USAID
FROM THE AMERICAN PEOPLE

РАЗОМ ДО ЗДОРОВ'Я • TOGETHER FOR HEALTH

The Impact of Clinical Training on Health Providers' Family Planning and Reproductive Health Practices

Viktoriya Tymoshevska
Nadia Salo
Asta-Maria Kenney

August, 2008

РАЗОМ ДО ЗДОРОВ'Я ФІНАНСУЄТЬСЯ АГЕНТСТВОМ США З МІЖНАРОДНОГО РОЗВИТКУ ТА ВПРОВАДЖУЄТЬСЯ ІНСТИТУТОМ ДОСЛІДЖЕНЬ ТА ТРЕНІНГІВ КОРПОРАЦІЇ ДЖОНА СНОУ У СПІВРОБІТНИЦТВІ З АКАДЕМІЄЮ СПРИЯННЯ ОСВІТІ ТА ШКОЛОЮ ГРОМАДСЬКОГО ЗДОРОВ'Я ГАРВАРДСЬКОГО УНІВЕРСИТЕТУ

TOGETHER FOR HEALTH IS FUNDED BY THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT AND IMPLEMENTED BY JSI RESEARCH AND TRAINING INSTITUTE INC. IN COLLABORATION WITH THE ACADEMY FOR EDUCATIONAL DEVELOPMENT AND HARVARD SCHOOL OF PUBLIC HEALTH

The Impact of Clinical Training on Health Providers' Family Planning and Reproductive Health Practices

Viktoriya Tymoshevska
Monitoring & Evaluation Coordinator;
Nadia Salo
Clinical Director;
Asta-Maria Kenney
Project Director

August, 2008

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID).
The contents are the responsibility of JSI Research & Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States Government.

Acronyms and Abbreviations

COC	Combined oral contraceptive
EC	Emergency contraception
FAP	*Feldsher-accousherski punkt*
FP	Family planning
GOU	Government of Ukraine
IEC	Information, education and communication
IUD	Intrauterine device
LAM	Lactational Amenorrhea Method
M&E	Monitoring and evaluation
MOH	Ministry of Health
N	Number (in a sample)
NGO	Nongovernmental organization
Ob-gyn	Obstetrician-gynecologist
OC	Oral contraceptives
POP	Progestin-only pills
RH	Reproductive health
STI	Sexually transmitted infection
TfH	Together for Health project
USAID	United States Agency for International Development
v.	versus
WRA	Women of reproductive age (15-49)

I. Introduction

Together for Health (TfH) is a five-year project (2005-2010) that aims to reduce the abortion rate, unintended pregnancy and sexually transmitted infections (STIs) in Ukraine, through increased use of modern methods of contraception. It is made possible by the United States Agency for International Development (USAID) and implemented by JSI Research & Training Institute (JSI) in collaboration with the Academy for Educational Development and Harvard School of Public Health. The project has adopted a "systems approach," working with health care providers and pharmacists to increase and improve the supply of family planning (FP) services, while at the same time building demand by informing the population about the benefits of FP as compared to abortion.

An important project strategy is to train health workers to provide FP information and services. The obstetrician-gynecologists (ob-gyns) who are currently the only providers of FP services need updated knowledge and skills and the project also seeks to get new cadres, including family doctors, internists, midlevel staff[*] and others, involved in providing care, to make it more accessible to the population. Recognizing that a single training is not sufficient to change providers' practices, the project undertook to provide supportive supervision visits to TfH-trained providers to strengthen the lessons learned during training and to encourage the application of the new knowledge and skills. The goal of both the training and the supervision visits is to update providers' knowledge and skills on FP and related reproductive health (RH) services in line with modern evidence-based approaches, with a special emphasis on demedicalizing care, strengthening counseling skills and emphasizing clients' decision-making role on whether or not to use FP and which method to use. Also underlying the training is the involvement of a range of different providers—ob-gyns, family doctors, midwives and others—to broaden the range of providers offering FP/RH services. The expectation is that, combined with TfH's other interventions aimed at pharmacists and the population, clinical training and supervision should contribute to increased contraceptive use and a decrease in the abortion rate.

II. Objectives of the Provider Observations

The provider observations that are the subject of this report were the first step in TfH's approach to supportive supervision. They entailed observing a sample of ob-gyns, family doctors, midwives and feldshers *before* they received training from TfH and another sample of *TfH-trained* providers approximately four to six months after training. The visits had a dual purpose:

- The primary purpose was to support TfH-trained providers in implementing lessons learned during the training, answering their questions and addressing any doubts.
- The other purpose was to learn about providers' practices a few months after the training. This would provide valuable information on the impact of the training, allow for any necessary modifications to be made to the curriculum and to plan for any further program interventions that might be useful.

The focus of this report is on the second point: what was learnt about providers' practices a few months after the training, compared to the practices of providers who did not receive that training. The assumption is that differences between the two groups are probably due to the training; but at the same time, they cannot be attributed solely to the TfH training, since health providers also receive information from medical representatives and participate in other continuing medical education activities. It is recognized that provider observations have a number of limitations in accurately gauging providers' practices. Most significantly, providers usually perform as well as possible when they are being observed, so that the observations are likely to present a more positive picture of service delivery than occurs in day-to-day practice.

The information presented in this report is designed to be used not only by TfH staff, but also by trainers, chief ob-gyns, local health authorities and providers themselves. Project staff and trainers will be able to identify the strengths and weaknesses of the TfH training program, share the successes and determine any needed changes. Partners in local health authorities and health facilities can identify areas where further work is needed to strengthen providers' skills and can use the observation tools to implement supportive supervision on their own.

[*] Midlevel staff includes nurses, midwives and feldshers.

III. Methodology

The basis for the provider observations was a detailed provider observation tool which was developed based on examples from other projects and resources such as MEASURE's *Profiles of Health Facility Assessment Methods; Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning;* and *Better Practices in Evaluation: Measuring Provider Performance,* as well as the Ministry of Health of Ukraine's Family Planning Training Manual produced with technical assistance from the project. The provider observation tool was to serve as a systematic guide for the observer to assess providers' performance against an ideal standard. The tool consists of several detailed checklists that follow the flow of an initial FP visit, starting with medical history-taking, the client's FP/RH background, counseling on contraceptive choices, STI risk assessment, and prescription/provision of all 15 methods of contraception available in Ukraine:

- Combined oral contraceptives (COCs);
- Progestin-only pills (POPs);
- Intrauterine devices (IUDs);
- Vaginal ring;
- Patch;
- Injectable;
- Spermicides;
- Condoms;
- Voluntary female sterilization;
- Emergency contraception (EC);
- Lactational Amenorrhea Method (LAM); and
- Fertililty-awareness-based (FAB) methods (body basal temperature method, calendar method, cervical mucus and symptothermal method.)

Each method-specific checklist contains the following sections:

- Advantages and disadvantages of the method;
- Side effects;
- Counseling on how to use the method;
- Screening;
- Examination of the client;
- Counseling on method use; and
- Follow-up visits.

Some methods have additional sections relevant for the specific method, e.g. the IUD checklist has sections on IUD insertion and removal procedures, the injectable checklist has a section on the injection procedure.

Each section of the tool was structured in such a way as to allow the observer to check which key steps the provider had followed and then assign a score based on how many of the key steps he/she had performed. A provider would score 100% of he/she mentioned/performed every item on a checklist; only 80% of he/she mentioned/performed 80% of the items, etc.

The observations were conducted in the first two oblasts to participate in the TfH project, Kharkiv and Lviv, and, as already noted, involved observation of a sample of health providers before they received training from TfH and another sample four to six months after training.

The sample size was calculated using PC Size software (Dallal, G.E. (1986), *PC-SIZE: A Program for Sample Size Determinations*, The American Statistician, 40,52) with the key indicator of adequate FP counseling (defined as at least three out of five key FP/RH messages mentioned by the health provider during the counseling session), a power of .80 and a 95% level of confidence. The current prevalence of adequate FP counseling was estimated to be around 10% (based on information provided by TfH's clinical team.) In order to detect a statistically significant change of 30 percentage points (i.e. from 10% to 40%) the sample size would have to be 31 providers per oblast. To adjust for missed providers, any who declined to participate or were absent, the sample size was increased by an additional 10%, to 35 providers.

The types of providers to be observed were ob-gyns, family doctors, midwives and feldshers working in women's consultations, maternity hospitals, general hospitals with an ob-gyn department, central rayon hospitals, family planning centers and cabinets in polyclinics since these reflected key groups included in

TfH's training courses**.** Although the project trained significant numbers of providers in smaller health facilities, such as family doctors' ambulatories, FAPs, and village hospitals, providers working in these settings were not included in the sample because the observers would have had to spend many days waiting for a sufficient number of FP/RH clients to come to these small facilities.

For the first round of observations, a list of the types of health facilities mentioned above was obtained from the two oblast health departments, along with the numbers of each type of health provider at each facility. Based on these numbers, 35 providers *not* trained by TfH were randomly selected and a list was created of the providers to be observed. Ob-gyns were over-sampled as they are the key professional group providing FP/RH services to the population. The distribution of the health providers observed, by type, is presented in the table below.

Table 1. Distribution of Observed Health Providers, by Provider Type and TfH Training Status

Provider Type	Not trained by TfH		Trained by TfH	
	N=70	%	N=70	%
Ob-gyn	49	70.0%	43	61.4%
Family doctor	9	12.9%	11	15.7%
Midwife, feldsher, nurse	12	17.1%	16	22.9%

TfH chose some of its FP/RH trainers to conduct the observations, even though this could potentially bias the research. The reasons for this were, first, that they were the only people with a good understanding of the new approaches embodied in the training and, second, that the supportive supervision function of the visits was more important than the data collection function.

