

TANZANIA

THE ZANZIBAR FAMILY PLANNING
SITUATION ANALYSIS STUDY



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List of Abbreviations

AIDS	- Acquired Immune Deficiency Syndrome
CBD	- Community Based Distribution
COC	- Combined Oral Contraceptive
EPI	- Expanded Programme on Immunization
FLE	- Family Life Education
FP	- Family Planning
HE	- Health Education
HIV	- Human Immunodeficiency Virus
IEC	- Information, Education and Communication
IUCD	- Intrauterine Contraceptive Device
MA	- Medical Assistants
MCII	- Maternal Child Health
MCHA	- Maternal Child Health Aide
MCH/FPP	- Maternal Child Health and Family Planning Programme
MIS	- Management Information System
MOH	- Ministry of Health
NFP	- Natural Family Planning
NFPP	- National Family Planning Programme
NGO	- Non Governmental Organization
OR/TA	- Operations Research/Technical Assistance
POP	- Progesterone Only Contraceptive Pill
SDP	- Service Delivery Point (MCH/FP clinic)
STD	- Sexually Transmitted Disease
USAID	- United States Agency for International Development
UMATI	- Uzazi na Malezi Bora Tanzania (Tanzania Family Planning Association)
UNFPA	- United Nations Population Fund
VSC	- Voluntary Surgical Contraception
ZFPP	- Zanzibar Family Planning Programme
ZPPU	- Zanzibar Population Planning Unit

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We also received very useful comments and recommendations from the service providers interviewed. The programme has taken them on board in one way or the other in that either some activities are already in place or are planned to be implemented in the next phase. We would like to extend our sincere thanks for their contributions and assure them that something will be done, the magnitude of which will be dependent on the resources available to the programme. The full list of the comments and recommendations are to be found in Appendix 1.

Lastly, but not least, many thanks go to UNFPA, the main donor of the MCH/FPP and particularly to the Fund's Country Director, Mr J Bill Musoke who greatly facilitated the Principal Investigator to undertake this important activity throughout.

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Executive Summary

Background The Government of Zanzibar, with assistance from the United Nations Fund for Population Activities, launched the Zanzibar Family Planning Project (ZFPP) in 1985 to reduce maternal morbidity and mortality¹. From the start, the Government of Zanzibar conceived family planning services as an integral part of the overall maternal-child health (MCH) care services in Zanzibar and established family planning services in the existing MCH clinics. Family planning services expanded quickly from 6 clinics in 1985, to 76 in 1990, to 104 in 1995. Recently the ZFPP initiated community-based distribution (CBD) of family planning information and methods. The Government of Zanzibar recognizes that services are under-utilized. Contraceptive prevalence of modern methods in Zanzibar was estimated at 6.6 percent by the Tanzania DHS of 1992. Against this background of low contraceptive prevalence, government officials remain concerned about the high birth rate which is considered to be a contributing factor to Zanzibar's high maternal morbidity and mortality.

Objectives The ultimate objective of the study is to provide comprehensive information on the availability, functioning, and quality of family planning services in Zanzibar. In order to plan for the needed improvements and expansion of the program, the study thus has three immediate objectives: (1) to assess the quality of care provided to clients through the ZFPP, (2) to assess the availability and functioning of the program's major subsystems, and (3) to refine estimates of staff and equipment needs.

Study Design The Zanzibar Situation Analysis covered all 104 FP service outlets on the islands of Unguja and Pemba, usable data were obtained from 100 facilities. The fieldwork for the study was carried out in November-December, 1994. Data were collected by eight teams, each consisting of a nurse/midwife and an interviewer. Five data collection instruments were used:

- An inventory of facilities available and services provided at each service delivery point (n=100)
- Observations of interactions between family planning clients and providers (n=141)
- Exit interviews with family planning clients (n=141)
- Exit interviews with MCH clients (n=510)
- Interviews with staff providing family planning services (n=191)

Results Family planning services are offered in 104 of 107 MCH clinics in Zanzibar and family planning visits account for 12 percent of all MCH visits in Zanzibar. However, family planning clients are highly concentrated in a few service delivery points (SDPs): one MCH/FP clinic alone handles 33% of the roughly 75,000 annual family planning visits and a second clinic receives another 20% of these visits. The remaining MCH/FP clinics average 57 new acceptors and 340 revisits per annum.

¹ Zanzibar, located in the Indian Ocean off the east coast of mainland Tanzania, consists of two large islands--Unguja and Pemba--as well as numerous small islands. While politically part of the United Republic of Tanzania, Zanzibar maintains separate government structures and policies in all areas except foreign affairs, defense, communications, currency, and higher education.

In terms of proximity and the hours in which services are offered, the ZFPP has succeeded in providing accessible services to a significant portion of the population. More than half of family planning clients live within 30 minutes travel time of the SDP. Ninety percent of SDPs offer family planning services four or more days per week and 60 percent offer services for more than 25 hours each week.

The availability of family planning services is promoted within the SDP. For example, 80 percent of SDPs had at least one family planning poster. Consequently, four out of five MCH clients knew that family planning services were available at the service delivery point which they were attending that day.

Most clinics demonstrated a reasonable state of readiness to provide family planning services. The ZFPP's efforts to upgrade the MCH/FP clinics have been a success in a number of areas. Over 80% have clean examination rooms with adequate privacy and light. Fully 99% have access to sterilizing equipment, and over 90% have specula, blood pressure machines, and stethoscopes. Nonetheless, clinic infrastructure could still be improved. More than half of the SDPs have no running water, two-thirds do not have electricity, and between 40% and 50% of SDPs are missing a flashlight or angle poise lamp, gloves, needles, and syringes. Almost 60% are in need of thermometers.

The majority of family planning providers in Zanzibar are Maternal and Child Health Aides. Two-thirds of those interviewed had been trained or retrained within the last five years and more than 80 percent of staff had a supervisory visit within three months of the survey. However, a worrisome result is that more than one-third of staff designated to provide MCH/FP services were absent on the day of the interview.

Pills and injectables are the most popular methods in Zanzibar (DHS, Table 4.5) and were used by 96% of the family planning users interviewed. Almost all of SDPs offer combined oral contraceptives and injectable contraceptives, but only 55% offer condoms and fewer than half offer progesterone only pills, IUDs, or spermicides. Stockouts of the offered methods are infrequent.

The quality of services was measured through data from observations and interviews with family planning clients and clinic staff. A key element of quality is a choice of methods and comprehensive information about each method. Yet providers in Zanzibar present clients with a somewhat limited range of methods. During the consultation, pills and injectables were by far the most commonly mentioned methods, IUDs and condoms were mentioned in about two-thirds of the interactions and the other methods in fewer than half. Although, in the staff interview most staff could specify appropriate method recommendations for spacing or limiting births, only 36% of new users were asked about their spacing or limiting needs. Reflecting the population's conservative attitudes towards contraceptive use, many providers restrict who may be provided family planning methods. Marital status is the strictest barrier for every method, over 70% of providers will not prescribe to an unmarried woman. Furthermore, between 32% and 56% of providers, depending on the method, also require spousal consent for a prescription. Half or more of providers place age restrictions on all methods, and a quarter or more place parity restrictions on all methods, particularly injectables, one of the most common methods in the program.

Over 90% of staff can mention at least one serious medical problem that should bring a pill, injectable, or IUD user back to the clinic for a revisit. However, many of these problems -- for example, chest or leg pain for pill users, severe headaches for injectable users, or unusual discharge for IUD users -- were mentioned by less than a quarter of providers. Four out of five new users were told how to use a method, but far fewer were given additional information about advantages, disadvantages, side effects, and what to do if problems arise. Only about half of revisit clients were asked if they had concerns with their method and well over half of pill and injectable users could not name one serious side effect for which they should return to the SDP for further consultation.

The technical competence of the providers was observed to be relatively strong on some points and weaker on others. Roughly 80% of all new clients were weighed, had their blood pressure taken, and were asked their medical history and LMP. However, half or fewer had a breast or pelvic examination or were asked about unusual bleeding, pelvic pain, or discharge.

Of the procedures that did take place - pelvic examinations, IUD insertion/removals, and injections - most measures of quality were followed by the vast majority of providers. An area which requires improvement are practices which promote sterility. 43% of providers did not wash their hands before pelvic exams (half of those SDPs did not have running water), and 23% did not disinfect the site of injections.

Because 40 percent of all family planning clients are breastfeeding a child, it is important that providers give correct advice to these clients. Only one-half of clients were asked about their breastfeeding status (although the provider may have observed other women feeding their child). Two-thirds of providers would advise the client to continue to breastfeed and use a family planning method--either the progesterone-only pill or another method.

Dissemination The results of the Situation Analysis Study were disseminated at a seminar in Zanzibar in August, 1995 to the senior officials in the Ministry of State Planning (the Principal Secretary chaired the seminar) and Health, Women, and Children Affairs, all the MCH/FP coordinators, coordinators of population programs in other ministries, namely education and planning, donor representatives (UNFPA, WHO, UNICEF), senior MCH/FP programme staff, members of the Family Planning Advisory Committee, and midwives and interviewers who participated in the study.

Even before this dissemination meeting, the results of the inventory invoked an immediate response from the Government of Zanzibar. Since the completion of the Situation Analysis Study, the MCH/FP unit has been purchasing and distributing the missing equipment, including torches, gloves, needles and syringes. IEC activities have been intensified, planning for refresher and newcomers courses are underway, and quality of care indicators, based on the measures collected through the Situation Analysis, are being developed to monitor and evaluate future program performance.

The results have also been used to plan the next phase of the ZFPP which will be a broader based reproductive health, family planning, and safe motherhood programme. There are plans to collaborate with the AIDS Control Programme to educate MCH/FP service providers on the

preventive measures against STDs including HIV transmission. Management and supervisory courses for the MCH/FP supervisors have also been included in the next phase of the programme.

Programmatic recommendations

- 1 The MCH/FP policy should be translated into Kiswahili and enough copies made available to service providers
- 2 **Infrastructure** Efforts should be made in collaboration with the local authorities and departments of water and electricity to ensure that water and electricity are available in the clinics. The concerned ministry staff (MOH) should initiate this in their respective areas and the programme should follow up
- 3 **Equipment** Regular monitoring of the clinics by the MCH/FP supervisors is necessary so that the needed equipment can be procured, supplied from the warehouse or re-distributed
- 4 **Contraceptive mix** The programme should procure adequate supplies of the various methods available e.g. progesterone only pills, in order to have a wide range of methods available at all SDPs. More emphasis should be directed towards introduction of Norplant[®], promotion of IUCDs and availability of VSC facilities for those who need them
- 5 **Staff training** Service providers need to be updated through refresher courses to enable them to give more information to clients and counsel them effectively
- 6 **IEC materials and activities**
 - Relevant culturally sensitive IEC materials ought to be produced and distributed
 - MCH clients attending clinics need to be actively motivated, counselled and given moral support as it has been found that 70% of them do approve of use of FP methods

Future plans Conduct further operations research to

- i investigate the demand for family planning in the catchment areas of SDPs which have a high volume of clients and those with a low volume to address the question of whether supply factors such as the quality of services are predictors of service utilization
- ii determine the roles and contribution of the CBD agents in FP motivation

I BACKGROUND

A Demographic Characteristics and Government Policies

Zanzibar, located in the Indian Ocean off the east coast of mainland Tanzania, consists of two large islands, Unguja and Pemba, as well as numerous smaller islands. While politically part of the United Republic of Tanzania, Zanzibar maintains separate government structures and policies in all areas except home and foreign affairs, defense, communications, currency and higher education. Administratively, Zanzibar is divided into five regions (three in Unguja and two in Pemba) and ten districts (six in Unguja and four in Pemba).

