Utilisation of progestogen only and combined oral contraceptive pills in Zimbabwe - A rapid assessment

Alford Phiri

Farirai Mutenherwa

Zimbabwe National Family Planning Council

Ityai Muvandi

Consultant, Family Health International

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ZNFPC

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fhi Family Health International

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PREFACE

An analysis of consumption and distribution data of oral contraceptives from the Ministry of Health and Child Welfare (MOH&CW) and the Zimbabwe National Family Planning Council (ZNFPC) from 2000 to 2004 revealed a disproportionately high use of progestogen only pills (POP) compared to consumption patterns in other parts of the world.

It is against this background that the ZNFPC in collaboration with the MOH&CW, and other development partners undertook a rapid assessment of the utilisation of oral contraceptives. The purpose of the rapid assessment was to systematically explore oral contraceptive consumption patterns and practices and their determinants in the country.

This report presents the findings of the rapid assessment. It is envisaged that findings from this assessment will go a long way in improving the quality of service in the provision of oral contraceptives in the country particularly client decision-making vis-à-vis choice of appropriate oral contraceptives. Specifically, the information will be used during training and refresher courses for family planning service providers. Findings on the procurement and distribution of oral contraceptives will contribute significantly to strengthening the logistics management system.

It is our hope that implementation of the study recommendations will ultimately result in matching clients to appropriate oral contraceptives while at the same time assisting users to attain their reproductive health goals.

Munyaradzi Murwira (Dr)
Acting Executive Director
ZIMBABWE NATIONAL FAMILY PLANNING COUNCIL

ACRONYMS

AMC	-	Average Monthly Consumption
CBD	-	Community Based Distributor
COC	-	Combined Oral Contraceptive

CPR	-	Contraceptive Prevalence Rate
CSO	-	Central Statistical Office
DFID	-	Department for International Development
DTTU	-	Delivery Team Top Up
FHI	-	Family Health International
FP	-	Family Planning
JSI	-	John Snow International
MOH&CW	-	Ministry of Health and Child Welfare
POP	-	Progestogen Only Pill
PSI/Z	-	Population Services International Zimbabwe
RDC	-	Rural District Council
SDP	-	Service delivery Point
UNFPA	-	United Nations Population Fund
USAID	-	United States Agency for International Development
ZDHS	-	Zimbabwe Demographic and Health Survey
ZNFPC	-	Zimbabwe National Family Planning Council

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EXECUTIVE SUMMARY

Zimbabwe has one of the most successful family planning programmes in sub-Saharan Africa with a contraceptive prevalence rate of 54 percent (ZDHS 1999). The Zimbabwe National Family Planning Council (ZNFPC) has the mandate to coordinate all family planning activities, including procurement and distribution of contraceptives in the country. Oral contraceptives make up the greatest proportion of the contraceptive method mix. About 81 percent of oral contraceptive users in Zimbabwe obtain the pill from the public sector, that is, rural and municipal clinics, Rural Health Centres, Government Hospitals and clinics, ZNFPC clinics and ZNFPC Community Based Distributors.

Pills are obtainable in two forms, progestogen only pills (POP) and combined oral contraceptive (COC) pills. According to the ZNFPC family planning service delivery guidelines, ideally, women should use POPs from the time of delivery until the sixth month of breastfeeding and then switch to COCs. Data on the utilization of oral contraceptives in six African countries (Cameroon, Ethiopia, Ghana, Madagascar, Tanzania and Uganda) for the period 2001 through 2004 show that the share of POP among oral users is between 1 percent and 8 percent. These data are consistent with international patterns of consumption of oral contraceptives. However, data on the consumption of oral contraceptives from the Ministry of Health and Child Welfare (MOH&CW) and

ZNFPC show that the consumption of oral contraceptives constitutes between 40 percent and 50 percent of the total consumption of oral contraceptives in Zimbabwe. Thus, there is likely to be an overuse of POP in Zimbabwe.

This realization prompted the MOH&CW and ZNFPC in collaboration with other partners commissioned a rapid assessment in 2004 that sought to establish the factors contributing to the overuse of POPs in Zimbabwe. Results from the study can be used to match oral contraceptive users to the most appropriate pills while at the same time assisting these women to meet their reproductive goals.

A rapid assessment methodology that coupled qualitative and quantitative methods was used to collect data for this study. Data collection methods used include desk review, interviews with samples of trainers, family planning service providers, family planning programme managers and current users of oral contraceptives from purposively selected public health facilities and training institutions. The research was conducted in Harare, Mashonaland East and Midlands provinces. In all, 6 family planning trainers, 36 family planning service providers, 23 purposively selected managers and 150 current users of oral contraceptives were interviewed.

The research revealed that within the health facilities studied, 44 percent of the 28, 716[1] cycles of oral pills distributed during the last quarter of 2004 were POPs, that is, ovrette and micronor while the remaining 56 percent were COCs, that is, Lo-femenal, trinordiol and ovral. An analysis of data from current users of oral contraceptives found that more than half, 54 percent, were on POP and the remaining 46 percent on COC. Thus, both statistics consistently show that use of POP is disproportionately high among the health facilities studied.

About 39 percent of current users of oral contraceptives surveyed were breastfeeding at the time of the study. An analysis of current oral contraceptive use and the duration of use revealed that 57 percent of current POP users had been using the method for a continuous period greater than six months. Thirty-seven percent had been on POP for a period more than one year whilst 43 percent had been continuously using a POP for six months or less. Only 35 percent of current pill users were ever informed by family planning service providers of the need for mothers breastfeeding babies over six months of age to switch from POP to COC.

When asked about the time when a breastfeeding mother should transition from POP to COC, 25 percent of the service providers reported that a woman could continue with the same method as long as she is not experiencing any method-related problems.

Twenty-five percent of current users of oral contraceptives were of the opinion that mothers breastfeeding babies less than six months old should use the same pill as non-breastfeeding women.

When asked how they chose their current oral contraceptive method, 46 percent of current users reported that the decision to use the current pill was based on their personal preferences. Twenty-three percent reported that a family planning service provider recommended the method. Another 23 percent reported that a doctor, nurse or CBD prescribed their current method.