The project conducted a one-day training for the FP/RH trainers to prepare them for the observation visits. The training focused on data collection and correct use of the provider observation tool; procedures for obtaining consent from all parties (the chief doctor of the facility, the health provider to be observed and the client); and role plays were used to practice and discuss situations that could arise during the observation sessions**.** All trainers/observers were given a list of facilities, and departments within those facilities, where observations would be conducted and told the necessary number of health workers to be observed.

Observation of providers *not* trained by TfH was conducted during a 10-day period in April 2007. Each trainer/observer was assigned to observe 6 to 8 health providers in the sample of 35 randomly selected providers. These providers were randomly divided between the trainers/observers in each oblast. On arrival at a health facility, the trainer/observer introduced him/herself to the chief doctor and received oral approval to conduct the observation sessions. Each health provider was observed during four family planning visits with women of reproductive age (15 to 49 years old). Before observing a session, the trainer explained to the woman why he/she was there and obtained a written informed consent form from each woman. After all four observations of a given provider were completed, the trainer/observer prepared a summary of the observations and discussed it with the health provider. Key points of this discussion were reflected in an observation visit summary table, where items that were omitted by the provider were listed and reasons for omission were discussed with the provider. This part of the observation was critical for supportive supervision, since it gave the trainer/observer an opportunity to point out areas for improvement, while at the same time presenting an opportunity for the health provider to ask questions from an experienced colleague.

Four to six months after the first TfH training courses in the two oblasts, in September 2007, the same FP/RH trainers/observers were asked to conduct a second round of observation visits to randomly selected *TfH-trained* health providers. Thirty five TfH-trained health workers in each of the two pilot oblasts were randomly selected from the project database of trained providers. All the preparatory steps and procedures for the observation sessions were repeated as described above.

Conducting provider observations before the training and four to six months after training allowed the project to make comparisons between the two time points, between the two oblasts as well as to compare providers with different training status (trained by TfH v. not trained by TfH). However, it is important to note that, because there was no control group, the ability to attribute change to the project's training is limited. To rule out other possible causes for change, the project collected information from key informants

(national trainers, project field staff, oblast officials, etc.) on other educational events or activities on FP/RH for these providers that might have influenced their performance. No FP trainings or seminars, other than those offered by TfH, were conducted in either of the two oblasts, so the only possible influence might be from visits of medical representatives or journal articles (which are not known to have appeared.) Therefore it is possible to conclude that the detected changes in providers' practices are probably due to project activities.

Data from the observations was entered by a consultant into the project's MS Access database and data analysis was performed in MS Access. When appropriate and feasible, data were disaggregated by oblast or by provider type.

IV. Key Results

The observation tools followed the typical flow of an initial FP visit and the results are presented in that order. Thus, they cover the following major topics:

- Collection of a general medical and ob-gyn history;
- Counseling on contraceptive choices and method selection;
- STI risk assessment;
- Prescription or provision of the method selected.

In addition, the analysis is broken down according to whether the visit was an *initial* FP visit or a *follow-up* visit. The trainers/observers also subjectively assessed whether the client's confidentiality was adequately protected during the visit; and they noted the availability of information, education and communication (IEC) materials produced by the project.

The level of providers' skills was determined by calculating the average number of *all* items on the relevant checklist(s) (e.g. medical history-taking checklist, FP method selection checklist, STI risk assessment checklist, and checklists for all contraceptive methods) that were mentioned/performed by the provider. The results presented below are the number and percent of the recommended items on each checklist that were mentioned/performed by providers, comparing those who were trained by TfH with those who were not.

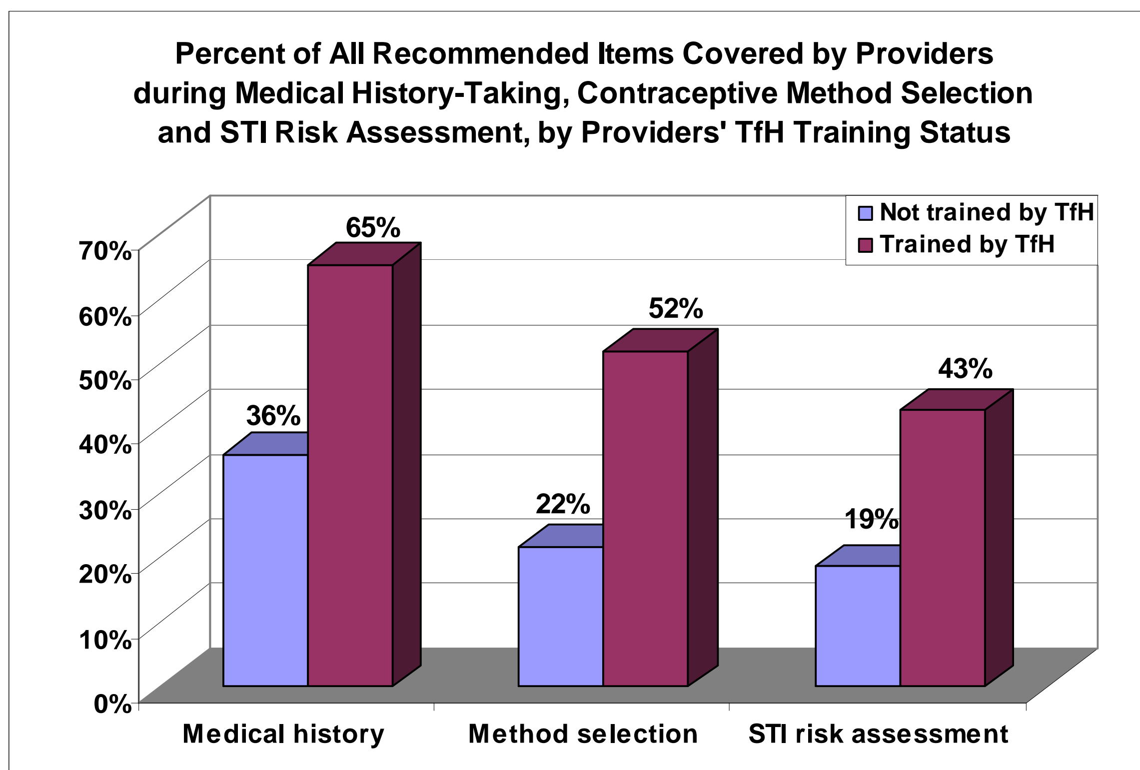
To put the results of the observations into perspective, the women whose FP sessions with a provider were observed were generally 20 to 30 years old: over 60% of women seen during observation sessions in each oblast. Almost a quarter were postpartum: 20% of those seeing TfH-trained providers and 28% of those seeing non-TfH-trained providers; and less than 10% were post-abortion. A large majority—over three quarters—were neither postpartum nor postabortion. (See Annex Tables 1 and 2 for data about the women's characteristics).

Overall, TfH-trained providers scored considerably better than those who were not trained on all aspects of FP/RH counseling. During medical history-taking, *non*-TfH-trained providers mentioned 36% of the recommended items on the checklist, whereas *TfH-trained* providers mentioned 65%. Providers *not* trained by TfH mentioned a standard set of items relevant to clinical care, including information about prior pregnancies, last menses, past and current contraceptive use, and inquired about complaints such as vaginal discharge and lower abdominal pain. *TfH-trained* providers also mentioned these items, but incorporated a more public health-oriented, client-centered approach as well, including information about possible complications of abortion and messages about the safety and affordability of modern FP methods to encourage clients to make healthy choices.

TfH-trained health providers were also more than twice as likely as *non*-TfH-trained providers to cover the recommended items when counseling clients about FP method selection (52% v. 22%) and STI risk assessment (43% v. 19%). Providers that hadn't participated in TfH training most often mentioned condoms, COCs, IUDs and spermicides when counseling clients on their contraceptive choices, while those who went through the training also included POPs, the patch, the vaginal ring, the injectable, FAB methods, emergency contraception and LAM. When conducting STI risk assessment, both TfH-trained and non-TfH-trained providers often told clients that STIs may have no symptoms, that they can cause infertility, that clinical signs are urethral discharge and pain during urination, and they prescribed laboratory tests to confirm the

diagnosis. After the training, however, providers were more proactive in their screening, mentioning the key messages more frequently and going beyond just looking for symptoms.

Figure 1.