According to the 1988 census, the population of Zanzibar was estimated at 640,578, roughly 60 percent live on Unguja and the remaining 40 percent on Pemba. The current total population is estimated at 800,000 (1995). The population is almost entirely Muslim. Approximately 60 percent of the population lives in rural areas while the urban population is concentrated mostly around Zanzibar town and three smaller towns of Mkoani, Chake and Wete in Pemba Island.

The country's population growth rate was estimated at 3 percent by the 1988 census, compared to 2.7 percent reported in the 1978 census. The total fertility rate is variably estimated at 6.6 or 7.2^{2,3}. The TFR is high, irrespective of which of these estimates is selected. Zanzibar's high fertility rate is perceived to be one of the major contributing factors to the country's high maternal mortality and morbidity rates. Current estimates for maternal deaths is reported to be 300 per 100,000 live births⁴.

The clear trend of a rising population growth rate with its consequent impact on social services, employment and education, is exacerbated by the fact that the population of these islands is very young, with about 47% under 15 years of age. It is estimated that by the year 2000, Zanzibar's population will be close to one million at the current growth rate, which is higher than the rate of growth of the economy.

The government of Zanzibar considers these rates of maternal deaths unacceptable and has initiated specific policies to address the problem. For example, a specific policy for maternal and child health/family planning (MCH/FP) was approved in 1992. (The policy is currently awaiting ratification by the house of representatives). The policy lists activities to be undertaken to improve MCH and FP services. In addition to the broad objectives of increasing contraceptive prevalence from 5 to 15 percent and awareness from 20 to 50 percent, the policy statement contains some explicit guidelines for the family planning program. They are to

- ensure that family planning services are available at all health facilities,

² "Tanzania Demographic and Health Survey 1991 - 1992 Preliminary Report" Bureau of Statistics Planning Commission Government of Tanzania and Macro International July 1992

³ Statistical Tables for Health Planners and Administrators Ministry of Health Statistical Unit March 1989

⁴ Women and Children in Tanzania A Situation Analysis UNICEF Country Office 1991

- maintain at least three health workers trained in family planning services at each Primary Health Care Unit (PHC Unit),
- provide afternoon family planning services at health facilities to avoid overcrowding,
- follow up family planning dropouts using Traditional Birth Attendants and family planning providers,
- establish community-base distribution systems for selected modern methods and
- surgical sterilization services (tubal ligation and vasectomy) should be made available for those who need them at all health units that have the necessary facilities and staff

B Structure of the Government Health System

The health delivery system in Zanzibar is comprised of four General Hospitals, four Primary Health Care Centers (formally known as cottage hospitals), five Specialist Hospitals and 113 Primary Health Care Units (formally known as dispensaries), which are staffed mostly by health assistants and MCH Aides. These units provide basic preventive and curative services. Of the 113 Primary Health Care Units, 107 offer MCH services, and 104 of these have integrated MCH/FP services. Health services are well distributed in Zanzibar; it is estimated that 90 percent of the population lives within five kilometers of a health facility. The following table shows the type, number and location of health facilities in the country.

Table 1: Type, number and location of health facilities in Zanzibar

Location	Primary Health Care Units	Health Units providing MCH/FP services	General Hospitals	Specialist Hospitals	Primary Health Care Centers
Unguja	66	58	1	3	2
Pemba	47	46	3	2	2
Totals	113	104	4	5	4

Maternal-Child Health and Family Planning (MCH/FP) Services

MCH services started in 1965 mainly in urban areas, with mobile teams and midwives serving some rural areas. It soon became obvious that the rural areas needed more services on a more regular basis. Beginning in 1979, in response to this need, the government of Zanzibar introduced the MCH Aides cadre of health workers in the provision of MCH services.

Organized family planning services began in 1985 when the United Nations Fund for Population Activities (UNFPA), provided financial assistance for the implementation of the Zanzibar Family Planning Project (ZFPP). The first phase of the project (1985-1989) focussed on two objectives

The first objective was awareness creation and enlisting official support for the program. The project's second objective was ambitious to recruit about 40% of women of reproductive age (WRA) into modern contraceptive practice. During the second phase (1990/93) emphasis was placed on staff training, strengthening the physical infrastructure and improving management systems. A third project phase is under consideration, during which the emphasis will be on strengthening the Safe Motherhood Initiative and integrating its activities with those of the family planning program. Attention will also be paid to community mobilization through intensified IEC and CBD activities and on improving the quality of MCH/FP services at the SDPs and in the community.

Family planning services in Zanzibar have expanded quickly, from 6 clinics in 1985, to 76 in 1990, to 104 in 1994. In addition to the clinic-based family planning services, the Zanzibar Family Planning Project has recently initiated community-based services, mostly through TBAs or satisfied users, trained either by MCH Aides or centrally through the project.

From the initial stages, family planning services were an integral part of MCH care, and it is estimated that nearly 97 percent of MCH facilities currently have a family planning component. Only 12 MCH facilities currently do not offer FP services regularly, and it is believed that these facilities lack trained staff. The delivery of FP, however, is limited by the fact that daily MCH clinics reportedly are held at only about 60 percent of the facilities, while most of the rest are said to hold these clinics in fewer than five days a week and at times only once per week.

The success of these early activities generated interest in FP and MCH services among other funding agencies. GTZ has been implementing a comprehensive family health project in Pemba, with an important family planning component. In addition, DANIDA has been supporting a Community Based Health Care Program (CBHC) aimed to take services closer to rural populations, and UNICEF has been supporting TBA and MCHAs training and provision of some MCH equipment to the clinics through the Child Survival Protection and Development (CSPD) programme. Save the Children Fund, UK provided an MCH advisor. A technical review of the Family Planning Programme conducted in February 1993 identified the following strengths⁵

- Family planning services had been successfully integrated into MCH
- SDPs had at least one trained family planning provider
- SDPs had the basic equipment needed for the provision of FP services
- No stock-outs were noted
- SDPs physical infrastructure was in good repair

Weaknesses noted in the same evaluation report are as follows

N A Mandara P M Riwa and A T Kapesa Technical review of the Zanzibar Family Planning Program
URT/90/P03 (1993)

- Due to limited case load of IUD clients in rural areas, providers in such areas are losing IUD insertion and removal skills
- Even though services are said to be integrated, linkages between them are still weak
- Staffing shortages, particularly within the MCH Aides category (the main FP providing group), act as a barrier to service delivery
- Follow-up mechanisms are not adequately in place
- Lack of MCH/FP or general public health training among MCH Coordinators and lack of supervisory tools weaken their supervisory capability
- Aspects of the logistics and IEC need to be strengthened

II THE PROBLEM AND STUDY JUSTIFICATION

The Government of Zanzibar is concerned that, in spite of the long list of program strengths listed above, family planning services are underutilized. Contraceptive prevalence of modern methods in Zanzibar was estimated at 6.6 percent by the TDHS of 1992⁶. Underutilization is even more acute in rural areas. In Zanzibar town, the prevalence rate in 1988 was recorded as 10.4 percent, compared to 4.1 percent in rural Unguja and 1.7 in rural Pemba⁷. More recent estimates show some slight improvement. Of the 11,393 current users from the six districts in Unguja in 1992, 75 percent were from the urban town district. In Pemba nearly all of the current users in 1992 were from the largest city, Wete⁸.

The differential contraceptive prevalence rates noted above suggest differences in service conditions between rural and urban areas, either in terms of service availability, functioning and quality, or in terms of the demand situation, or both. Keen to increase contraceptive use in the low prevalence areas, but unsure about which of the two reasons is the main obstacle, the Zanzibar Family Planning Project requested for assistance from the Africa OR/TA Project II to conduct a situation analysis study to obtain more comprehensive information on the strengths and weaknesses of the program. Additionally, in the third phase of the Zanzibar Family Planning Project, activities will focus, among other things, on improving quality of MCH/FP services. In order to do this effectively, the quality of existing services needs to be assessed to know where the improvements are needed. Also planned for the third phase is the increased use of CBD agents for family planning services. However, the quality of services being offered by the various categories of agents currently operating in the country is not known. Findings from this study clarify this issue. A pertinent question to be addressed by the study is what factors differentiate

⁶ Tanzania Demographic and Health Survey 1991-1992 Ibid

⁷ Statistical Tables for Health Planners and Administrators Ministry of Health Statistical Unit 1989 Table F 11 p 96

⁸ Technical Review of the Zanzibar Family Planning Programme Ibid

the active urban SDPs from the inactive rural facilities? Does the answer lie in lack of demand in the more conservative rural areas, or better quality and more acceptable services in urban areas?

III STUDY METHODOLOGY

a Objectives

Ultimate objective

The ultimate objective of this study is to provide comprehensive information on the availability, functioning and quality of family planning services in Zanzibar in order to plan for the needed improvements and expansion of the program

Immediate objectives

- Assess the quality of care provided to clients through the ZFPP clinics
- Assess the availability and functioning of the programs major subsystems
- Refine the estimates of staff and equipment needs

b Data collection

Five data collection instruments originally developed by the Population Council and adapted by the programme were used The instruments were

- i Inventory of facilities available and services provided at the service delivery point (N=100)
- ii Interview schedule for staff providing family planning at the service delivery point (N=191)
- iii Observation Guide for interaction between consenting family planning clients and service provider (N=141)
- iv Exit interview (questionnaire) for family planning clients attending the service delivery point who had been observed by a nurse observer (researcher) in the consultation room (N=141)
- v Questionnaire for female MCH clients attending the service delivery point (N=510)

Sources of data

- i All staff providing FP services at the SDP

- ii All services statistics and the available commodities at the SDP
- iii All new family planning clients
- iv A random sample of revisiting FP clients
- v A random sample of at least five MCH clients in every SDP

Advance Preparations

A group of eight senior nurse midwives with family planning training paired with a similar number of social scientists were selected as researchers. The sixteen researchers attended a 10 days training workshop conducted by the programme, with assistance from one resource person from the Population Council and two trainers in the research methodology who teamed up with the principal investigator.

