



LUSAKA IMPACT STUDY

“Changes in Contraceptive Use Dynamics After the Introduction of Norplant®”

(Results of the baseline data and
First Follow-up)

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Acknowledgments

Changes in Contraceptive Use Dynamics After the Introduction of Norplant® and Depo-provera study commonly known as “Lusaka Impact Study” is longitudinal stretching up to the year 2000.

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Lastly, should any reader have questions regarding the report, please do not hesitate to contact the Principal Investigator Oliver J.M Chinganya at Central Statistical Office, Lusaka Zambia.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBoH	Central Board of Health
CFA	Client Flow Analysis
CSO	Central Statistical Office
DHS	Demographic and Health Survey
DHMT	District Health Management Team
DMPA	Depo-Medroxy Progesterone Acetate
FP	Family Planning
HIV	Human Immuno Deficiency Virus
IEC	Information, Education and Communication
IUD	Intra-Uterine Device
JSI	John Snow, Incorporated
LAM	Lactational Amenorrhea Method
LIS	Lusaka Impact Study
LDHMT	Lusaka District Health Management Team
MoH	Ministry of Health
MCH	Maternal and Child Health
RH	Reproductive Health
RTI	Respiratory Tract Infection
STD	Sexually Transmitted Disease
SEATS	Family Planning Services Expansion and Technical Support
USAID	United States Agency For International Development

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CHAPTER ONE

Background

1.1. Introduction

The concept of quality of care has been widely accepted in recent years by health and family planning service delivery agencies. One important operational component of quality of care is contraceptive choice. The available information on the impact of choice, reviewed by Jain, suggests that expanding contraceptive choice through the addition of a new method increases contraceptive prevalence, increases all method continuation rates, and reduces unintended pregnancy. These outcomes occur because the addition of a new method tends to attract new, first time users, and offers current users the opportunity to switch to the new method rather than discontinue use altogether when they are dissatisfied with the old method.

While these outcomes seem intuitively plausible, they are based on relatively weak empirical evidence from studies conducted in the 1960s and 1970s and cross country comparisons. There have been relatively few empirical studies conducted in the 1980s and 1990s that measure the effect of contraceptive choice on continuity of use and unintended pregnancies. In part, this has been because impact studies necessarily must be longitudinal in nature, take time (usually 24 months or more), require follow-up measures of clients and often costly. This study offers the opportunity to test on a longitudinal basis various hypotheses related to choice. The Ministry of Health, in collaboration with USAID and other donors, embarked on a systematic process of expanding the availability and the accessibility of family planning services. CARE and SEATS Project of JSI upgraded some clinics in Lusaka. Upgrading consisted of a three-week family planning course for providers which covered counselling, quality of care, and practice delivering methods such as the Combined and Progestagen-only pills, IUD, female and male condoms, foam, and Depo-provera. In addition, clinics received new equipment required to deliver methods. Providers at two clinics supported by CARE were also trained in Norplant® insertion. This situation provides the opportunity to compare the effect in terms of unintended pregnancies and continuity of use after introducing new methods (Norplant® and DMPA) into a clinic setting.

1.2. Rationale

Most family planning clinics in Zambia have a relatively limited number of contraceptive methods available to offer clients. While the reasons for this may be many (contraceptive stock-outs, policy restrictions on the use of certain methods, lack of trained providers, or other factors), the result is always the same, fewer contraceptive options for clients to meet their own particular needs. As the individual contraceptive needs of a client change over her reproductive years, the type of contraceptive she needs may also change. A relatively young woman who desires more children may want a method that is easily reversible such as the pill or condom, while an older woman who wants to limit fertility or space for an extended period may desire a method such as the IUD, Norplant® or sterilization. Other circumstances may also influence a woman to change her method of contraception. For example, some women may find that the method they first use is unacceptable in terms of convenience of use, cost or side effects, and they may wish to change

to another more acceptable method. Other women may have changes in their partnership arrangements which may lead them to different contraceptive needs.

When a woman wants to change her method of contraception but finds that other methods are not available, she has only two options, continue with the current method or discontinue contraception use altogether. In either case, this often results in client dissatisfaction, method discontinuation and/or sometimes, unintended pregnancy. The addition of a new contraceptive method to a clinic setting can change the situation at least for some women. Additional methods offer clients additional choices that may enable them to meet their own changing life circumstances and reproductive health needs. When the addition of new methods is coupled with effective provider training, adequate supplies, and equipment, not only is method availability increased, but also provider technical competence and client information improves.

1.3. Objectives of the Study

The primary objective of the Lusaka Impact Study (LIS) is to evaluate the effect of adding new contraceptive methods to the existing method mix on client behaviour. The specific outcomes considered in the study are, increase in contraceptive continuation rates and a decrease in the number of unintended pregnancies. In order to achieve the outcomes, Norplant® and Depo-provera (DMPA) were added to the method mix in public sector clinics in Lusaka.

1.4. Design of the Study and Sample Size

The study design consists of 8 clinics which have been classified into 3 levels; level A has two clinics offering DMPA and Norplant® in addition to the program methods; level B has two clinics offering DMPA in addition to the program methods; level C has four clinics offering only program methods.

Table 1.1: Clinics by Level and Characteristics of Inclusion in the Study

Number of Clinics	Clinic level	Characteristics
2	A	FP Providers trained, equipment upgraded and Norplant® and DMPA added to the method mix
2	B	FP Providers trained, equipment upgraded and DMPA added to the method mix.
4	C	FP Providers trained, received new equipment, IUDs and Noristerat added to the method mix.

Note: *Method mix program methods includes Combined and Progestagen-only pills, Male and Female condom, Foam, Noristerat, IUD, Emergency Contraception, NFP and LAM.*

The study design is longitudinal in nature stretching over a period of 36 months. During the first three months of the study, a panel of contraceptive users identified and their consent obtained for study participation. The panel consists of new, re-starters and switching users. A “new user”

is defined in this study as one who has never used contraception before, while a “re-starter” is one who is returning to contraception after stopping for a substantial period, usually after pregnancy and childbirth. A “switcher” is a continuous contraceptive who is changing methods. All panel members are expected to be re-interviewed between the 4th and 8th month, the 16th and 20th month and the 28th and 32nd month of the study. Interviews will be conducted at home or clinics depending on the client's choice. However, it is anticipated that there will be more interviews at home than at the clinic during the second and third round due to the period involved after recruitment. Many clients may not remember the appointment date after one or two years.

The design requires a total of 2,520 clients spread equally over the levels, i.e 840 per level. However during recruitment of clients to the study, level C clinics were not able to recruit the desired sample size within 3 months while level A and B clinics recruited more than the required sample. As a result, two more clinics were added to level C and the period of recruitment was extended by one more month in order to achieve the Level C sample requirement. Consequently, a total number of 3,203 clients from all the clinics were recruited and have all been included in the analysis.

1.5. Description of Clinics

The 8 clinics included in this study are under the jurisdiction of Lusaka District Health Management Team (LDHMT) but receive support from various donor agencies in terms of training and provision of equipment and materials. Level A clinics, in addition to FP services, provides delivery and other curative services such as ante-natal, under-five, MCH etc. The estimated population for one of the clinic catchment areas is 150,000 people characterised by low income households and informal sector activities. The other clinic catchment area's estimated population is 75,000 and has similar economic characteristics.

Level B includes two clinics, both with catchment areas of high population density and low income levels. Equally these clinics provide delivery services and other curative services in addition to family planning. The estimated population for one of the clinics catchment area is 105,000 while that of the other is 308,000. The households in these areas have low per capita incomes characterised by informal sector activities.

Level C clinics have a mix of medium and high density areas. Two clinics are categorised as medium density areas, and the majority of the adults are economically active in the formal sector. The estimated population for the catchment areas of the four clinics are 106,000; 87,000; 100,000; and 59,000 respectively.

The details of the client load, methods being provided and how the clinics have been supported are extensively described in the report of Client Flow Analysis (CFA, CSO/Population Council, 1998).

1.6. Data Collection

1.6.1. Instruments

As described in the earlier section, information was collected on the functioning of the clinics, and the clients as they were recruited into the panel. Information was collected on

staff providing family planning services and an inventory of the health facility using instruments adapted from the standard situation analysis methodology designed to assess the preparedness and readiness of health facilities. Observations of client-provider interactions were conducted to assess the quality of care provided at the clinics and Exit interviews were conducted with new family planning users. These are the members of the longitudinal panel. Three months after the baseline interviews, they were re-interviewed to learn of the interim experience using a follow-up instrument.

Below are the instruments used for data collection:

- Inventory of facilities available
- Exit interview (translated in the local language)
- Interviews of staff providing family planning services
- Observation of the interaction between FP providers and FP clients
- Service delivery statistics
- Follow-up (FU-1) at 3 months from admission into the study

1.6.2. Reviewing of Instruments and Pre-test

After the instruments were designed and reviewed several times, two social scientists (statisticians) and two medical staff (nurses) were recruited to undertake the pre-test. The instruments were tested in two clinics which are not part of the study. The pre-tested instruments were reviewed, this time with the research assistants. After the joint review, another pre-test was conducted and finally a few questionnaires for each type of instrument were printed in readiness for training.

1.6.3. Recruitment and Training of Field Staff

A total of 20 researchers were recruited to undertake the study, these comprised of 12 social scientists and 8 nurses. In addition, 3 computer personnel were recruited and trained together with the data collectors. Most of the data collectors participated in the Zambia Situation Analysis Study of 1997. The training of researchers took 5 days.

1.6.4. Client Flow Analysis (CFA)

Prior to the training of research assistants, a CFA was undertaken at the study sites (clinics) in order to assess the client load and staff utilization. Two teams of social scientists consisting of two members were recruited to undertake the exercise after the CFA instrument was designed. The CFA helped to describe qualitatively the study clinics in terms of provision of family planning services, workload of family planning staff providers and time taken to serve. Most importantly, the CFA assisted in determining the exact number of research assistants required to undertake the study.

1.6.5. Fieldwork

Data collection commenced on 12th August 1998 and ended on 18th December, 1998. Each clinic was visited by a team of three consisting of two social scientists (one of them was a team leader) and one nurse. The social scientists collected data on the inventory of facilities available, conducted service providers interviews and conducted exit interviews with the FP clients. The nurses observed the interaction between the provider and the client in the consultation room.

As mentioned earlier, data were collected over a period of 3 months for levels A, B and 2 of the level C clinics, while for the other 2 level C clinics, data were collected over a period of 4 months, thus, from mid August to mid December 1998. The research teams were rotated across the study clinics with each team spending one week at a time at a facility.

Since the data were collected over an extended period of time, it was possible to eliminate any daily and weekly fluctuations in the numbers of clients attending the clinics and those who were observed. Further, this method of data collection alleviated the problem of typical Situation Analysis in which there could be no respondents or clients to be observed or interviewed on the day of the visit.

1.6.6. Data Entry and Coding

EPI-INFO package was used for data entry. Screens for data entry were designed and developed to include logic checks. Three persons were recruited to enter the data on the computer. Data entry staff did both coding and entering the data. They were trained for two days on how to code and enter the data. The data entry process was designed to allow for data entry to be done as questionnaires came from the field, after they have been edited and coded both in the field and in the office.

1.7. Analysis

EPI-INFO package has been used for running frequencies and other basic tables. Advanced analysis will be done in SPSS.

1.8. Quality Checks

The quality of data collection was maintained by regular weekly inspection by the Principal Investigator. Further, weekly meetings of the research assistants were held which were used to discuss problems and identify solutions.

Use of the EPI-INFO program eliminated problems of wrong entries during data entry. In addition, the built-in skip and consistency checks reduced the chances of wrong entries. After the data entry, frequencies of all variables were run to check for consistency.

1.9. Ethics

Population Council's Institution Review Board (IRB) approved the project protocols, before the study commenced. Consent forms were designed for the respondents. Only those family planning users who consented to be part of the study were recruited. Consent was also obtained during the first follow-up interviews. The confidentiality of all interviewed - family planning users, and service providers being maintained. Respondents are identified only by Identification Number which are managed by the Principal Investigator.

1.10. Characteristics of the Sample

Table 1.2 shows the distribution of clients by level and reason for visit to the clinic. Over 50 percent of FP clients who visited the clinics were New Acceptors (never used family planning at all). About 77 percent of clients recruited to the study had their interaction with the provider observed.

Table 1.2: Percent Distribution of Clients by Purpose of Visit

Category of FP Client (from Exit instrument)	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
New Acceptor (never used FP at all)	58	62	47	56
Restart FP Acceptor (after pregnancy)	26	26	29	27
Switching (Wanted to change method)	16	12	24	17
<hr/>				
Category of FP Client (from observation instrument)	Level A (n=800)	Level B (n=1010)	Level C (n=644)	Total (n=2454)
New Acceptor (never used FP at all)	58	61	45	56
Restart FP Acceptor (after pregnancy)	27	28	31	28
Switching (Wanted to change method)	14	11	24	16

The structure of the sample which shows the number of people interviewed per instrument is shown in Table 1.3. The table shows that the number of Exit interviews are more than Observations. This is because in many of the study clinics, there is only one consultation room and the staff load of high resulting in reduced consultation time and high turnover of Exit interviews. This scenario meant that there would be more Exits than Observations and the emphasis was placed on making more Exit interviews. It is worth noting that all observation clients were given an Exit interview.