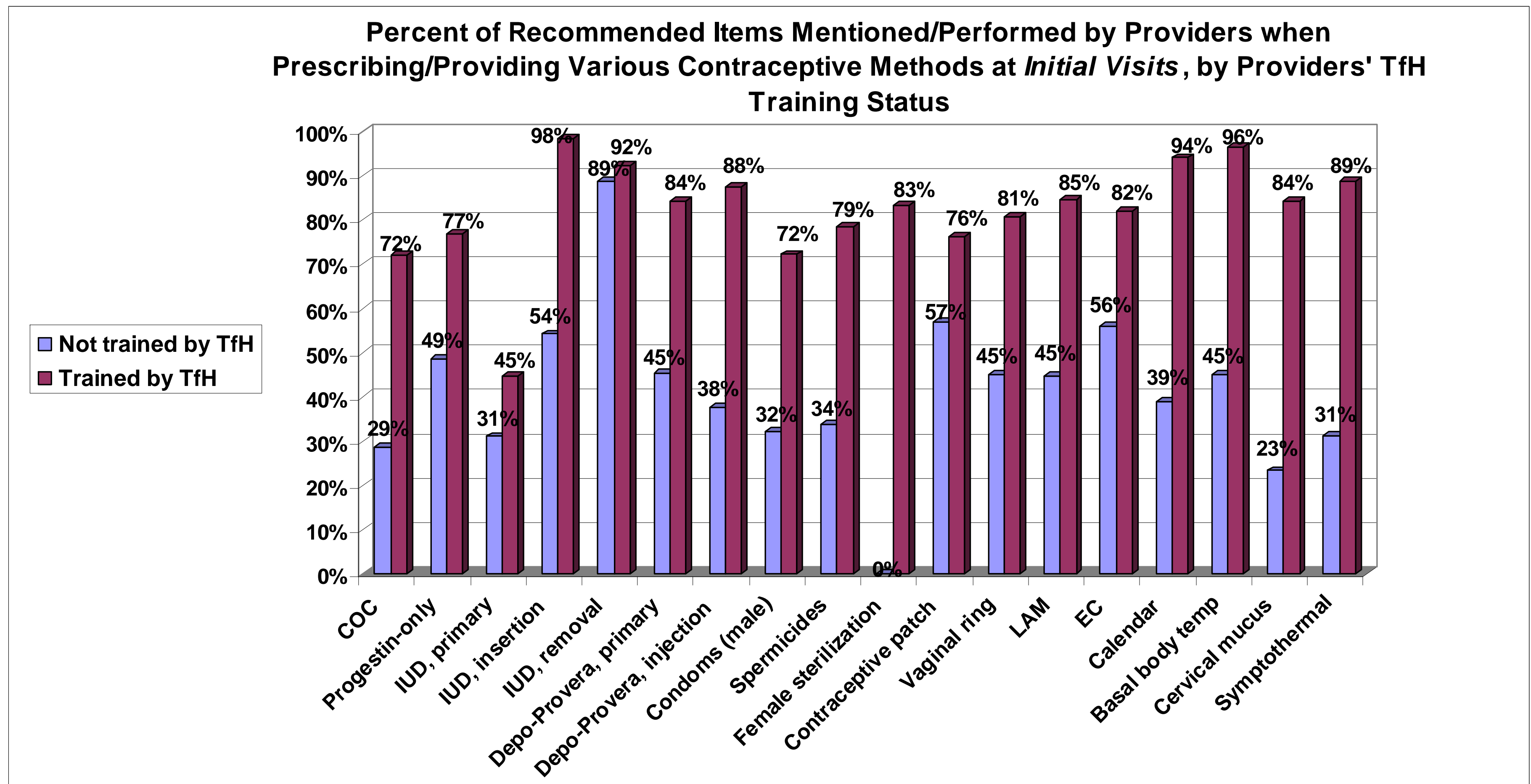
More details on providers' practices on medical history-taking, method selection counseling and STI risk assessment, as well as prescription/provision of specific contraceptive methods, are presented in the Annex Tables, starting with Table 3.

TfH-trained providers also provided better quality services when actually prescribing/providing contraceptive methods, as judged by the percentage of all recommended items mentioned/performed. The number and percent of key items covered for each contraceptive method is shown in Figure 3a for initial visits and Figure 3b for follow-up visits.

Analyzing *initial* visits, the greatest differences between *TfH-trained* and *non*-TfH-trained providers were observed for FAB methods, the injectable, spermicides, IUD insertion, COCs, LAM and condoms. TfH-trained providers achieved double the scores of the non-TfH-trained providers for FAB, COCs, the injectable, condoms and spermicides. For example, important information was included in trained providers' counseling on the injectable: that the method is very effective, completely confidential and safe for breastfeeding women, while it has the disadvantage of not protecting from STIs; and they noted conditions when DMPA is contraindicated – unexplained vaginal bleeding and liver disease. The most important change on IUD insertion was that more than 75% of insertions by TfH-trained providers used the "no touch" technique for loading of the IUD, while non-TfH-trained providers used this technique in less than 25% of cases.

TfH-trained providers also did better than non-TfH-trained providers when prescribing/providing the vaginal ring (81% v. 45%), POPs (80% v. 51%), emergency contraception (82% v. 56%), and IUDs (45% v. 31%.) The skill-set where the least improvement was evident was in IUD removal, where TfH-trained providers scored only 3% points higher than the non-TfH-trained providers, who achieved an already-high score of 89%. These data are presented in Figure 2 on the next page.

Figure 2.



A similar situation was found during observation of *follow-up* visits. TfH-trained providers demonstrated better skills than their non-TfH-trained counterparts for all FP methods except COCs—but this is due to the fact that there were only two observations of COC follow-up visits among non-TfH-trained providers, compared to 11 among the TfH-trained providers.

It is important to note, however, that since the checklists for follow-up visits on FP methods contained only 1 to 4 items and there were few observations of follow-up visits, the improvements in prescribing/providing methods during follow-up visits are not as valid as for initial visits.

Detailed information on the skills of the observed providers appears in Annex Tables 7 through 34

Overall, the contraceptive method mix prescribed/provided during *initial* visits was not dramatically different between TfH-trained and non-TfH-trained providers. There were some exceptions, however. One was for COCs, where the frequency of prescription increased from 18% of all visits observed among *non*-TfH-trained providers to 26% among *TfH-trained*. With respect to the injectable (Depo-Provera), non-TfH-trained providers counseled on this method in less than 1% of initial visits observed, compared to almost 3% among TfH-trained providers. Conversely, TfH-trained providers were less likely to counsel on LAM (only 15% of visits) than non-TfH-trained providers (25%.) This is probably because most LAM counseling sessions take place immediately postpartum in maternity hospitals, while most sessions observed took place in other health facilities, such as women's consultations, central rayon hospitals, FP centers and cabinets and gynecological departments in general hospitals. Also it should be noted that postpartum women were represented more often during observations of non-TfH-trained providers (28%) than of TfH-trained providers (20%.)

The same analysis for *follow-up* visits showed that the proportion of sessions where COCs were prescribed doubled from 9% among non TfH-trained providers to 18% among TfH-trained providers, which could suggest that there are more women using COCs then before. In contrast to initial visits, among follow-up visits, counseling on LAM increased from 14% among non-TfH-trained providers to 23% among TfH-trained health professionals. Most of these LAM follow-up visits were to select a new contraceptive method for women who would need to discontinue the method soon because they no longer meet the criteria for LAM to be effective (not shown in the table below).

Figure 3a.

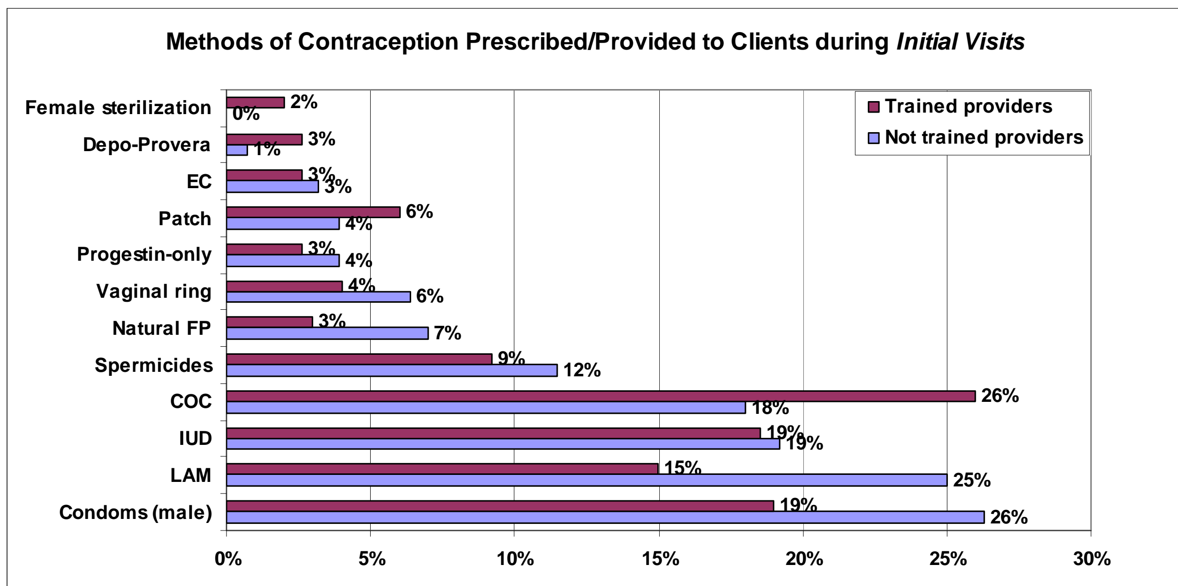
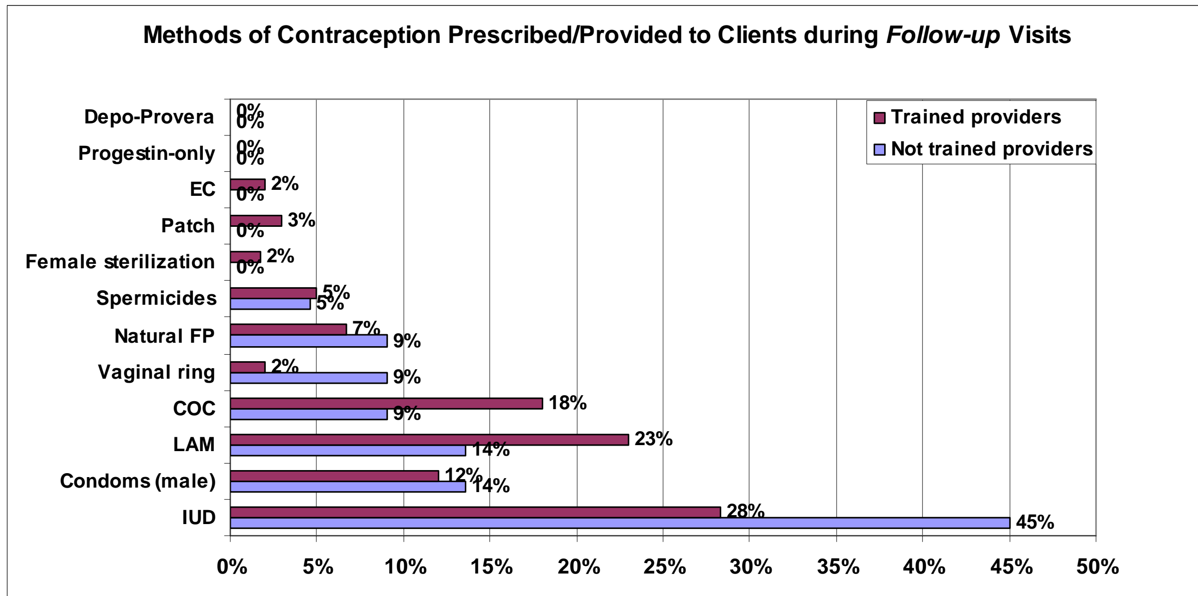