During the training workshop (which began on 15th November 1994), the researchers were introduced to the SAS methodology and reviewed contraceptive technology and the data collection instruments. Their roles were explained and they were cautioned on the need for good quality data collection. Following practise interviews done through role playing, the data collection instruments were field tested. A few changes in wording and formatting were made in the instruments following the recommendations drawn from the field experience.

Field Work

The field work was scheduled to last for three weeks beginning early December and to end on 23rd December 1994 just before Christmas. A total of eight teams was formed. Each team consisted of a social scientist (interviewer) and a nurse observer with one of the trainers (principal investigator) leading two teams and the other trainers leading three teams each. Each team visited one clinic and therefore eight clinics were being covered in a day. The principal investigator was responsible for coordinating the comprehensive planning of daily routes, logistics, timing and arranging report giving sessions every evening.

During data collection, one person from each team would ensure that all the logistic requirements for the team were in place for the following day. These requirements included the questionnaires, breakfast and packed lunch, and knowledge of the car number assigned for the group/team. Early in the morning, depending on the distance to be covered, the team would leave the residential hotel to the clinics assigned, dropping two members at each clinic and the car would remain with the members at the furthest clinic. The objective was to reach the SDP before the official opening time of 7.30 a.m. The nurse observer would mainly observe the provider-client interaction and hand over the client to the interviewer who would be outside the clinic either interviewing a female MCH client or observing other aspects. Later during the day, usually at the end of the working day, the nurse would do the inventory and the social scientist would interview the service providers. All the completed questionnaires would be handed over to one of the trainers leading the team or an assigned person to check for accuracy and completeness before leaving the SDP. The assigned person or team leader

(trainer) would have written notes to present in the evening sessions. All issues including administrative matters would be sorted out and put in order each evening before moving to new clinics the following morning. The evening session was also a venue for announcing changes, for example in routes or clinics to be visited.

c Sampling

This study covered all the clinics providing family planning services on the islands of Unjuga and Pemba so as to obtain comprehensive information from every clinic. Therefore, no sampling was done. Although all 104 clinics were visited in the study, four were left out of the final analysis due to some missing instruments. Therefore, results are presented for 100 SDPs.

d Data processing and analysis

Data entry and cleaning were done in Zanzibar. Two statisticians were identified in advance and attended the training workshop of the researchers so that they would get acquainted with the instruments. They also participated in the field testing of the instruments and first week of field work. A member of the staff from The Population Council office in Nairobi trained them in the use of Epi Info for data entry, management of questionnaires and data entry procedures. The initial frequencies were done in Zanzibar and later data analysis was done in Nairobi (in May 1995) by the Principal Investigator⁹.

e Dissemination of study results

The preliminary study results were disseminated by the Principal Investigator at a seminar organized by the programme on 17th August, 1995. The seminar was well attended by the senior officials from the Ministries of State Planning, Health, Education, Women and Children's Affairs, all MCH/FP coordinators, the senior programme staff, some of the nurse observers and interviewers, the donor community, (SCF, UNFPA, WHO, UNICEF), some members of the advisory committee and a representative from the Nairobi Population Council office.

This final report will be distributed to the programme field staff, all interested parties, population researchers and relevant donors. This is a very useful study for the programme and MOH because it has yielded much valuable information, some of which has already been utilized.

⁹ The involvement of ZFPP staff in the technical aspects of the study was received very positively by the project as it contributed to building capacity and capability in data management within the project.

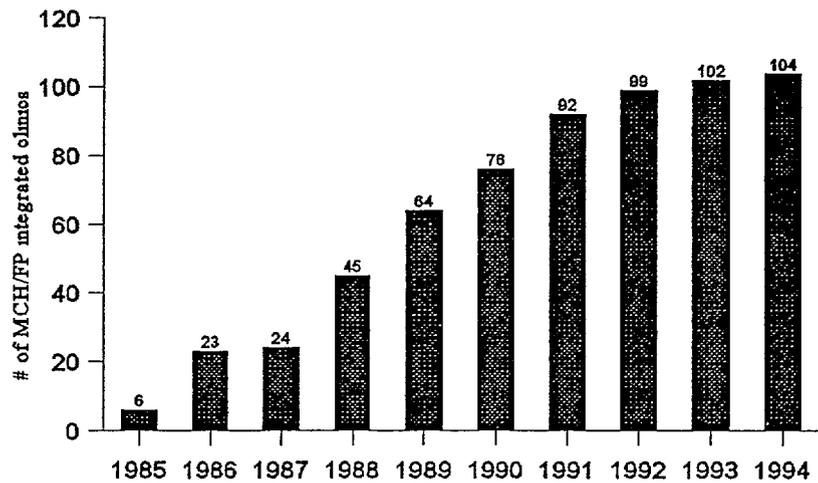
IV RESULTS

A Activities and clients at the SDPs

1 Family planning services

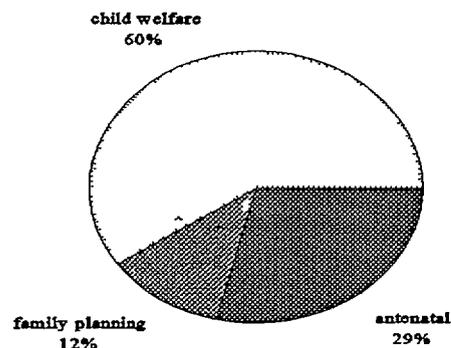
a Family planning services in Zanzibar are offered as an integral part of the MCH services. In the mid 1980s there were about 50 MCH clinics. Since then, the government has been expanding the MCH services to other areas which were not yet being served. Whenever a clinic was opened, the programme made sure that a FP service outlet was established, thus ensuring MCH/FP integration. The total number of MCH/FP integrated clinics has now reached 104 (97 percent) out of a total of 107 clinics. The rate at which integration has been undertaken is quite impressive, with an increase from six integrated clinics in 1985 to 76 in 1990 and 104 by December 1994 (figure 1)

Fig 1 Family planning service outlets
Total MCH clinics = 107



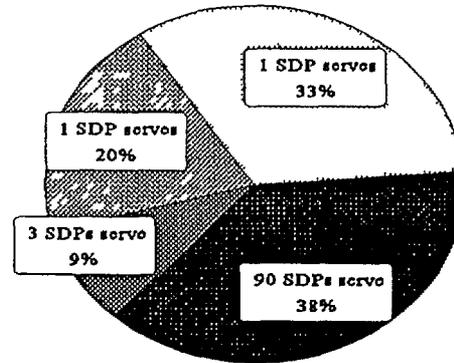
b Clinic records of MCH/FP visits to the facility were examined for the previous 12 month period, or the longest continuous period possible. These records showed that FP client visits constitute only 12 percent of the total MCH/FP visits. The majority of the visits are for child welfare (60 percent) and antenatal services (28 percent). Notably, there are no formal records of postnatal visits. This is an area of service to be looked at in the next phase of the program.

Fig 2 Total visits by type



c The FP client load varies significantly among the SDPs, as shown in figure 3. One third of the FP clients are served by one SDP, another 20 percent by a second SDP, nine percent by three SDPs (each serving two-four percent of the total), and the remaining 90 SDPs serve only 38 percent of the clients (each serving <two percent of the total). The two clinics that are serving 53 percent of clients are both urban clinics, which is not surprising as family planning acceptance is highest in Zanzibar town.

Fig 3 Distribution of all FP clients among SDPs (n=95)

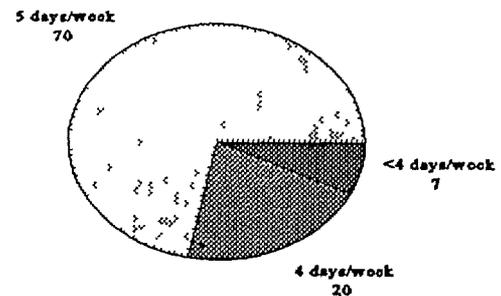


There is now a need to determine the reasons for such discrepancy in utilization rates among SDPs, as there could be important policy implications from these findings. It is planned to conduct a follow up study to look at the catchment areas of high and low utilization SDPs to assess the relative importance of supply and demand issues and shed some light on this phenomenon.

ii *Accessibility of Services*

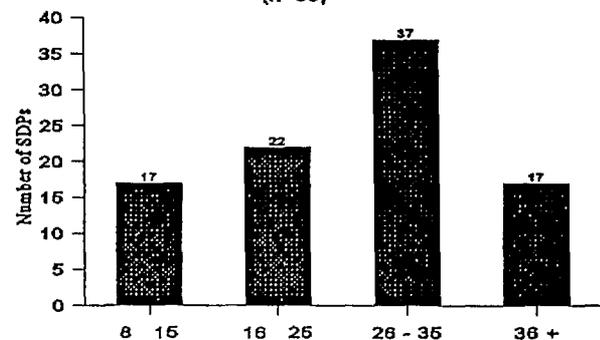
Accessibility to services for clients is affected by many factors. Clinic opening times, hours that services are offered, distance to the clinic, etc are measures of how easy or difficult it is for clients to obtain services.

Fig 4 Days per week FP services are offered (n=97 SDPs)



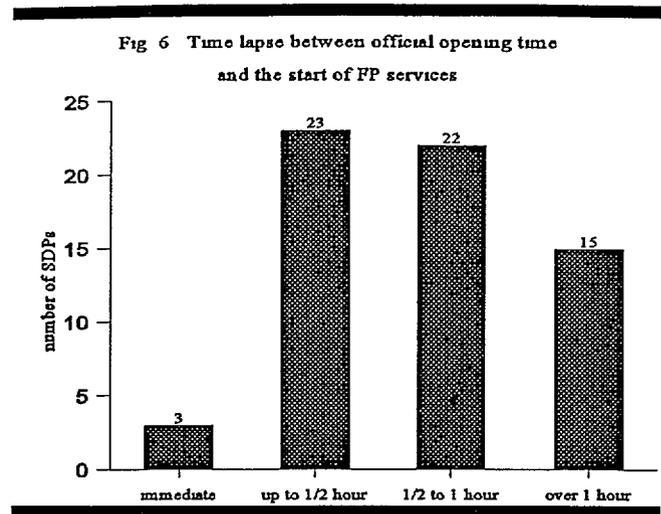
a As shown in figure 4, most clinics (70) offer services five days a week. However, some clinics (20) offer services for four days a week and the other seven clinics offer services less than four days per week, which is contrary to the MCH/FP policy requiring that FP services be offered for five working days a week. Over one third of the SDPs offer FP services for 26-35

Fig 5 Hours/week FP services are offered (n=83)

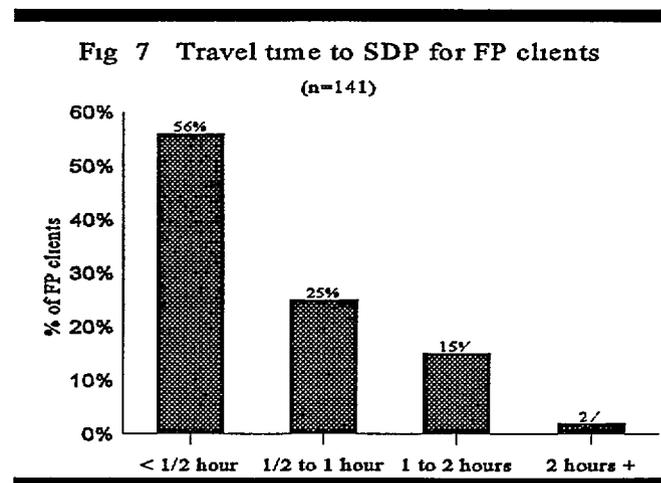


hours per week (figure 5), with a range from 8-15 hours/week to more than 36 hours/week amongst the various clinics

- b In many of the SDPs there was roughly a ½ hour lapse between official opening time and the start of FP services. This is understandable, due to the preparatory activities for service delivery, such as boiling, cleaning, ordering items, etc. However, beyond 30 minutes to one hour is certainly too long. It was observed that more than half of the SDPs start offering services more than ½ hour after the official opening time (7:30 am). In 15 SDPs, the time lapse was more than one hour. Long waiting time may act as a barrier to service and hence discourage some clients from visiting the respective SDPs.



