Oral contraceptives and cancer

Many of this Journal’s older readers will be familiar with the Oxford-Family Planning Association (Oxford-FPA) contraceptive study and will have made important contributions to data collection. Accordingly, I was delighted that the Journal Editor had chosen the most recent publication from the study1 as the focus for a Journal Review. I am also grateful to Dr Mills for taking so much trouble to produce a succinct summary of a complex paper.2 There are, however, one or two points about the review to which I would like to draw readers’ attention.

First, I would like to stress that the majority of the women in the study were followed up individually until mid-1994, although individual follow-up for a substantial subgroup of women ceased earlier than this. With regard to cancer registrations and death notifications, all women (save for those who emigrated) were followed up until the end of 2004 using information provided by the National Health Service Central Registers to supplement data collected during the course of individual follow-up.

Second, the Journal Review does not include any confidence intervals for the rate ratios (no doubt in the interests of saving space). This is, perhaps, of concern mainly for invasive cervical cancer, where the Oxford-FPA findings were considerably more unfavourable than has been described in most other studies. As the Oxford-FPA study included only 59 cases of this disease, it is of no surprise that six cases in the reference group who never used oral contraceptives), confidence intervals around the rate ratios were wide.

Finally, while the population studied was certainly of higher social class than the general population, it was not “predominantly Social Class 1”. The paper only gives the proportion of women from Social Classes I and II combined and this figure was 41%.

References
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References

Increase in IUD expulsions

Further to the letters of Drs Hawkins and Callander1 and my own,2 I received a telephone call from a doctor in Hong Kong expressing satisfaction of changing practice of fitting and found entirely satisfactory since 1996.

He tried hard to find a manufacturer to adopt the new design and found one in India. He fits 80 intrauterine devices a month with no problems. He draws my attention to an article4 that found entirely satisfactory since 1996.


detract from the substance and conclusions of the careful review prepared by Dr Mills.

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Reference

Pressed for time: providing the Standard Days Method and oral contraceptives in India

Recently, we reported in this Journal1 that Rwandan providers exchanged on average 39 items of relevant information as they counselled clients who chose the Standard Days Method (SDM)2 and only 31 with those who chose pills. Since specific SDM items and only six pill items were addressed at least 95% of providers in the consultations. We concluded that SDM counselling is generally satisfactory and that providers perform behind capacity when they deliver counselling on pills. These findings emerged in clinics of the Ministry of Health (MOH) in which providers offered consultations that lasted about 44 minutes with SDM clients and 38 minutes with pill clients.

Yet, in many settings, practical constraints limit the amount of time a family planning provider can spend with a client, which may impair the quality of care. Frequently, client load is overwhelming and time becomes a scarce asset: providers must see as many clients as possible each day. At MOH clinics of the Ranchi district in the Jharkhand state of India, providers engage in short consultations. To test the generalisation of the Rwandan findings, we replicated the study in 69 clinics of the Rancho and Ormanjhi blocks of Ranchi. The SDM was introduced through a 2-day workshop for providers after a 2-day contraceptive update workshop that reinforced pill (and other methods) delivery.

The consultations lasted on average 9 minutes and 41 seconds with SDM clients and 8 minutes and 4 seconds with pill clients. The number of information items exchanged with SDM clients reached 23.20 on average and with pill clients 21.75. Only 16 specific items from the SDM checklist were addressed by at least 60% of providers. Essential contra indications questions (e.g. asked whether my periods come more or less when I expect them, 59%; Asked about partner’s willingness to abstain or use protection on fertile days, 48%) and follow-up instructions (e.g. Told me to see the provider if period does not return the day on which the band passes over the last head, 46%; See the provider if period returns before the day on which the band should reach the dark brown head, 43%) routinely failed to meet the 60% standard. Important gaps were found in pill counselling as well (e.g. Asked about my blood pressure or measured it, or someone else did, 3%; Told me to return to the clinic right away if I have severe headaches and/or blurry vision, 9%; To return if I have any question or concern, 3%).

Nonetheless, the study results suggest that SDM and pills might be successfully offered in less than 10 minutes if counselling were further streamlined and focused. This still require prioritising items in the service delivery protocol and training providers to focus counselling on essential topics. A satisfactory list of 23 essential SDM items can be established and emphasised in SDM training. If providers, instead of using a more personal selection of items from the SDM protocol, addressed such 23 items in 9 minute and 41 second consultations, they would cover all of the basic topics of SDM counselling despite the limited session length. Analogous recommendations apply to pill counselling.

The SDM and pill results from our India study suggest that counselling training for providers pressed for time must help them select from the extensive information contained in method delivery protocols, family planning technology tables, or national reproductive health care guidelines a subset of essential items for standard use in interactions with clients.

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