Even if the current oral contraceptive method were to be given a different name, 79 percent of the current users of oral contraceptives indicated that they would continue using the method. The key reasons why they would continue using the current pill were:

- Have faced no problems with current pill;
- Current method has no side effects;
- Same drug works the same; and
- Effective method of contraception.

[1] This figure is an underestimate (but indicative) due to poor record keeping at some of the facilities

On the other hand, 21 percent of the oral contraceptive users were against the change in name. For their criticism, they indicated that they questioned the authenticity of the *"new pill"*, its drug composition and effectiveness as well as possible side effects. They also expressed scepticism over the reasons for the change in name.

According to family planning service providers interviewed, what is referred to as the *"Client Rights"* in Zimbabwe are an integral component of the family planning service delivery system. The rights emphasize the importance of informed choice on the part of clients. Thus, in practice it is rather difficult to talk about prescription practices of service providers since the ultimate choice of a contraceptive method rests with the client.

When asked whether there were any risks associated with prolonged use of POP beyond six months of breastfeeding, a high proportion of service providers, 69 percent, reported that there were no risks. Eight percent did not know whether there were any risks.

In terms of training of service providers, 42 percent of the providers interviewed had not undergone any formal training in the Family Planning Clinical Course. However, family planning service providers who received formal training in the Family Planning Clinical Course reported that the training was adequate. Of the six trainers interviewed, one had not received any formal family planning clinical training.

The research revealed that family planning trainers put more emphasis on theory rather than clinical practice. All trainers from the different institutions send their students on clinical attachment. The trainers use a performance guide and checklist to ensure that their students are able to correctly provide oral contraceptives.

According to family planning trainers, family planning service delivery guidelines stipulate that COCs affect the quality and quantity of milk, due to the effect of oestrogen. Thus, breastfeeding mothers are encouraged to use POPs for the first six months post-partum. Although some family planning trainers are aware of the timing of the transitioning from POP to COC for breastfeeding mothers, others confessed ignorance.

In the event of stock outs of COCs, trainers reported that they instruct service providers to give non-breastfeeding mothers or mothers breastfeeding babies aged more than six months any family planning method including POPs.

Before the inception of the Delivery Team Top Up (DTTU) system there were no clear and standard procedures or formulae for calculating and projecting quantities of oral contraceptives required at each service delivery point. Currently, the DTTU system treats each service delivery point as a separate "warehouse" and replenishes its supplies according to consumed oral contraceptives based on the average monthly consumption (AMC).

The rapid assessment showed that among health facilities visited and current users of oral contraceptives interviewed, there was a disproportionately high use of POP in relation to the overall use of oral contraceptives in the country. The imbalance is attributable to a number of factors that include information provided to clients by service providers; knowledge levels on the part of both trainers and service providers; attitudes of both service providers and clients; and the excessive workload on the part of service providers.

In order to match clients to the most appropriate oral contraceptives, the following are recommended:

- Train all family planning service providers in the Family Planning Clinical Course. For those who have already been trained, they need frequent refresher courses.
- In the event that clients are opting for an inappropriate oral contraceptive as they exercise their right, service providers should make efforts to explain the potential problems associated with such choices.

- There is need to ensure that each health facility has at least one service provider trained in the Family Planning Clinical Course.
- The shortage of staff at most of the public sector health facilities needs to be addressed as it compromises the quality of service delivery.

I STUDY BACKGROUND

The Zimbabwe National Family Planning Council (ZNFPC) is charged with the responsibility to procure and distribute contraceptives in Zimbabwe. The contraceptive prevalence rate (CPR) for Zimbabwe is 54 percent, while the CPR for modern family planning (FP) methods is 50 percent (ZDHS 1999). The pill is the most commonly used method of contraception in the country with a CPR of 36 percent up from 23 percent in 1984 (ZDHS 1999).

The majority (81 percent) of the current users of the pill obtain the method from the public sector (ZDHS 1999). The public sector sources of the pill include rural and municipal clinics (35 percent), Rural Health Centres (21 percent), Government Hospitals and Clinics (11percent), ZNFPC Clinics (6 percent) and ZNFPC CBDs (5 percent), (ZDHS, 1999).

Pills are obtainable in two forms, namely the progestogen only pill (POP) and the combined oral contraceptive (COC). According to the current ZNFPC service delivery guidelines, women are supposed to use the POP from delivery up to the sixth month of breastfeeding after which they should switch to the COC. In Zimbabwe, skilled personnel assist 73 percent of the deliveries, the majority being delivered by a nurse or a midwife in clinics and/or hospitals (ZDHS, 1999). Six weeks post-delivery, mothers take their babies to clinics for review. It is usually during these visits that mothers are initiated on a family planning method. At this stage, the most appropriate oral contraceptive for these breastfeeding women are POPs. Thus, most mothers are initiated on the POP, which in the Zimbabwe public health facilities is usually ovrette.

JSI/DELIVER, is involved in the Delivery Team Top Up (DTTU) system in Zimbabwe and also participates in the delivery of oral contraceptives in other African countries. Service statistics for six selected African countries (Cameroon, Ethiopia, Ghana, Madagascar, Tanzania and Uganda) for the period 2001 to 2004 show that POP consumption constituted 1 percent to 8 percent of the total oral contraceptive consumption in those countries. This is in line with international standards. By contrast, MOH&CW and ZNFPC service statistics show that POP consumption constitutes 40 percent to 50 percent of the total consumption of oral contraceptives in Zimbabwe.

United States Agency for International Development's (USAID) POP shipment statistics for different countries worldwide for the period 1999 to 2003 show that approximately 40 percent of POP deliveries were made to Zimbabwe. This is in sharp contrast with distribution trends elsewhere. The only other country that received similar quantities of POPs from USAID is Bangladesh whose population is 12 times greater than that of Zimbabwe.

The high usage of the POP in Zimbabwe could, therefore, be a result of the following:

i) failure by service providers to follow proper guidelines;
ii) insistence to use POPs by clients as they exercise their rights to make their own choices and decisions;
iii) lack of correct knowledge on the part of service providers and trainers; and
iv) limited time for provider-client interaction.