- c Eighty-five percent of the FP clients walk to the clinic, nine percent use public transport, one percent use a personal car, and five percent use other means, including bicycle, motorbike, boat or lifts. Although most clients walk, figure 7 shows that over half of the clients live within ½ hour travel time from the SDPs, 25 percent within ½ - 1 hour, 15 percent take between 1-2 hours to travel to the SDP, and two percent require more than 2 hours of travel time. The time it takes for a client to reach a clinic can be an important factor in whether she will utilize services. These findings indicate that, in general, respondents lived within a reasonable distance from the SDP.

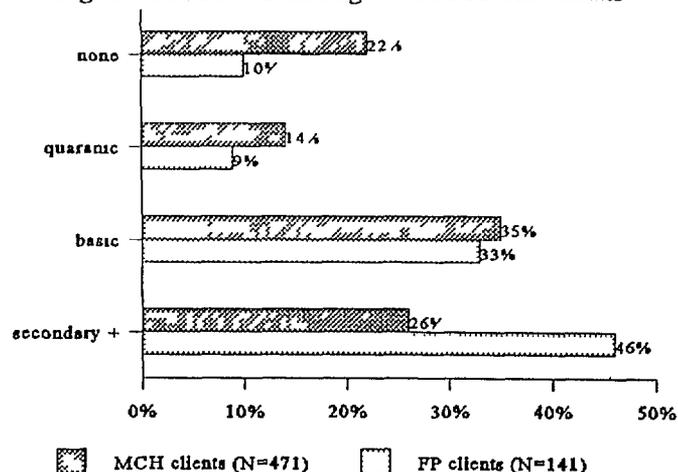


iii *MCH and FP client profiles*

- a Family planning clients are on average slightly older than MCH clients, with a mean age of 28.7 vs 26.6. They also have higher parity, with a mean of 4.2 living children as compared with a mean of 3.2 for MCH clients. Figure 8 shows that FP clients tend to have higher levels of education than MCH clients. 46 percent of FP clients have attended secondary school as

compared with 26 percent of MCH clients. While 22 percent of MCH clients have no formal education, only 10 percent of FP clients have never attended school. Consequently, literacy rates are higher among FP clients, with 70 percent able to read and write in Kiswahili as compared with only 52 percent among MCH clients. This raises the issue of the link between education and contraceptive use. There are several factors which could be contributing to an association between education and contraceptive use among Zanzibari women. Higher rates of employment, greater concern about costs of raising children as opposed to the benefits of large numbers of children and delay in starting childbearing among educated women may contribute to their higher preference to use contraception.

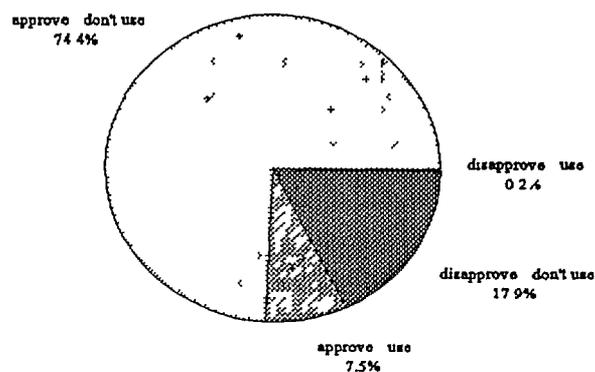
Fig 8 Education among FP and MCH clients



b Of the 141 FP clients observed and interviewed, almost three-quarters were revisit clients, about one-fifth were new clients and the remaining 6 percent either had problems, wanted to change methods or discontinue FP. The pill and injectables dominate the method mix among FP clients, with 58 percent using the combined pill, 39 percent injectables, and the remaining four percent using either the IUD, condom or spermicide. There seems to be an increase in injectables at the expense of pills. In the previous years, more clients were using pills (about 75 percent) and very few were using other methods, including injectables¹⁰. This study shows that injectable use has increased. IUD use on the other hand is not increasing, and use of condoms and spermicides appears quite low, though this can be partially attributed to the fact that the distribution of

Fig 9 Approval and use of FP by MCH clients

(n=504)



¹⁰ Zanzibar Family Planning Programme Annual Service Statistics

these methods is often not recorded

The majority of the MCH clients (72 percent) know the combined pill and 55 percent of them know about injectables, the two most widely used methods in Zanzibar (Table 2) Thirteen percent of MCH clients have used the pill and four percent were using at the time of the study Four percent of MCH clients had experience with the injectable and two percent were current users Notably, only one third of the MCH clients know about the IUD (loop) The use of the IUD in Zanzibar is thus very low amongst them Education on all available FP methods should be emphasized so that the clients can have a wider choice This may increase the use of the other less known methods

**Table 2. MCH clients' knowledge, ever and current use of FP methods
(percent of the total sample, N=510)**

method	knowledge	ever used	currently using
pill	72%	13%	4%
IUD	33%	1%	2%
injectable	55%	4%	2%
condom	25%	2%	6%
spermicide	5%	0	0
NFP	7%	2%	6%
breastfeeding	2%	1%	(not asked)
traditional	6%	4%	6%
other	4%	0	0

The contraceptive prevalence among MCH clients is seven percent for modern methods and 6 percent for traditional methods and/or natural family planning This is comparable to the 1992 DHS finding of a contraceptive prevalence of six percent for modern methods among married women in Zanzibar Of these 36 current users, the majority (72 percent) cite the SDP where they were interviewed as their source of supply, eight percent are supplied at a hospital, and the remaining 19 percent mentioned other sources

When clients were asked if they wanted more children, 74 percent of FP clients said yes while 87 percent of MCH clients indicated that they wanted more children MCH clients were asked when they would like to have their next child The majority (72 percent) would like to wait more than one year, while only eight percent would like another child immediately and three percent would like to wait less than one year Though current contraceptive prevalence is low, these numbers indicate that there is potentially unmet demand, as a large number of women would like to wait some time before their next pregnancy and birth

While 83 percent of FP clients can discuss family planning with their partners, only 48 percent of MCH clients state that they can do so. When MCH clients were asked about their perception of husband's approval of their use of FP, 48 percent indicated that their husbands did approve. Twenty-nine percent responded that their husbands did not approve of their use of FP methods, and this may be a factor in their non-use of modern FP methods. Twenty-three percent did not know whether their husbands approved or not.

- c. Among FP clients, 46 (33 percent) have experienced an unwanted pregnancy. Forty of those women (87 percent) went along with the pregnancy nonetheless. Three (7 percent) attempted to terminate their pregnancy, and of these three, two succeeded and one failed. Three (7 percent) did not want to declare what they did. Among MCH clients who are not using FP, 128 (27 percent) have experienced an unwanted pregnancy, 120 (94 percent) of those women went along with the pregnancy, while 7 (5 percent) attempted to terminate their pregnancy. Three of these succeeded and four failed. One did not want to declare what she did. These women who are not using FP methods but attempt to terminate their unwanted pregnancies should be strongly advised to practice contraception as that is the safest option. Termination of pregnancy in countries like Tanzania where it is illegal is very unsafe, and pregnancy-related illnesses are one of the major causes of death among women in Zanzibar and other developing countries.

Almost all of the FP and MCH clients had heard about AIDS (99 percent and 98 percent, respectively). 88 percent of FP clients said that they can discuss AIDS with their partners, while 97 percent of the non users said yes to this.

B Functioning of the SDP subsystems

Various subsystems of the SDP were examined to assess the readiness of the SDP to deliver quality services. Findings are presented in six broad categories: infrastructure, equipment and physical facilities, staff availability, experience and training, IEC materials and activities, contraceptive supplies and logistics, management and supervision, and record keeping and reporting.

1 *Infrastructure, equipment and physical facilities*

a The SDP infrastructure was assessed in terms of having certain qualities and facilities. The facilities examined were the availability of running water, electricity, waiting rooms and toilets available for the clients. The examination rooms were also examined to find out if they had certain selected qualities. Figure 10 shows the findings in terms of infrastructure found at the SDPs. The majority of the SDPs had waiting rooms (89 percent), 61 percent had clients' toilets, 45 percent had running water and 36 percent had electricity. The availability of water is extremely important to enable the staff to maintain aseptic conditions and general cleanliness at the SDPs. Likewise, the availability of electricity for boiling of instruments is an important factor in maintaining aseptic conditions. The lack of either water or electricity can compromise the ability of the SDP to provide quality services to its clients.

b As shown in figure 11, most examination rooms (>80 percent) had auditory and visual privacy, cleanliness ("clean" means at the start of the day, floors swept and mopped, no dust on window sills and tables) and adequate light (defined as functioning electric light or sufficient

Fig 10 Infrastructure available on day of visit
(n=99)

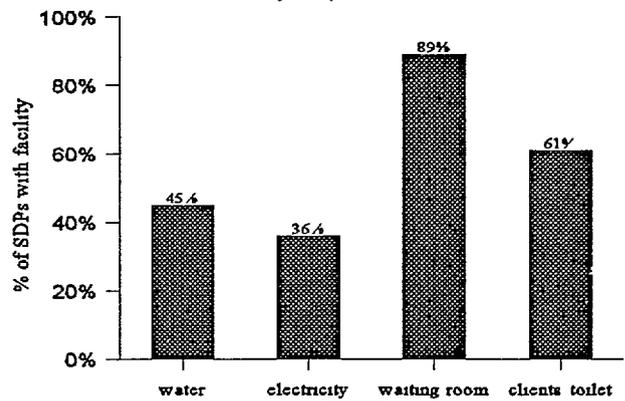
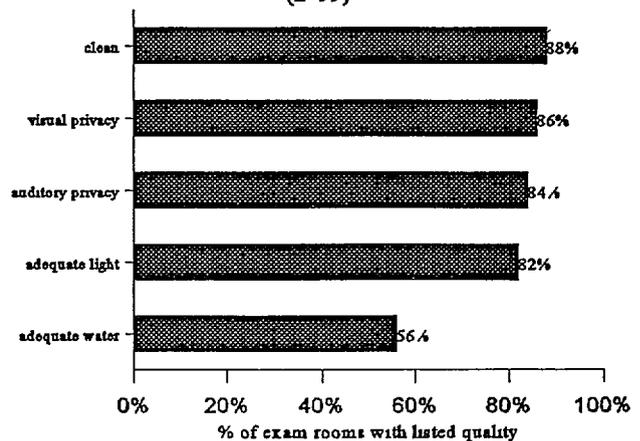