Figure 3b.



After a trainer/observer had watched four FP/RH sessions conducted by a provider, he/she filled in a short form reflecting the items on the checklists that had been omitted or not performed by the provider. Then these items and the reasons for their omission were discussed with the provider and recorded on a form by the trainer/observer. These forms provided valuable qualitative information that could not be gleaned from the observation checklists, including the following insights.

In general, most *non*-TfH-trained family doctors and midlevel professionals did not provide any FP/RH services at all. TfH-trained providers, by contrast, offered general FP/RH counseling. Non-TfH-trained family doctors, and even some TfH-trained family doctors, asked their clients about their pregnancy plans and collected a basic medical history, and then referred them to an ob-gyn. When asked why they do not provide more in-depth FP/RH counseling themselves, the family doctors said, "I don't have enough knowledge and skills; therefore I feel more comfortable when I refer my clients to a TfH-trained ob-gyn." TfH-trained family doctors often limited themselves to providing information about condom use, FAB methods and LAM. TfH-trained midwives and feldshers, however, offered a somewhat broader range of contraceptives and took a better medical history, but did not actually provide/prescribe methods. Generally, they limited themselves to COCs, IUD counseling (midlevel staff are not authorized to insert/remove IUDs), condoms and spermicides. One explanation for this came from the trainers/observers who noted that health administrators do not encourage nurses, midwives and feldshers to provide FP services, but only let them collect key information for the medical history, record vital signs and pass on this information to the doctor (ob-gyn) who then helps the client select a method and actually provides/prescribes it. .

Some providers taking a medical history limited themselves to the most critical information related to the client's status or complaint, with other information either coming from the medical chart (when available) or simply omitted. More detailed information about medical history-taking is presented in Annex Table 3.

With very limited time allotted for each client visit, according to health providers, they sometimes mentioned the FP methods they considered most appropriate for the woman or the methods with which they were most familiar and comfortable. These tended to be condoms, COCs, IUDs and spermicides. It would appear that providers have not yet fully made the transition to asking a woman or couple which method she/they would like, or asking if she/they have any questions.

TfH's training addresses the importance of client confidentiality in the provision of services; and, according to the observers' reports, TfH-trained providers ensured clients' confidentiality during almost all observed sessions (98%), while only 66% of the non-TfH-trained providers did so. In a few cases when the client's confidentiality was not protected, this was due to lack of space in the clinic or ward. For example, in one

situation, counseling about LAM was conducted in a postpartum ward for two to four women at a time; in some other cases, due to a lack of time, the doctor asked a few women interested in information about family planning to come together for a small group counseling session.

TfH informational and educational materials were found in the counseling/examination rooms in almost all health facilities where TfH-trained providers worked: 95% of rooms had the TfH contraceptive methods poster and brochures; and the "FP-friendly" logo, which indicates that providers have been trained, was observed in 83% of health facilities with TfH-trained providers.

Table 2. Characteristics of Health Facilities where Provider Observations were Conducted, by Providers' TfH Training Status

Facility Characteristics	Not trained by TfH		Trained by TfH	
	N=274	%	N=265	%
Patient confidentiality ensured	182	66.4%	259	97.7%
TfH contraceptive methods poster displayed	Not applicable		251	94.7%
TfH contraceptive methods brochure available	Not applicable		258	97.4%
TfH "FP-Friendly" logo displayed	Not applicable		221	83.4%

V. Discussion and Implications

Overall, the provider observations showed important improvements in the practices of TfH-trained health providers compared with non-TfH-trained providers.

When a woman or couple seeks FP services, one of the first steps is for a provider to counsel them about their contraceptive choices. TfH-trained health providers were more than twice as likely as non-TfH-trained providers to cover the recommended items in method selection counseling. Providers who *hadn't* participated in TfH training usually mentioned condoms, COCs, IUDs and spermicides when counseling clients on their contraceptive choices, while those who went through the training also included most other methods, including progestin-only methods, emergency contraception, FAB methods and LAM. This improved counseling, however, was not reflected in the method mix actually prescribed/provided to clients, as might have been expected. There were no dramatic differences between TfH-trained and non-TfH-trained providers in the methods they provided/prescribed to clients. One exception, though, was that the frequency of prescribing COCs increased from 18% of visits among *non*-TfH-trained providers to 26% among TfH-trained providers. Some of this may be due to the fact, seen in the provider observations, that providers have not yet have fully made the transition to a client-oriented perspective—asking a woman or couple which method she/they would like, or asking if she/they have any questions—and there is still a lingering tendency to make assumptions about which method is appropriate for a specific client. It should also be kept in mind that it takes time to change *public* attitudes toward unfamiliar methods of contraception and their willingness to try something new. All these factors imply a need to keep reinforcing providers' counseling skills on method selection as well as the need to reach the public directly with information about the range of methods available and the advantages and disadvantages of each one.

In terms of providers' practices when actually providing/prescribing a method, the most important change was seen on IUD insertion skills. More than 75% of insertions by TfH-trained providers used the "no touch" technique, which greatly reduces the likelihood of post-insertion infections by loading the IUD while it is still in its sterile package, instead of outside the package. By contrast, only 25% of non-TfH-trained providers used this technique. The training seems to have had a large positive impact on wider use of the "no touch" technique, although improvement is still called for to reach a 100% level. There is a need to strengthen the TfH training in this regard and an urgent need to familiarize all ob-gyns in the country with the "no touch" technique. With IUDs used by about 1.7 million women, according to the Ministry of Health of Ukraine, protecting these women from readily preventable infections which, in extreme cases could even jeopardize their reproductive future, is critical.

The observations captured other improvements in providing/prescribing contraception. TfH-trained providers achieved double the scores of non-TfH-trained providers when providing/prescribing FAB methods, COCs, the injectable, condoms and spermicides and made notable improvements for the other methods. Considering the time-lag since the training, these results are good, but there is still room for improvement. The percent of key items mentioned/performed was still below 80% when prescribing/providing COCs, the patch, condoms, and IUDs. Good quality counseling when prescribing or providing a method is important to clients' correct use of their method, their understanding of possible side-effects and how to handle them, as well as their overall satisfaction with the method which, in turn, is related to continuation rates and ultimately reduced risk of unintended pregnancy. At sites where the TfH project has worked, leaders in the ob-gyn community could use project-provided resources, such as the MOH FP manual and the check-lists used to conduct these observations, to reinforce the messages included in the training. In much of the country, where TfH has not worked, other means need to be found to update health providers' knowledge and skills. These might include postgraduate medical education, which doctors are required to take every five years, print materials, occasional meetings of ob-gyn leaders with health facility staff and other approaches.

Among other changes noted were improved medical history-taking, with TfH-trained providers covering the recommended items 65% of the time, versus *non*-TfH-trained providers who covered them only 36% of the time. TfH-trained health providers were also more than twice as likely to cover the recommended items on the STI risk assessment (43% v. 19%). Proper performance of these tasks is important to women's overall health care, disease prevention and early detection of any health problems, as well as providing the woman with appropriate advice in selecting a contraceptive method. This is another area where further work is needed, both among TfH-trained providers and others.

One of the objectives of TfH's training is to involve providers other than ob-gyns in the provision of FP services, so that services become more accessible to people. Observations of family doctors and midlevel professionals who had *not* been trained by TfH reinforced that these providers rarely provide FP/RH counseling or services at all. About nine out of 10 TfH-trained providers, by contrast, not only offered general FP/RH counseling, but actually provided/prescribed COCs, IUD counseling (they are not authorized to insert or remove IUDs), condoms or LAM. However, some said that they did not have sufficient knowledge and skills to provide FP themselves, so they just asked their clients about their pregnancy plans, collected a basic medical history and then referred them to an ob-gyn. While it should be kept in mind that the sample of family doctors was small, these results indicate significant progress. It takes time and reinforcement to encourage a health professional to provide a new service. Continuation of supportive supervision visits, such as those conducted for this study, could be helpful. And support and encouragement from ob-gyns in the community would also likely make a difference. In addition, informing the population that the new providers are now qualified to provide these services could also build demand, encouraging the doctors to actually provide care.