Failure to match contraceptive methods with the client's condition, duration of breastfeeding, may lead to high consumption rates of POPs and consequently unintended pregnancies. The resulting method failure can cause clients to lose confidence in the efficacy and effectiveness of oral contraceptives and consequently damage the image of the national family planning programme. Thus, there is a need to get a better understanding of factors contributing to the current utilisation of oral contraceptives in Zimbabwe.

It was against this background that the ZNFPC in collaboration with the MOH&CW and other collaborating and development partners with financial support from UNFPA and FHI undertook a rapid assessment of the utilisation of POPs and COCs in Zimbabwe in 2005.

The research was conducted in Harare, Midlands and Mashonaland East provinces. Mashonaland East and Midlands provinces were selected for this study because, according to ZNFPC service statistics, they have higher POP consumption rates than all other provinces. The provinces maintained high mean POP consumption rates over the past four years, from 2000 to 2003. Harare on the other hand was selected to represent the major urban centres. Gweru was surveyed as part of Midlands province to represent the conditions found in medium cities.

II GOAL AND OBJECTIVES

Broadly, the study sought to establish the factors associated with the imbalance in the utilisation of POPs and COCs in Zimbabwe.

Specifically the study was designed to generate information on the:

- Service providers' prescription practices for POPs and COCs to women aged 15 to 49 years;
- Attitudes of clients towards the use of POP and COC pills;
- Consumption patterns of POP and COC pills by women aged 15 to 49 years;
- Course content of the Family Planning Clinical Course and other training manuals with regards the prescription and issuing of oral contraceptives; and
- Factors that influence quantities of POPs and COCs distributed to service delivery points.

III STUDY DESIGN AND METHODOLOGY

A combination of qualitative and quantitative research methods were used to collect data from purposively selected samples of current oral contraceptive users, service providers, trainers of the family planning service providers as well as family planning programme managers. The study was designed in such a way that data were collected from the aforementioned cadres from purposively selected ZNFPC, Ministry of Health and Child Welfare, mission, municipal and rural district council health facilities as well as ZNFPC CBDs from each of the selected provinces. Service statistics on quantities of oral contraceptives distributed during the last quarter of 2004 were also collected at each of the service delivery points visited during the study period.

The study used the rapid assessment procedures since the aim was to gather information quickly about what was happening on the ground in terms of consumption of oral contraceptives. A desk review of consumption and distribution of oral contraceptives in Zimbabwe was conducted. Specifically, the review included past Demographic and Health Surveys; ZNFPC and PSI service statistics; service delivery policies and standards; and training and procedure manuals used by ZNFPC service providers. A review of the ZDHS reports revealed that there is no information on the breastfeeding status of current users of oral contraceptives.

A structured questionnaire was used to collect data from 150 current oral contraceptive users aged 15 to 49 years from 26 selected health facilities. Non-probability sampling techniques were used to select oral contraceptive users interviewed during the rapid assessment. Exit-interviews with current users of oral contraceptives were carried out at the sampled service delivery points.

Face-to-face interviews were also conducted with 36 service providers from the selected service delivery points, using a semi-structured questionnaire. At least one family planning service provider was selected from each of the selected service delivery points.

A semi-structured questionnaire was also administered to six (6) trainers involved in the training of family planning service providers. Family planning trainers were purposively selected from Parirenyatwa Hospital, Chitungwiza General Hospital and Zimbabwe National Family Planning Council Head Office. Harare Central Hospital had also been sampled but interviews could not be conducted due to administrative problems.

Another semi-structured questionnaire was administered to 23 purposively selected cadres at management level involved in the distribution and management of contraceptives. Table 1 below shows the different management cadres interviewed during the study. The Reproductive Health and Child Welfare Coordinator, MOH&CW was also scheduled for interviewing, but was out of the country on duty during the time of the study fieldwork.

Table 1: Distribution of managers interviewed according to location and designation

Location	**Designation**
ZNFPC Head Office	(i) Assistant Director Service Delivery (ii) Assistant Director Training (iii) Logistics Manager (iv) Acting Sister In-Charge (Spilhaus Clinic)
Mashonaland East Province	(i) Provincial Manager (ZNFPC) (ii) Service Delivery Coordinator (ZNFPC) (iii) Sister in Charge Community (ZNFPC) (iv) Provincial Nursing Officer (MoH&CW) (v) Sister in Charge / Matron (all facilities)
Midlands Province	(i) Acting Provincial Manager (ii) Sister in Charge Community (iii) Provincial Nursing Officer (iv) Senior Nursing Officer (Gweru City)

Service statistics on new acceptors of oral contraceptives and revisit clients, quantities of oral contraceptives distributed and oral contraceptive stock status were also collected from the selected 26 service delivery points.

Data management and analysis

Quantitative data from the oral contraceptive user's and service provider questionnaires and service statistics were captured and analysed using Epi-Info. Responses from open-ended questions were analysed manually.

IV FINDINGS

4.0 Background characteristics of oral contraceptive users

The 150 current oral contraceptive users interviewed were women aged 15 – 49 years. The majority of the respondents (74 percent) were aged between 20-34 year age bracket. Ninety four percent of the women interviewed were currently in a union, either married or cohabiting. Seventy five percent had attained secondary education or higher whilst 24 percent and 1 percent had primary level or no education respectively. Although 49 percent of the interviewed women indicated that they were employed, 73 percent of those employed were self-employed. Table 2 below illustrates the socio-demographic characteristics of the oral contraceptive users who were interviewed during the study.

Table 2: Percent distribution of oral contraceptive users by selected socio-demographic characteristics

Characteristic	Percent (n=150)
Age Group	
15-19	6
20-24	30
25-29	24
30-34	20
35-39	11
40-44	6
45-49	3
Total	**100**
Marital Status	
Never Married	3
Married or cohabiting	94
Previously married	3
Total	**100**
Highest Level of Education	
None	1
Primary	24
Secondary	71
Higher	4
Total	**100**
Employment Status	
Unemployed	48
Employed	49
Student	1
Other	1
Total	**99***

***** Total does not add up to 100 because percentages were rounded off to the nearest whole number.

4.1 Trends in Oral Contraceptive Use Among Current Users

Out of the 150 oral contraceptive users interviewed during the study, 95 percent had ever used ovrette. This was followed by 70 percent and 10 percent who had ever used lo-femenal and micronor respectively. Smaller proportions had ever used trinordiol (4 percent) and ovral (2 percent).

