Integration of Family Planning into Maternal and Child Health and other services at Harare Central Hospital

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INTRODUCTION

Family Planning (FP) is promoted in Zimbabwe as an essential strategy to promote better maternal and child health. However, in Zimbabwe, as in many other developing countries, it appears that many more couples are interested in family planning than actually use contraceptive methods\(^1-9\). One of the reasons for this discrepancy is the lack of accessible services available at the time of need for potential family planning clients.

Harare Central Hospital (HCH) is a busy national referral hospital, which caters for high-risk maternities, as well as gynaecological, surgical, medical, paediatric and psychiatric referrals. There is, therefore, an enormous potential family planning clientele who until the initiation of the project to be described, had to make another visit elsewhere for their contraceptive needs, and often failed to do so. It was the view of the Obstetrics & Gynaecology department at HCH, that by making a service, providing contraceptive facilities and counselling available for fertile women at the same time as their or their children’s hospital admission or visit, would increase the uptake of FP. Patients selected included: ante- and post-natal women, post-abortal women and patients with chronic medical and psychiatric problems. Mothers of malnourished children were also visited. Thus with the logistical and financial support of the United Nations Fund for Population Activities (UNFPA), and the support of the University of Zimbabwe (UZ) and the Ministry of Health (MOH), a programme was started to integrate family planning into maternal and child health and other services at HCH.

Family planning provision at Harare Central Hospital before commencement of the project

- **Pharmacy:**
  Previously, the pharmacy did not stock contraceptives for the understandable reason that it would exceed its drug budget, which was under pressure any way, and patients could get free contraceptives elsewhere. The effect of this policy was that no one at HCH could prescribe contraceptives, not even the Professor of Obstetrics & Gynaecology.

  Junior staff-members were not taught the medical and technical aspects of contraception outside the lecture room and were not prepared psychologically for the fact that FP should be an integral part of the service they provided for every woman attending for health care.

- **Gynaecasualty (Emergency Gynaecology Unit):**
  As reported in this Journal before\(^10\), a study carried out on the 4000 patients presenting annually with incomplete abortion in HCH showed that at least 23% had interfered with their pregnancy. In the same study only 33% of the patients stated, when asked, that they definitely had wanted the index pregnancy.
Patients with incomplete abortions usually did not get any FP advice. This was because the staff were busy before the evacuation of the uterus with clerical duties, organising for surgery and blood transfusions and because they did not think about the necessity for FP counselling. After evacuation under pethidine/diazepam, the patients were too sleepy to be receptive and they were discharged as soon as possible because of the extreme lack of room and privacy in Gynae-casualty.

Patients seen with Pelvic Inflammatory Disease (PID) and hence sexually active were seldom given contraceptive advice even though they form a sub-group of patients in which the use of contraceptives is often advisable. As well as preventing unwanted pregnancies, condom and hormonal contraceptive usage decreases the incidence of PID with nearly 100% and 50% respectively\(^{11,2}\), and of course condoms protect against HIV transmission.

- **Out Patient Department (OPD):**
An estimated 80 new gynaecological patients were seen at the OPD every week and many more follow-up visits were made there. Although many patients were interested in contraception, doctors did not often ask them about this; if contraceptives were suggested, then patients could only collect them at another time and at another institution. Patients seen for rape could not even be prescribed post-coital contraception. (Morning-after pill, for the instructions read Appendix).

- **Antenatal Clinic (ANC):**
During the ante-natal period there was very little discussion of post-partum contraception. Very often prime candidates for tubal ligation (TL) did not have sterilisations although they did want them. For example: a mother of 5 with diabetes and hypertension and 2 previous caesarean sections had no sterilisation performed during her third CS, although she had wanted that very much, because the paperwork was not in order and the husband was not available to give a signature on the consent form, even though she said that he agreed. Similar cases occurred frequently in the past and are still seen to a certain extent.