As for the midlevel professionals, TfH-trained midwives and feldshers in rural areas counseled their clients about a broader range of methods than their non-TfH-trained counterparts, and they actually provided/prescribed COCs, condoms and spermicides and counseled about IUDs. As with the family doctors, these providers need continued support. In urban areas, where a great proportion of midlevel staff work in large health facilities assisting doctors and performing administrative functions, they told the trainers/observers that they were not authorized to provide FP counseling or services. Policy and administrative changes in these health facilities, such as large city maternities, large ob-gyn departments in oblast hospitals and elsewhere, are needed to reinforce the role of midlevel personnel in FP counseling, relieving doctors of some of their workload and allowing these providers to perform a valuable professional function.

It is clear that family doctors and midlevel personnel—particularly in rural areas—have considerable potential to improve access to FP services and they should continue to be included in FP/RH training. To make such training more sustainable, it would be beneficial to update medical education to include updated information and skills to provide FP counseling and services.

Although the provider observations did not include a client perspective, they imply that changes in public attitudes and behaviors are needed. IEC materials (posters and brochures) about contraceptive methods produced by the project were seen in almost all health facilities with TfH-trained providers and the health

workers often said how valuable these materials were in educating the population. Systems need to be found to produce and distribute such materials in the future.

Finally, although it is not related to the purpose of the provider observations, it is striking that the majority of clients seen during a visit to a health professional were 20 to 30 years old. Very few younger women attended the health facilities, indicating a need to reach younger people and teens to reduce unplanned pregnancies in this critical younger generation.

The follow-up visits, and the observation tools themselves, proved a valuable tool for reinforcing new knowledge and updated practices among trained providers. It is noteworthy that in most health facilities, after the observations, the providers asked for copies of the check-lists, so they could work on improving their own or their staff's performance. Clearly, supportive supervision can support the significant shift in practices involved in modernizing FP service provision to make it more client centered. And it can help dispel the myths and misinformation about modern contraception that are still widespread among providers in Ukraine—as in other post-Soviet societies—and constrain the availability of improved, more client-centered FP services. Thus, they can support appropriate method choice and method adherence and reduce the number of unintended pregnancies.

Annex Tables

Table 1. Age Distribution of the Women Served during Provider Observations, by Provider's TfH Training Status 17
Table 2. Status of Women Served during Provider Observations, by Provider's TfH Training Status 17
Table 3. Number and Percent of All Recommended Items Covered by Providers during Medical History-Taking, Contraceptive Method Selection and STI Risk Assessment, by Providers' TfH Training Status 17
Table 4. Number and Percent of all Recommended Items Mentioned/Performed by Providers when Providing/Prescribing Methods of Contraception, *Initial Visits*, by Providers' Training Status 18
Table 5. Number and Percent of All Recommended Items Mentioned/Performed by Providers when Providing/Prescribing Methods of Contraception, *Follow-up* Visits, by Providers' Training Status 18
Table 6. Methods of Contraception Prescribed/Provided During Provider Observations, by whether this was an Initial or a Follow-up FP Visit, and by Providers' TfH Training Status (among all FP method counseling sessions observed 19
Table 7. Medical History Taking: Percent of All Recommended Items Asked by Providers (among all client visits observed) 20
Table 8. Counseling on Contraceptive Method Selection: Percent of All Recommended Items Asked by Providers (among all client visits observed) 21
Table 9. STI Risk Assessment: Percent of All Recommended Items Asked by Providers (among all client visits observed) 22

Initial Visits: Tables 10 – 24
Table 10. Combined Oral Contraceptives: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 23
Table 11. Progestin-only Pills: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 24
Table 12. IUDs: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 25
Table 13. Injectable (Depo-Provera): Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 27
Table 14. Condoms: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 28
Table 15. Spermicides: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 29
Table 16. Voluntary Female Sterilization Counseling: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 30
Table 17. Contraceptive Patch: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 31
Table 18. Vaginal Ring: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 32
Table 19. Lactation Amenorrhea Method: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 33
Table 20. Emergency Contraception: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 34
Table 21. Fertility Awareness-Based Methods – Calendar Method: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 35
Table 22. Fertility Awareness-Based Methods – Basal Body Temperature Method: Percent of All Recommended Items Covered/Performed by Providers at Initial (among all initial sessions observed) 36
Table 23. Fertility Awareness-Based Methods – Cervical Mucus Method: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 37
Table 24. Fertility Awareness-Based Methods – Symptothermal Method: Percent of All Recommended Items Covered/Performed by Providers at Initial Visits (among all initial sessions observed) 38

Follow-up Visits: Tables 25 – 34

Table 25. Combined Oral Contraceptives: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 40

Table 26. IUD: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 40

Table 27. Condoms: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 40

Table 28. Spermicides: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed)) 40

Table 29. Voluntary Female Sterilization Counseling: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 41

Table 30. Contraceptive Patch: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 41

Table 31. Vaginal Ring: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 41

Table 32. Lactation Amenorrhea Method: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 41

Table 33. Emergency Contraception: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 42

Table 34. Fertility Awareness-Based Methods – Calendar, Basal Body Temperature, Cervical Mucus, and Symptothermal Methods: Percent of All Recommended Items Covered/Performed by Providers at Follow-up Visits (among all follow-up sessions observed) 42

Table 1. Age Distribution of Women Served during Provider Observations, by Providers' TfH Training Status

Age	Not trained by TfH		Trained by TfH	
	N=274	%	N=265	%
15 – 19 years	24	8.7%	40	15.1%
20 – 25 years	101	36.8%	92	34.7%
26 – 30 years	81	29.6%	64	24.2%
31 – 35 years	43	15.6%	44	16.6%
36 – 40 years	14	5.1%	16	6.0%
41 – 45 years	9	3.3%	8	3.0%
46 – 49 years	2	0.7%	1	0.4%

Table 2. Status of Women Served during Provider Observations, by Providers' TfH Training Status

Women's Status	Not trained by TfH		Trained by TfH	
	N=274	%	N=265	%
Postpartum	76	27.7%	53	20.0%
Postabortion	25	9.3%	22	8.3%
Neither postpartum nor postabortion	175	63.9%	190	71.7%

Table 3. Number and Percent of All Recommended Items Covered by Providers during Medical History-Taking, Contraceptive Method Selection and STI Risk Assessment, by Providers' TfH Training Status

Provider type	Number of Items in Checklist	Not trained by TfH, all visits		Trained by TfH, all visits	
		Average # of items mentioned	%	Average # of items mentioned	%
Medical history-taking	19	6.8	35.8%	12.4	65.3%
Counseling on FP method selection	16	3.5	21.7%	8.3	51.9%
STI risk assessment and counseling	11	2.1	18.6%	4.7	42.7%

Table 4. Number and Percent of all Recommended Items Mentioned/Performed by Providers when Providing/Prescribing Methods of Contraception, *Initial Visits*, by Providers' Training Status

Provider type	Number of Items in Checklist	Not trained by TfH, all visits		Trained by TfH, all visits	
		Average # of items mentioned	%	Average # of items mentioned	%
Combined oral contraceptives	26	7.4	28.5%	18.7	71.9%
Progestin-only pills	24	12.2	50.8%	19.2	80.0%
IUD, initial visits	23	10.9	31.0%	15.6	44.6%
IUD, insertion visits	12	6.5	54.2%	11.8	98.3%
IUD, removal visits	9	8	88.9 %	8.3	92.2%
Injectable, initial visits	23	14	45.2%	19.4	84.4%
Injectable, injection visits	8	3	37.5%	7	87.5%
Condoms (male)	18	5.8	32.2%	13	72.2%
Spermicides	13	4.4	33.7%	10.2	78.5%
Female sterilization	18	no observations		15.8	83.3%
Female sterilization, post-operation visits	4	no observations		1	25.0%
Contraceptive patch	19	10.8	57%	14.5	76.3%
Vaginal ring	16	7.2	45.0%	12.9	80.6%
LAM	14	6.7	47.9%	12.7	90.7%
Emergency contraception	20	11.2	56.0%	16.4	82.0%
FAB-Calendar method	16	6.6	41.3%	15.7	97.3%
FAB-Basal body temp method	21	9.9	47.1%	20.2	96.1%
FAB-Cervical mucus method	26	6.3	24.2%	22.8	87.7%
FAB-Symptothermal method	38	12.2	32.1%	34.6	91.1%

Table 5. Number and Percent of All Recommended Items Mentioned/Performed by Providers when Providing/Prescribing Methods of Contraception, *Follow-up* Visits, by Providers' Training Status

Provider type	Number of Items in Checklist	Not trained by TfH		Trained by TfH	
		Average # of items mentioned	%	Average # of items mentioned	%
Combined oral contraceptives	4	4	100%	2.9	72.5%
Progestin-only pills	2	no observations		no observations	
IUD	5	5.2	58%	4.7	94.0%
Injectable	3	no observations		no observations	
Condoms (male)	3	2	66.7%	2.1	70%
Spermicides	3	3	100%	3	100%
Female sterilization	2	no observations		2	100%
Contraceptive patch	4	no observations		3	75%
Vaginal ring	4	3	75.0%	4	100%
LAM	4	3.3	83.2%	3.4	85%
Emergency contraception	1	no observations		2	100%
FAB-Calendar method	3	1.5	50%	3	100%
FAB-Basal body temp method	3	1.5	50%	3	100%
FAB-Cervical mucus method	3	1.5	50%	3	100%
FAB-Symptothermal method	3	1.5	50%	3	100%