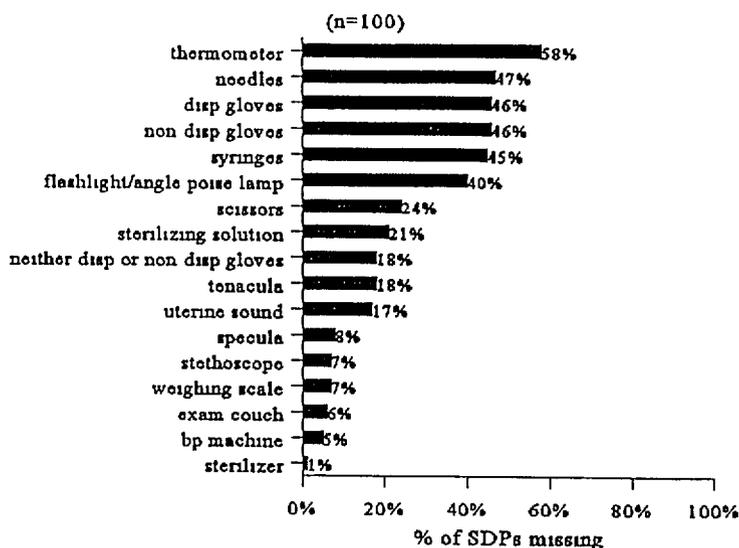
Fig 11 examination room facilities
(n=99)



natural light) Only 56 percent were found to have adequate water (defined as a sufficient quantity of clean water for washing hands and equipment)

c Most of the SDPs had the essential equipment for service provision. These equipment include examination couches, sterilizer or other sterilizing equipment, blood pressure machine, weighing scales, specula, uterine sounds and tenacula. However, figure 12 indicates that many SDPs are missing important pieces of equipment. The lack of flashlight or angle poise lamps, scissors, adequate sterilizing solution, gloves, needles and syringes are significant impediments to the provision of efficient and

Fig 12 % of SDPs missing necessary equipment



quality services. Some corrective measures have already been undertaken in response to the noted lack of some important equipment. For example, flashlights, syringes, gloves and scales have been procured and distributed.

ii *Staff availability, experience and training*

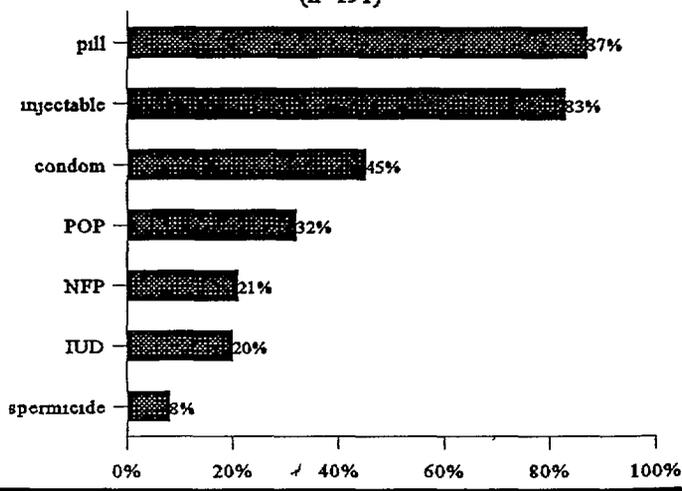
a Staff availability Only 64 percent (183/287) of the MCH/FP staff (all cadres) assigned to the SDP were found on duty on the day of the study. Of all the cadres found on duty, Maternal and Child Health Aides (MCHAs) were the majority and they are also the main service providers at the SDPs. The total number of MCHAs who were expected to be on duty was 170, but 56 of them (33 percent) were found to be absent on the day of the visit. The reasons for absence were not determined, but among the possibilities are that some of them were on leave, sick, off-duty, or had gone for further training. If most of them were on leave, then leave rosters can be improved so that fewer are off duty. Ideally, there should be 25 percent or less to be on leave or absent for the reasons given above so that services are not affected. Nurse-midwives and health orderlies form another large group after the MCHAs in FP service provision. Therefore, they should be considered for training in FP provision as a second priority group.

Table 3 Staff on duty and absent on day of visit, by type

Designation	# on duty	# absent	total
Doctor	0	1	1
Asst Medical Officer	0	2	2
Med Asst	13	8	21
Senior Nurse Midwife	21	19	40
MCH Aide	114	56	170
Public Health Nurse A	0	2	2
Public Health Nurse B	5	4	9
Medical Health Asst.	15	2	17
Medical Health Orderly	13	10	23
Dental Asst	1	0	1
Pharm Aux	1	0	1
Totals	183	104	287

b Staff training Sixty-seven percent of the MCHAs were trained in FP between 1991 and 1994. The MCH/FP training policy puts emphasis on inservice training, including refresher courses (at least once every 2-3 years) when necessary. Forty-four percent of them were trained more than three years ago and would therefore need a refresher course anytime from the beginning of 1995 onwards. There is a discrepancy between theoretical and practical training. While over 90 percent of the staff have received theoretical training in all methods except Norplant® (which is not currently being provided), the practical training in VSC is zero and low for the IUD (insertion and removal), diaphragm and

Fig 13 % of Staff providing methods in last three months (n=191)



natural family planning There is a need to expose the trainees to practical training to improve their skills in providing these methods

c Staff experience Most staff (>80 percent) provided the commonly available and used methods (combined pill and injectable) to clients in the previous three months (figure 13) Of the 189 staff providing FP services, 128 (68 percent) had been providing services in the range of 3 years to over 9 years (figure 14) Only a third had less than three years experience in FP service provision

iii *IEC materials and activities*

As shown in figure 15, there is a limited supply of IEC materials in the SDPs apart from posters and contraceptive samples, which are available in more than 3/4 of all the SDPs Since many clients (more than 50 percent of MCH clients) are literate in Kiswahili, leaflets in Kiswahili could supplement the limited number of IEC materials available at the SDPs

Almost 2/3 of the SDPs visited (63 percent) did not hold health talks on the day of the visit Of the 36 SDPs that did hold health talks, less than 1/3 of them (11) included family planning in their health talks It is advisable that health talks including family planning be given more frequently in order to motivate MCH clients and the general public to use modern contraceptive methods

Fig 14 # of years staff have been providing FP

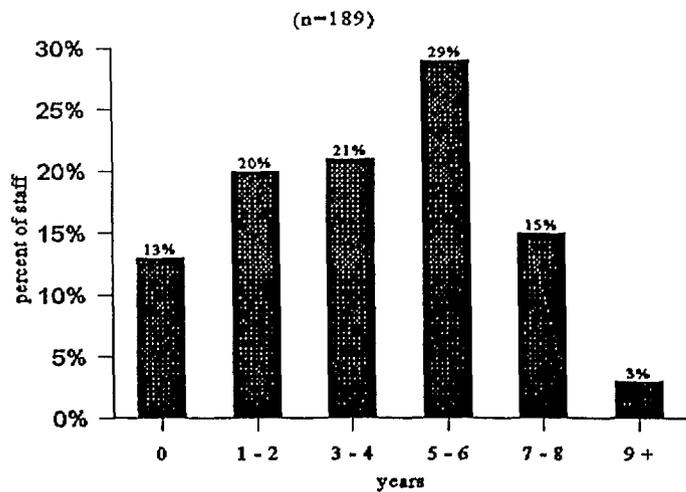
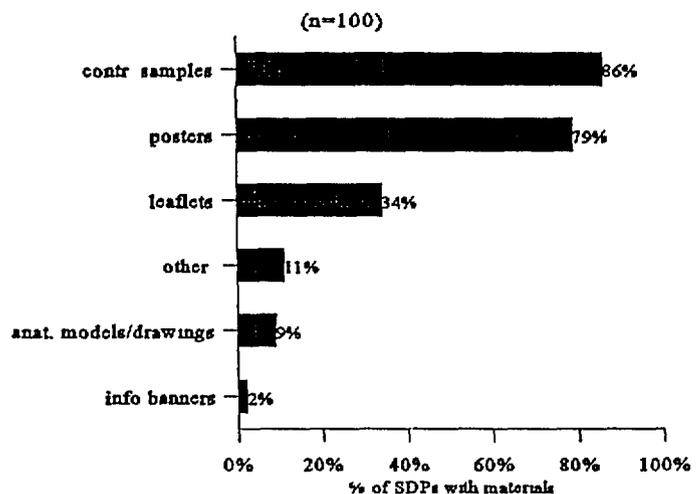


Fig 15 IEC materials available at SDPs

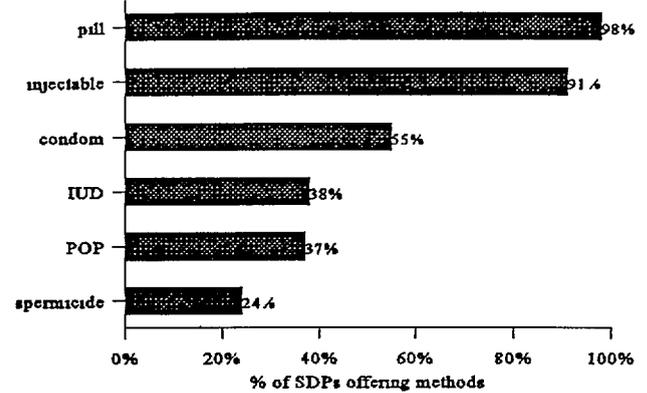


iv *Contraceptive supplies and logistics*

The commonly used contraceptives are available in the SDPs, with the combined pill available in 98 percent of the SDPs and injectable offered at 91 percent. However, there is a limited availability of progestin only pills, which is one of the methods to have available for breastfeeding clients who choose hormonal methods during the first six months after delivery. Stockouts of contraceptive supplies are uncommon. Of the 92 SDPs offering the injectable, none were currently out of stock, of the 98 SDPs with the pill available, only one percent was out of stock, while five percent of the 38 SDPs offering the IUD were currently in need of supplies.

Eighty-two percent of the SDPs have a system for commodities management. Of these, 77 percent store their supplies by expiration date. 81 percent of SDPs have adequate storage facilities (adequate is defined as no exposure to rain and sun, adverse temperatures, and protected from rats and pests).

