

### 3. Understanding and removing fears about pregnancy and labour

"I used to be petrified about childbirth and never understood how a big child can pass through such a small opening. Knowing about labour, I feel a little calm and I am happy that I understand things better." (An 18-year-old girl about to get married) "Now I know ... how the uterus can grow in my tummy and why I urinated so frequently when I was pregnant." (Adult woman) "I used to be petrified about childbirth...I now understand things better." (Engaged girl)

### 4. Menstruation

"I understand where menstrual blood comes from...I will be able to tell my daughter that menstrual pain is not abnormal. It is part of growing up." (Adult woman)

### 5. Contraception

There was a lack of prior knowledge about the IUD, which was easily dispelled by demonstration using the simulator. "I now know where the copper T is placed, before we thought that it was in the vagina." (Adult woman)

Other content related to understanding of personal hygiene, vaginal discharge, the effects of the menopause and the potential usefulness of seeing a model of the male anatomy was also discussed.

### Discussion

In developing countries, medical students' learning of pelvic examination is constrained by the limited availability of informative literature, audio-visual material and simulators. Working and training conditions are often crowded and lacking in privacy so that inappropriate practices with regard to pelvic examination are likely to be propagated. However, as a simple and non-costly clinical skill there is no fundamental reason why vaginal examination should not be properly learned and practised in poor countries.

While some guidance for nurses is available,<sup>3</sup> training materials are usually designed for use by doctors. In Western countries innovative approaches have included the use of 'assistants', volunteers who are prepared to allow students to undertake intimate examinations, providing guidance and feedback.<sup>4</sup> This concept may not be culturally

acceptable in many developing countries and does not provide adequate simulation of IUD insertion. We believe the wider use of pelvic simulators would enhance the training in, and quality of, family planning services.

Sexual health education can be undertaken very effectively using line drawings and does not require expensive or complex tools such as a simulator.<sup>5</sup> However, our study suggests that such a device can also be of great interest to clients. Local manufacture and distribution of low-cost pelvic simulators for training needs to be considered with support from funding agencies active in reproductive health.

### Conclusions

Where working and training conditions are crowded and lacking in privacy, inappropriate examination practices are likely to be propagated. Training for intimate examinations can be enhanced by the use of pelvic simulators. Further research is needed to quantify the extent of non-use of services resulting from clients' fears of ineptly performed intimate examinations, compared to other barriers to access.

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**Competing interests.** None identified.

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## Provider resistance to advance provision of oral contraceptives in Africa

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### Abstract

**Context.** In Africa, many new family planning clients are not menstruating at the time they present for services. Where pregnancy tests are unavailable, clients are often denied their method of choice and sent home to await menses. For pill clients, one obvious solution is 'advance provision' of oral contraceptives for later use. However, this practice is rare in Africa.

**Objective.** To assess the level of provider resistance to advance provision of oral contraceptives.

**Design.** We added questions about advance provision of pills to five provider surveys in three African countries. We also used simulated clients in Ghana to assess provider resistance to the practice.

**Results.** In Kenya, only 16% of providers thought it safe to give women oral contraceptives to be started at a later date.

In Ghana and Senegal, fewer than 5% of providers mentioned advance provision as a way to manage non-menstruating pill clients.

**Conclusion.** Training programmes and service delivery guidelines in developing countries should provide for advance provision of pills to appropriate clients

### Introduction

In Africa and other regions, many family planning programmes cannot afford pregnancy tests, so a substantial proportion of new family planning clients are sent home without their desired method and told to return for services at the onset of menses.<sup>1</sup> This policy is often enforced for oral contraceptive (OC) clients who could easily carry pill packets home to initiate later. This 'advance provision' of pills, common in much of the world, is safe<sup>2</sup> and can reduce unwanted pregnancies while saving clients' time and money. In sub-Saharan Africa, however, where the health risks associated with pregnancy are the greatest, we have noticed that family planning providers seem particularly resistant to advance provision of pills.

### Methods and results

We used provider surveys and qualitative methods to collect data in Kenya, Ghana and Senegal on provider resistance to advance pill provision.

In our 2000 survey in 72 family planning clinics in Kenya, only 16% of providers (n = 177) agreed with the statement: 'non-menstruating clients can safely be given a cycle of pills to carry home to start when they get their period'. In a 2000 survey in Ghana, only 4% of providers (n = 124) stated that they managed non-menstruating clients by allowing them to carry pills home for later use at the onset of menses (together with a barrier method). In a similar study in 313 clinics in Ghana in 1997, the proportion was only 5% (n = 570).<sup>3</sup> In Senegal, the proportion of providers who volunteered that they would allow a non-menstruating client to carry home their chosen method (pills were not specified, but are the only available non-barrier method that could be 'carried') together with a barrier method was only 2% (n = 269) in 194 clinics in 1997<sup>4</sup> and 4% (n = 720) in 335 clinics in 1998.<sup>5</sup> In the Senegal and Ghana studies, the most common strategies for managing non-menstruating clients cited by providers were to use pregnancy tests, which often are not available, and to send clients home to await menses.

In Ghana, we also used a three-round simulated client study (1996, 1998, 1999) to assess provider attitudes towards advance provision in 20 urban and peri-urban clinics. Each simulated client played the role of an unmarried woman in her late teens with no children. When faced with the clients' request to carry pills home for later use, most providers reacted negatively, telling clients to return home because initial provision could only happen during menstruation.

### Conclusions

Why such resistance to advance provision of pills in these three African countries? These data are quite limited

and more research is needed, but our findings may corroborate earlier research in Africa showing that providers have an exaggerated sense of the dangers of hormonal contraception.<sup>6</sup> Providers may also object to advance provision on the grounds that it is wasteful or that clients may give away or sell their pill packets. Finally, the international family planning community – donors, agencies, and non-governmental organisations (NGOs) – may also be responsible in part. We know of no explicit mention of advance provision of pills in any of the national or international family planning guidance documents, nor have we seen the practice mentioned in any training curricula or materials.

Allowing clients to carry pills home for later use makes practical sense because it economises on the time and resources of both clients and providers. Nor is there any reason to believe that well-counselled clients who wait to initiate pill use – a common practice throughout the world – are at any greater risk than clients who begin immediately. Ironically, provider resistance to advance pill provision exists side by side in the countries studied and many others with social marketing programs that allow 'over the counter' sales of pills in pharmacies, shops, and open-air markets.

In developing countries, where the risks of incorrect pill use are dwarfed by the risks inherent in unwanted pregnancies, advance provision of pills to intermenstrual and postpartum clients makes good sense, and should be included in national and international service delivery guidelines.

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## ERRATUM

*Journal of Family Planning and Reproductive Health Care* 2002; **28**(4)

We wish to apologise to Michael Cox for his name inadvertently being omitted under Service Advisors within the Editorial Advisory Board listings, which appeared on the inside front cover of the October 2002 issue of the Journal.