VIEWPOINT

How to Help Clients Obtain More Preventive Reproductive Health Care

By Ricardo Vernon and James Foreit

Many countries have subscribed to the Programme of Action drafted at the International Conference on Population and Development held in Cairo in 1994,[1] and these countries must now move beyond policy statements to actually implement integrated reproductive health programs. But doing so confronts health program managers with multiple challenges.

First, a commitment to implementing the principles established in Cairo requires an increase in the number and types of services that must be provided by health programs. Second, because population growth will continue, so too will the number of people requiring the expanded range of services. Third, if more health services for more people are to be paid for, the overall efficiency of reproductive health programs will have to be improved. Integrating various reproductive health services is generally thought to be the best way to meet these challenges.

"In-Reach" as a Solution

To expand the number of clients seeking services, family planning and reproductive health providers often undertake outreach activities—promoting their services to community members who may not have been aware of the provider or of the services offered. However, many integrated programs miss individuals who need preventive health services by failing to systematically screen their existing clients. Operations research projects in Latin America have demonstrated that integration can be made more effective through what we call "in-reach"—providing more services to individuals who already make use of health facilities in other ways and using simple screening instruments to produce changes in the knowledge and behavior of clients and providers.

Even before the Cairo conference, almost all public and not-for-profit health care providers in Latin America offered reproductive and maternal and child health care in their hospitals, clinics and health posts. Such services include prenatal and postnatal care, family planning, preventive services for breast and cervical cancer, and the diagnosis and treatment of sexually transmitted diseases. In addition, women can bring their children to health care facilities for pediatric services and well-baby care, which creates additional opportunities for providing reproductive health care. Although these services are usually available at the same time and in the same locations, they are often underutilized and their existence may not be well-known to the client population.[2] In Latin America, then, it is not so much an absence of services but a lack of promotion of existing services that is a principal barrier to increasing the utilization of reproductive health care.

A study in Guatemala found that approximately 29% of women attending health centers did not know that family planning services were available in their health centers, and that 11% were not aware that well-baby services were offered at these clinics.[3] Instituto Peruano de Paternidad Responsable (INPPARES), a Peruvian not-for-profit organization, offered many new reproductive health services in 1995, most of which were underutilized. In 1996, the organization surveyed clients to determine which additional services they might wish to receive from INPPARES health clinics. More than 34% of clients surveyed said they wanted treatment for one of the following health problems: sexually transmitted diseases, cancer screening and other reproductive health services that were already being offered by the clinic.[4]

One reason for this lack of awareness is that clients tend to seek one health service at a time. A mother who brings her child to a clinic for a vaccination may not inquire there about family planning, even though she may wish to use contraceptives. Providers, in turn, tend to concentrate on treating the specific problem they are presented with and do not always inform clients about, or screen for, needed preventive services, even when they are readily available.

In the Guatemala study, 167 women visiting health centers for non–family planning preventive services were also interested in practicing contraception, but only one received a family planning appointment during her visit.[5] Similarly, large numbers of women in Mexican health centers were found to have an unmet need for counseling regarding breastfeeding and for cervical and breast cancer screening, but very few of these women were screened or offered these services by providers: Only 16% of women in need were offered cervical cancer screening, and fewer than 15% of women who might have benefited from information about breastfeeding received it.[6] Situation analyses in Africa indicate that the problem of inadequate screening for preventive services is not limited to Latin America.[7]

We believe that there would be several benefits associated with better screening and the provision of more health services at each clinic visit. The extent of clients' unmet need for preventive health care could be reduced, and clients would have to spend less time and money traveling and waiting for services. From the program standpoint, it should be more efficient and less costly to provide multiple services in a single visit than to provide the same services at separate visits.

A major cost element in health care is payment for the provider's time. One

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study in Mexico found that a single preventive care service is given in an average of 17.2 minutes, but that the second service adds only 5.2 minutes and the third service takes approximately 6.7 minutes more.[8] Thus, each additional service increased client-provider contact time per visit by about one-third. In the same study, the average cost of the first reproductive health service (including staff time and materials) was $3.21. The marginal cost per service for up to two additional services was less than $1, implying a savings of more than $2 for multiple-service visits over single-service visits. Similarly, a study in Guatemala found that providers used only about 15% more time when they provided or gave information about two services instead of one in a single visit.[9]

How can program managers make their integrated services more effective, efficient and available for clients? The answer lies in changing the behavior of both clients and providers. Clients must be made aware of the range of services available from the health facility and of their own need for preventive health care so that they will seek additional services. Providers need to give information about health services when it is salient and can be easily acted upon. Providers must also improve their screening behaviors. These changes can be implemented by using simple instruments in health care facilities.