Table 1.3: Sample Structure

Type of Instrument	Clinic Type			Total
	Level A	Level B	Level C	
Inventory (No. of Clinics)	2	2	4	8
Staff Interview	14	7	21	42
Exit Interview	1,052	1,269	882	3,203
Observations	800	1,010	644	2,454
3 months Follow up interviews	720	836	644	2,200

CHAPTER TWO

Preparedness of Health Facilities

2.0. Introduction

The findings discussed in this report are based on data collected during the four months of recruitment of new family planning users. For purposes of this study, this data collected is referred to as baseline data. Results also include data from the first follow-up (FU-1) or re-interviews after three or four months of admission to the study. The results also include the findings from family planning providers.

The preparedness or readiness of the health facility to deliver a service depends on a number of factors such as among other things, accessibility, infrastructure including equipment, materials and staffing.

2.1. Access

Although all 8 study clinics are officially open at 07:30hrs, they only start to provide services at 08:30 and remain open until 16:00hrs. The average total time of providing FP services in the clinics is about five and half hours. In regard to the number of days of providing particular services, FP is at least offered for 5 days in all clinics while curatives services (sick child and delivery) are offered 7 days per week. All the clinics have a sign announcing FP services, either outside or inside the building and display the contraceptives samples or posters of methods available, although diaphragm, female condoms and sterilization methods are not displayed in two of the clinics.

About 93 percent of the women walk to the health facility while the rest use public transport or private vehicles.

Table 2.1: Percent of Women by Minutes it Takes to get to the Clinic

Minutes	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
1 -5	6	6	13	8
6 - 20	27	24	29	26
21 - 30	19	16	19	18
31 - 60	12	12	12	12
60 +	20	21	13	18
Can't remember	16	20	14	17
Average Minutes	29	30	28	29

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Table 2.1 shows the number of minutes it takes to get to the health facility. A third of the women take less than 20 minutes to get to the clinic, 18 percent take more than an hour. Interestingly, 95 percent of the women reported that they do not find it difficult to get to the clinic, despite the fact that nearly 50% take more than 30 minutes to get to the clinic.

Women in the study were asked about how long they had to wait between the time they first arrived at the facility and the time they began receiving services. Overall, 20 percent of the women waited for less than 20 minutes, although across the levels there seems to be some variations; level A, 16 percent, level B, 11 percent and level C, 34 percent. Slightly over a third waited to receive the services for more than one hour; the situation is more pronounced at levels A and B clinics. This could be attributed to high load of clients that have to be attended to each day. About 92 percent of clients spent less than 30 minutes in the consultation room with the provider as seen in Table 2.2.

Table 2.2: Percent of Clients by Minutes spent in the Consultation Room with the Provider

Minutes/Hours	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
Less than 30 minutes	88	94	84	92
30 minutes to 1 hour	9	5	6	6
Over 1 hour	3	1	0	2
Average minutes spent	19	17	17	18

2.2. Infrastructure and Equipment

All the clinics included in the study have piped running water, electricity, a room for clients to wait, working toilets and incinerator for safe disposal. The clinics have a good registration system. This is as expected given that all are situated in the city and are not only supported by the government but by other agencies as well.

The condition or status of the consultation rooms, were examined to determine how prepared they are to provide quality service. All the FP units of the clinics were adequate in terms of the items listed to check their status on the day of visit. Thus, there were adequate auditory privacy, visual privacy, clean floors, clean tables, clean windows, adequate lights, clean linen and adequate water. Adequate light was defined as functioning electric light or sufficient natural light, while adequate water as a sufficient quantity of clean water for washing hands and equipment. It was also found that in each of the levels, there was a clinic with 2 consultation rooms.

The clinics were also checked for selected laboratory equipment such as microscope, slides, slide covers, test tubes, chocolate agar medium, potassium hydroxide, vaginal swabs and cooler for transportation of samples. Clinics in levels A and B had five of the equipment while in level C only one or the other clinic had some of them as can be seen in Table 2.3 below.

Table 2.3: Selected Laboratory Equipment in Clinics

Equipment	Level A (n=2)	Level B (n=2)	Level C (n=4)
Microscope	2	2	1
Slides	2	2	1
Slide covers	2	2	1
Test tubes	2	2	1
Chocolate Agar Medium	0	2	1
Potassium Hydroxide	1	0	0
Vaginal swabs	2	1	1

2.3. Methods Provided at Health Facilities

Program methods such as Combined and Progestagen-only pills, IUD, Noristerat, Condoms, Foam tablets, Emergency contraception, Natural Family Planning and Lactational Amenorrhoea Method are usually provided at all the clinics. In addition levels A and B clinics provide Depo-provera and at level A clinics, Norplant® is usually provided. Diaphragm and sterilization methods are not provided at any of the clinics apart from counselling.

Researchers were asked to find out if there were any stock-outs of any methods during the past six months prior to the study. Only one clinic in level B had run out of combined pill, and Progestagen only-pill was at one point out of stock at one of the clinics in level A and B respectively. Norplant® implants had also run out at one of the level A clinics. Overall, the clinics had adequate supplies of methods in stock most of the time and written and up-to-date inventories were available.

2.4. Record Keeping and Supervision

Commodities such as contraceptives and drugs for RTI/STD treatment are recorded as they are supplied in an inventory book. Nearly all the facilities have a written inventory for both commodities. However, only half of the clinics (2 in Level A and 1 each in Levels B and C) have an up-to date and complete inventory of drugs for RTI/STD treatment. In cases where there is a complete inventory, the commodities are kept by expiry date.

On the question as to whether reports on FP and RTI/STD are sent to a higher unit or supervisor, all clinics reported that they do send reports on a monthly basis. The reports mainly contain the statistics of movements of stock and the distribution for the month. When asked about the number of times a DHMT supervisor visited the facility in the last 6 months prior to the study, 6 clinics (4 of them from level C) reported that they had at most two visits, and one clinic in each of levels A and B reported that they have had at least 4 visits in the past 6 months.

Information about the action taken by the DHMT supervisor during the last visit was collected and the statistics are in Table 2.4. From the table it can be seen that most of the supervisors

suggestion for improvements. Supervisors tend to be Public Health Nurses except in two clinics which are supervised by a doctor and one by a registered nurse midwife.

Table 2.4: Clinics by Actions taken by DHMT Supervisor during the Visits

Action taken	Level A (n=2)	Level B (n=2)	Level C (n=2)
Observe delivery of different services	1	0	3
Observe only service responsible of	2	0	1
Inquire about service problem	2	2	3
Examine the records	2	1	2
Make suggestions for improvement	2	0	2
Offer praise for good work	1	0	2

2.5. Staffing and Experience

As earlier mentioned the study included 42 providers, of which 14 are at level A clinics, 7 at level B and 21 at level C. The FP unit is dominated by Enrolled Nurse Midwives, about nearly half. Family Health Nurses and Registered midwives take the second and the third positions in terms of prominence.

Table 2.5 provides the distribution of FP providers by the number of years worked. The average number of years of experience for providers at Level A is 12.8 years compared to Levels B and C, 19.7 and 17.2 years, respectively.

Table 2.5: Providers by Number of Years of Experience

Number of years	Level A (n=14)	Level B (n=7)	Level C (n=7)
0 - 5	3	0	1
6 - 10	4	0	2
11- 15	2	3	5
16 - 20	1	1	7
21 - 25	4	1	4
26 - 30	0	2	2
Mean years of experience	12.8	19.7	17.2

Apart from providing family planning services, family planning staff provide other services, such as antenatal care, delivery, postnatal, child welfare, RTI/STD management and HIV/AIDS counselling services.

The basic training of the family planning providers included among other topics general clinical skills in family planning, record keeping, management and supervision, STD screening,

counselling etc. Three quarters of the providers have had refresher training at one point during the last 3 years prior to the study. When the providers were asked about the adequacy of the training, a quarter said that the training was not adequate and that they needed additional skills in the provision of Lactational Amenorrhoea Method, IEC and record keeping. The providers at level A clinic indicated that they need more training on Norplant® .

2.6. Staff Provider's Knowledge of Methods

Generally providers seem to be knowledgeable about most of the methods. Complete results on providers' knowledge on specific methods are in Annex 3.

2.6.1. Pill

Providers were asked about the side effects of the pill. Most of them reported, nausea, mild headaches, and dizziness as the major ones. However, when the results are analysed by levels, spotting and bleeding as side effect were reported in slightly over half of the providers at level C clinics while the other levels, less than a third reported.

On warning signs or major problems that require a woman taking pills to return to the clinic, the providers reported severe chest pains and breathlessness, severe headache and severe abdominal pain as the main signs. The providers also know what advice to give clients with high risk of infection with RTI/STD or HIV. Nearly 80 percent reported that they would advise the client to continue with the pill but use a condom also.

2.6.2. IUD

On knowledge about when IUDs can be inserted, about half of the providers reported that IUDs can be inserted soon after menses and another half said anytime it is certain that the woman is not pregnant or anytime during menstrual cycle. With respect to side effects, providers tended to mention cramps or lower abdominal pain, bleeding and spotting between menstrual periods.

Just under half of the providers reported that a woman using IUD should go for checks for at least 3 times after the first check and one quarter reported that a woman can go when need arises. Nearly three quarters of the providers reported that Copper T-380A can remain effective for 9 to 10 years. Regarding problems for which a woman should come back to the clinic, expulsion or not feeling the thread, severe lower abdominal pains with cramps, heavy discharge and prolonged bleeding were reported. On advice given to clients at high risk of infection with RTI/STD or HIV/AIDS, providers said that they would advise the woman to continue with the IUD but use a condom or switch from the IUD to the condom.

2.6.3. Injectable

Similarly providers were knowledgeable about the provision of the injectable method. Over half of the providers said that an injectable method should be given within 1st - 5th day of menses. On the side effects, mild headaches, irregular bleeding and amenorrhoea were reported by most of the providers in all levels. The warning signs reported were heavy bleeding and severe headache. Providers also reported that they would advise a client at high risk of infection with an RTI/STD or HIV/AIDS to continue with the injection but use a condom.

2.6.4. Norplant®

Norplant® is only provided in 2 of the clinics in the study but all providers in the study were asked about their knowledge on Norplant®. Half of the providers said that Norplant® can be given within 1st and 5th day of menses and a similar proportion reported that it can be given when reasonably sure that a woman is not pregnant. The side effect of Norplant® were reported to be irregular bleeding, mild headaches, and amenorrhoea by most of the providers.

On the major problems for which a client using Norplant® should return, providers mentioned prolonged bleeding. As regards the time when a woman must go back for removal, half said when need arises and another half said after five years. They also reported that a woman at high risk of infection with an RTI/STD or HIV/AIDS can continue using but should use a condom as well.

2.7. Constellation of Services

Over two thirds of the providers reported that they had screened clients for RTI/STD, counselled, or treated syndromically 3 months prior to the study. They also reported advising clients to use condoms specifically for preventing RTI/STD/HIV infection and further reported that they would provide family planning services including counselling for a woman with HIV/AIDS.

The providers were asked if they knew whether adolescents go to the health facility, nearly all said they do and that they mainly go for family planning and antenatal care.

Providers were asked if they have any knowledge about women in the community who abort as a way of preventing unwanted births. Most of them reported that they are aware that unsafe abortion is common. They have many times given advice (counselled) on termination of pregnancy and post abortion care. Further, providers reported that some women come to the clinics for medical treatment as a consequence of an incomplete or induced abortion.

CHAPTER THREE

Demographic Profile

3.1. Introduction

Information on the background characteristics of family planning users is essential as it helps to understand certain patterns in their response, particularly, regarding choice of methods. The study collected information on age, education, religion, marital status and children ever born.

3.2. Age

Over two-thirds of the respondents were between 20 and 29 years old as seen in Table 3.1. This age distribution is typical of family planning users and the pattern is the same across the levels. The 1996 Zambia DHS reported that just under 50 percent of the women were currently using contraceptives in this age group. It is therefore not surprising that in the Lusaka study over two thirds of users belong to this age group. Adolescent age group, 14 to 19 years represent about 15 percent of the users in the study.

Table 3.1: Percentage Distribution of Family Planning Users by Age Group

Age group	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
14 - 19	14	18	12	15
20 - 24	40	40	43	41
25 - 29	26	24	26	25
30 - 34	11	9	11	10
35 - 39	5	5	5	5
40 - 44	2	2	2	2
45 - 49	0	0	0	0
> 49	0	0	0	0
Don't know	0	2	0	2
Mean Age	25.1	25.0	25.2	25.1

3.3. Education, Religion and Marital Status

Characteristics such as education, religion and marital status play a major role in family planning. Table 3.2 shows the distribution of contraceptors by education level attained, religion and marital status. In terms of education achievement, most of the respondents had some schooling. Over 50 percent of the users have primary education and only 6 percent have never been to school. About two-fifths have at least a secondary education. No significant differences were found across the levels.

Table 3.2: Percentage Distribution of FP Users by Selected Background Characteristics

Variable	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
Education:				
No Schooling	4	8	4	6
Primary	59	62	45	56
Secondary	35	29	47	36
Post Secondary	1	1	5	2
Religion:				
Catholic	20	28	21	24
Protestant	77	71	77	74
Muslim	1	0	0	0
None	2	1	1	1
Marital Status:				
Married	95	96	89	94
Co-habiting	0	1	1	0
Never married	2	1	6	3
Separated/divorced	2	1	2	2
Widowed	1	1	2	1

Nearly all the respondents were Christian, with under a quarter being Catholics and the rest Protestant. Table 3.2 further shows that in nearly 95 percent of the users are married except for level C where 89 percent are married. The proportion of users who have never married is comparatively high in level C with 6 percent compared to the sample proportion of 3 percent in the overall total.