Table 6. Methods of Contraception Prescribed/Provided During Provider Observations, by whether this was an Initial or a Follow-up FP Visit, and by Providers' TfH Training Status (among all FP method counseling sessions observed)

Contraceptive Method	Not trained by TfH				Trained by TfH			
	Initial visits		Follow-up visits		Initial visits		Follow-up visits	
	N=156	%	N=22	%	N=195	%	N=60	%
Combined oral contraceptives	28	18.0%	2	9.1%	51	26.2%	11	18.3%
Progestin-only pills	6	3.9%	0	0%	5	2.6%	0	0%
IUD	30	19.2%	10	45.5%	36	18.5%	17	28.3%
Injectable (Depo-Provera)	1	0.7%	0	0%	5	2.6%	0	0%
Condoms (male)	41	26.3%	3	13.6%	37	18.5%	7	11.7%
Spermicides	18	11.5%	1	4.6%	18	9.2%	3	5.0%
Female sterilization	0	0%	0	0%	4	2.0%	1	1.7%
Contraceptive patch	6	3.9%	0	0%	12	6.2%	2	3.3%
Vaginal ring	10	6.4%	2	9.1%	7	3.6%	1	1.7%
LAM	39	25.0%	3	13.6%	33	15.4%	14	23.3%
Emergency contraception	5	3.2%	0	0%	5	2.6%	1	1.7%
FAB-Calendar method	10	5.8%	2	9.1%	5	2.6%	4	6.7%
FAB-Basal body temperature method	13	8.3%	2	9.1%	5	2.6%	4	6.7%
FAB-Cervical mucus method	10	5.8%	2	9.1%	5	2.6%	4	6.7%
FAB-Symptothermal method	13	8.3%	2	9.1%	5	2.6%	4	6.7%

N.B. Totals may add to more than 100% because some sessions covered more than one method.

For ease of interpretation, items are grouped into three categories:

- *Most frequently mentioned/performed* – those mentioned/ performed in 80% or more of sessions observed;
- *Frequently mentioned* – those mentioned/ performed in 50% - 79% of observed sessions;
- *Rarely mentioned* – those mentioned/ performed in less than 50% of observed sessions;
- *Never mentioned*—those mentioned/performed in 0% of observed sessions.

Table 7. Medical History Taking: Percent of All Recommended Items Asked by Providers (among all client visits observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Provider asks if the woman is planning a pregnancy.								
2.	… about prior pregnancies, outcome of pregnancies, date of last delivery.								
3.	… about past or current contraceptive use.								
4.	… about side effects with past or current contraceptive use.								
5.	… the date of her last menstrual period.								
6.	… if she has had any vaginal discharge.								
7.	… if she has had any lower abdominal pain.								
8.	… if she has had open sores in the genital area.								
9.	… if she has any diseases.								
10.	… if she is taking any medications.								
11.	… if she currently smokes cigarettes and how much she smokes.								
12.	…it is a good idea to plan pregnancy.								
13.	…modern contraception is safe.								
14.	…modern contraception is effective.								
15.	…most methods of modern contraception are affordably priced.								
16.	…contraception is a better choice than abortion.								
17.	…abortion can lead to infertility.								
18.	…abortion can lead to infection.								
19.	…abortion can lead to miscarriage/early delivery in subsequent pregnancy.								

Table 8. Counseling on Contraceptive Method Selection: Percent of All Recommended Items Asked by Providers (among all client visits observed)

No.	Action / Indicator	Non-TfH-trained				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Provider asks if the woman would like information about contraception.								
2.	Provider asks if the client already knows which method she wants.								
Provider mentions…									
3.	… Combined oral contraception								
4.	… Patch								
5.	… Vaginal ring								
6.	… Progestin-only Pill								
7.	… Injectable DMPA								
8.	… IUD								
9.	… Condom								
10.	… Spermicidal								
11.	… LAM								
12.	... Fertility awareness-based methods								
13.	... Emergency contraception								
14.	Provider asks the client if she has any questions.								
15.	Provider asks the client which method she would like to hear more about.								
16.	Provider uses other audio-visual aids (samples of contraceptives, non-TfH brochures/fliers, non-TfH poster, flip charts, etc.) in discussing the methods.								

Table 9. STI Risk Assessment: Percent of All Recommended Items Asked by Providers (among all client visits observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	… STIs often have no signs or symptoms—the person thinks he/she is healthy.								
2.	… STIs can be easily treated.								
3.	… STIs can cause infertility.								
4.	… it is hard to talk about STIs—but important.								
Provider asked client if her partner has had any of the following symptoms in the last 3 months:									
5.	… urethral discharge.								
6.	… pain when urinating.								
7.	… open sores in the genital area.								
8.	Provider explains that the client should protect herself against STIs.								
9.	… prescribes lab tests.								
10.	… advises client that her partner should have lab tests done.								
11.	… describes steps on condom checklist.								

Initial Visits

Table 10. Combined Oral Contraceptives: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective if taken regularly								
2.	Reduces menstrual pain and bleeding and regulates the menstrual cycle								
3.	Fertility returns immediately after stopping the pills								
4.	Decreases the risk of some cancers and anemia (low blood iron)								
5.	You must remember to take the pill each day								
6.	Do not protect from sexually transmitted infections								
7.	Many women experience side effects when they start taking pills (headache, nausea, slight weight gain), but these usually subside when the body adapts.								
8.	Breast tenderness/fullness								
9.	Mood changes/depression								
10.	Weight gain or loss								
11.	High blood pressure								
12.	Over age 35 and smokes								
13.	Severe headaches with focal neurological symptoms								
14.	Liver/gallbladder diseases								
15.	History of stoke, heart attack or blood clot								
16.	Diabetes								
17.	Client weighed								
18.	Blood pressure taken								
19.	Lab tests are prescribed only if indicated due to medical history								
20.	When to start								
21.	How to take the pills								
22.	What to do if she forgets one or more pills								
23.	Explains warning signs when she must see a doctor (abdominal and chest pain, headaches, eye problems, severe leg pain)								
24.	Where to get the pills, available choices and approximate price								
25.	When to come for a return visit								
26.	Asks if client has any questions								

Table 11. Progestin-only Pills: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective if used according to instructions								
2.	Safe for breastfeeding mothers and women who cannot take other oral contraceptives; do not harm a baby's health								
3.	Often brings about lighter, less painful menstrual periods								
4.	Fertility returns immediately after stopping the pills								
5.	Protects against certain cancers and anemia								
6.	Must be taken exactly according to the schedule at the same time every day								
7.	Minor weight gain or loss is possible in certain cases								
8.	Do not protect from STIs								
9.	Spotting and minor bleeding is possible between menstrual periods in certain cases								
10.	Breast tenderness								
11.	Headaches								
12.	When to start								
13.	How to use (take a tablet at the same time very day)								
14.	What to do if she forgets one or more pills (even for 2-3 hours):have condoms or emergency contraception available for situations when she forgets to take a pill for more than 3 hours								
15.	Explains warning signs when she must see a doctor (severe lower abdominal pain, severe headaches)								
16.	Where to get the method and approximate price								
17.	When to come for a return visit								
18.	Asks if a client has any questions								
19.	Breastfeeding and less than 6 weeks postpartum								
20.	Breast cancer in last 5 years								
21.	Circulatory disorders								
22.	Liver disease (including viral hepatitis)								
23.	Taking anti-seizure medication								
24.	Lab tests are prescribed only if indicated due to medical history								

Table 12. IUDs: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Highly effective in preventing pregnancy								
2.	Easy to use—once it is inserted, virtually no additional effort is required								
3.	Provides years of protection from unintended pregnancy—up to 10 years or longer								
4.	Safe for women who are breastfeeding—does not harm the baby								
5.	An inexpensive approach to long-term protection								
6.	Does not protect from STIs								
7.	Increases the risk of pelvic infection if the woman has an STI								
8.	Requires a visit to an obstetrician-gynecologist for insertion								
9.	Changes in monthly bleeding—usually heavier periods—particularly after insertion								
10.	Explains procedure to the client								
11.	Where to get the method and approximate price								
12.	When to come for a return visit								
13.	Asks if a client has any questions								
14.	Checks that the client is NOT pregnant								
15.	Sepsis during delivery or abortion in last 3 months								
16.	STIs								
17.	Unexplained vaginal bleeding								
18.	Diabetes								
19.	Malignancy of the reproductive organs								
20.	More than one sexual partner								
21.	Conducts bimanual exam to determine position of the uterus								
22.	Palpates abdomen and checks for abnormalities								
23.	Screening for STIs (vaginal exam with specula and vaginal smear)								

Table continued on next page

Table 12 *continued.* IUDs: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

IUD insertion									
1.	Applies traction to align uterus								
2.	Determines uterine depth								
3.	Performs “no touch” loading of the IUD								
4.	Applies antiseptic solution two times to cervix and vagina								
5.	Cuts strings to approximately 3-4 cm length								
6.	Disposes of waste in leak proof container								
7.	Shows patient how to feel for strings								
8.	Observes patient for at least 15-20 minutes								
9.	Explains that cramps can occur right after insertion								
10.	Explains warning signs (heavy bleeding during menses, woman couldn’t locate the strings after the period, severe abdominal pain) when she must see a doctor								
11.	Teaches the client how to feel the strings and reminds her to do this regularly								
12.	Reminds patient to return if she has excessive bleeding or misses her period								
IUD Removal									
1.	Asks the reason for IUD removal								
2.	Describes the removal procedure								
3.	Performs bimanual exam								
4.	Performs vaginal exam								
5.	Applies antiseptic solution two times to cervix and vagina								
6.	Grasps strings close to cervix and pulls gently to remove IUD								
7.	Disposes of IUD in leak proof container								
8.	Records IUD removal in client’s record								
9.	Recommends FP method								