- **Postpartum Care:**
Patients in the post natal wards were fortunate if anybody discussed contraception with them. If contraception was discussed and the patients wanted supplies, then they had to be referred to another institution. Even those women requesting post-partum TL often did not have these operations done. They were given a low priority on the maternity unit theatre list having to compete with emergency CSs, and were often cancelled for petty administrative reasons. Often patients left the hospital embittered after having been starved day after day and their TL repeatedly postponed. Although agreeing to come back in 6 weeks, they hardly ever did and if they did, the operation had to be performed
in the main operating theatre where there was a waiting time of many months. Not surprisingly, some of these patients were seen again in the ANC!

- **The Postnatal Clinic (PNC):**
  This was the one place where a rudimentary family planning service was provided. Staff members of the Zimbabwe National Family Planning Council (ZNFPC) visited the PNC. Only a small portion of patients who delivered at HCH, however, does attend for the postnatal visit. Progestagen-only pill (POP) was the main contraceptive given to breastfeeding mothers. Those requesting TL or an intrauterine contraceptive device (IUCD) had to be referred to the Spilhaus FP clinic, a separate institution. Follow-up of postnatal women on POP was inadequate with the result that many women continued with this method after weaning, when its failure rate increases and a combined pill would have been more effective.

- **General Hospital:**
  The hospital admits various patients with an excellent motivation or indication for contraception, e.g., mothers with babies with malnutrition in the Paediatrics Ward or the Malnutrition Rehabilitation Unit and women with psychiatric and serious medical conditions.

  Female patients were treated for hypertension, diabetes and cardiac disease but contraception was not even discussed, although it should be viewed as an integral part of their management.

**The Family Planning Project - The current situation at Harare Central Hospital**

Since October 1986 there are, thanks to the Ministry of Health, UNFPA, ZNFPC and UZ, two nurse-midwives with extra training in FP who are released from normal nursing duties and who spend their days providing FP counselling and services. They visit in- and outpatients to advice about and to prescribe contraceptives and a final year medical student is attached to them. The pharmacy has contraceptives in stock donated by ZNFPC and Gynaec-casualty has a stock of contraceptives for after hours dispensing and for post-coital contraception. There is a Tuesday afternoon contraception clinic where a specialist sees women with complicated FP problems, where IUCD’s are inserted and where students and junior doctors are taught. There is also a lunch-hour staff contraception clinic. Unfortunately, due to lack of theatre space and time the situation concerning sterilisations did not change significantly.
RESULTS

After a year of the project’s operation with two sisters working full-time and two gynaecologists assisting on a part-time basis, there were 3822 new acceptors and 5423 return visits or visits of previous acceptors (Table 1). The figures for the first half of 1988 show a 25% increase in the above two groups of acceptors.

Table 1  Statistics Harare Central Hospital Family Planning Programme from October 1986 until October 1987.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>New acceptors</td>
<td>3822</td>
</tr>
<tr>
<td>Return visits/previous acceptors</td>
<td>5423</td>
</tr>
<tr>
<td>Total visits</td>
<td>9245</td>
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</tbody>
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Breakdown of visits:
- Post vaginal delivery: 1381
- Post Caesarean Section: 513
- Post natal visit: 5177
- Mothers in nutrition rehabilitation programme: 57
- Mothers of admitted babies/infants: 459
- Post abortal women: 378
- Post delivery with hypertension: 117
- P.I.D./Puerperal sepsis: 110
- Mental disorders: 23
- Menstrual disturbances: 27
- Various diagnoses: 56
- HIV positive: 2

Methods

A  Pill strips
   - Progestagen only pill: 21044
   - Combined pill 30 mcg oestrogen: 2604
   - Combined pill 50 mcg oestrogen: 83

B  Tubal Ligation: 68

C  Intra Uterine Devices, Cu T.: 80

D  Depot medroxy-progesterone acetate: 170

E  Diaphragm/Cream: 2

F  Condoms: 36621

Calculated Couple Years Protection (CYP): 3114
If the same calculation technique used by ZNFPC in their 1986 Annual Report is utilised, it can be worked out that the two sisters provided 3114 Couple Years Protection (CYP). CYPs are calculated by dividing the total strips of pills dispensed by 13, the condoms by 100, IUCD’s by 0.4, injectables by 4 and sterilisations by 0.1.