It is worth noting that when respondents were asked about whether they do any work for pay or in kind, about a quarter of the respondents said they were working. On the question of whether they have lived in Lusaka all their lives, nearly half the respondents had been residents all their lives, implying that the other half were migrants. There is no noticeable difference across levels, Level A 46 percent, B 53 percent and C 49 percent.

3.4. Reproductive History and Intentions

Information about reproductive history and intentions was collected from the women in the panel. Table 3.3 shows the profile of FP users by their reproductive history and intentions. The table shows that almost all the women in the panel had ever been pregnant and about three quarters of them have had live births. Looking at parity, nearly 60 percent of the women reported having between 1 and 2 children and another 28 percent report to have 3 and 4 children.

Reproductive loss is fairly high, thus, women who reported deaths of children represent about 26 percent. Three percent of the users experienced a stillbirth and 13 percent had experienced a miscarriage of pregnancy.

Table 3.3: Profile of FP Users by their Reproductive History and Goal/Intentions

Variable	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
Reproductive History:				
A. Ever been pregnant (%)	100	100	95	100
Live Births (%)	73	71	79	74
B. With Dead Children (%)	27	29	21	26
Average number of dead children	1.4	1.4	1.4	1.4
C. With miscarriage (%)	15	12	12	13
Average number of miscarriage pregnancy	1.2	1.3	1.2	1.2
D With Still births (%)	3	4	4	3
Average number with stillbirth	1.3	1.2	1.2	1.2
Intentions:				
A. Wants more children	77	77	75	77
B. Average number of months of waiting before next birth	41	41	43	41
Percent of clients who wanted to wait for 3 years	61.2	59.0	56.4	59.0
C. Average number of desired children	4.24	4.28	3.85	4.15
D. Average number of own living children	2.7	2.6	2.4	2.5
Last Pregnancy: Wanted to be pregnant, (%)				
(i) Then	43	40	42	42
(ii) Later	29	30	31	30
(iii) Not at all	29	30	27	28

Table 3.3 further reveals that at the time of the survey, over three-quarters (77 percent) of the respondents reported wanting more children. Those reporting wanting more children were further questioned as to how long they would like to wait before the birth of their next child. On average 59 percent of the women wanted to wait for at least 3 years and one quarter for two years. Women were questioned about their feelings concerning the timing of their last pregnancy. Two-fifths reported wanting the pregnancy while a little less than a third reported that it was mistimed and another third reported not wanting it all. It is possible to conjecture that the experience of an unwanted or untimed pregnancy could be the reason for adopting contraception. In this study

CHAPTER FOUR

Quality of Care

4.1. Introduction

Quality of care is essential for maintaining the health and satisfaction of family planning clients. In this study, quality of care is important as it result in increasing continuation rates and decreasing the number of unintended pregnancies.

4.2. Interpersonal Relations

Rapport between the provider and client is an important element of care. Providers can create an atmosphere of trust by doing several things including being accessible, treating the client in a humane manner, and engaging them in discussion. This way, clients can continue using the health facilities and services.

Universally all the respondents across the levels during the exit interview reported that they were satisfied with the services they received. Expressions of satisfaction in exit interviews may be influenced by courtesy bias or fears of being denied services in the future. Due to these biases, expressions of satisfaction should be viewed with caution or used alongside with other data on actual recommendation of the facility by the respondent. Ninety-one percent of the respondents reported that they would be willing to recommend the facility to others, primarily due to the higher levels of information that providers give.

All the women in the panel perceived that the provider had been friendly and this is borne out by information from observations as well. Observations of client-provider interactions indicate that universally all providers in all clinics greeted their clients in a friendly manner.

Almost half of the women (47 percent in level A, 43 percent in level B, and 50 percent in level C) reported during the exit interviews that they had questions to ask the provider. Ninety-four percent of the users who had questions had been allowed by the provider to ask and ninety-nine percent had their queries answered to their satisfaction. Furthermore, over 90 percent felt that they had been given enough information during the consultation which led them to choose an appropriate contraceptive.

4.3. Understanding Clients' Needs

In an ideal situation, providers are required to assess the needs and circumstances of their clients so as to assist clients to choose an appropriate method. Typically information should be collected on reproductive intentions, age of the last child and breastfeeding status, family planning knowledge and experience, and sexual behaviour. Only the salient points recorded during observations and exit interviews are reported here.

Table 4.1: Assessment of Clients to Understanding Client's Need

Assessed Provider asked	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
Would like another child	71	56	67	64
When to have another child	64	51	58	58
Breastfeeding	82	85	84	84
Date of last period	94	93	95	94

Table 4.1 shows that at the exit interview, about 64 percent reported that the provider had asked them about their intention to have another child. Thus, in nearly two-fifths of the time, providers do not enquire about the reproductive intentions of their clients which is significant omission of assessing clients' needs as an appropriate method may not be discussed.

Observations of interactions with new and restarting family planning clients indicate that between a half and three-quarters were asked about their reproductive intentions as shown in Table 4.2. For example, in 72 percent of the interactions, providers asked clients if they wanted to space or limit births. In level A 73 percent were asked while in levels B and C, accounted for 67 and 78 percent respectively.

Table 4.2: Percentage Distribution of New or Re-starting FP Users
(Assessment made during the Provider-Client Interaction)

Assessed Provider asked	Level A (n=687)	Level B (n=897)	Level C (n=488)	Total (n=2072)
Space/delay or limit births	73	67	78	72
Timing of next birth	60	46	59	54
No. of children wanted	72	64	73	69
Age of youngest child	92	94	94	93
Breastfeeding	87	91	89	89

As regards timing of next birth, overall in 69 percent of the interactions the desired number of children was ascertained; 72 percent in level A, 64 percent in level B and 73 in level C). However, in just about a half of the interactions was the desired timing of the next birth asked; 60 percent in level A, 46 percent in level B and 59 percent in level C. The appropriate choice of a method depends to a large degree on the reproductive intentions of the client, and not obtaining complete information on it can lead to an inappropriate choice.

Providers are also required to ascertain the menstrual and breastfeeding status as the former can indicate whether the client is pregnant and the latter to indicate screening for combined oral contraception. Table 4.2 further reveals that 84 percent of the women responded that providers had enquired about their breastfeeding and 94 percent asked date of their last menstrual period. Observations of interactions are consistent with the exit interviews in this regard. For instance, in at least 90 percent of the interactions, the providers had solicited information on these aspects,

see Table 4.2. Providers typically do not forget to ask these screening questions as has been observed in a number of different settings.

Table 4.3: Percentage Distribution of New or Re-starting FP Users
(Assessment made during the Provider-Client Interaction on knowledge and experience)

Assessed	Level A (n=687)	Level B (n=897)	Level C (n=488)	Total (n=2072)
Preferred method	94	93	94	94
Knowledge of specific method	66	63	67	65
Previous use of method	89	89	93	90
Concerns about contraceptive use	32	17	23	23
History of STDS	72	84	88	81
No. of sexual partners	5	2	4	4
STDS and HIV/AIDS concerns	16	10	12	12

Table 4.3 shows the assessment made on knowledge and experience of new or re-starting FP users during the interaction with providers. In ascertaining family planning knowledge and prior experience in over 90 percent of the interactions across the levels, providers asked clients about their prior family planning experience and discussed their preferred method.

However, the providers asked the client if she had any concerns about using contraception in about between a third and a fifth of the interactions.

In over 80 percent of the interactions, the providers were observed to obtain a medical history. In addition to the general medical history, providers are also required to obtain information on symptoms of Sexually Transmitted Infections (STIs) so as to be able to tailor relevant information according to the sexual exposure of the client. While in 67 percent of interactions providers did enquire about pelvic pain (15 percent in level A, 71 percent in level B, and 62 percent in level C), abnormal vaginal bleeding (40 percent) and discharge (13 percent), and genital itching (13 percent) tend to get short shrift. This is also borne out by the following information -- While the client's history of STD exposure is discussed about four-fifths of the time, there is hardly any discussion about the number of sexual partners (4 percent) and very little attempt to address the client's concerns about STDs or HIV/AIDS (12 percent).

4.4. Information to Clients

Contraceptive acceptance, continuation, and continued use of the facilities depend to a large degree on the information that a user of the services takes away at the end of an interaction with a service provider. Users who are given more information are more likely to accept and continue contraception than those who receive inadequate or incorrect information. In order to gauge the level of information that clients take away with them, the exit interviews collected data on these aspects. The observations of the interactions are also an independent and alternate source of data to compare the findings from the exit interviews. To a large extent data from the exit interviews and observations are consistent with each other. Table 4.1 gives details of information given as reported by all women during the exit interviews (at recruitment).

Table 4.1: Information on Methods given (Percent)

Information Given	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
How method works	94	91	90	92
How to use method	63	66	58	63
Possible side effects	84	74	82	77
Warning signs	80	67	79	75
How to deal with problem	90	83	85	86
Switching	86	78	78	81
Another clinic (alternative source of supply)	18	20	29	22
Timing of next visit	89	86	92	89
Method which can prevent STD/HIV/AIDS	52	51	44	50

While over 90 percent of the exit interviewees reported that the provider had clearly explained how their recently chosen family planning method worked, only 63 percent reported that they were given a demonstration of how to use it. However, at least three-quarters were informed of the possible side-effects (77 percent), and warning signs (75 percent). It is also encouraging to note that 86 percent of the women reported that they were given instructions on actions to be taken in the event of problems. These data do not permit us to explore the content of these instructions and we surmise that clients were told to return to the clinics. Detailed information is in the method specific section.

The observations of the interactions also present a similar picture as the exit interviews. Eighty-five percent of the new clients observed were told how to use the method, 65 percent how it works, 70 percent of its advantages and 61 percent of its disadvantages. The data on side effects and warning signs mentioned are also compared at 85 percent and 71 percent respectively. Similar to the exit interviews, 85 percent of the observations indicated that the clients were instructed on actions to take in the event of problems with the method during use.

Furthermore, over four-fifths of the exit interviewees reported being counselled that they could change methods should they be dissatisfied with the chosen method, with a slightly greater percentage being reported among those attending level A clinics (86 percent in level A, and 78 percent in levels B and C). It is interesting to note that overall, just about a fifth of the women were told of alternative sources of supply. This appears to be more true for those attending level A and B clinics than those attending level C (18 percent in level A, 20 percent in level B and 29 percent in level C). We surmise that as level C clinics offer a slightly reduced range of contraceptives, the providers are more likely to inform the clients of other sources of supply where other methods could be availed.

Contrary to the exit interviews, observers noted that less than half of the clients were informed of the possibility of switching contraceptives should they be dissatisfied with the method accepted; 46 percent of observations as compared to 81 percent of exit interviews. It is possible that respondents at the exit interviews did not comprehend the question or that they truly perceived

that the possibility of switching had been mentioned. There are inter level differences as well, with clients observed in level A clinics (52 percent) tending to be informed more than those attending level B (40 percent) or level C (9 percent) clinics. In terms of information of alternative supply sources, the observations are almost similar to the exit interviews. Overall, 11 percent of clients were observed to being told of alternative sources, with the range being from 9 percent in level A clinics, 15 percent in level B, to 24 percent in level C.

In terms of other information given to clients, 89 percent of the women reported that they were informed about their next scheduled visit at the clinic. Surprisingly, only half the women reported that providers had informed them about any method which could prevent sexually transmitted diseases and HIV/AIDS. Observations of interactions are consistent with these items reported in the exits. The service guidelines require providers to inform clients about methods of protection against sexually transmitted diseases; that this is not done could be due to the well known reasons of provider discomfort in talking about sensitive topics such as sexuality and sexually transmitted infections.

4.5. Choice of Methods

The choice available to a client depends on the availability of methods at the health facility, whether the method is mentioned to the client so that she is aware of its existence, provider attitudes towards providing certain methods and availability of trained providers.

4.5.1. Methods Preferred and Discussed by and with the Client

Ninety-five percent of exit respondents felt that there were sufficient methods available to them at the clinic to make a choice. A similar high proportion also reported that they were asked about the family planning method they would prefer (98 percent), and received the method of their choice (93 percent). A third of those who did not receive their method of choice were disappointed. These findings are consistent with the observations as well, in which 93 percent of new clients received their method of choice. Those clients who were denied their chosen method, were told to return with their menses (48 percent), or the provider felt that the method was inappropriate (20 percent), or there were contraindications (13 percent). Nearly all those who did not receive their chosen method, were provided with an alternative method for the interim.

Table 4.5: Client preferred Method of Choice (Percent)

Method	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
Combined Pill	42	38	41	40
Progestagen only Pill	9	18	12	13
IUD	1	1	2	1
Depo-Provera (DMPA)	36	31	1	24
Noristerat	3	6	41	15
Norplant®	6	0	0	2
Condoms (Male/Female)	1	3	1	2
Foam Tablets	1	2	1	1

In terms of preference for various methods, Figure 5 shows that, overall over half (53 percent) of the panel respondents cited oral pills (both COC and POP) as their method of choice and two-fifths (39 percent) cited injectables. There are clear differences between levels, as those women recruited from level A and B clinics tended to prefer DMPA to Noristerat, while those from level C clinics tended to prefer Noristerat to DMPA. These differences are largely a function of the availability of the methods in the clinics. Similarly, 6 percent of the women attending level A clinics mentioned Norplant® as their preferred method as this contraceptive is available only at these clinics.

Choice of method is enhanced when a user knows at least one additional method to the contraceptive being used. Three quarters of the panel respondents reported being informed of at least one method in addition to the one received. Table 4.2 shows other methods mentioned by the provider other than the one received.