Table 13. Injectable (Depo-Provera): Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective in preventing unintended pregnancy								
2.	Easy to use – one injection is sufficient for three months								
3.	Safe for breastfeeding women from six weeks after delivery								
4.	Reduces the risk of uterine tumors and ectopic pregnancy								
5.	Completely confidential – it's impossible to know if a woman is using it								
6.	There can be a delay in the return to fertility—as long as 6-12 months in some cases								
7.	Do not protect from sexually transmitted infections and HIV								
8.	Changes in menstrual bleeding—possibility of no bleeding								
9.	Injection has to be administered by a health care provider								
10.	Possible weight gain								
11.	Possible minor headache								
12.	Possible breast tenderness								
13.	Possible depression								
14.	When to start								
15.	Where to get the method and approximate price								
16.	When to come for a return visit								
17.	Asks if client has any questions								
18.	Breastfeeding a baby less than 6 weeks old								
19.	Had a stroke, heart attack or blood clot								
20.	Breast cancer in the last 5 years								
21.	Liver disease or jaundice								
22.	Diabetes								
23.	Unexplained vaginal bleeding								
	Injection Procedure								
1.	Checks expiration date of vial								
2.	Sterilizes injection site								
3.	Deep IM injection in deltoid/gluteal muscle								
4.	Does not massage injection site								
5.	Disposes of needle and syringe appropriately								
6.	Lab tests are prescribed only if indicated due to medical history								
7.	Return in 3 months for next injection								
8.	Explains warning signs when she must see a doctor (repeated severe headaches, heavy vaginal bleeding, depression, severe lower abdominal pain, pus, prolonged pain or bleeding at injection site)								

Table 14. Condoms (Male); Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective if used according to instructions								
2.	No health risks								
3.	No need to go to a doctor								
4.	Protects against unplanned pregnancy and STIs, including HIV								
5.	Easily available								
6.	The need to interrupt love-making to put on the condom								
7.	Some men can refuse using it								
8.	If not used correctly, a condom can tear or slip off								
9.	In some cases, people are allergic to latex								
10.	Use a new condom for each sex act								
11.	Put the condom onto an erect penis before entering the vagina								
12.	“Pinching” the tip of condom								
13.	Unrolling the condom								
14.	Holding rim when withdrawing								
15.	What to do if condom breaks								
16.	Where to get the method and approximate price								
17.	Asks if a client has any questions								
18.	Symptoms of STIs								

Table 15. Spermicides: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	No prescription required								
2.	Essentially no side effects								
3.	Can be easily purchased in pharmacies								
4.	Not very effective in preventing unintended pregnancy								
5.	The need to follow the exact recommended timing of spermicidal use and love-making								
6.	Does not protect from STIs								
7.	A few women experience allergies or irritation								
8.	When to start								
9.	How to use - Important to follow the manufacturer's recommendations—instructions differ								
10.	How to use - Place the spermicidal high in the vagina, so it covers the cervix								
11.	How to use - Apply a second time when there is a second act of intercourse more than an hour after the first act								
12.	Where to get the method and approximate price								
13.	Asks if a client has any questions								

Table 16. Voluntary Female Sterilization Counseling: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective in preventing unplanned pregnancy	No observations							
2.	Effective immediately after the procedure								
3.	Do not influence breastfeeding								
4.	Appropriate for women to whom pregnancy is contraindicated								
5.	Method is not associated with sexual intercourse								
6.	Almost irreversible method								
7.	Does not protect from STIs and HIV								
8.	Requires surgery, availablity of skilled ob-gyn and anesthesiologist and expensive surgical equipment								
9.	Possible infection of the procedure site								
10.	Possible injury of the bladder or gut (very rare)								
11.	Possible hematoma or superficial hemorrhage								
12.	Possible development of complications associated with anesthesia								
13.	Explained key steps during the surgery								
14.	Asked if a client has any questions								
15.	Pregnancy test								
16.	Unexplained vaginal bleeding								
17.	Acute pelvic or systemic infection								
18.	Checked woman's decision to not have more children								
19.	Lab tests prescribed in cases indicated								
Post-operative counseling									
1.	Explains that it's necessary to keep the incision ste dry for 2 days post-operation	No observations							
2.	Explains that it's necessary to avoid sexual intercourse for 1 week after the surgery								
3.	Tells when to come back for a follow-up visit (7-14 days post-operation)								
4.	Lists cases when a woman has to seek medical care (vaginal bleeding, constant or increasing abdominal pain, purulent discharge, pain or bleeding from the incision site, high fever)								

Table 17. Contraceptive Patch: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective if used according to instructions								
2.	Fertility returns immediately after stopping the method								
3.	Decreases the risk of some cancers and anemia (low blood iron)								
4.	Do not protect from sexually transmitted infections								
5.	Some women experience minor side effects (headache, nausea, irregular menstrual cycle, slight weight gain), especially during the first months of use								
6.	When to start								
7.	Should be applied to the skin (lower abdomen, buttocks, upper arm and upper body except to the breasts)								
8.	Apply a patch once a week, for 3 weeks; then go without a patch for a week, then start with a new patch once a week, for 3 weeks and continue this pattern								
9.	Where to get the method and approximate price								
10.	When to come for a return visit								
11.	Ask if client has any questions								
12.	Checks that woman weighs less than 90 kg (if >90kg do NOT prescribe method)								
13.	High blood pressure								
14.	Over age 35 and smokes								
15.	Severe headaches with focal neurological symptoms								
16.	Liver/gallbladder diseases								
17.	History of stoke, heart attack or blood clot								
18.	Diabetes								
19.	Lab tests are prescribed only if indicated due to medical history								

Table 18. Vaginal Ring: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Very effective if used according to instructions								
2.	Fertility returns immediately after stopping the method								
3.	Do not protect from sexually transmitted infections								
4.	Some women experience minor side effects (headache, nausea, irregular menstrual cycle, slight weight gain), especially during the first months of use								
5.	When to start								
6.	Is inserted high into the vagina, should stay in place for 3 weeks, and then removed for a week. Start with a new ring for 3 weeks and continue this pattern								
7.	Where to get the method and approximate price								
8.	When to come for a return visit								
9.	Asks if client has any questions								
10.	High blood pressure								
11.	Over age 35 and smokes								
12.	Severe headaches with focal neurological symptoms								
13.	Liver/gallbladder diseases								
14.	History of stoke, heart attack or blood clot								
15.	Diabetes								
16.	Lab tests are prescribed only if indicated due to medical history								

Table 19. Lactation Amenorrhea Method: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	No risks for health								
2.	No need to go to a doctor								
3.	Free of charge								
4.	Promotes the benefits of breast-feeding for the baby								
5.	Can only be used during the first 6 months after childbirth.								
6.	Requires frequent breastfeeding of the baby, day and night. Periods between feeding should not exceed 6 hours.								
7.	Does not protect from sexually transmitted infections.								
8.	No side effects								
	Provider explains 3 conditions for LAM to be effective								
9.	Baby is less than 6 months old;								
10.	Woman's menses have not returned;								
11.	Baby is getting nothing but breast milk, with feedings day and night								
12.	Explains when another method is needed								
13.	Asks if a client has any questions								
14.	For clients' compliance with the method (less than 6 month after the delivery, menses have not returned, baby is breastfed exclusively or almost exclusively)								

Table 20. Emergency Contraception: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-80%	80-100%	0%	1-49%	50-80%	80-100%
1.	Does not require lab tests or other screening before prescribing emergency contraception								
2.	Must be taken exactly within the right time period								
3.	Do not protect from sexually transmitted infections								
4.	Emergency contraception will not protect the client from unintended pregnancy during the rest of her current menstrual cycle—she should use another method								
5.	Nausea and vomiting								
6.	Irregular bleeding or spotting								
7.	Headache, dizziness, fatigue								
8.	Mentions all possible means of emergency contraception (Postinor, COC's scheme, IUD)								
9.	How to use - explains that the client should take emergency contraceptive pills as soon as possible after intercourse; if she uses a 2-dose regimen, the second pill should be taken 12 hours later.								
10.	Explains if vomiting occurs within 2 hours of taking the pills, the dose should be repeated - vaginally if necessary.								
11.	Not 100% effective								
12.	Checks if client used contraception and, if so, why she needs emergency contraception								
13.	Explain that emergency contraception should not be used as a regular form of contraception								
14.	Discusses other contraceptive methods with the client;								
15.	Explains when to start another contraceptive method								
16.	Where to get the method and approximate price								
17.	When to come for a return visit								
18.	Asked if a woman has any questions								
19.	The first act of unprotected intercourse took place less than three days (72 hours) ago.								
20.	Determines if the woman is already pregnant—in which case the pills will not be effective								