Figure 1. Algorithm for the systematic offer of reproductive health services, Guatemala Ministry of Health

Provide requested care. Then ask:	
Are you married or in union (are you sexually active)? If "yes," then:	Inform of services: Family planning and contraceptive methods. Prenatal and postpartum care. Services for children. Sex education.
Are you pregnant? If "yes," then:	Check: Attendance to prenatal care.
Have you had a birth in the last 2 months? If "yes," then:	Provide postpartum services. Ask: Is your child alive? If "no," then: advise and provide family planning If "yes," then check: Lactation. Well-baby care. Immunizations. Family planning.
Do you have a child less than one year old? If "yes," then:	Check: Lactation. Well-baby care. Immunizations. Family planning.
Do you want a pregnancy in the following year? If "yes," then:	Check reproductive risk: If "no risk," then recommend prenatal care and teach natural family planning. If "yes risk," then advise family planning.
Are you using a method? If "yes," then:	Check: Satisfaction with method. Secondary effects. Absolute contraindications. Correct use.
Do you want a method? If "yes," then:	Determine reproductive intentions: If "spacing," then advise and provide temporary methods. If "limiting," then advise and provide long-lasting method. Provide temporary method in the meantime.
If "no," then:	Determine why she does not want a method and provide education: Ask for reasons and provide a solution if possible. Educate about the benefits of family planning. Verify risk factors/explain the risks the woman has. Assure her of the availability of family planning services whenever she wants them.

Screening Instruments

In Guatemala, the Ministry of Health developed a seven-question algorithm (Figure 1) and trained its health center staff in its use.[10] Staff training lasted between two and four hours. Afterwards, screening more than doubled for most problems, and the provision of information increased dramatically: Forty-three percent of all health center users were given an appointment or referral for additional family planning services after the training, compared with 19% before.[11] Following the study, the Ministry of Health issued the algorithm to providers throughout the Guatemalan health system.

In Mexico, the Social Security Institute for State Workers conducted exit interviews with clients to learn whether the use of a modified version of Guatemala's provider algorithm resulted in increased screening.[12] Their results demonstrated that more women were offered additional services after the providers received algorithm training than before: The percentage of clients who received offers from their provider for breast examination increased from 8% to 59%, the percentage of clients who were offered family planning services increased from 2% to 21%, child immunizations among children not intially being seen for this purpose rose from 4% to 33% and the percentage of clients who received well-baby services increased from 2% to 16%. Depending on which additional service was offered, between one-half and two-thirds of all women who were offered additional services either accepted or requested further information about the service.

Provider behavior can be difficult to change. Even with training and supervision, many physicians and nurses participating in the studies discussed here continued to fail to screen their clients. In an attempt to bypass medical professionals in the screening process, INPPARES experimented with an interactive screening process involving clients and clinic receptionists.

A self-screening client brochure based on the algorithm shown in Figure 1 was developed. Clients randomly included in an experimental group received the brochure from a receptionist, who reviewed the information it contained with the client and urged the client to request any additional needed services. Clients in the control group did not receive the brochure or any encouragement to request special screening from providers. Members of the experimental group received 13% more services than controls at their first visit and 64% more services than controls at subsequent visits made in the month following the first visit. INPPARES estimates that the use of the brochure could increase a clinic's yearly revenue by almost $47,000, with a cost of approximately $7,000 for the brochure and the time and training of the receptionist. The brochure is now being used routinely in INPPARES clinics.[13]

Conclusions

The temporal and physical integration of reproductive health services do not necessarily guarantee that the Cairo mandate of providing more reproductive health services to women will be met, nor do they automatically make the delivery of reproductive health services more efficient or less costly. When services are integrated, client knowledge and provider behavior must also be changed. Of possible approaches for promoting the successful use of integrated health services, the use of simple instruments at the service delivery point has been demonstrated to be both low-cost and effective.

Programs need to make this kind of inreach a higher priority. Unlike providing information about clinic services during ordinary outreach activities, the INPPARES brochure gives clients information when they are most able to act on it. Unlike a single training course or official memo, the Guatemalan Ministry of Health's algorithm fixed to the provider's desk or consulting room wall can also act as a constant reminder of the need for client screening.

As researchers, we believe that different screening instruments need to be tested in additional programs, to compare the effectiveness of different instruments and to compare the relative effectiveness of client-oriented and provider-oriented instruments. Different training and supervision strategies for reinforcing screening behaviors at the service delivery point also need to be tested. Above all, service delivery organizations should start making in-reach a priority.

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