Table 4.6: Methods Mentioned by the Provider (Percent)

Method	Level A (n=811)	Level B (n=958)	Level C (n=643)	Total (n=2412)
Combined pill	53	53	51	53
Progestagen only pill	52	53	44	50
IUD	65	69	54	64
Depo Provera	59	58	24	49
Noristerat	61	61	42	56
Norplant®	61	61	42	56
Male condom	70	71	67	70
Female condom	68	68	61	66
Diaphragm	2	2	2	2
Foam Tablet	47	46	40	45
Emergency Contraception	2	4	8	5
Natural Family Planning	8	13	7	10
Lactational Amenorrhoea Method (LAM)	1	3	2	2
Tubal ligation	5	9	8	8
Vasectomy	3	6	4	4

Relatively high proportions of women reported hearing about male and female condoms (70 and 66 percent respectively), the IUD (64 percent), Noristerat (56 percent) and oral pills (53 percent COC and 50 percent POP) in addition to the method they received. The data also indicate that there is no promotion of any specific method as just 4 percent of the panel respondents reported that their providers had emphasized a particular method. The proportions are similar across the levels.

The results from the observation of provider-client interaction indicate that oral pills and injectables are mentioned by the provider at least 70 percent of the time. Other commonly mentioned methods include the IUD (70 percent), male and female condoms (73 and 68 percent respectively), foam tablets (67 percent), and Norplant (57 percent). Sterilization, Lactational Amenorrhoea Method (LAM) or natural family planning, is mentioned in less than 40 percent of the interactions. It is interesting to note that there are some differences by level of clinic, in that methods which are available in only level A or level B clinics tend to be mentioned more in these settings. For example, Norplant is mentioned in 78 percent of the interactions in level A, and less than 53 percent of the time in the other two levels as it is available only in level A clinics. A similar finding can be observed for DMPA, which is available in only in levels A and B. Consequently, while it is mentioned over 80 percent of the time in these levels, it tends to be mentioned less than two-fifths of the time in level C. The data also indicate that generally providers do not promote anyone method over another.

4.5.2. Provider's Restrictions in the Provision of Family Planning Methods

Some providers indicated restrictions in the provision of methods. They require a client to fulfil certain conditions or to meet certain criteria before a method is presented or given. According to about over half of the providers interviewed, the minimum age required before a hormonal method is presented is between 15 and 18 years while the maximum age is between 42 and 44. Providers in level C clinics reported that age 14 would be the minimum. Levels A and B do not show a significant difference in their reporting between them. For barrier methods, providers reported that on average the minimum age required is between 13 and 15 years although providers in level B clinics reported age 17 as minimum. The maximum age for barrier methods was reported to be about 54 years and with is no pronounced difference between levels. Regarding sterilization methods, the minimum and maximum age required as reported by providers were 31 and 51 years respectively.

The providers were asked if they can prescribe a method to a unmarried woman. All of them reported that they would for all methods except for sterilization. On the question of recommending FP methods to women who would like to delay or space their next birth assuming there are no contraindications, one would expect that 100 percent of the providers would report positively for spacing methods, but there were providers who felt that these methods were not appropriate as may be seen in Table 4.7.

Table 4.7: Number of Providers who would Recommend FP Methods to Women who would like to Delay or Space their Next Birth

Method	Level A (n=11)	Level B (n=7)	Level C (n=18)	Total (n=36)
Combined Pill	11	6	17	34
Progestagen only Pill	9	7	17	33
Depo- provera	9	6	14	30
IUD	10	5	16	29
Noristerat	11	5	12	32
Norplant®	10	4	15	26

However, when the providers were asked about the methods they could recommend to women who would like to have no more children, almost all of them said that sterilization would be most appropriate. About the same number of clients reported that they would not recommend IUD to clients with or exposed to RTI/STIs and, would not recommend combined pill to clients who are currently breastfeeding.

4.6. Information, Education and Communication (IEC) Material

IEC materials for family planning are available at most of the clinics in the study, particularly flip charts. Posters for family planning, RTI/STD, HIV/AIDS and post-natal care are in at least three of the clinics. However, it appears that IEC materials are not often used during an interaction with the client even when they are available at the clinic. Sixty-three percent of the exit respondents indicated that the provider had used IEC materials during their consultation. Observations of provider interactions with new clients indicate that providers tended to use contraceptive samples (83 percent), flip charts (42 percent), and anatomical models (25 percent).

4.7. Technical Competence

Providers' competence can be gauged by observations of an independent observer during routine service provision. In this study qualified nurses were engaged to observe the client-provider interaction without interrupting.

Weight and blood pressure measurements are routine procedures to be conducted before method provision. While the blood pressure of new clients was measured in over 80 percent of the interactions, weight tended to be measured in roughly half the cases (54 percent). In just about a quarter of the cases, physical exams (26 percent) and breast exams (27 percent) were conducted.

In 8 percent of the interactions observed, the provider conducted a pelvic exam. Consistent with our observations above, over half of the pelvic exams observed were from level C, and a quarter each from level A and B respectively. Universally, in all the clinics the providers explained to the clients about the pelvic exam. While in nearly 90 percent of observations providers washed their hands prior to the examination, 96 percent used clean gloves, the proportion using a clean speculum falls to 71 percent. Furthermore, clean speculums were used in just a third of the pelvic exams in level A clinics. It is not clear as to whether the high client loads in these clinics were the reason for not being able to clean the speculums in time for an examination, or whether there was a shortage of speculum sets or disinfectants. In over 90 percent of the observations, the providers washed their hands after examination; 76 percent in level A and 100 percent in level B and C clinics). In 85 percent of the exams, providers were observed informing the client about the results of the exam.

4.8. Mechanisms to Encourage Continuity

Continuity of contraception or any service is ensured when a user knows more than one facility from which to avail the service. Just about a third of the exit respondents could report at least one other source of family planning services as seen in Table 5.8. Nearly 90 percent of the clients

were told when to return to the health facility and about half reported having been given a reminder card. Other public sector clinics and hospitals were the most commonly mentioned.

Table 4.8: Percent of Clients by Characteristics of Continuity

Characteristics of continuity	Level A (n=1052)	Level B (n=1269)	Level C (n=882)	Total (n=3203)
Client told when to return	89	86	92	89
Client given a written reminder (Card)	55	50	55	53
Client knows another clinic where to obtain a method	30	29	46	34

CHAPTER FIVE

Client's Knowledge of Specific Methods

5.1. Introduction

An effort was made to gauge the level of clients' knowledge about the method they accepted. Table 5.1 shows the percentage distribution of clients by method received during the visit. About two fifth received combined pills and is almost the same for all levels. Depo-provera was dominate at Levels A and B while Noristerat was at Level C as expected.

Table 5.1: Method Received during the Visit

Method	Percentage of Clients			
	Level A	Level B	Level C	Total
Combined pill	43	38	40	40
Progestagen only pill	11	19	15	15
IUD	0	1	2	1
Depo Provera	32	29	0	22
Noristerat	3	6	40	14
Norplant®	5	0	0	2
Male condom	2	4	1	3
Female condom	1	0	0	0
Diaphragm	4	3	2	3

Specifically, information was collected at the exit interviews on how the method works, its duration of effectiveness, possible side-effects, warning signs, and when to return for a follow up. The hypothesis being tested is that women who know more may be more likely to use their method effectively, be prepared for potential side-effects, and be less likely to drop out. In general, it appears that users' knowledge is incomplete and inaccurate on some elements. While knowledge of how to use the method is universal, that on side-effects, warning signs and protection against STDS and HIV is more limited. We also present data from the observations to provide some insight into whether the process of service delivery affects the information received by clients.

Note that the client's knowledge of specific method tables are detailed in Annex 2.

5.2. Oral Pills

Ninety-two percent of respondents who had accepted pills reported receiving 3 cycles during their consultation. This is in accordance with the service guidelines. Nearly three-quarters of pill users were given COCs and the others POPs. (See Annex 2, client knowledge on specific method).

In terms of their knowledge about pills, the data suggests that 80 percent knew when the pill could be commenced. It is commendable that 61 percent of those who knew this could in fact recall that the pill could be commenced at any time so long the user was not pregnant. While knowledge of the frequency of taking the pill is universal, about a quarter did not know what to do should she forget to take one pill. It is important to note that there are clear inter-level differences; for example, 40 percent of pill users from level C clinics did not know that the correct procedure would be to take the forgotten pill immediately and continue with the cycle. One possible reason for clients' poor knowledge is that in a quarter of the interactions with pill acceptors, providers did not inform them about what they had to do should they forget to take the pill on a given day.

Knowledge of other issues such as how the pill works, or its side-effects or the warning signs when medical care must be sought are limited. Almost two-fifths of the pill users were unsure how the pill worked (35 percent in level A, 30 percent in level B, and 49 percent in level C). Once again, a partial explanation for clients' knowledge could be that they were not informed. For example, observations of pill acceptors indicate that 40 percent had not been informed how the pill works, with significantly more in level C clinics (34 percent in level A, 39 in level B and 48 percent in level C).

In terms of side-effects, those most commonly mentioned were mild headaches (54 percent), dizziness (37 percent), nausea (34 percent), spotting (16 percent), and heart palpitation (16 percent). There are some inter-level differences, the reasons for which are not clear. For example, users in level C mentioned some side-effects more often (nausea and mild headaches) and other side-effects less often (dizziness). This pattern of reporting on side-effects is consistent with those recorded by the observer.

In terms of warning signs, users' knowledge is more limited. For example, signs such as severe headaches were mentioned by less than two-fifths of the exit respondents. Those attending clinics in level A seemed more likely to mention severe abdominal pain (39 percent compared to the total of 29 percent), and severe leg pain (26 percent compared to the total of 13 percent). It is worrisome that half the pill users reported incorrect warning signs or reported that they were not informed of any. It appears that the clients were indeed told of these signs from the observations but this information was not fully understood or retained by the clients.

Finally, it is interesting to note that three-quarters of the pill users were aware that oral pill does not protect against STDs or HIV, even though in less than half of the interactions the provider was not observed informing the client so.

Information was also collected about whether the users knew about when they should return for re-supply. High proportions reported that they were told when to return (88 percent) and that they had to return to the same clinic for re-supply (90 percent).

Despite the observed inadequacies on the client's knowledge about oral pills, family planning providers appear to be knowledgeable about issues relating to pill use as seen previously on staff

provider knowledge on specific method. It appears there may be a gap between what the providers know and how they administer or provide services and information to clients for a particular method. This trend seems apparent for all methods.

5.3. IUD

In the panel of 3203 respondents, there were only 27 IUD users and most of them (16) were recruited from level C clinics. As the number of users is small, data are not presented in terms of proportions, and possible directions are discussed. Nearly all the users knew that they could check if the IUD was in place by touching the threads, (see Annex 2). However, about 30 percent did not know how the method works. About half the IUD users knew that they could keep the IUD in the absence of problems for ten years and a quarter did not know that the method did not offer protection against STDs and HIV.

There is indication that women knew some of the side effects associated with IUD use: cramps or lower abdominal pain, backache and a moderate increase in bleeding. Knowledge of warning signs appears to be more limited; severe lower abdominal pain, expulsion of the IUD, and prolonged bleeding were some of the warning signs reported by the respondents.

Nearly all the women had been informed of the need for a return visit.

5.4. Norplant®

There were 52 Norplant® users in the sample, and all were recruited from level A clinic. Thirty percent of the users did not know how the method worked, and 6 percent did not know that implants could remain inserted in the absence of problems for five years. The finding that 30 percent of users do not know how the method works is consistent with data from the observations which indicate that providers did not inform clients 29 percent of the time.

Knowledge of the possible side-effects is partial. For example, common side-effects such as mild headaches (54 percent), irregular bleeding (58 percent), amenorrhoea (24 percent), and nausea (23 percent) were not mentioned in the proportions expected. Further, inaccurate ones such as backaches (17 percent) and other conditions (23 percent) were also mentioned. Among the warning signs, prolonged bleeding (56 percent), severe headache (54 percent), infection at site (27 percent), and blurred vision (25 percent) were mentioned. Further, nearly two-fifths of the users did not know that Norplant does not protect against STDs and HIV. These data indicate that in general, while knowledge exists, it tends to be partial and inaccurate.

The observations of the interactions indicate that amenorrhoea (89 percent), irregular bleeding (86 percent), mild headaches (54 percent), weight loss or gain (43 percent), and nausea (37 percent) were mentioned by the provider. Further, among the warning signs, prolonged bleeding (91 percent), severe backache (49 percent), infection at site (49 percent), and blurred vision (37 percent) were mentioned. It appears that users are able to report only some of the side-effects that they are informed about. The poor knowledge of clients regarding the protection granted by Norplant® against STIs can be explained partially by the fact that in half the observed interactions, the users had not been informed that Norplant® would not protect against sexually transmitted infections.

Nearly all the users were told to return to the clinic for a check up. Seventy-one percent of the users reported that they were told when to return for removal of the implants. It is interesting to note that half of these respondents also said that they were told that the implants could be removed at any time should she want to do so.

5.5. Injectable

There were 1,164 injectable users in the study. Fifty-eight percent of them had accepted DMPA and the rest had accepted Noristerat. All the DMPA users were recruited from level A and B clinics and Noristerat users from level C. A high proportion knew how often they should get injected. A little less than a tenth of Noristerat users were not aware that they needed to be injected every 2 months. It appears that they also did not receive information on the duration of effectiveness of the injection.