Table 21. Fertility Awareness-Based Methods – Calendar Method: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	No side effects								
2.	Free of charge								
3.	Both man and woman are involved								
4.	Can be used both for avoiding pregnancy and also for determining the best time to get pregnant								
5.	Not very effective in preventing unintended pregnancy								
6.	Complicated to use: requires daily observations and record-keeping								
7.	The couple must be willing to abstain from sex or use a barrier method (condoms or spermicides) for 8-16 days each month								
8.	Not effective for women with irregular menstrual cycles, such as adolescents, older women or those who recently gave birth or had an abortion								
9.	Do not protect from sexually transmitted infections (STIs)								
	Counseling on method use – Calendar method								
10.	For 6 menstrual cycles, record the first day of menstruation on a calendar								
11.	Take the shortest cycle and subtract 18 days—this is the first fertile day								
12.	Take the longest cycle and subtract 11—this is the last fertile day								
13.	Avoid sexual relations from days 8 to 18 of the menstrual cycle—these are fertile days								
14.	A barrier method of contraception, such as a condom, should be used during the 6 cycles when the menstrual cycle is being charted								
15.	A barrier method, such as condom, can be used as a back-up method								
16.	Asks if a client has any questions								

Table 22. Fertility Awareness-Based Methods – Basal Body Temperature Method: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	No side effects								
2.	Free of charge								
3.	Both man and woman are involved								
4.	Can be used both for avoiding pregnancy and also for determining the best time to get pregnant								
5.	Not very effective in preventing unintended pregnancy								
6.	Complicated to use: requires daily observations and record-keeping								
7.	The couple must be willing to abstain from sex or use a barrier method (condoms or spermicides) for 8-16 days each month								
8.	Not effective for women with irregular menstrual cycles, such as adolescents, older women or those who recently gave birth or had an abortion								
9.	Do not protect from sexually transmitted infections (STIs)								
	Counseling on method use – Basal Body Temperature method								
10.	Keep thermometer right next to the bed								
11.	Take temperature every day, immediately after waking up: before getting out of bed and before taking a hot or cold drink or food								
12.	Note the temperature on a special chart								
13.	Always take the temperature the same way (in mouth, rectum or vagina)								
14.	Take temperature at the same time each day								
15.	Ignore the temperatures during the first 4 days of the menstrual cycle								
16.	"Unsafe" days start when the temperature rises on 3 consecutive days—above the temperature of the previous 6 days								
17.	"Safe" days are those after 3 days of increased temperature and continue until the next menstrual cycle								
18.	Basal body temperature method is usually used together with cervical mucus method for greater effectiveness								
19.	A barrier method, such as condom, can be used as a back-up method								
20.	Come back if the couple has any questions								
21.	Asks if a client has any questions								

Table 23. Fertility Awareness-Based Methods – Cervical Mucus Method: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	No side effects								
2.	Free of charge								
3.	Both man and woman are involved								
4.	Can be used both for avoiding pregnancy and also for determining the best time to get pregnant								
5.	Not very effective in preventing unintended pregnancy								
6.	Complicated to use: requires daily observations and record-keeping								
7.	The couple must be willing to abstain from sex or use a barrier method (condoms or spermicides) for 8-16 days each month								
8.	Not effective for women with irregular menstrual cycles, such as adolescents, older women, those who recently gave birth or had an abortion								
9.	Do not protect from sexually transmitted infections (STIs)								
	Counseling on method use - Cervical Mucus Method								
10.	Record sensation of dryness, moistness or wetness felt at the opening of the vagina at least twice a day, morning and evening.								
11.	Collect some mucus.								
	Note properties of the mucus:								
12	- Color: white, cloudy or clear								
13	- Consistency: thin and lubricating or thick								
14	- Elasticity: by stretching it between two fingers to see if it breaks								
15	Record the features of the mucus on a special chart each evening.								
16	Mark the last day of slippery mucus and the following 3 days.								
17	The last day can only be noted when the mucus is no longer slippery/elastic.								
18	If slippery mucus reappears, that is the correct last day of slippery mucus.								
19	There are two sets of "safe" days.								
20	One set of "safe" days is starting right after the menstrual period and continuing until the first sign of cervical mucus.								
21	The second set of "safe" days is starting on the evening of the 4th day after the last day of slippery mucus.								
22	Abstain from sex completely in the first month to observe vaginal secretions								
23	Drugs used for colds or sinusitis may also dry the mucus, making the observations less reliable.								
24	A barrier method, such as condom, can be used as a back-up method.								
25	Come back if the couple has any questions.								
26	Asks if a client has any questions								

Table 24. Fertility Awareness-Based Methods – Symptothermal Method: Percent of All Recommended Items Covered/Performed by Providers at *Initial* Visits (among all initial sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	No side effects								
2.	Free of charge								
3.	Both man and woman are involved								
4.	Can be used both for avoiding pregnancy and also for determining the best time to get pregnant								
5.	Not very effective in preventing unintended pregnancy								
6.	Complicated to use: requires daily observations and record-keeping								
7.	The couple must be willing to abstain from sex or use a barrier method (condoms or spermicides) for 8-16 days each month								
8.	Not effective for women with irregular menstrual cycles, such as adolescents, older women or those who recently gave birth or had an abortion								
9.	Do not protect from sexually transmitted infections (STIs)								
	Counseling on method use – Basal Body Temperature method								
10	Keep thermometer right next to the bed								
11	Take temperature every day, immediately after waking up: before getting out of bed and before taking a hot or cold drink or food								
12	Note the temperature on a special chart								
13	Always take the temperature the same way (in mouth, rectum or vagina)								
14	Take temperature at the same time each day								
15	Ignore the temperatures during the first 4 days of the menstrual cycle								
16	"Unsafe" days start when the temperature rises on 3 consecutive days—above the temperature of the previous 6 days								
17	"Safe" days are those after 3 days of increased temperature and continue until the next menstrual cycle								
18	Basal body temperature method is usually used together with cervical mucus method for greater effectiveness								
19	A barrier method, such as condom, can be used as a back-up method								
20	Come back if the couple has any questions								
21	Asks if a client has any questions								
	Counseling on method use - Cervical Mucus Method								
22	Record sensation of dryness, moistness or wetness felt at the opening of the vagina at least twice a day, morning and evening.								
23	Collect some mucus.								

	Note properties of the mucus								
24	- Color: white, cloudy or clear								
25	- Consistency: thin and lubricating or thick								
26	- Elasticity: by stretching it between two fingers to see if it breaks								
27	Record the features of the mucus on a special chart each evening.								
28	Mark the last day of slippery mucus and the following 3 days.								
29	The last day can only be noted when the mucus is no longer slippery and elastic.								
30	If slippery mucus reappears, that is the correct last day of slippery mucus.								
31	There are two sets of “safe” days.								
32	One set of “safe” days is starting right after the menstrual period and continuing until the first sign of cervical mucus.								
33	The second set of “safe” days is starting on the evening of the 4th day after the last day of slippery mucus.								
34	Abstain from sex completely in the first month to observe vaginal secretions.								
35	Drugs used for colds or sinusitis may also dry the mucus, making the observations less reliable.								
36	A barrier method, such as condom, can be used as a back-up method.								
37	Come back if the couple has any questions.								
38	Asks if a client has any questions								

Follow-up Visits

Table 25. Combined Oral Contraceptives: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method								
2.	Answers client's questions								
3.	Checks blood pressure								
4.	Checks weight								

Table 26. IUD: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method								
2.	Answers client's questions								
3.	Checks for strings								
4.	Reminds patient to feel for strings								
5.	Tells woman to come back if she misses a period—she could be pregnant								

Table 27. Condoms (Male); Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method								
2.	Answers client's questions								
3.	Mentions that if the woman misses her period, she may be pregnant and should visit a health worker								

Table 28. Spermicides: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method								
2.	Answers client's questions								
3.	Mentions that if the woman misses a period, she may be pregnant and should visit a health worker								

Table 29. Voluntary Female Sterilization Counseling: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Answers all questions of the client regarding the procedure and method itself	No observations							
2.	Reminds that the method does not protect from STIs and HIV								

Table 30. Contraceptive Patch: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method	No observations							
2.	Answers client's questions								
3.	Checks blood pressure								
4.	Checks weight								

Table 31. Vaginal Ring: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method								
2.	Answers client's questions								
3.	Checks blood pressure								
4.	Checks weight								

Table 32. Lactation Amenorrhea Method: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1.	Asks about satisfaction with the method								
2.	Answers client's questions								
3.	Reminds about 3 conditions for LAM								
4.	Explains when to come back to choose another method								

Table 33. Emergency Contraception: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-80%	80-100%	0%	1-49%	50-80%	80-100%
1.	If the client doesn't have her period when it is expected, she should return to verify if she is pregnant	No observations							
2.	If the client has irregular bleeding and/or pain the lower abdomen, she should contact a health care provider								

Table 34. Fertility Awareness-Based Methods – Calendar, Basal Body Temperature, Cervical Mucus, and Symptothermal Methods: Percent of All Recommended Items Covered/Performed by Providers at *Follow-up* Visits (among all follow-up sessions observed)

No.	Action / Indicator	Not trained by TfH				Trained by TfH			
		0%	1-49%	50-79%	80-100%	0%	1-49%	50-79%	80-100%
1	Asks about satisfaction with the method								
2	Answers client's questions								
3	Mentions that if the woman misses her period, she may be pregnant and should visit a health worker								

Progestin-Only Pill and Injectable Counseling: No observations

Together for Health
46-v (46-в) T. Shevchenko Boulevard, Office 15, Kyiv 01032, Ukraine
Tel: (+38 044) 581-1520, Fax: (+38 044) 581-1521, e-mail: info@fprh-jsi.org.ua

Разом до Здоров'я
бул. Т. Шевченка, 46-в, офіс 15, Київ 01032, Україна
тел: (+38 044) 581-1520, факс: (+38 044) 581-1521, e-mail: info@fprh-jsi.org.ua