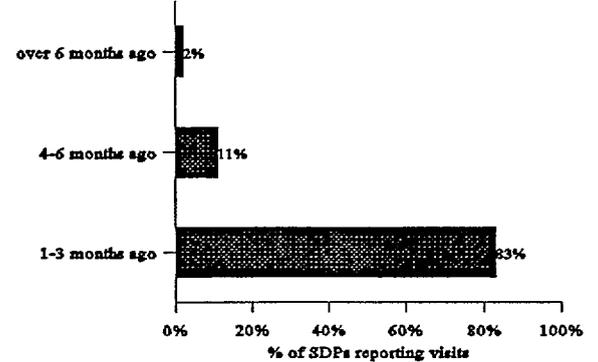
Fig 16 Availability of methods at SDPs (n=100)



v *Supervision*

Supervision is an important activity for ensuring good quality of care, inservice training, staff support and motivation, and monitoring of programme activities. Most SDPs (83 percent) were visited within the last three months for supervision. However, some clinics (11 percent) received their last supervisory visit 4-6 months ago and two percent were not supervised at all for a period of over 6 months.

Fig 17 Recency of last supervisory visit (N=99)



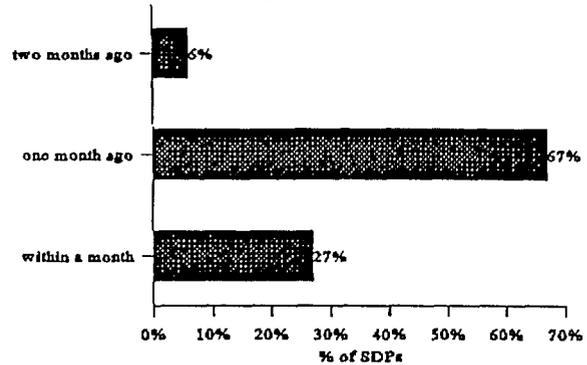
vi *Record keeping and reporting*

Record keeping was generally found to be very good at the SDPs. Ninety-nine percent of the SDPs maintain client medical record cards, 97 percent of SDPs maintain a daily FP activities register and 94 percent of SDPs maintain a client register. In 75 percent of the SDPs with client records, these records were found to be properly filled and ordered. In 17 percent the records were properly filled, but improperly ordered, five percent were improperly filled but

properly ordered, while only two percent had improperly filled and ordered records

The majority of SDPs (67 percent) had sent a monthly service statistics report one month ago, 27 percent had sent their last report within the past month, and six percent sent a report two months ago (figure 18) Sixty-three percent of the SDPs received some form of feedback on their reports It is desirable that all service providers receive feedback for their reports SDPs are supposed to submit service statistics reports every month, so very few (six percent) of the SDPs were late in submission of their reports

Fig 18 Recency of last report sent
(N=97)



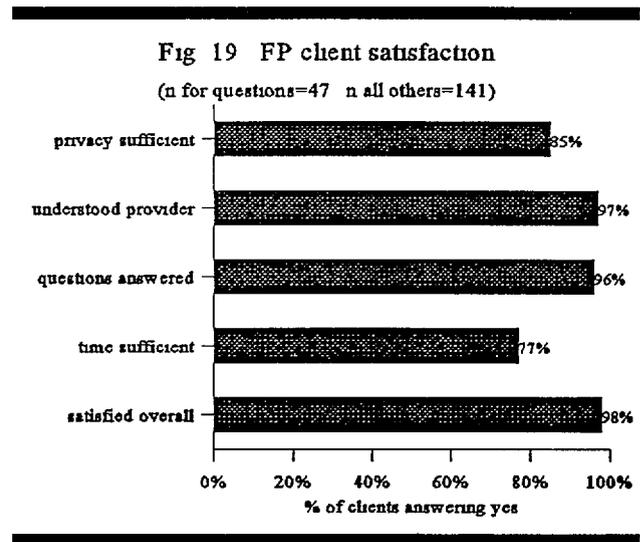
C Quality of Care at SDPs

Information on quality of care at the SDPs was collected through observation of the client-provider interaction, exit interviews with clients and interviews with staff. The assessment of quality is presented here using the Bruce-Jain framework of six elements of quality of care: interpersonal relations, choice of methods, information given to clients, technical competence, mechanisms to encourage continuity, and constellation of services.

i Interpersonal relations

In general, clients expressed satisfaction with the services at the SDPs. Almost all of the clients were satisfied overall (98 percent), understood the provider (97 percent) and felt that their questions were answered (96 percent). Most also felt that the privacy had been sufficient (85 percent) and that the time spent during their consultation was satisfactory (77 percent). Although these numbers are encouraging, it should be noted that there is generally a courtesy bias in answering these types of questions.

Sixty percent of the FP clients did not have to wait for services. This is probably related to the low utilization of services, as clients will not have to wait long at clinics that are not busy. Twenty-five percent waited for less than 1/2 hour, eight percent waited for 1/2 to one hour, and another eight percent waited for one to two hours. Of the 40 percent who waited, 38 percent felt that the waiting time was too long (therefore, 15 percent of all the clients felt that they waited too long).

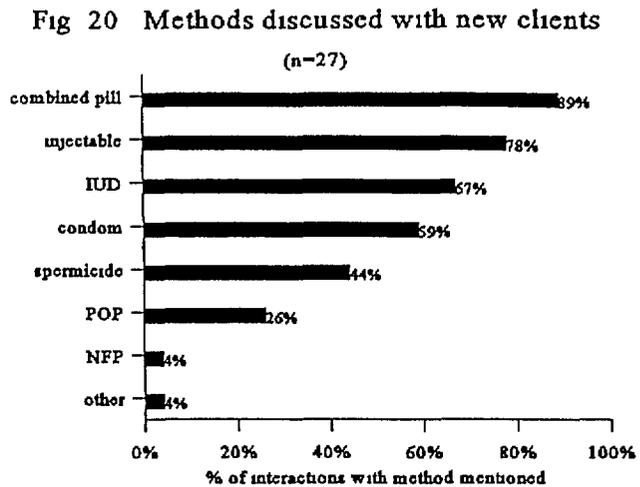


ii Choice of methods

It is important for clinics to provide a range of contraceptive methods to meet the needs of different clients. Choice of methods is affected by many factors: first of all, the availability of methods at the SDP, secondly, whether the method is mentioned to a client so that she knows it is available, and lastly, whether the provider places any barriers on provision of the method. As mentioned previously, the combined pill and the injectable are almost universally available, while the progestin-only pill is only in stock in just over one-third of SDPs.

a This method availability is reflected in the methods that are mentioned to clients. The

combined pill, injectable and IUD are the most commonly mentioned by the provider during the consultation, while the progestin-only pill is less commonly mentioned. With the MOH currently planning to intensify postnatal care, more breast-feeding mothers should be attending the clinics and POP, which is recommended during the first six months of the breast-feeding period, is an appropriate method for them. Providers need to be updated in order to ensure proper information is provided and this choice made available to the client. In interviews conducted with clients after observation of the client-provider interaction, clients were asked which methods were discussed during the interaction. Those methods which are readily available at the clinics are often mentioned.



Thirteen out of 27 new clients (48 percent) expressed a preference for a particular method six of them did not get their preferred method one client was advised against the method by the provider. The reasons for the others not getting their preferred method is not available. In only four of the 141 interactions observed (three percent), the providers were observed to promote one method in particular.

- b Even if methods are available, it is still possible for provider biases and restrictions to affect method choice. In the staff interview, providers were asked which methods they would recommend for spacing births, for limiting births, and which methods, if any, they would never recommend. Almost all the staff recommend effective methods for spacing births, with the pill, injectable and IUD the most mentioned methods. In addition, most recommend the correct methods for limiting births with tubal ligation and vasectomy the most frequently mentioned (90 percent and 70 percent, respectively). Thirty-four percent would recommend the injectable and seven percent the IUD. There were few methods that providers would never recommend, with the exception of spermicides, which was mentioned by 14 percent of providers.

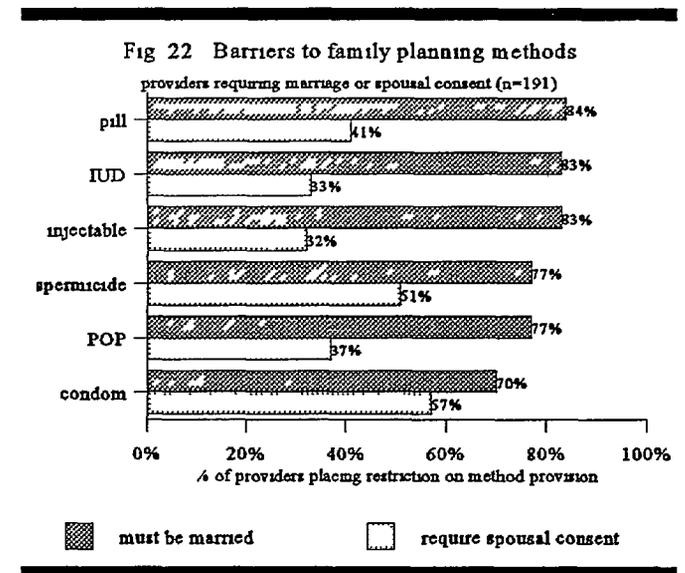
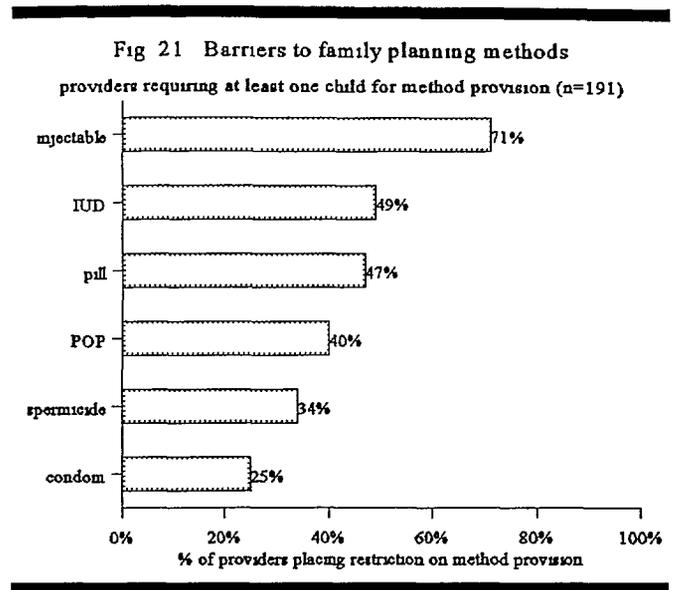
Providers were also asked about barriers to provision of family planning methods. The barriers that were looked at were number of children, marital status, spousal consent and breastfeeding (figures 21 and 22). Seventy-one percent of providers felt that a client must have at least one child before they would prescribe the injectable, while just under one half placed this restriction on provision of the IUD or the pill (49 percent and 47 percent). Some

providers feel that clients must have some children before prescribing FP methods