It is also interesting to note that close to two-fifths of injectable users did not know that the method worked by thickening the cervical mucus and or stopping ovulation. Greater proportions of level C users (47 percent) were less knowledgeable about how the method works than those from the other two levels (36 percent in level A and 30 percent in level B). Further, a little over half the users could identify the most common side-effect—spotting and bleeding. Amenorrhoea, another common side-effect was mentioned by 45 percent of the women. Other side-effects such as mild headaches (39 percent) and dizziness (25 percent) were reported to a lesser degree. A quarter of the users did not know any side-effect, and 13 percent reported not being told of any. While it is possible that clients were indeed informed but reported otherwise during the interview, the data does suggest that in terms of information taken away at the end of the interaction, a sizeable proportion did not receive the information. In most of the interactions, providers were observed to mention at least one side-effect, as only in 6 percent were no side-effects mentioned. Amenorrhoea (89 percent), irregular bleeding or spotting (76 percent), and headaches (39 percent) were most commonly mentioned. Reconciling the reports from the observations and exit interviews, it appears that women are not able to retain all the information on side effects imparted to them. At the same time, part of the ignorance of the injectable acceptors on how the method works could be due to not being informed about it by the provider. For example, in 41 percent of the interactions, the clients were not told that the injectable works by thickening the cervical mucus and or by stopping ovulation. This appears to occur more in level C clinics than other clinics (36 percent in level A, 39 percent in level B, compared to 49 percent in Level C).

In terms of the warning signs known, users could identify only severe headache (35 percent) and severe abdominal pain (29 percent). Similar to the findings on side-effects, a quarter of the women reported that they were not informed of any warning sign. This is supported by data from observations, where in a quarter of the interactions, the provider did not mention heavy bleeding, severe headache, or prolonged bleeding as warning signs. As seen with the other contraceptives, a quarter of injectable users did not know that it did not protect against STDs and HIV, despite the fact that nearly half of all those observed had been informed by the provider.

High proportions of users reported being told about their next visit, and date of visit.

5.6. Barrier Methods

There were 83 foam tablet and 97 condom acceptors. Most of the condom users used male condoms (92 percent). Data on numbers of units distributed indicate that a month's supply is normally given. We surmise that these methods are given as a "waiting" method while the client is asked to return later, possibly with her menses. This could explain why barrier method users had very little knowledge about side-effects. A positive finding is that 92 percent of condom users knew that it protected against STDs and HIV. However, over 90 percent of foam tablet users had no knowledge about its protective effect.

CHAPTER SIX

Experience

6.1. Experience prior to the Study

A number of women in the panel have some previous experience with family planning methods as many were switchers or re-starters. Slightly under 50 percent of the women in the study have personally or their partners used family planning methods. Across the clinics, 44 percent of the women in level A have used a method, 40 and 54 percent levels B and C, respectively. Of those women (45 percent) who have used a method before, 70 percent have used oral contraceptives.

On the day of interview, oral pills and injectables appear to be the most popular methods as most of the respondents reported receiving these methods. For instance, 54 percent of the respondents from the level A clinics reported having received oral contraceptives and 32 percent reported receiving DMPA, and 3 percent received Noristerat; in level B clinics 57 percent of the respondents received oral pills and 29 percent received DMPA and 6 percent received Noristerat; in level C clinics, 55 percent of the respondents reported oral contraceptives and 39 percent received Noristerat.

6.2. Lost to Follow-up Clients

6.2.1. Characteristics of FP Users

The study design included a 3 months follow-up after the baseline interview. Of the 3,203 family planning users recruited during the baseline, 69 percent were re-interviewed, thus, 31 percent were lost to follow up for a variety of reasons. Some of the reasons are:-

- (i) Heavy rains, that made some areas impassable.
- (ii) Outbreak of Cholera and as a result some of the clinics in the study were turned into Cholera Centres. This sent wrong signals to potential FP users as they avoided clinics altogether.
- (iii) Unorganised house numbering made it difficult to trace addresses.
- (iv) High frequency of households shifting in the high density areas.
- (v) False names and addresses. Some FP users gave intentional wrong names and addresses, making it difficult to locate them.

The distribution per level of clinic in Table 6.1 below.

Table 6.1: Distribution of Users Lost to Follow-up

Clinic Level	Family Planning Users	
	Number	Percent
A	327	31
B	436	34
C	240	27
Total	1,003	31

From the table, it is clear that level B clinics lost more users than the other two levels. Level B clinics have the largest catchment area, difficult to access and has the most disorganised numbering of houses, making it difficult to locate the addresses.

The clients who were lost came to the clinic for similar reasons as those who were re-interviewed. New family planning acceptors accounted for 58 percent, re-starters 24 and those who came to switch, 16 percent. These statistics are not different to those re-interviewed.

Table 6.2 shows the distribution of users by methods received at recruitment.?????

Table 6.2: Distribution of Users by Method Received

Methods	Percent (n=2200)
Combined Pill	44
Progestagen only Pill	16
IUD	1
Depo- Provera	16
Noristerat	11
Norplant	3
Male Condoms	4
Foam Tablets	4

The distribution of users on selected characteristics is in Table 6.3.

Table 6.3: Distribution of Lost Follow-up by Selected Characteristics

Age Group	Percent
14 - 19	16
20 - 24	43
25 - 29	24
30 - 34	10
35 - 39	5
40 - 44	1
45 - 49	1
Education	
No Schooling	5
Primary	58
Secondary	35
Post Secondary	2
Marital Status	
Married	93
Co-habiting	1
Never married	3
Separated/Divorced	2
Widowed	1

About 47 percent of the lost to follow-up users have lived in Lusaka all their life and 99 percent have ever been pregnant.

As earlier mentioned, the proportions on various variables presented in this section are similar to those of users who were re-interviewed, therefore the hypothesis that the lost to follow-up users are different to the former may not hold. Their characteristics are similar in many ways and therefore other factors may account for the loss. Interesting enough 96 percent of the users said that they would rather have the re-interview at the clinic, but they never showed up.

6.3. Users Experiences after three months

Information is available on the contraceptive experience of the respondents. The respondents were interviewed three months after they had started contraception and hence the findings reported here reflect three months of use. Of the 3203 women recruited to the panel, 2200 were re-interviewed, indicating a 69 percent rate of follow-up. Table 6.4, shows the distributions of women at the time of recruitment by method received and rate of re-interviews three months later.

Table 6.4: Distribution of Women Recruited and Re-interviewed after three months

Item	Pill	IUD	Foam	Condoms	Norplant®	Injectable	Other	Total
Number recruited	1763	27	83	97	52	1164	17	3203
Number re-interviewed	1186	19	31	32	24	901	7	2200
Re-interviewed (%)	67	70	37	33	46	77	41	69

Looking at the re-interviews rates per method, 67 percent of the women who had received oral pills at recruitment were re-interviewed three months later. For those who received IUD, 70 percent were re-interviewed, 37 percent foam tablet, 33 percent condoms, 46 percent Norplant®, 77 percent injectables and 41 percent other methods.

At the time of the interview, 91 percent of the 2,200 reported that they were currently contracepting, implying that 9 percent had discontinued. Of the women who had stopped contraception, 72 percent of women in level A clinics reported that at recruitment they had received oral pills, 17 percent injectables (14 percent DMPA and 3 percent Noristerat), 3 percent Norplant® as seen in Table 6.5. Similarly women from level B clinics reported that 69 percent had started with oral pills, 27 percent with injectables (18 percent DMPA and 9 percent Noristerat), and 3 percent with foam tablets. Fifty-nine percent of the women recruited from level C clinics had started on oral pills and 30 percent on Noristerat.

Table 6.5: Percentage Distribution of Women who Discontinued Contracepting by Method Received at Recruitment

Method	Level A (n=35)	Level B (n=101)	Level C (n=69)	Total (n=205)
Combined Pill	63	56	46	54
Progestagen only Pill	9	13	13	12
Depo-Provera (DMPA)	14	18	0	11
Noristerat	3	9	30	15
Norplant	3	0	0	1
Condoms	0	1	0	1
Foam Tablet	6	3	6	4
Other	2	0	5	3
Total discontinuation Rate	4.9	12.1	10.7	9.3

An important finding is that 9 percent of those who discontinued reported that they had done so due to a pregnancy (3 women from level A clinics, 9 women from level B clinics, and 6 women from level C clinics). It is not clear from this data whether the women were inadequately screened for pregnancy during method provision or had become pregnant while using the method. However, the most common reasons for discontinuation were side-effects (37 percent in level A, 29 percent in level B, and 38 percent in level C), opposition to contraceptive use by various

in level A, 14 and 8 percent in levels B and C respectively. Those who reported concerns about health were 6 percent in level A, and 5 and 13 percent in levels B and C respectively. Reduced exposure to sex, were 18, 16 and 17 in levels A, B and C respectively. It is also interesting to note that 11 percent of the women from level A clinics cited that the method was inconvenient to use while 16 percent of those from level B indicated that they had problems of accessing the services.

Those respondents who had cited side effects as a reason for discontinuation were further probed to describe the nature of their experience. In total, 93 women across the three types of clinics cited that they had experienced side effects, with 15 women from level A clinics, and 39 each from level B and C clinics. Due to the small numbers of cases, the findings should be interpreted with caution. As expected, the most commonly reported side-effects were those related to hormonal method use. This is consistent with the pattern of contraceptive use, which is predominantly oral pills and injectables. For example, between a fifth and a third of women reported headaches and dizziness (33 percent in level A, 31 percent in level B, and 23 percent in level C). Between a quarter and a third reported bleeding problem including spotting, prolonged and heavy bleeding (34 percent in level A, 26 percent in level B, and 26 percent in level C). Other reasons included chest and abdominal pain.

It is interesting to note that, despite having problems with their method, just over a quarter of the women had sought medical care and the majority of them reported that providers counselled them (16 women) and/or switched their method (3 women).

6.4. Method Specific Experience

Women were asked about their experience over the last three months for the method they received. In this section we present details of their experience with the method received at recruitment. (See Annex 1).

6.4.1. Pill Users

Most of the women (85 percent) who received oral pills rated their experience as being good with 15 percent rating it as bad. Of those reporting a bad experience, overall 46 percent complained of mild headaches, (53 percent in level A, 44 percent in level B, and 41 percent in Level C). Those who complained about abdominal pain, account for 31 percent overall and 27, 35, and 28 in levels A, B and C, respectively. For nausea and dizziness overall 29 percent, 27 percent in level A, 30 percent each in levels B and C. For spotting or bleeding 19 percent overall, 22 percent in level A, 16 percent in level B, and 22 percent in level C. It is worrying that 12 percent of the pill users reported vision loss or blurring during use. Despite such high reporting of problems, only one in three women opted for medical care and over three-fifths reportedly did nothing.

In 69 percent of the cases, the provider counselled the client, though the content of the counselling is not available from these data. The respondents were also asked if their problem had been resolved; a little more than half reported that their problem had been solved. It is interesting to note that almost a fifth (18 percent) indicated that they were not likely to continue with oral pills. Fifty-eight percent cited side effects and those wanting to switch to a different method as a reason, represented 15 percent of the women who did not intend to continue with oral pills.

6.4.2. IUD Users

A similar picture of experience emerges from 19 IUD users. Five of the 19 IUD users re-interviewed had bad experiences, largely arising from side-effects. The most commonly reported side-effects were those which have been documented in several studies: Backache, heavy bleeding, heavy discharge, and spotting. In about half the cases, the women had sought medical care; the most common type of management that providers undertake is to counsel the user. The utility and effectiveness of such counselling are unclear at this point. As noticed with the pill users, five of the 19 IUD users intend to discontinue with the method.

6.4.3. Norplant® Users

Twenty-four Norplant® users were re-interviewed during the three months follow up. Five women reported bad experiences and cited the well-known side-effects such as spotting and heavy, prolonged bleeding. It is worrisome that one woman reported an expulsion of the capsule and the reasons are not clear at this stage. Two reported headaches with blurred visions. It appears that all five women sought medical care and reported that the providers treated them. Further, four women reported that the problem was resolved. However, 21 of the 24 women intended to continue to use Norplant® .

6.4.4. Injectable Users

Injectable is the second highly accepted method after oral pills. Eight-five percent of the injectable users re-interviewed said that they had a good experience. All the 15 percent who had a bad experience cited problems. Overall 42 percent complained of irregular bleeding or spotting, 32 percent in level A, 55 percent in level B, and 37 percent in level C. Those who complained about headache, represented 17 percent overall and 16, 17, and 19 percent in level A, B and C. A quarter complained of heavy bleeding, 28 percent in level A, 17 and 34 percent in levels B and C. Those who complained of abdominal pains accounted for 15 percent overall and 10, 17 and 19 in levels A, B and C respectively.

CHAPTER SEVEN

Health Status

7.1. Introduction

The survey also collected information on womens' perceptions of their health and health seeking behaviour. Questions on health seeking behaviour probed for both hospital and clinic visits. A distinction was made between hospital and clinic visits to account for differences in severity of conditions requiring differential treatment. A hospitalisation is defined as an admission to a facility for more than 24 hours, while a clinic visit is defined as out-patient care.