Almost half (49 percent) of the respondents were currently using ovrette while 43 percent were on lo-femenal. The rest were currently using micronor (5 percent), trinordiol (3 percent) and ovral (1 percent). This effectively

means that 54 percent of the respondents were current users of POPs while the remaining (46 percent) were on COCs.

Service statistics for the period October to December 2004 were also collected from the 26 service delivery points (SDPs) surveyed as a way of cross checking data obtained from the oral contraceptive users. Record keeping was found to be generally poor at most SDPs, thus, the service statistics presented here are only indicative of the general trend in oral contraceptive utilization during the period under review. Out of a total of 28 716 oral pill cycles that were dispensed, 44 percent were POPs (i.e. ovrette and micronor) while 56 percent were COCs (i.e. lo-femenal, trinordiol and ovral). The main brands issued were ovrette (39 percent) and lo-femenal (53 percent).

Ninety percent of the current users had never had unintended pregnancies while on the pill. Of the 15 users who experienced unintended pregnancies, 8 were using ovrette while 6 users and 1 user were using lo-femenal and micronor respectively. This means that in all, 9 out of 15 of the current users who got an unintended pregnancy were using a POP while 6 were on COCs.

4.2 Perceptions about irregular consumption patterns

Interviews with service providers revealed that 81 percent of the providers did not perceive the disproportionately high consumption of POPs as a problem.

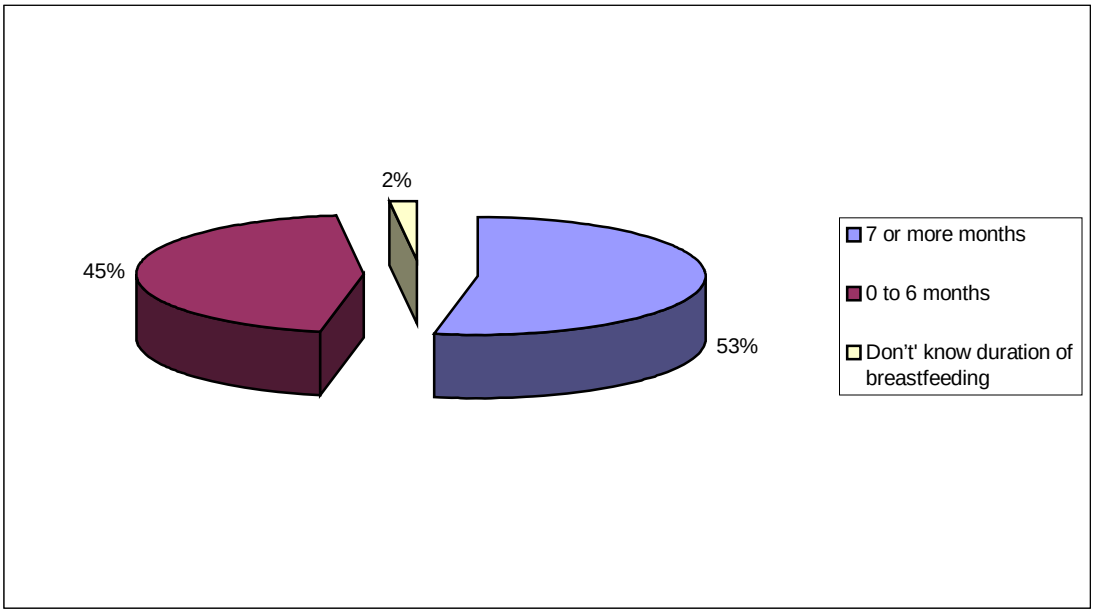
The interviewed trainers, service providers and other people responsible for the management of oral contraceptives indicated that the high consumption of POPs could be attributed to the following factors:

- Service providers recommend POPs to breastfeeding mothers;
- POP users are not well educated on the use of the contraceptive;
- There are more breastfeeding mothers on contraception compared to non-breastfeeding mothers;
- POPs are always available in most health institutions;
- POPs have fewer side effects than COCs;
- POPs suppress menstruation;
- Clients lack knowledge on method switching; and
- Clients are advised to continue on POPs as long as they do not experience any method related problems or are not contraindicated to the drug

4.3 Breastfeeding Practices and Use of Oral Contraceptives

Slightly less than two-fifth (39 percent) of the respondents were breastfeeding at the time of the survey while 61 percent were not. The majority (95 percent) of those women who were breastfeeding were using ovrette. The remaining 5 percent were using micronor, trinordiol or duofem (1.7 percent each). Of he women who were greastfeeding and using overette, 45 percent had been breastfeeding for six months or less while the majority (53 percent) had been breastfeeding for 7 or more months as illustrated in Fig 1 below.

Fig 1: Percentage distribution of ovrette users by duration of breastfeeding



This finding confirms the assertion made by oral contraceptive service providers that ovrette is regarded as *"a pill for breastfeeding mothers"*.

4.4 Clients' Attitudes Towards Use of Oral Contraceptives

The majority of the clients reported that the decision to use the current oral contraceptive was based on their personal preferences (46 percent). This was followed by 23 percent who reported that a service provider recommended the method. A similar proportion, 23 percent indicated that their current oral contraceptive was prescribed by a doctor, nurse and/or family planning CBD. Less than a tenth (7 percent) had been advised by a relative or friend.