This figure of 3114 CYP is a considerable number. It is 5.1 % of the total CYP generated by all 35 ZNFPC clinics, including Spilhaus. These clinics employ 998 people.

**Plans For The Future:**

Although good, these results could be improved still further if the original plans of the project were to be implemented. These plans include:

1. Five (rather than 2) sisters so that there would be 24-hour and full weekend contraception cover. This arrangement would also allow staff to perform more research and also provide a community outreach service.

2. Provision for transport so that sisters could follow-up clients to see whether they were continuing with methods provided. Research would be possible into side-effects, beliefs around those, and best ways to present contraceptives. Also, with adequate transport, the sisters would be able to contact husbands or partners more often.

3. Funding for the building of a Women’s Clinic. Here all gynaecological patients would be seen: there would be a theatre to insert IUCD’s and to perform mini-laparotomies and laparoscopic TLs and to carry out investigations for infertility and sexually transmitted infections. The extra room would also provide working space for the nurses and privacy for the patients.

4. Education and entertainment of patients in the post/antenatal ward and, while waiting, in Gynae-casuality with a locally made video film about child spacing.

5. Follow-up of patients and collection of relevant data and processing them with the help of a secretary and a computer.

**Areas not covered in the project and problems still to be solved.**

1. A weakness of this study is that no follow-up of patients was carried out after provision of contraception. The continuation rate in non-TL patients was not known although clients are advised to visit a FP clinic before their supplies run out. We have tried to follow-up patients in an earlier study mentioned above and it was found that many patients could not be traced and did not want to be traced. Especially, those whose behaviour suggested that they needed contraception most.

2. Design and printing of a new sterilisation consent-form. There are at the moment at least 6 different forms in circulation. Some to be signed in duplicate, some by the husband, and a doctor and a specialist and the hospital superintendent. We favour one of the three forms used by the ZNFPF with space for the patient to sign and for this signature to be witnessed by somebody, preferably but not compulsory, the husband.
only other signatory is the surgeon. The legal position vis-à-vis sterilisation including age, consent of spouse and hospital superintendent etc. should be explained on the back of the forms.

3. Large hospitals should have staff FP clinics and after-hour FP services. In the two large Bulawayo hospitals, the situation is exactly the same as it was in HCH in the past: no contraceptives are stocked in the pharmacy. Even Parirenyatwa Hospital, the MOH’s flagship, sends patients home during office hours after evacuation of incomplete abortions without contraceptive assessment and counselling.

4. FP nurses are very efficient but fill a gap that should not exist in the first place. They let the doctors off the hook. This could prevent those doctors from giving attention to FP when they start working in other hospitals or units because they have not acquired the habit of providing FP themselves.

5. The ZNFPC is trying very hard to integrate FP training into the training of all the health workers. Senior doctors and senior nurses, with encouragement from the MOH need to make sure that this extra training is implemented and that all doctors and nurses in every speciality think about FP as part of comprehensive care.

The impression is gained that staff in clinics and district hospitals is better informed about and motivated for a comprehensive approach to health than the staff in the Central Hospitals. The excellent work done by the Provincial Medical Directorates in the continuing education of health workers is probably responsible. These developments, however, are little noticed by middle-grade doctors directly involved in patients care in the Central Hospitals. They are seldom invited to the relevant workshops.

**CONCLUSION**

This programme shows how, with a few resources and a lot of motivation, family planning was integrated into all services at Harare Central Hospital. The result was a very high acceptance of family planning with much less inconvenience to the patients concerned. This example could and, we hope will, be replicated in other central, provincial and district hospitals.

**APPENDIX**

Prescribe either; A four tablets of low dose (30 mcg oestrogen) combined contraceptives and to be repeated after 12 hours; or, B two higher dose (50 mcg oestrogen) containing combined pills and repeat after 12 hours. One of the two above regimens should be started maximally 72 hours after unprotected intercourse, preferably sooner. After 72 hours, but before 7 days an IUCD could be used if not contra-indicated.
REFERENCES