7.2. Health Status of Women on Recruitment Day

Most respondents reported to being in good health. On the day of interview, 93 percent reported to be in excellent or good health when asked about their health, while 5 percent reporting fair and another 2 percent poor health. This is consistent with our expectation that family planning acceptors tend to contracept only when they perceive themselves to be in good health. Of the 64 women (2 percent) that reported poor health, 41 women had not been hospitalised or sought medical care. Table 7.1 shows the reason for poor health

Table 7.1: Women who Reported Poor Health but were not Hospitalised or Sought Medical Care by Reason of Poor Health

Reason	Level A (n=20)	Level B (n=16)	Level C (n=5)	Total (n=41)
Headache	4	2	2	8
Abdominal pain	3	2	1	6
Malaria	5	5	1	11
Coughing/sneezing	4	3	0	7
Backache	4	4	1	9

Further, women were asked for the reason for not seeing anyone for the poor health, 24 women cited being afraid or not having a medical scheme as the reason. Another 7 women said it was not serious enough to see anyone, 5 thought would it not help even if they saw anyone, while another 5 said it is expensive. A medical scheme is a system where a person or family pre-pays for the basic medical expenses, such as registration and consultation and each time she is sick she presents the scheme card to the clinic without payment.

The results also show that 16 percent of the respondents reported having being hospitalised in the past 12 months prior to recruitment to the study. Almost half (52 percent) were hospitalised for childbirth and 89 percent of them had their problem resolved after hospitalisation. The findings across the levels are similar.

Respondents were asked whether they had sought medical care or advice other than being hospitalised in the past 12 months before the study, 21 percent of the respondents had sought out-patient care. Public clinics tend to have been the most commonly used facilities (88 percent), with private clinics and pharmacies (7 percent), and traditional attendants (4 percent) being other sources. In terms of the reasons for seeking care at out-patient facilities, the data indicate that women seek care for non-reproductive health conditions, including headaches, TB, and malaria .

7.3. Health Status of Women three months after Recruitment

As mentioned earlier 77 percent of the respondents were re-interviewed three months after the baseline interview. There was no substantial change of proportions in their health status, with 38 percent reporting being in excellent health, 56 percent good health, 5 percent fair, and 1 percent (22 women) poor health.

During the three months, 19 women had been hospitalised for various problems not related to reproductive health. A small proportion (10 percent) reported seeking out-patient care in the interim 3 months. Once again public facilities are the chosen source of care, with 74 percent of these respondents reporting having visited them.

For those with poor health who did not seek medical care, lack of personal medical scheme was cited.

7.4. Reproductive Health Status after three months

At the three months follow-up, information was collected from women on their experience of symptoms of vaginal discharge and urinary problems. In this section we describe the reproductive status of the 2200 women re-interviewed.

Women were asked whether they had abnormal vaginal discharge on the day of interview. Overall, only 7 percent (156 women) of the women reported having an abnormal vaginal discharge, while in levels A and B the proportion was similar at 8 percent compared to level C at 4 percent. Figures 8a, 8b and 8c shows the distribution of women who reported having an abnormal vaginal discharge by other related condition.

Table 7.2: Reproductive Health Profile

Condition/Symptoms	Level A (n=60)	Level B (n=71)	Level C (n=25)	Total (n=156)
Women with abnormal vaginal discharge;	8.3	8.5	3.9	7.1
With itching or irritation	78	62	40	65
Noticeable bad odour	65	48	32	52
With severe lower abdominal pain not related to menstruating	60	42	44	49
With a fever	58	41	52	49

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Condition/Symptom	Level A (n=84)	Level B (n=68)	Level C (n=48)	Total (n=200)
Women with pain in the lower abdomen;	11.7	8.1	7.5	9.1
Frequent need to urinate	61	41	40	49
With burning or stinging	61	43	37	49
Very sudden urge to urinate	55	25	25	38
With blood in urine	11	9	8	9
Limiting daily activities	6	26	17	15
Condition	Level A (n=112)	Level B (n=84)	Level C (n=55)	Total (n=249)
Bleed or spot between periods for more than a day	76	70	55	69
Unusually heavy bleeding	32	42	42	37
Limiting daily activities	2	14	4	6

Table 7.2 reveals that, overall in a high proportion of cases the discharge was accompanied by itching and irritation (65 percent), bad odours (52 percent), severe abdominal pain (49 percent), and fever (49 percent). Despite reporting the occurrence of these symptoms, only 7 percent of the women reported that they limited their activities. On being probed further about how their activities were limited, 82 percent reported general weakness. It appears that the respondents carried out their normal activities but with a feeling of lethargy. It is also interesting to note that despite the symptoms, less than a fifth of the women sought treatment for vaginal discharge and the main source of treatment was the public sector (76 percent). Those who had not sought care, (53 percent) cited reasons such as their symptoms not being serious, 8 percent thought it would not help, and 8 percent said they had no time. Surprisingly 11 percent of women also reported that they thought the discharge was normal which appears to be odd considering that they had reported the discharge to be abnormal.

When they were asked about urinary problems experienced on that day, Figure 8b Shows that 9 percent (200 women) of the women re-interviewed reported that they had pain in the abdomen. Of these, 49 percent had a frequent urge to urinate, 49 percent reported that they experienced burning and stinging, and 38 percent had an urge to urinate, and 9 percent had blood in the urine. The pattern is similar in all levels except for level A, which has high proportions. Due to these symptoms, 15 percent reported that they were limited in their daily activities, because they were feeling weak (33 percent), had severe pain (37 percent). Only 17 percent sought treatment for these symptoms mainly from public clinics. Those not seeking care did so because they did not think it was serious enough (62 percent) or did not think it would help (11 percent).

Women were further asked about whether they had a period lasting for more than 7 days, 249 (11 percent) of the women re-interviewed reported that they had on the day of interview a period which had lasted for more than seven days. Sixty-nine percent of these women reported bleeding or spotting between periods for more than a day, 37 percent reported unusually heavy bleeding. Only 6 percent of them said that these problems limit their daily activities, mainly caused by weakness and traditional reasons such as not cooking or putting salt in food. Twenty-eight

percent of the women with such problems sought medical advice or were treated at public clinics. Those who did not seek medical attention thought the problem was not serious (67 percent).

Reporting of symptoms is not a diagnosis of possible existing reproductive health conditions but is an important indicator of women's perceptions of their health.

ANNEX 1

METHOD SPECIFIC EXPERIENCE (as reported after 3 months Follow-up Interview)

PILL

Table 1: Experience with the Pill (Percent)

Response	Level A (n=377)	Level B (n=451)	Level C (n=358)	Total (n=1186)
Good	88	82	87	85
Bad	12	18	13	15

Table 2: Reason for Bad Experience (Percent)

Bad Reason	Level A (n=45)	Level B (n=81)	Level C (n=46)	Total (n=172)
Problems	100	99	96	98
Other (Specify)	0	1	4	2

Table 3: Percent of Clients by Type of Problem

Type of Problem	Level A (n=45)	Level B (n=81)	Level C (n=46)	Total (n=172)
Nausea	20	20	17	19
Headaches (Mild)	53	44	41	46
Spotting/Bleeding	22	16	22	19
Amenorrhoea	2	12	9	9
Weight gain	0	0	2	1
Chest pain/shortness of breath	11	6	13	9
Vision loss or blurring	24	9	7	12
Abdominal pain	27	35	28	31
Leg pain	7	1	4	3
Inconvenient to use	7	0	2	2
Backache	9	10	4	8
Dizziness	7	10	13	10
No milk in the breast	4	1	0	2
Too forgetful	0	1	0	1
Feverish	0	1	0	1
Body Weakness	7	4	7	5
Other (Specify)	13	20	11	16

Table 4: Action taken after experiencing the Problems (Percent)

Action taken	Level A (n=45)	Level B (n=81)	Level C (n=46)	Total (n=172)
Nothing	67	67	59	64
Sought Medical care	31	31	0	34
Stopped	2	2	41	2
Took pain killers	0	0	0	0
Other (Specify)	0	0	0	0

Table 5: Provider's Action for those who sought Medical Care (Percent)

Provider's Action	Level A (n=14)	Level B (n=25)	Level C (n=19)	Total (n=58)
Counselled	64	56	90	69
Nothing	7	12	0	7
Treated	14	12	11	12
Other (Specify)	14	20	0	12

Table 6: Percent of Women whose Problem went away

Response	Level A (n=45)	Level B (n=81)	Level C (n=46)	Total (n=172)
Problem went away	51	49	67	55

Table 7: Percent that intend to continue with Method

Response	Level A (n=377)	Level B (n=451)	Level C (n=358)	Total (n=1186)
Intend to continue	87	77	85	82

Table 8: Percent of those who do not intend to continue by reason

Reason	Level A (n=50)	Level B (n=105)	Level C (n=55)	Total (n=210)
Side effects	60	61	51	58
Want baby	6	5	7	6
Want to switch	20	9	20	15
Amenorrhoea	0	0	0	0
Other (Specify)	14	25	22	21

Table 9: Percent of those or whose partner used another method to protect against STD in the past 3 months

Response	Level A (n=377)	Level B (n=451)	Level C (n=358)	Total (n=1186)
Used another method	13	12	10	11

IUD

Table 1: Experience with IUD (Percent)

Response	Total (n=19)
Good	79
Bad	21

Table 2: Reason for Bad Experience (Percent)

Bad reason	Total (n=4)
Problems	75
Other (Specify)	25

Table 3: Percent of Clients by Type of Problems

Type of Problem	Total (n=4)
Cramps/Lower abdominal pain	5
Backache	75
Spotting between menstrual periods	25
Heavy bleeding	50
Heavy discharge	25
Expulsion or cannot feel threads	0
Late or missed period	25
Pain during intercourse	0
Inconvenient to use	0
Interferes with body's normal processes	25
Other (Specify)	25

Table 4: Action taken after experiencing the Problem (Percent)

Action taken	Total (n=4)
Nothing	50
Sought Medical care	50

Table 5: Provider's Action for those who sought Medical Care

Provider's Action	Total (n=2)
Counselled	50
Nothing	50

Table 6: Percent of Women whose problem went away

Response	Total (n=4)
Problem went away	50

Table 7: Percent that intend to continue with method

Response	Total (n=19)
Intend to continue	74

Table 8: Percent of those or whose partner who used another method to protect against STD in the past 3 months

Response	Total (n=19)
Used another method	32

FOAM TABLETS

Table 1: Experience with Foam Tablets (Percent)

Response	Level A (n=6)	Level B (n=13)	Level C (n=12)	Total (n=31)
Good	33	46	67	52
Bad	67	54	33	48

Table 2: Reason for Bad Experience (Percent)

Bad reason	Level A (n=4)	Level B (n=7)	Level C (n=4)	Total (n=15)
Problems	100	100	75	93
Other (Specify)	0	0	25	6

Table 3: Percent of Clients by Type of Problems (Percent)

Type of Problems	Level A (n=4)	Level B (n=7)	Level C (n=4)	Total (n=15)
Side effects	100	71	25	67
Other (Specify)	0	29	75	33

Table 4: Action taken after experiencing the Problem (Percent)

Action taken	Level A (n=4)	Level B (n=7)	Level C (n=4)	Total (n=15)
Nothing	75	57	75	67
Sought Medical care	25	29	25	28
Stopped any method	0	14	0	7

Table 5: Percent of Women whose Problem go away

Response	Level A (n=4)	Level B (n=7)	Level C (n=4)	Total (n=15)
Problem went away	50	86	50	67

Table 6: Percent that intend to continue with Method

Response	Level A (n=6)	Level B (n=13)	Level C (n=4)	Total (n=31)
Intend to continue	17	31	42	32

Table 7: Percent of those who do not intend to continue by Reason

Reason	Level A (n=5)	Level B (n=9)	Level C (n=7)	Total (n=21)
Side effects	60	44	14	38
Want baby	0	11	0	5
Abdominal pains	40	33	14	38
Suspect pregnancy	0	11	0	5
Husband opposed	0	0	27	10
Other (Specify)	0	0	14	5

53

Table 8: Percent of those or whose partner who used another method to protect against STD in the past 3 months

Response	Level A (n=6)	Level B (n=13)	Level C (n=12)	Total (n=31)
Yes	17	23	42	29

CONDOM

Table 1: Experience with Condoms (Percent)

Response	Total (n=32)
Good	78
Bad	22

Table 2: Reason for Bad Experience (Percent)

Response	Total (n=7)
Problems	86
Other (Specify)	14

Table 3: Percent of Clients by Type of Problem

Type of Problems	Total (n=7)
Side effects	57
Other (Specify)	43

Table 4: Action taken after experiencing the Problem (Percent)

Action Taken	Total (n=7)
Nothing	51
Sought medical care	14
Other (Specify)	29

NORPLANT

Table 1: Experience with the NORPLANT (Percent)

Response	Total (n=24)
Good	79
Bad	21

Table 2: Reason for Bad Experience (Percent)

Reason	Total (n=5)
Problems	100
Other (Specify)	0

Table 3: Percent of Clients by Type of Problems

Type of problem	Total (n=5)
Spotting between menstrual periods	20
Heavy prolonged bleeding	20
Weight gain	20
Weight loss	20
Expulsion of capsule	20
Headache with blurring vision	40
Other (Specify)	40

Table 4: Provider's Action for those who sought Medical Care

Provider's action	Total (n=5)
Treated	80
Other (Specify)	20

Table 5: Percent that intend to continue with Method

Response	Total (n=25)
Intend to continue	88

55

Table 6: Percent of those or whose Partner used another Method to protect against STD in the past 3 months

Response	Total (n=24)
Used another method	4

INJECTABLE

Table 1: Experience with Injectables (Percent)

Response	Level A (n=301)	Level B (n=345)	Level C (n=255)	Total (n=901)
Good	83	85	88	85
Bad	17	15	12	15

Table 2: Reason for Bad Experience (Percent)

Bad reason	Level A (n=50)	Level B (n=53)	Level C (n=32)	Total (n=135)
Problems	100	100	100	100