A majority (79 percent) of the respondents indicated that they would feel comfortable continuing to use the oral pill they were currently using even if it were to be given a different name. Family planning clients who reported that they would continue using the current pill were further asked to state the main reason they would feel comfortable to continue using the oral contraceptive if it were to be given a different name. Because of the variety of responses given, the responses were post-coded and re-grouped into five categories. The five categories and the proportions of respondents who cited each category of responses are as follows:

(1) Have faced no problems with current pill (45 percent); (other responses under this category are have no problems with the pill, used to the pill, pill works well for me);

(2) No side effects (19 percent); (does not dry breast-milk, does not interfere with menstruation)

(3) Pill would have the same drug, which works the same as the current one (19 percent), (why change if it is only a change of the name, as long as the mode of action is the same)

(4) Effective method of contraception (10 percent); and

(5) Other (7 percent); (as long as there is a good explanation on how it works, do not know any other contraceptive, is the right method to take)

For the 21 percent who would feel uncomfortable, the main reasons were that they would question the authenticity of the pill and doubt if the pill would have the same drug. The users also expressed concern over possible side effects of the "*new pill*" as well as its effectiveness. In addition, they also indicated that they would be suspicious of the reasons for the change in name. These scepticisms were demonstrated by an oral contraceptive user who said, *"I would first of all need to know why the change of name? Secondly, I would want to know if the pill works as it used to"*.

Some oral contraceptive users also revealed that they were currently experiencing method-related problems with the current pill. Consequently, they would be uncomfortable continuing to use the same oral contraceptive even if it were to be given a different name.

The data show that as long as clients are not experiencing any serious method-related problems and/or side effects, they can comfortably continue using the same oral contraceptive even if the name of the oral contraceptive changes.

In order to demonstrate that when women are satisfied with a particular oral contraceptive they are not interested in switching, we analysed the duration of uninterrupted current use of POPs. The percentage distribution of POP users and duration of uninterrupted use is shown in Table 3 below.

Table 3: Percentage distribution of current POP users according to duration of uninterrupted use

Duration of Use (Months)	**Number**	**Percent**
0 – 6	35	43
7 -12	16	20
13-24	16	20
25+	14	17
Total	**81**	**100**

The data in Table 3 show that 57 percent of current POP users had continuously used their current pill for a duration beyond six months. According to current users interviewed, a plausible explanation for this tendency could be that they had not encountered serious method-related problems.

The attitudes of oral contraceptive users are most likely to be influenced by their lack of knowledge on the need to transition from POP to COC at some point. For example, 1 in every 4 current users of oral contraceptives thought that women breastfeeding babies aged six months and below should use the same oral contraceptives with non-breastfeeding women. Although 64 percent of current users surveyed knew that women breastfeeding babies aged six months or less should use different oral contraceptives from non-breastfeeding women, most clients do not know when to transition from a POP to a COC considering that 57 percent of current POP users have continuously used the type of method for a duration beyond six months.

The tendency of oral contraceptive users to continue using a POP beyond six months when they are not experiencing method-related problems is also influenced by the information given to clients by family planning service providers – they tell clients that POPs are oral contraceptives for breastfeeding mothers. Thus, as long as clients are breastfeeding, they would not like to be changed to COCs.

4.5 Prescription Practices

The findings on prescription practices of oral contraceptives are based on information collected from family planning service providers, current oral contraceptive users, trainers of family planning service providers and a review of the family planning training and procedure manuals.

4.5.1 Family planning service providers' perceptions

The 36 family planning service providers were asked about the duration that breastfeeding mothers should use POPs before switching to COCs. The majority, (25 percent) reported that as long as the woman is not experiencing method-related problems she could continue using the POP. Other noteworthy responses and the proportions of respondents citing each category are as follows:

- For 6 months (11 percent);
- When mother stops breast -feeding (11 percent);
- Mothers should use POPs for 12 to 18 months after delivery and then switch to COCs (17 percent);
- Mothers should use POPs for a period between 18 and 24 months after delivery before transitioning to COCs (11 percent);
- Mothers should use POPs for 6 to 12 months after delivery and then switch to COCs (17 percent); and
- It is the choice of the woman to choose the type of oral contraceptive that she wants at any stage of her reproductive life cycle (8 percent).

These responses are indicative of the varied understanding of the correct use of oral contraceptive, which can be interpreted as follows: (a) use of oral contraceptives is not standardized; and (b) service providers do not have correct information on the correct use of oral contraceptives. In fact, ovrette is referred to as *"the breastfeeding pill,"* which implies that as long as mothers are breastfeeding, they can remain on the POP. The fact that family planning service providers believe that mothers can be on POP for up to two years or more and the fact that Zimbabwe has a breastfeeding population partly explains the high share of POPs in the overall consumption of oral contraceptives in the country.

In Zimbabwe, there is what is known as *"The Client's Rights"* which are an integral part of the family planning service delivery system. One of these client's rights is informed choice on the part of the client. Thus, in theory, family planning service providers do not prescribe oral contraceptives to clients. Instead they provide complete information on the orals available including their side-effects; advantages and disadvantages of each method; and timing of transitioning from POPs to COCs. Family planning service providers conduct physical examinations and let the client make her choice on the basis of complete information. Thus, ideally, the choice of the pill to be used is entirely the client's responsibility.

The research, however, revealed that in practice most of the clinics in the public sector are under-staffed, a situation that leads to extreme work overload. The heavy workload results in reduced time for service provider-client interaction. Thus, when a family planning client comes for a revisit and she has no serious method-related problems, she is re-supplied with the current method irrespective of the duration she has been breastfeeding.

Family planning service providers were also asked whether there were any risks associated with use of POPs beyond six months of breastfeeding. A high proportion, 69 percent, of the service providers reported that there were no risks. Eight percent of the service providers did not know whether there were any risks associated with the use of POP beyond six months of breastfeeding. Only 1 in 5 (22%) of the family planning service providers interviewed reported that there were risks associated with prolonged use of POPs. This finding partly explains why some service providers indicated that women could be on POP for up to two years.

The Ministry of Health and Child Welfare (MOH&CW) and the Zimbabwe National Family Planning Council's family planning service delivery guidelines recommend mothers breastfeeding babies less than six months old should use POPs. After infants are six months old, the ideal approach is for mothers to switch to COCs except in

situations where the woman is contra-indicated (for example, if mother has a heart problem or is diabetic). However, results from the study revealed that only 35 percent of the users had ever been informed by a service provider of the need for mothers breastfeeding babies over 6 months old to switch from POP to COC. Likewise, only 21 percent of oral contraceptive users had ever been informed of the need for mothers breastfeeding babies less than 6 months old to switch from COC to POP while the remaining 79 percent had never been informed.

