y América Latina. Las listas fueron traducidas, revisadas y evaluadas en lo tocante a su adecuación a las directrices de la OMS. Se elaboró un conjunto de listas de comprobación preliminares para el uso de AOC y DMPA, relacionándolas con cada una de las enfermedades clasificadas en las categorías 3 y 4 de la OMS, a fin de identificar a las mujeres que no pudiesen comenzar esos tratamientos a través de un dispensador de asistencia de los SBC. Se llevó a cabo una amplia revisión de las listas de comprobación mediante un proceso en tres niveles. Las listas se sometieron a pruebas de campo entre trabajadores y usuarias de SBC de cinco sitios internacionales. Los resultados de las pruebas indicaron que era necesario distribuir junto con las listas una guía de una página (anexo 1) para aclarar el propósito de éstas y el sentido de cada una de las preguntas incluidas (anexo 2).

A lo largo del proyecto quedó demostrada la utilidad de un enfoque de varios niveles para la elaboración de directrices y material de atención sanitaria, como son las listas de comprobación de los SBC. Ese enfoque proporcionó una valiosa información sobre la necesidad de un proceso participativo y creador de consenso que implicara a los dispensadores de atención y a los instructores. La colaboración de expertos de diversos ámbitos, como la Administración, la universidad y organizaciones de investigación, muchos de los cuales tenían una amplia experiencia sobre el terreno, enriqueció el proceso con distintas perspectivas que aumentaron la credibilidad del producto final. Mediante un debate cara a cara, esos expertos consensuaron cada uno de los detalles de las listas de comprobación. Sin embargo, el paso final de las pruebas de campo fue quizá uno de los más decisivos para conseguir por fin documentos que pudieran utilizarse eficaz y correctamente. Esperamos que esos instrumentos y el método empleado para desarrollarlos puedan aprovecharse para suministrar anticonceptivos de manera inocua a poblaciones subatendidas a través de los programas de SBC en todo el mundo.

En último término, el objetivo de elaborar, perfeccionar, probar y distribuir esas listas consiste en capacitar a los dispensadores locales de atención para ofrecer los mejores servicios posibles al máximo número de mujeres en las zonas subatendidas. Esperamos que esas listas puedan ser integradas en los programas de SBC en todo el mundo y aumenten la calidad de los servicios y la asistencia, así como el acceso de las mujeres a los anticonceptivos.

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