Table 3: Percent of Clients by Type of Problem

Type of problem	Level A (n=50)	Level B (n=53)	Level C (n=32)	Total (n=135)
Irregular bleeding/spotting	32	55	37	42
Amenorrhoea	8	9	3	7
Headaches	16	17	19	17
Weight gain	4	0	0	2
Heavy bleeding	28	17	34	25
Inconvenient to use	2	0	0	1
Interferes with body normal processes	6	0	3	3
Abdominal pains	10	17	19	15
Weakness	2	4	12	5
Dizziness	0	9	3	4
Prolonged period	14	6	6	9
Other (Specify)	0	13	9	10

Table 4: Action taken after experiencing the Problems (Percent)

Action taken	Level A (n=50)	Level B (n=53)	Level C (n=32)	Total (n=135)
Nothing	60	53	34	51
Sought Medical care	40	47	63	48
Other (Specify)	0	0	3	1

Table 5: Provider's Action for those who sought Medical Care (Percent)

Provider's action	Level A (n=20)	Level B (n=25)	Level C (n=20)	Total (n=65)
Counselled	40	32	75	48
Nothing	15	8	0	8
Treated	45	56	20	41
Other (Specify)	0	4	5	3

Table 6: Percent of Women whose Problem went away

Response	Level A (n=50)	Level B (n=53)	Level C (n=32)	Total (n=135)
Problem went away	34	40	59	42

Table 7: Percent that intend to continue with Method

Response	Level A (n=301)	Level B (n=345)	Level C (n=255)	Total (n=901)
Intend to continue	91	87	91	90

Table 8: Percent of those who do not intend to continue by Reason

Reason	Level A (n=26)	Level B (n=45)	Level C (n=22)	Total (n=93)
Side effects	81	78	95	83
Want baby	8	7	0	5
Other (Specify)	11	16	5	12

Table 9: Percent of those or whose Partner used another Method to protect against STD in the last 3 months

Response	Level A (n=301)	Level B (n=345)	Level C (n=256)	Total (n=901)
Used another method	10	10	11	10

ANNEX 2

CLIENTS' KNOWLEDGE ON SPECIFIC METHODS (as reported during Exit Interview)

PILL

Table 1: Percent of Clients by Number of Cycles/Packets Given

Circles	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
1	8	3	7	6
2	0	0	3	1
3	89	96	88	92
> 4	2	1	2	1

Table 2: Clients by Type of Brand Given (Percent)

Type of Brand	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
Microlut (POP)	21	37	31	30
Microgynon (COC)	79	63	68	70
Safe Plan	0	0	0	0

Table 3: When a Woman in a Menstrual Cycle can start using the Pill (Percent)

When to start using pill	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
Anytime provide not pregnant	50	51	44	49
During 1 st - 5 th day of menses	30	26	38	31
Other (Specify)	6	6	5	6
Don't know	14	17	12	15

Table 4: Frequency of taking a Pill (Percent)

Frequency	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
One every day	99	98	99	99
Other (Specify)	0	1	0	0
Don't know	1	1	1	1

Table 5: Percent told when to Return

Response	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
Told	89	85	93	88

Table 6: Percent told to Return by Purpose

Purpose	Level A (n=496)	Level B (n=613)	Level C (n=448)	Total (n=1763)
When need arises/re-supply	96	97	91	95
Other (Specify)	4	2	8	4
Don't know	1	1	0	0

Table 7: Percent told where to go for Re-supply/Check-up

Where to go	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
To this clinic	89	87	94	90
To another clinic	1	1	1	1
Pharmacy	0	0	0	0
CBD	0	0	0	0
Other (Specify)	0	0	0	0
Not told	10	12	5	9

Table 8: How the Pill works

How pills work	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total
Stops ovulation and thickens cervical mucus	65	70	52	63
Other (Specify)	17	13	23	17
Don't know	18	17	26	20

Table 9: Action to take if forget to take a Pill for one day (Percent)

Action	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total
Take the forgotten one immediately and then continue	75	80	60	73
Other (Specify)	10	9	14	11
Don't know	15	11	26	16

Table 10: Possible "side effects" that Women might experience after taking the Pill

Side effects	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
Nausea	33	31	40	34
Mild headaches	58	45	63	54
Spotting/bleeding	19	13	18	16
Amenorrhoea	11	11	6	10
Weight gain	7	4	5	5
Heart palpitation	19	11	22	16
Dizziness	47	45	37	43
Other (Specify)	17	15	16	16
Not told	14	25	16	19

Table 11: Warning Signs/Problems Reported (Percent)

Problems	Level A (n=559)	Level B (n=721)	Level C (n=483)	Total (n=1763)
Severe chest pain/Breathlessness	14	6	16	11
Severe headache	42	30	43	37
Blurred vision	16	18	17	16
Severe abdominal pain	39	24	24	29
Severe leg pain	26	6	8	13
Other (Specify)	24	24	28	25
Not told	22	37	24	28

Table 12: Pills Protection against STDs and HIV/AIDS

Response	Level A	Level B	Level C (n=483)	Total
Protect	6	8	5	6
Don't know	16	22	17	19

IUD

Table 1: How to check if IUD is in Place

How to check	Total (n=27)
Touching the thread	96
Other (Specify)	4

Table 2: How IUD works (Percent)

How method works	Total (n=27)
(a) Prevent sperm and eggs from meeting (b) Makes it hard for sperm to move (c) Reduce the ability of the sperm to fertilize an egg (d) Prevent egg from implanting in the uterus	70
Other (Specify)	4
Don't know	26

Table 3: Told when to get a Check-up (Percent)

Response	Total (n=27)
Told	93

Table 4: Told to Return by Purpose (Percent)

Purpose	Total (n=25)
After one month or earlier if need arises	52
Other (Specify)	48

Table 5: Where to go for Check-up (Percent)

Where to go	Total (n=24)
To this clinic	100
To another clinic	0
Other (Specify)	0

62

Table 6: Possible "side effects" that Women with an IUD might experience (Percent)

Side effects	Total (n=27)
Cramps/Lower abdominal pain	67
Moderate increased bleeding	26
Backache	30
Spotting between menstrual periods	7
Increased discharge	0
Other (Specify)	7
Don't know	22

Table 7: Warning Signs/Problems Reported (Percent)

Problems	Total (n=27)
Heavy discharge	26
Severe lower abdominal pain with cramps	59
Prolonged bleeding	26
Amenorrhoea (Missed periods)	11
Expulsion or cannot feel threads	41
Pain during intercourse	7
Infection (PID)	4
Other (Specify)	15

Table 8: How long a Woman can keep an IUD once it has been inserted (Percent)

Number of Years	Total (n=27)
1	4
3	15
5	11
10	52
Don't know	18

Table 9: IUD protection against STDs and HIV/AIDS

Response	Total (n=27)
Protect	4
Don't know	22

FOAM TABLETS

Table 1: Number of Units of Foaming Tablets given to Clients (Percent)

Number of Units	Level A (n=38)	Level B (n=32)	Level C (n=13)	Total (n=83)
1	89	59	39	69
2	8	31	38	22
3	0	6	23	6
4	0	0	0	0
5	0	3	0	1
20	3	0	0	1

Table 2: How Foaming Tablets works (Percent)

How method works	Level A (n=38)	Level B (n=32)	Level C (n=13)	Total (n=83)
Kill sperm or make sperm unable to move towards the egg	84	81	62	80
Other (Specify)	5	6	23	8
Don't know	10	12	15	12

Table 3: Told when to Return

Response	Level A (n=38)	Level B (n=32)	Level C (n=13)	Total (n=83)
Told	89	84	92	88

Table 4: Percent told Return by Purpose

Purpose	Level A (n=34)	Level B (n=27)	Level C (n=12)	Total (n=73)
When need arises/re-supply	79	63	100	77
Other (Specify)	21	33	0	22
Don't know	0	3	0	1

Table 5: Percent told where to go for Resupply

Where to go	Level A (n=28)	Level B (n=26)	Level C (n=13)	Total (n=66)
To this clinic	100	100	100	100
To another clinic	0	0	0	0
Pharmacy	0	0	0	0
CBD	0	0	0	0
Other (Specify)	0	0	0	0

Table 6: Possible "side effects" that women using Foam Tablets might experience

Side effects	Level A (n=38)	Level B (n=32)	Level C (n=13)	Total (n=83)
Irritation	29	22	15	22
Other (Specify)	11	6	9	10
Not told	60	72	67	69

Table 7: Foam Tablet protect against STDs and HIV/AIDS

Response	Level A (n=38)	Level B (n=32)	Level C (n=13)	Total (n=83)
Protect	8	6	9	6
Don't know	21	31	23	23

CONDOM

Table 1: Number of Condoms Given (Percent)

Number of Units	Level A (n=27)	Level B (n=57)	Level C (n=13)	Total (n=97)
1 - 8	18	5	23	11
9 - 16	15	5	8	6
17 - 24	22	21	46	25
> 24	45	69	23	58

65

Table 2: Type Condoms Given (Percent)

Type of Condom	Level A (n=27)	Level B (n=57)	Level C (n=13)	Total (n=97)
Male Condom	85	95	92	92
Female Condom	15	5	8	8

Table 3: How Condoms work

How method works	Level A (n=27)	Level B (n=57)	Level C (n=13)	Total (n=97)
Preventing sperm and eggs from meeting Makes it hard for sperm to move Reduce the ability of the sperm to fertilize an egg	89	81	69	81
Other (Specify)	4	9	0	6
Don't know	7	10	31	12

Table 4: Percent told to come back by Purpose

Purpose	Level A (n=20)	Level B (n=43)	Level C (n=10)	Total (n=73)
When need arise/re-supply	90	79	90	84
Other (Specify)	10	19	10	15
Don't know	0	2	0	1

Table 5: Percent told where to go for Resupply

Where to go	Level A (n=21)	Level B (n=45)	Level C (n=11)	Total (n=77)
To this clinic	95	100	100	99
To another clinic	0	0	0	0
Pharmacy	5	0	0	1
CBD	0	0	0	0
Other (Specify)	0	0	0	0

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Table 6: Possible "side effects" that women using condom might experience

Side effects	Level A	Level B (n=57)	Level C (n=13)	Total (n=97)
Irritation	4	3	0	3
Pain during intercourse	7	4	8	5
Other (Specify)	26	19	31	23
Don't know	63	74	62	69

Table 7: Condom protection against STDs and HIV/AIDS

Response	Level A	Level B (n=57)	Level C (n=13)	Total (n=97)
Protect	93	91	92	92
Don't know	7	4	5	4

NORPLANT

Table 1: How Norplant works

How method works	Total (n=52)
Thickens cervical mucus/Stop ovulation	69
Other (Specify)	15
Don't know	15

Table 2: Percent told when to come back by Purpose

Purpose	Total (n=50)
(a) After one month (b) Annually (c) When need arises	48
Other (Specify)	52
Don't know	0

Table 3: Percent told where to go for Checkup/Resupply

Told	Total (n=50)
To this clinic	98
Another clinic	2

69

Table 4: Possible "side effects" that women using NORPLANT might experience

Side effects	Total (n=52)
Backache	17
Nausea	23
Mild headaches	54
Irregular bleeding/spotting	58
Weight gain/loss	21
Amenorrhoea/Absence of period	24
Skin changes	2
Other (Specify)	23

Table 5: Warning Signs/Problems

Problems	Total (n=52)
Prolonged bleeding	56
Severe headache	54
Blurring vision	25
Infection at insertion site	27
Other (Specify)	31

Table 6: Told when to come for Removal of the Implants

Response	Total (n=52)
Told	71

Table 7: Percent told to come by Purpose

Purpose	Total (n=37)
If the woman wants no matter the reason	49
After five years	51
Other (Specify)	0

Table 8: How long a Woman can keep Implants (Percent)

Number of Years	Total (n=52)
3	2
5	94
6	2
10	2

Table 9: NORPLANT protection against STDs and HIV/AIDS

Response	Total (n=52)
Protection	14
No	61
Don't know	25

INJECTABLE

Table 1: Type of injection received on Day of Visits (Percent)

Type of injection	Total (n=1164)
Depo-Provera (DMPA) (three months)	58
Noristerat (two months)	42
Other (Specify)	0
Don't know	0

Table 2: How often one should get an Injection

	Level A (n=820)	Level B (n=977)	Level C (n=642)	Total (n=2439)
Once every three months	89	81	6	64
Once every two months	10	17	91	34
Other (Specify)	1	2	3	2

Table 3: Told when to return for a Check up/Resupply (Percent)

Response	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1164)
Told	93	93	94	93

Table 4: Percent told when to come back

Told	Level A (n=340)	Level B (n=413)	Level C (n=329)	Total (n=1081)
After 3 months and when need arises	91	82	2	61
After 2 months and when need arises	7	16	88	35
Other (Specify)	0	1	9	3
Don't know	1	1	1	1

Table 5: Percent told where to go for Resupply/Check up

Told	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1164)
To this clinic	93	94	93	93
To another clinic	0	0	1	1
Other (Specify)	0	0	1	0
Not told	7	6	5	6

Table 6: How the Injection works

Work it works	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1164)
Thickens cervical mucus/Stops ovulation	64	70	53	63
Other (Specify)	15	10	22	15
Don't know	21	20	25	22

Table 7: Possible "side effects" that Women might experience after having a Injection

Side effects	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1164)
Nausea	17	14	17	16
Mild headaches	42	28	49	39
Spotting/bleeding	58	52	53	54
Amenorrhoea	43	46	45	45
Weight gain	6	3	5	5
Heart palpitation	12	8	12	10
Dizziness	31	23	21	25
Other (Specify)	12	11	15	13
Not told	10	16	12	13