4.5.2 Trainers' perceptions about prescription of oral contraceptives to breast-feeding women

Five out of the six trainers interviewed indicated that women breastfeeding babies aged six months and below should not use the same oral contraceptive as non-breastfeeding women or women breastfeeding babies aged more than six months. Most of the trainers (four) also revealed that breastfeeding mothers should use POPs for the first six months post-partum before switching to other methods. However, one trainer confessed ignorance about the duration of POP use by breastfeeding mothers that is recommended before switching to other contraceptive methods. Another trainer said that oral contraceptive users should be on POP for about one year. It was also found that almost all of the trainers interviewed (5) perceived that there are no known risks associated with the continued use of POPs by mothers breastfeeding beyond six months post-partum.

When asked about the content of the guidelines in relation to method choice and breastfeeding, two of the trainers indicated that the guidelines stipulate that COCs affect the quality and quantity of milk, due to the effect of oestrogen. The other three trainers indicated that breastfeeding mothers are encouraged to practice exclusive breastfeeding for the first six months after which they can switch to other types of contraceptives. If desired family size has been attained, trainers also reported that mothers may also consider permanent methods. One of the trainers could not remember what the guidelines say about method choice in relation to breastfeeding. Such results are worrying as the people who are supposed to impart information to service providers either do not know the guidelines or have incorrect information.

In the event of stock outs of COC, trainers indicated that they instruct service providers to give non-breastfeeding mothers or mothers breastfeeding babies beyond six months, any of the short term or long term methods including POPs. On the other hand, should there be a stock out of POPs, trainers instruct service providers to give whatever contraceptive is available including COCs, to mothers breast-feeding babies aged six months or below. Permanent methods are also encouraged where the desired family size has been attained. However, stock outs were found to be very rare during the last six months prior to the study.

4.6 Training in the provision of oral contraceptives

The results showed that 21 of the 36 service providers interviewed were trained in the formal Family Planning Clinical Course while 15 did not receive this training. Of the 15 service providers who did not receive formal family planning clinical course training, 10 received in service/ on the job training whilst the remainder (5) did not receive any training at all.

With regards to training adequacy, 20 of the service providers who were trained in the Family Planning Clinical Course felt that they had received adequate training in the provision of oral contraceptives. On the other hand, only 3 of those service providers who received in service and/or on the job training felt that they received adequate training in the provision of oral contraceptives.

Twelve of the service providers who were trained in the Family Planning Clinical Course attended a refresher course whilst 9 did not. Additionally, eleven of the service providers who received a refresher course felt that the provision of oral contraceptives was covered adequately. The most recent refresher course attended by some of the service providers who were interviewed was held in 2003, indicating that most service providers are not abreast with recent developments in the provision of oral contraceptives. Ideally, six months after training

service providers in the Family Planning Clinical Course, the trainers are supposed to make follow ups to evaluate the trained service providers. If any gaps are identified, refresher courses are arranged six months after the follow up.

4.6.1 Content of the Family Planning Clinical Course

A thorough review of the Family Planning Clinical Course Training Manual revealed that the manual lacks detail, clarity and specific instructions on oral contraceptive method matching and switching according to a client's reproductive health condition and goals. Specifically, there is limited information on matching of oral contraceptives to breastfeeding status of the mother. Instead of getting clear instructions and guidelines from the manual, the trainer is only made to infer from its content. Also, the manual includes no information about the duration of POP use before a breastfeeding mother can switch to COC or vice versa. There is concern that the lack of clarity of the guidelines and training manual allows individual trainers to interpret the information differently.

The information on method matching is inadequately presented under precautions that a service provider should consider when issuing a client with COCs. According to the Family Planning Clinical Course Training Manual, the service provider should determine if the client ***"Is breastfeeding a baby less than six months of age***… the rationale being that ***oestrogen can slightly decrease the amount and nutritional content of breast milk a lactating women produces"*** (pp 6-1-7). However, no further information is provided. With regards to transitioning from POPs to COCs, the only relevant information available in the manual is that the service provider must tell the client that she can change to another method. If the couple wants to stop childbearing they can also consider voluntary surgical contraception (pp 6-1-16).

Some of the topics covered in the manual on oral contraceptives include the following: definition of oral contraceptives; mechanism of action; misconceptions; advantages and disadvantages; contraindications and their rationale; instructions given to clients; danger signs; and problem management. When the trainers were asked about the content of the Family Planning Clinical Course, they clearly stated most of these topics.

4.6.2 Quality of training in the provision of oral contraceptives

The results showed that 1 out of the six trainers interviewed was not trained in the Family Planning Clinical Course. In addition, three of the trainers also revealed that they put more emphasis on theory as opposed to clinical practice when training service providers whilst two trainers indicated that they emphasise on both theory and practice. All the training institutions use lectures and demonstrations during their training courses. In addition to these two approaches, some trainers indicated that they use role-plays, group discussions and brainstorming.

It was also found that all the trainers at the different institutions deploy their students for family planning clinical attachment as part of the training. Most trainers indicated that they attach their students to City Council Health Centres followed by government hospitals and ZNFPC clinics. The cadres responsible for the supervision of students on attachment depend on the type of institution a student is attached, that is, whether it is ZNFPC, Government, City Council, Rural District Council, or Mission Hospital /Health Centre. Training Officers or tutors, Community Health Sisters as well as in-charges of the respective health facility where the student is attached, were the most common supervisors cited as responsible for supervision of students on attachment. Ideally, tutors are supposed to visit and assess all their students on attachment. However, it also emerged that due to fuel and transport problems, supervision and assessment by tutors was rarely done.

All the Trainers who send their students for attachment use a performance guide or checklist to ensure that their students are able to correctly provide oral contraceptives. Each student is required to examine, counsel and then

provide or recommend the correct oral contraceptive method as part of the assessment process. However, most of the trainers acknowledged that there is no minimum number of family planning clients that a student should attend to during training, with only two trainers indicating that there is a minimum number of family planning clients that a student should attend to during training. One of the trainers indicated that the minimum number is 10 while the other trainer said that it is 15. Return demonstrations are also used to assess the capability of students to offer oral contraceptives after the attachment.