The majority of providers state that they would not provide most methods to unmarried clients 83 percent would not prescribe the pill or injectable, 83 percent would not provide the IUD, 77 percent mentioned POP and spermicide and 70 percent would not give condoms to unmarried women Spousal consent was also mentioned by many providers as a barrier to family planning Over one half would not provide condoms or spermicide without spousal consent (57 percent and 51 percent), 41 percent would not offer the pill, 37 percent require consent for POP, 33 percent for the IUD and 32 percent for injectables

Half of the providers will not prescribe the combined pill to breastfeeding women Fourteen percent indicated that they will not provide the POP, which is surprising given that this is the method most commonly recommended for breastfeeding women Only a few providers mentioned the condom, spermicide, IUD or injectable as a method that they would not recommend to a breastfeeding client In principle, only the combined pill should not be prescribed to breastfeeding women during the first six months after delivery as it interferes with milk production Some providers are reluctant to give depo provera because it interferes with the post-partum resumption of menses If these women choose hormonal methods, they should preferably be given POP

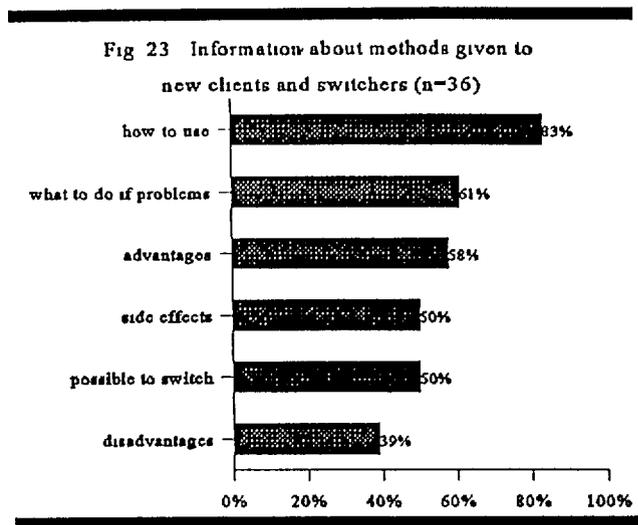
It is important to view these barriers in the context of where the services are being provided Zanzibar has a population that is over 99 percent Moslem The islands have a conservative



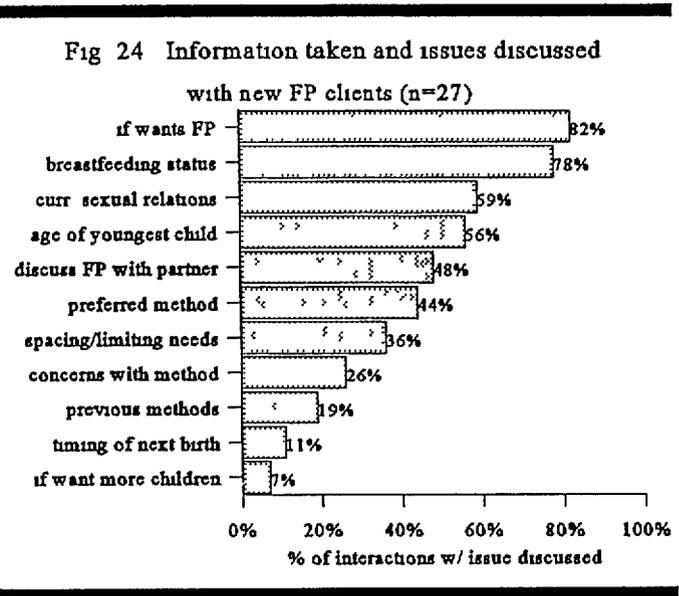
culture and as noted earlier still have a fairly low contraceptive prevalence. Therefore, providers must take this into consideration so that the services they offer are acceptable to the community in which they serve.

iii *Informing and counselling clients*

a As figure 23 shows, most new clients and method switchers (83 percent) were told how to use their chosen method. However, only half were told about side effects and the possibility of switching. Balanced information would increase the chances of the clients continuing with the methods because they will know what is expected to happen and what to do if they have a problem. It is advisable to raise the levels of the various information given to the new clients and switchers.



b Figures 24 and 25 indicate the information taken and issues discussed with new and revisit family planning clients. Though most new clients (78 percent) were asked about their breastfeeding status, few revisiting clients were (18 percent). Over half of the providers asked new clients about the age of the woman's youngest child, but few inquired about the preferred timing of the next birth (11 percent) or previous methods used (19 percent). Although over half of new clients were asked about their current sexual relations, only eight percent of revisits had these issues discussed in their consultation. With the increasing interest in providing broader reproductive health services, it is important to address issues beyond fertility preferences and contraceptive use. For example, questions about a client's sexual relations are important to assess a client's potential risk of contracting a sexually transmitted infection (STI). The above points to the need for further training of providers in counselling.



There were 48 clients who reported a problem with their method. For 25 percent of these, the provider discussed the problem, in 13 percent the client switched methods, in seven percent of the interactions the provider treated the client medically, in another seven percent the provider performed an examination, and in no cases was the client referred elsewhere. It seems there are no clients or very few who are referred for having problems. However, lack of availability of a referral clinic for such cases may influence the service providers' decisions to refer the clients, and, in addition, many problems might not require referral.

Clients were also asked method-specific knowledge questions to assess what kind of information was given to them.

Pill and injectable users were asked to name problems that might occur with their method which would require them to return to the SDP. For both of these methods, the knowledge was found to be quite low. 65 percent of pill users and 53 percent of injectable users did not mention any problems that would require their return to the clinic. Of 81 pill users, 17 percent did mention abdominal pain, three percent mentioned severe headache and vision loss, and only one percent mentioned either chest pain or severe leg pain. For the 53 women using injectables, 13 percent mentioned severe headaches and seven percent knew that bleeding could be a serious problem.

IV *Technical competence*

a Figure 26 indicates the medical history taken and examinations performed as observed in client-provider interactions. In general, thorough medical history is taken

Fig 25 Information taken and issues discussed with revisit FP clients (n=112)

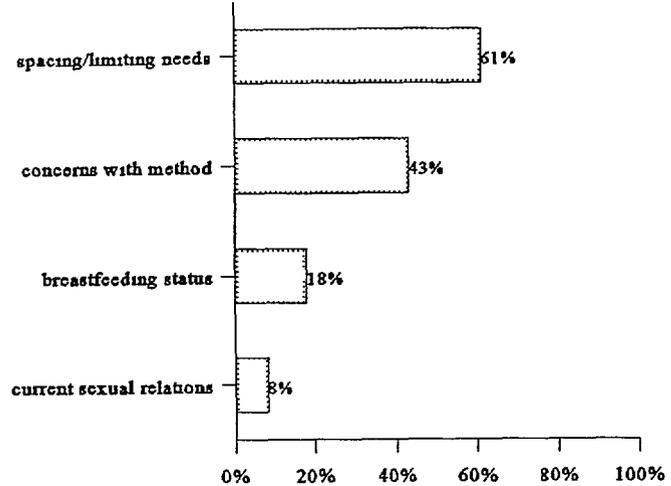
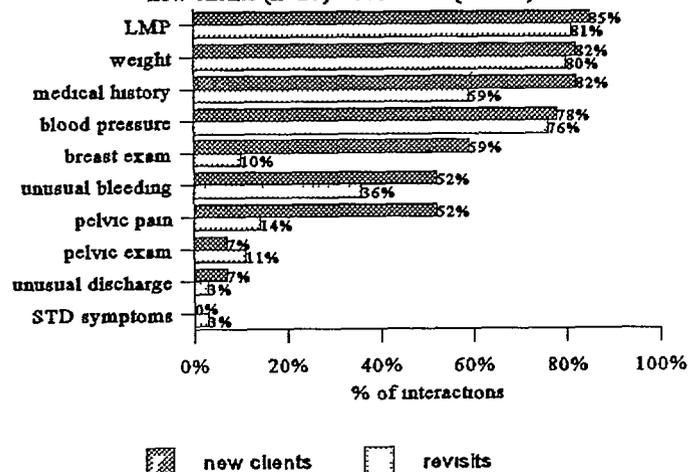


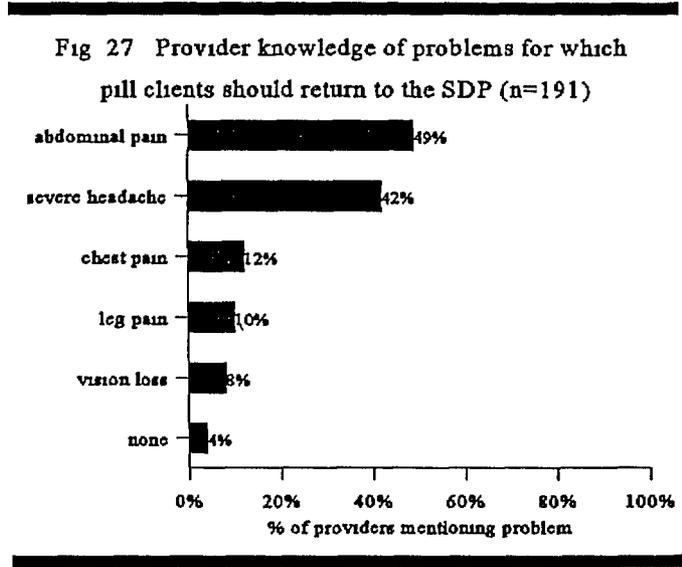
Fig 26 Medical history taken and exams performed new clients (n=27) and revisits (n=112)



and examinations performed for new clients. It is notable that although 59 percent of new clients had a breast exam performed, this was done with only 10 percent of revisit clients. Observers also noted whether or not clients were asked about potential STD symptoms. Just over half of new clients were asked about unusual bleeding and pelvic pain, though fewer revisit clients were asked about these. In addition, the findings show that history of STD symptoms is rarely asked of either new or revisit clients. This is important information which should be asked as it has an impact on contraceptive use as well as implications for women's health.

Fourteen pelvic exams were observed. Two of these were performed on new clients, while the remaining 12 were for revisits. The majority of providers discussed the examination before performing it (86 percent), used a sterile speculum (86 percent), used clean gloves (79 percent) and informed the client of the outcome (71 percent). However, only 57 percent of the time did the provider wash his/her hands. Washing hands is important as it minimizes the chances of infection. However, this could be attributed to the lack of water in some clinics (three of the six observations of providers not washing hands took place in SDPs without a water supply), but it should not be taken as a justification for not washing hands. All in all water should be made available.

There were 48 cases of observations of providers giving injections to clients. In general, appropriate precautions and actions are taken while giving injections. In almost every case, the provider used a sterile needle and shook the vial (98 percent for both), the correct dose was generally given (94 percent), and most massaged and disinfected the site (81 percent and 77 percent, respectively). Only one IUD insertion and one IUD removal were observed, but in both of these cases, the providers were observed to practice all the measured indicators of quality for insertion, sounding the uterus, using sterile equipment and providing emotional support, for removal, using sterile equipment and providing emotional support.