Table 8: Warning Signs/Problems (Percent)

Problem	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1164)
Severe chest pain/Breathlessness	11	6	14	10
Severe headache	41	28	38	35
Blurred vision	11	8	17	11
Severe abdominal pain	38	26	23	29
Severe leg pain	23	7	3	11
Other (Specify)	43	44	48	45
Not told	18	26	23	23

Table 9: Number of Months an Injection remain effective

Number of Months	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1164)
1	0	0	1	0
2	8	16	92	36
3	89	80	3	57
4	0	0	0	0
5	0	0	0	0
6	0	0	0	0
7	0	0	0	0
Don't know	3	4	4	4

Table 10: Injectables protection against STDs and HIV/AIDS (Percent)

Response	Level A (n=368)	Level B (n=446)	Level C (n=350)	Total (n=1160)
Protect	4	7	3	5
Don't know	16	25	20	20

ANNEX 3:

PROVIDERS' KNOWLEDGE ON SPECIFIC METHODS (as reported during Staff Providers Interview)

PILL

Table 1: Advice if a client forgot to take a Pill for one day

	Level A (n=14)	Level B (n=7)	Level C (n=21)	Total (n=42)
Take the forgotten one immediately and then continue	13	7	20	40
Other	1	0	1	2

Table 2: Known Side Effects

Side effects	Level A	Level B	Level C	Total
Nausea	12	7	20	39
Mild headaches	9	5	18	32
Spotting/bleeding	4	2	12	18
Amenorrhoea	2	1	2	5
Weight gain	1	0	4	5
Heart Palpitation	0	1	4	5
Dizziness	3	5	6	14
Other	6	4	4	14

Table 3: Major Problems that a Client must come back for

Major problems	Level A	Level B	Level C	Total
Severe chest pain/Breathlessness	6	0	10	16
Severe headache	9	6	16	31
Blurred vision	3	1	6	10
Severe abdominal pain	6	3	10	19
Severe leg pain	6	1	6	13
Other	9	4	10	23

Table 4: Advice given to Clients at high risk of infection with an RTI/STD or HIV/AIDS

Advice Given	Level A	Level B	Level C	Total
Continue to use the pill alone	1	0	2	3
Continue with the pill but also use a condom	10	6	17	33
Switch from pill to the condom	3	1	3	7
Stop using any type of contraception	1	0	0	1
Other	3	1	5	9

Table 5: Cycles routinely given to Clients at first Visit

Cycles routine	Level A	Level B	Level C	Total
1 - 2	3	1	4	8
2 - 3	11	6	17	34
3 and above	0	0	0	0

Table 6: Cycles routinely given to Clients on Return

Cycles routine	Level A	Level B	Level C	Total
1 - 2	0	0	0	0
2 - 3	6	2	11	19
3 and above	8	6	10	23

Table 7: Action taken if a New Client wants Pill or another hormonal Method but is not having Menses

Action taken	Level A	Level B	Level C	Total
Perform a pregnancy test	11	6	18	35
Tell her to come back at next menses	6	0	3	9
Try to induce menses	2	1	2	5
Supply condoms and ask her to return when menstruating	5	2	5	12
Supply hormonal method	1	0	1	2
Supply hormonal method and condoms and ask her to use condoms till her menses	3	1	1	5
Other	5	3	4	12

IUD

Table 1: When an IUD can be Inserted

When to Insert	Level A	Level B	Level C	Total
Anytime it is certain that the woman is not pregnant	6	4	8	18
Anytime during menstrual cycle	7	2	8	17
Immediate post delivery (within 10 minutes)	1	0	2	3
Within 48 hours of delivery	1	0	1	2
After 6 weeks postpartum	4	0	1	5
Soon after menses	5	5	11	21

Table 2: How to check if a IUD is in place

	Level A	Level B	Level C	Total
Touching the threads	12	6	21	39
Other	2	1	0	3

Table 3: Known Side Effects

Side effects	Level A	Level B	Level C	Total
Cramps/Lower abdominal pain	9	4	12	25
Moderate increased bleeding	7	2	11	20
Backache	5	3	4	12
Spotting between menstrual periods	8	1	7	16
Increased discharge	1	0	3	4
Other	0	2	3	5

Table 4: First Check-up after Insertion

Period	Level A	Level B	Level C	Total
After one month	9	4	9	22
After three months	2	1	3	6
After one year	0	0	0	0
After a menstrual period	2	0	4	6
Other	2	2	6	10

Table 5: Number of Checks after first Check-up

Number of checks	Level A	Level B	Level C	Total
1 - 2	4	2	2	8
3 - 4	3	3	13	19
5 - 6	0	0	0	0
> 7	1	0	0	1
Never	0	0	0	0
When need arise	6	2	4	12
Don't know	0	0	2	2

Table 6: Number of Years Copper T-380A can remain effective

Number of years	Level A	Level B	Level C	Total
0 - 4	0	0	2	2
5 - 8	1	3	6	10
9 - 10	12	4	12	28
11 - 12	0	0	0	0
> 13	0	0	0	0
Don't know	1	0	1	2

Table 7: Major Problems that a Woman should come back for

Major problems	Level A	Level B	Level C	Total
Heavy discharge	8	3	11	22
Severe lower abnormal pains with cramps	9	3	14	26
Prolonged bleeding	6	3	12	21
Amenorrhoea (missed periods)	5	1	4	10
Expulsion or cannot feel threads	11	3	15	29
Pain during intercourse	0	3	0	3
Infection (P.I.D)	6	1	7	14
Other	0	1	2	3

Table 8: Advice Given to Clients at high risk of infection with a RTI/STD or HIV/AIDS

Reasons	Level A	Level B	Level C	Total
Continue to use the IUD alone	0	0	1	1
Continue with the IUD but also use a condom	5	4	14	23
Switch from the IUD to the condom	11	2	5	18
Stop using any type of contraception	2	1	1	4
Other	2	1	5	8

INJECTABLE

Table 1: When a Client should start injections

When to start injections	Level A	Level B	Level C	Total
Within 1 st - 5 th day of menses	12	5	12	29
Six weeks postpartum	4	1	8	13
Reasonably sure that is not pregnant	3	5	11	19
Other	1	0	4	5

Table 2: Known Side Effects

Side Effects	Level A	Level B	Level C	Total
Nausea	2	0	7	9
Mild headaches	9	0	9	18
Irregular bleeding/spotting	13	5	19	37
Weight gain/loss	4	4	9	17
Amenorrhoea (absence of period)	9	3	14	26
Other	5	2	5	12

Table 3: Major Problems a Client should come back for

Major problems	Level A	Level B	Level C	Total
Headaches (severe, persistent)	10	3	12	25
Heavy bleeding	14	6	17	37
Frequent urination	1	2	0	3
Other	2	2	10	14

Table 4: Advice given to clients at high risk of infection with an RTI/STD or HIV/AIDS

Advice Given	Level A	Level B	Level C	Total
Continue to use the injectable alone	0	1	1	2
Continue with the injectable but also use a condom	12	6	17	35
Switch from the injectable to the condom	2	0	3	5
Stop using any type of contraception	0	0	0	0
Other	2	2	5	9

NORPLANT

Table 1: When a Client should start NORPLANT

When to start	Level A (n=14)	Level B (n=7)	Level C (n=21)	Total (n=42)
Within 1 st - 5 th day of menses	11	4	8	23
Six weeks postpartum	5	1	5	11
Immediately after abortion	3	0	3	6
Reasonably sure that is not pregnant	4	5	12	21
Other	2	0	4	6

Table 2: Known Side Effects

Side effects	Level A (n=14)	Level B	Level C	Total
Backache	3	0	2	5
Nausea	2	1	8	11
Mild headaches	8	2	7	17
Irregular bleeding/spotting	10	4	12	26
Weight gain/loss	3	3	9	15
Amenorrhoea (absence of period)	8	4	5	17
Skin changes	2	0	1	3
Other	5	2	7	13

Table 3: Major Problems a Client should come back for

Major problems	Level A (n=14)	Level B	Level C	Total
Prolonged bleeding	11	5	13	29
Severe backache	5	1	6	12
Blurred vision	2	0	3	5
Infection at insertion site	8	3	2	13
Other	6	3	8	17

Table 4: When Woman must come back for Removal

	Level A (n=14)	Level B	Level C	Total
When need arises	9	5	10	24
After five years	11	3	12	26
Other	1	0	1	2

Table 5: Advice given to Clients at high risk of infection with an RTI/STD or HIV/AIDS

Advice Given	Level A	Level B	Level C	Total
Continue to use the NORPLANT alone	0	1	2	3
Continue with the NORPLANT but also use a condom	12	6	16	34
Switch from the NORPLANT to the condom	1	0	0	1
Stop using any type of contraception	0	0	0	0
Other	2	3	3	8

ANNEX 4:

REPRODUCTIVE HEALTH PROFILE (for 2,200 Women re-interviewed after 3 months in the Study)

Table 1: Percent of Women with a Abnormal Vaginal Discharge

Response	Level A (n=720)	Level B (n=836)	Level C (n=644)	Total (n=2200)
Have a discharge	8	8	4	7
Percent of Clients with vaginal discharge by symptoms/Conditions				
Symptoms/Conditions	Level A (n=60)	Level B (n=71)	Level C (n=25)	Total (n=156)
Itching or Irritation	78	62	40	65
Bad Odour	65	48	32	52
Severe lower abdominal Pain	60	42	44	49
Fever	58	41	52	49
Discharge limits daily activities	7	10	0	7
Sought medical advice/treatment	17	21	16	19
Reasons for not seeking medical attention (for those who did not seek medical care (81%))				
Reasons	Level A (n=50)	Level B (n=56)	Level C (n=21)	Total (n=127)
Didn't think it would help	12	4	10	8
Too expensive (medical expenses)	2	4	0	2
No Transport	2	2	0	2
No Time	6	2	29	8
Not serious enough	42	66	43	53
Embarrassed	8	0	0	3
Afraid	2	0	0	1
Thought it was normal	6	19	0	11
No medical scheme	2	2	5	2
Other (Specify)	18	19	14	10

Table 2: Percent with Pain in the Lower Abdomen

Response	Level A (n=720)	Level B (n=836)	Level C (n=644)	Total (n=2200)
With pain	12	8	8	9
Percent of Clients with lower abdomen pain by Symptom/Conditions				
Symptom/Conditions	Level A (n=84)	Level B (n=68)	Level C (n=48)	Total (n=200)
Frequent need to urinate	61	41	40	49
Burning/Stinging	61	43	37	49
Urge to Urinate	55	25	25	38
Blood in Urine	11	9	8	9
Problem to limit daily activities	6	26	17	15
Reasons for not seeking Medical attention (For those who did not seek medical care (83%))				
Reasons	Level A (n=70)	Level B (n=59)	Level C (n=36)	Total (n=165)
Didn't think it would help	9	15	11	11
Too expensive (medical expenses)	1	10	6	5
No Transport	4	3	0	3
No Time	3	3	8	4
Not serious enough	63	59	64	62
Embarrassed	6	2	6	4
Afraid	1	0	0	1
Thought it was normal	4	0	0	2
Very busy	0	0	0	0
Did not know what to do	1	2	0	1
No medical scheme	0	0	3	1
Other (Specify)	7	5	3	5

Table 3: Percent with a Period lasting more than 7 days

Response	Level A (n=720)	Level B (n=836)	Level C (n=644)	Total (n=2200)
With period	16	10	8	11
Condition of Clients with period lasting more than 7 days				
Conditions	Level A (n=112)	Level B (n=84)	Level C (n=55)	Total (n=249)
Bleed/Spot between periods more than a day	76	70	55	69
Unusually heavy bleeding	32	42	42	37
Problem limiting daily activities	2	14	4	6
Reasons for not seeking medical attention (For those who did not seek medical care (72%))				
Reason	Level A (n=80)	Level B (n=61)	Level C (n=37)	Total (n=178)
Didn't think it would help	12	5	8	9
Too expensive (medical expenses)	1	3	0	2
No Transport	2	0	3	2
No Time	5	5	3	4
Not serious enough	60	67	81	67
Embarrassed	6	7	0	0
Afraid	4	0	0	0
Thought it was normal	9	7	3	6
Waiting for the next visit	0	0	0	2
Other (Specify)	0	13	3	9

ANNEX 6:

PERSONNEL INVOLVED IN THE STUDY

DIRECTOR OF CSO

Mr. David S. Diangamo

PRINCIPAL INVESTIGATOR

Mr. Oliver J.M Chinganya

CONSULTANTS

Dr. Davy Chikamata
Dr. Anrudh Jain
Dr. Saumya RamaRao

DATA COLLECTORS (Baseline)

Social Scientists

1. Dorothy Simambo
2. Loveness Mambo
3. Prisca. Mwenya
4. Mirriam Shawa
5. Mate Mate
6. Henry A. Banda
7. Alophos S Susiku
8. Martin Tolosi
9. Donald Chikule
10. Opah Zulu
11. Lawrence Chanda
12. Henry Zulu

Nurses

1. Beatrice Nakaanda
2. Grace C. Chanda
3. Inonge Mooka
4. Christine M Katongo
5. Rosemary Habbanti
6. Norah Mayaka
7. Rhoda C Mwansa
8. Melody K Gondwe

DATA PROCESSING STAFF

1. Perry Musenge
2. Christopher Mwenda
3. Macwani Muletambo
4. Susan Simbeye