The use of guidelines is universal at all the training institutions and the Family Planning Clinical Course Training Manual is the most common reference manual, followed by the Clinical Procedure Manual. Table 4 below shows the manuals used by trainers of oral contraceptive service providers during training courses, by author and year developed.

Table 4: Manuals used by trainers of oral contraceptive method service providers during their training courses, by author and year developed.

Name of Manual	**Developed by**	**Year Developed**
Family Planning Clinical Course Training Manual	ZNFPC	1994
Clinical Procedure Manual	ZNFPC	1985 1994
General Nurses Diploma Three Year Curriculum	Not Known	Not Known
Reproductive Health Service Delivery Manual	MOH&CW	2001
Contraceptive Technology Manual	Johns Hopkins University	1997
Oral Contraceptive Module	Not Known	Not Known

4.6.3 Trainers' recommendations on correct use of oral contraceptives

To ensure that clients are matched to the correct type of oral contraceptive, Trainers recommended that all service providers must be trained in the Family Planning Clinical Course and should be educated on the need to switch clients who are breastfeeding babies six months or older from POPs to other contraceptive methods. Clients should also be given information on use, side effects, advantages and disadvantages of each oral contraceptive so that they may make informed choices. They also recommended that thorough screening should be done before the issuing of any oral contraceptive in order to exclude clients with contraindications and match clients to the correct contraceptive depending on their reproductive health goals. Health education must also be given to the community as well as to service providers

In order to ensure that mothers breastfeeding babies above six months are aware of the need to change from POPs to other methods, health education and motivation were also recommended. The trainers recommended that information and education should be given to mothers in order to switch from POPs to COCs since the effectiveness of POPs is reduced when the baby stops breastfeeding or reduces the frequency of breastfeeding. Equal emphasis on the benefits of both COCs and POPs should be provided to family planning clients so that they can make informed and unbiased choices. They also recommended that clients should be counselled about family planning method choice before or during pregnancy and post-partum.

4.7 Forecasting and procurement procedures of oral contraceptives

Forecasting and procurement procedures for oral contraceptives at the service delivery points were also explored during the rapid assessment. For clarity, the results from the study vis-avis forecasting and procurement of oral contraceptives are presented in such a way that a comparison can be made between the current system, that is, the Delivery Team Top Up system (DTTU) and the systems that were used before.

4.7.1 Forecasting and procurement procedures before DTTU

The assessment revealed that before the inception of the DTTU there were no clear and standard procedures or formulae for calculating and projecting quantities of oral contraceptives required at each service delivery point. In addition, facilities under different authorities used different procedures for calculating and projecting quantities of oral contraceptives at their respective facilities.

Projections at the Central Warehouse at the ZNFPC Head Office were based on distribution data from the central warehouse to the different service delivery points countrywide as well as orders from the provinces.

In the provinces, before the inception of the DTTU, ZNFPC Service Delivery Coordinators in liaison with the Provincial Nursing Officers from the MOH&CW would calculate the average monthly consumption of oral contraceptives for the last three months in order to forecast the needs for the coming months. Annual stocks taken at the end of each year were also used as an indicator of the next annual requirements, that is, annual ordered quantities less stock on hand at the end of the year, was used to get the annual consumption/ replacement. The data were, however, based on quarterly returns from CBDs and ZNFPC holding points and excluded data from MOH&CW, Rural District Council facilities and other private providers.

At MOH&CW facilities, it was found that they used quantities consumed in the previous months plus 10 percent contingency allowance when forecasting their oral contraceptive requirements.

4.7.2 Current forecasting and procurement procedures (DTTU system)

Currently the ZNFPC Central Warehouse at Head Office considers shipments received, quantities ordered from suppliers, shipment plan and distribution data from central warehouse as well as consumption of oral contraceptives at facility level, when making projections for future requirements.

The DTTU system treats each service delivery point as a separate entity and replenishes its supplies according to consumed oral contraceptives based on the Average Monthly Consumption (AMC). At the ZNFPC provincial offices, they multiply the AMC by the number of months the stocks should last (usually four months), to estimate the maximum stock required. The AMC is calculated by dividing quantities consumed from the last delivery by the calendar days between the last and the current delivery, multiplied by 30. They then calculate the difference between current quantities in stock and the maximum stock quantity required.

If the current stock is smaller than the maximum stock quantity required, they order the difference. If it is greater than maximum stock quantity they do not order anything. The maximum stock level should be enough to last for four months. The data is now coming from all service providers, that is, ZNFPC stock-holding points, CBDs, MOH&CW, Rural District Councils and private practitioners. It was also evident that some Provincial Nursing Officers were not aware of the operations of the DTTU system. At each MOH&CW health facility the DTTU system balances the stocks after physical counts and replenishes the stocks based on quantities consumed.

Those responsible for ordering oral contraceptives at municipal clinics (mainly the sisters in charge) first calculated the minimum stock by multiplying quantities used per month by three. If the minimum stock exceeds stock on hand, they do not order and vice versa. They also make use of the reserve stocks.

V DISCUSSION

Data on quantities of oral contraceptives distributed in the facilities visited during the last quarter of 2004 show that 44 percent of the cycles were POPs. This is largely consistent with the proportion of the surveyed current users of orals who were currently on POPs (54 percent). Thus, findings from the rapid assessment demonstrate that at least within the health facilities and among current oral contraceptive users surveyed, there is a disproportionately high use of POPs.

Having established that there is a disproportionately high use of POPs, this section explores the factors that may be responsible for this situation. First, the attitudes of oral contraceptive users are likely to contribute to the pattern of use of oral contraceptives in Zimbabwe. The majority of current users, 46 percent reported that they chose their current oral contraceptive on the basis of personal preferences. This did not come as a surprise given that in Zimbabwe, there is what are known as *"Client Rights"***.** The client rights emphasize that choice of a family planning method shall be according to the client's preference within medically safe parameters. However, of concern is that another 46 percent reported that either a service provider had recommended or prescribed the oral contraceptive to them, which might be due to failure by service providers to follow and observe procedures in the correct provision of oral contraceptives. Another major concern is that family planning clients may not have the opportunity to make a fully informed choice, as providers' workloads are too great to allow them to spend sufficient time counselling clients.