- b Providers were asked various questions to assess their method-specific knowledge. For the pill, injectable and IUD, providers were asked to name problems that might occur with each method for which the client should return to the SDP. For the pill, about half of 191

providers mentioned abdominal pain and severe headaches (49 percent and 42 percent, respectively), while very few mentioned chest pain, vision loss or leg pain (12, 8 and 10 percent) Four percent did not mention any problems (figure 27) Most providers (82 percent) mentioned heavy bleeding as a potential problem for injectable users for which they should return to the clinic Only 1/4 mentioned severe headaches, and six percent did not mention any problems For the IUD, almost 2/3 mentioned cramps and expulsion (60 percent for both) and slightly less than half mentioned spotting (47 percent) Few mentioned discharge (15 percent), painful intercourse (six percent), RTI/PID (nine percent), or late period (three percent) Five percent did not mention any problems This fairly low knowledge among providers translates into the low knowledge found among users

Providers were also asked about the advice that they give to breastfeeding clients 1/3 (33 percent) would advise the client to continue breastfeeding and use any method, while roughly another 1/3 (31 percent) would advise to continue breastfeeding and use POP Twenty-two percent would just treat the woman as any other client, a few providers would advise not to breastfeed and use any method (two percent) or indicated that the advice would depend on the age of the child being breastfed (two percent), and less than one percent would advise the woman to continue breastfeeding and not use any method Although 64 percent of providers do give correct advice, the advice given to breastfeeding clients is often either incomplete, inaccurate or does not offer all the possible options to clients

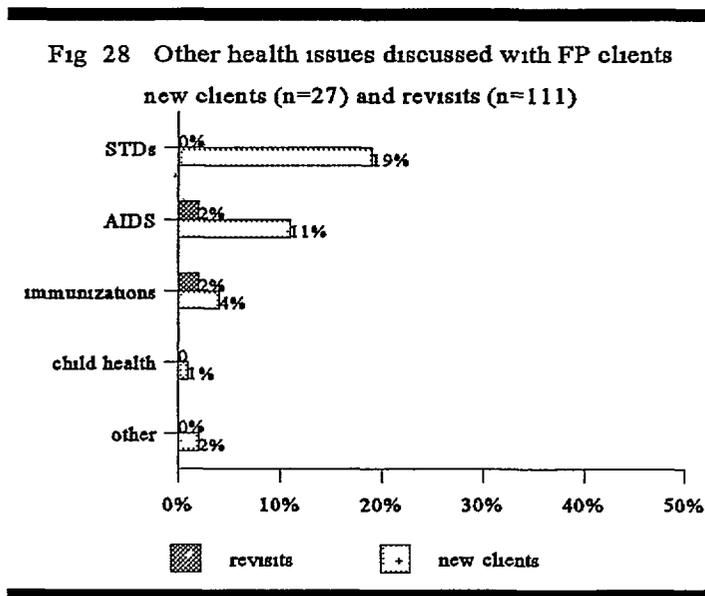
v *Mechanisms to encourage continuity*

94 percent of the clients were given their method at the time of the visit 98 percent of clients were told to return for a revisit Of these, 93 percent were given a written reminder of their return visit The good interpersonal relations which were observed and described above are also very important in encouraging continuity

vi *Constellation of services*

As mentioned previously, there is increasing interest in providing broader reproductive health services to women by looking

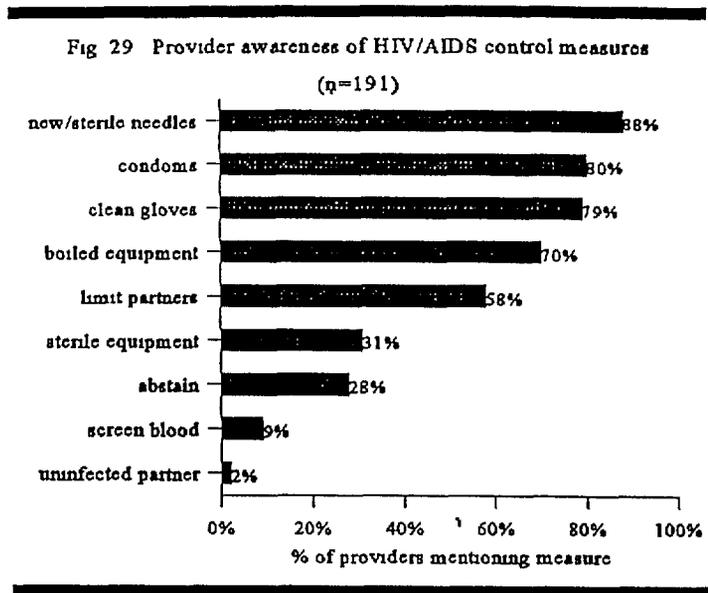
beyond family planning to issues such as STDs and AIDS Figure 28 shows that other health issues are more commonly discussed with new clients as compared with revisits, but were



rarely mentioned with either group. STDs were discussed in 19 percent of the interactions with new clients, but were not mentioned at all with revisits. Likewise, AIDS was discussed in 11 percent of interactions with new clients, but with only two percent of revisit consultations.

Almost all of the staff interviewed (97 percent) would be willing to counsel family planning clients on HIV/AIDS. 80 percent are willing to provide FP services to HIV/AIDS patients, indicating that there is still some stigma attached to people with HIV/AIDS.

Providers were also asked about their awareness of HIV/AIDS control measures. Most are aware of some control measures, but their knowledge on other specific control measures is fairly low. Most mentioned condoms (80 percent), new/sterile needles (88 percent), clean gloves (80 percent) and boiled equipment (70 percent). Over 1/2 mentioned limiting partners (58 percent), while less than 1/3 mentioned sterile equipment (31 percent) or abstinence (28 percent). Very few (nine percent) brought up the importance of screening blood.



Staff were also asked about their perceptions of abortion in the community. 60 percent believe that abortions are taking place in Zanzibar. 30 percent of the staff reported that clients ask them for advice on terminating an unwanted pregnancy. 25 percent indicated that clients come to their SDPs for postabortion treatment.

The above indicates that there is a need to offer more comprehensive reproductive health services in order to more fully meet women's health needs and effectively reduce maternal morbidity and mortality.

V Programmatic recommendations

- 1 The MCH/FP policy should be translated into Kiswahili and enough copies made available to service providers. This will enable the service providers get acquainted to the policy and observe the standard practice e.g. regarding clinic opening/closing times accordingly.
- 2 Infrastructure Efforts should be made in collaboration with the local authorities and departments of water and electricity to ensure that water and electricity are available in the clinics. The concerned ministry staff (MOH) should initiate this in their respective areas and the programme should follow up.
- 3 Equipment Regular monitoring of the clinics by the MCH/FP supervisors is necessary so that the needed equipment can be procured, supplied from the warehouse or re-distributed.
- 4 Contraceptive mix The programme should procure adequate supplies of the various methods available e.g. progesterone only pills, in order to have a wide range of methods available at all SDPs. More emphasis should be directed towards introduction of Norplant, promotion of IUCDs and availability of VSC facilities for those who need them. The mentioned methods seem to be in short supply or not introduced.
- 5 Staff training Service providers need to be updated through refresher courses because of the constantly changing contraceptive technology. This will enable the staff to give more information to clients and counsel them effectively.
- 6 IEC materials and activities
 - Relevant culturally sensitive IEC materials ought to be produced and distributed.
 - MCH clients attending clinics need to be actively motivated, counselled and given moral support as it has been found that 70% of them do approve of use of FP methods.

Future plans

Conduct further operations research to

- 1 investigate the demand for family planning in the catchment areas of SDPs which have a high volume of clients and those with a low volume to address the question of whether supply factors such as the quality of services or demand factors are better predictors of service utilization.
- 11 determine the roles and contribution of the CBD agents in FP motivation.

Appendix 1. Suggestions for improving FP services

The following list of suggestions is from the qualitative information collected in the staff interview questionnaire. The first five suggestions were the most commonly mentioned by providers.

- *Training in FP communication and clinical skills for new comers is needed
- *Refresher courses are necessary
- *Additional staff - (service providers) in the clinics
- *Male motivation must be intensified
- *Provision of missing equipment and supplies
- Increase supervisory visits to clinics
- There should be a special doctor for dealing with contraceptive problems and complications
- Training in infertility management is needed
- Community motivation and multi-sectoral involvement
- Improve privacy for FP clients
- In some clinics the service provision areas should be expanded
- Increase CBD training, increase no of CBD agents
- Motivate the clients
- Educate the Sheikhs, traditional birth attendants and healers
- Ministry of health senior officials should visit clinics
- Follow up of clients with problems
- Hospital orderlies be trained in FP
- Provide more IEC materials e.g posters, leaflets etc
- Family Life Education be given in schools
- There should be a special group for FP motivation

- Clarify FP bad rumors through mass media
- Condom supply for reduction of STDs including HIV transmission and for FP purposes be increased
- All health workers should be trained in FP
- Incentives be given to service providers
- Kit bags be provided for CBD agents for storage of contraceptives
- FP services should be available in the community not only in clinics (CBD of contraceptives)
- Provision of transport to service providers for outreach services to visit villages
- Give training to those who provider FP services without training in FP
- Give incentives to FP clients
- Give incentives to service providers/clinics with many continuing users (current FP users)
- Maintain confidentiality
- Proper counselling of clients
- Rehabilitate/renovate of the buildings
- Establish peer educators groups
- Prescribers training in FP is too short, increase duration -- prescribers training in FP lasts 3 weeks at the moment
- Establish district FP motivation teams
- Involve Sheshas (local administrators) in FP motivation and they should be given legal powers on the same
- The government should have a (population) policy on the number of children per family
- There should be a programme for showing films in the village (on FP)
- FP community motivation should be emphasized in rural areas

- School teachers should also be involved in FP motivation
- Rural health assistants should be trained in FP motivation
- Transport for FP supervision

Appendix 2. Socio-demographic characteristics of FP and MCH clients

Indicator		FP Clients n=141	MCH Clients (non-users) n=471
Age		Mean 28.7 Median 28.0 Range 18-45	Mean 26.1 Median 25.0 Range 16-50
Number of living children		Mean 4.2 Median 4.0 Range 0-12	Mean 3.2 Median 3.0 Range 0-11
More children desired		74 %	87%
Partner attitudes on FP		Can discuss FP with partner 83% Partner knows about FP use 81%	Partner approves of FP 48% yes 29% no 23% dk
Breastfeeding	Currently	42%	(not asked)
	Of these, exclusive	14%	
	supplementary	86%	
AIDS	Ever heard of AIDS	99%	99%
	Can talk with nurse about AIDS	91%	82%
	Can talk with partner about AIDS	88%	97%
Literacy (in Kiswahili)	Can read easily	70%	52%
	Can read with difficulty/illiterate	30%	48%
Religion	Moslem	95%	96%
	Catholic/Protestant	4%	3%
	Traditional/Other	1%	1%