Once initiated on POP women would like to continue using their method of choice as long as they are not experiencing method-related problems and they are still lactating. Furthermore, current users of POPs and COCs reported that they would continue using their current pill even if its name were changed mainly because they never had any problems with the current pill. These data seem to suggest that as women successfully use oral contraceptives, they develop and institutionalise some positive attitudes towards a particular method, a situation that makes them loyal to one pill. The situation is further worsened by the fact that the oral contraceptive users do not have the correct information on the proper use of oral contraceptives.

Information provided to users of oral contraceptives by family planning service providers during consultation is most likely to contribute to the current method mix among oral contraceptive users. Family planning service providers believe that there are no risks associated with prolonged use of the POP. Thus, service providers indicated that the POP could be used for periods beyond six months up to two years before a woman switches to a COC. Accordingly, when they give information to clients, family planning service providers refer to POPs as pills for breastfeeding mothers irrespective of the age of the baby and/or duration of uninterrupted use.

Furthermore, 65 percent of current users of oral contraceptives reported that they have never been informed by family planning service providers of the need to switch from a POP to a COC at some point in time. These findings seem to suggest that limited information on the proper use of oral contraceptives may be contributing to the disproportionately high use of POPs in the country.

The training received by family planning service providers in the family planning service delivery is another factor that can potentially influence the utilization of oral contraceptives in the country. About 42 percent of the family planning service providers interviewed during the rapid assessment have not been trained in the Family Planning Clinical course. Thus, they do not have the requisite skills in the provision of oral contraceptive services. Service providers interviewed during the rapid assessment recommended that in order to match clients

to appropriate oral contraceptives, all family planning service providers need to undergo formal training in clinical family planning.

Family planning service providers are supposed to acquire accurate information on the proper use of oral contraceptives during training, especially the Family Planning Clinical Course. However some trainers interviewed during the rapid assessment were not sure of when breastfeeding mothers should transition from using a POP to COC. Furthermore when there is a stock-out of COC pills, trainers reported that they would instruct family planning service providers to give mothers breastfeeding babies aged beyond six months any other contraceptive methods including POPs. Thus, it is the limited knowledge among both family planning trainers and service providers that may be contributing to the current disproportionately high use of POPs in Zimbabwe.

Findings from the rapid assessment indicate that most health facilities are understaffed. This problem is compounded by the fact that due to the increased burden due to the HIV and AIDS epidemic the few clinic health personnel become overwhelmed with the workload. The heavy workload reduces the time available for provider-client interaction, a situation that potentially results in clients not receiving adequate information on the correct use of oral contraceptives.

VI CONCLUSIONS AND RECOMMENDATIONS

Results from the rapid assessment confirm that there is a disproportionately high use of POPs at the health facilities visited and among oral contraceptive users surveyed. The variables that are likely to be responsible for this observed consumption of oral contraceptives include attitudes of service providers; partial adherence to the *Client Rights* approach, whereby clients are given a choice without being fully informed; training of family planning service providers; knowledge levels of service providers and clients on the proper use of oral contraceptives; information provided to clients during provider-client interaction and the excessive workload on the part of the few health service providers manning health facilities. However, despite the disproportionate use of POPs, incidences of unintended pregnancies reported by the FP clients interviewed were very low. In order to match family planning clients to appropriate oral contraceptives while at the same time enabling women to meet their reproductive goals, there is need to address these issues.

The results from the study also revealed the following:

- Clients were not bothered with changing names of oral contraceptives as long as the drug composition is not altered and they receive adequate information.

- Record keeping is very poor at most of the health facilities, in particular non-ZNFPC facilities. Additionally, the service statistics collected at some service delivery points are not standardised and comprehensive. This can be attributed to lack of proper management and support on the provision of oral contraceptives.

- Considering that almost half of the oral contraceptive users, (46 percent), did not choose their current method, it can be concluded that the client rights as stated in the Zimbabwe National Family Planning Programme Service Delivery Policies and Standards are not being fully observed.

- Trainers of oral contraceptive service providers, service providers and clients alike have insufficient and inaccurate information on proper use of oral contraceptives. In addition to having incorrect information, the information used by trainers is not standardised, which might compromise the quality of training.

- The DTTU system has been very effective in addressing problems previously encountered in the distribution and procurement of oral contraceptives at each service delivery point. However, most stakeholders are not aware of the operations of the DTTU system even though it has been in operation since November 2003.

There are a number of recommendations that can be made on the basis of results from the rapid assessment. The key recommendations are articulated below.

(1) Given that a majority of clients have not been informed by family planning service providers on the need to switch from POP to COC especially after breastfeeding for six months, there is need for family planning service providers to ensure that they provide this valuable information to clients. Once clients have been informed about the need to switch from a POP to a COC after using a POP for six months of breastfeeding, they are likely to transition even if they are not experiencing contraceptive method-related problems.

(2) Some service providers simply refer to POPs as contraceptive methods for breastfeeding mothers a situation that leads clients to use POPs as long as they are still breastfeeding. This clearly shows that some service providers have a "mindset" and there is need to unlock it. It is important for family planning service providers to give clients complete information on the correct utilization of POPs including the timely transition to COCs. This can be achieved through training and refresher courses for service providers, complemented by regular information dissemination to clients. The introduction of generic oral contraceptives is an opportunity to change this scenario, as this will facilitate re-orientation of service providers.

(3) There is need to strengthen skills of trainers of FP Service Providers with regards proper provision of oral contraceptives.

(4) The ZNFPC training materials need to be reviewed in order to standardise the information given to service providers during training.

(5) There is need to develop a comprehensive and standard way of collecting service statistics at all service delivery points in order to enhance monitoring and evaluation of the national family planning programme. Furthermore, in-charges at respective health facilities should ensure proper record keeping in order to get valid and up to date data.

(6) The assessment clearly revealed that the excessive workload on the part of the few health service providers negatively affects the quality of services provided to family planning clients. Thus, there is a need to address this issue in the long run. Family planning needs to be strengthened in pre-service training of nurses and doctors.

(7) Finally, stakeholders need to be educated on the full operations of the DTTU system.