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ADVANCE PROVISION OF ORAL CONTRACEPTIVES TO FAMILY PLANNING CLIENTS IN KENYA
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ABSTRACT

Objective: **In sub-Saharan Africa, many family planning programmes do not encourage advance provision of oral contraceptives to clients who must wait until menses to initiate pill use. Since some resistance to advance provision of pills is due to provider fears that the practice may be harmful, we conducted a study in Kenya in 1997 to compare pill-taking outcomes between 20 "advance provision" clients and 280 "standard" clients.**
Design: **Prospective observational study.**
Setting: **Six family planning clinics in Central and Western Kenya.**
Subjects: **Women presenting as new clients at MOH family planning clinics.**
Interventions: **Researchers used prospective tracking to compare indicators of pill-taking success between non-menstruating clients given pills to carry home for later use and menstruating clients who began pill use immediately.**
Main outcome measures: **Pill-taking outcomes such as side effects, compliance, knowledge, satisfaction, and a continuation proxy.**
Results: **Among clients returning for re-supply, those receiving advance provision of pills did no worse than, and often had superior outcomes to, their counterparts who started taking pills immediately after the clinic visit.**
Conclusions: **Advance provision of pills, already practiced worldwide, is safe and feasible. Explicit mention should be made of advance provision of pills in national family planning guidance documents and training curricula in Kenya and throughout sub-Saharan Africa.**

INTRODUCTION

In sub-Saharan Africa and other regions where women breastfeed extensively, many or most new family planning clients present for services during lactational amenorrhoea. Although a history, exam and/or pregnancy test can rule out pregnancy for most of these clients(1), some women find they must wait before initiating a new method, particularly where de facto menstruation requirements restrict services for non-menstruating clients, and neither clinics nor clients can afford pregnancy tests. As a result, many new family planning clients in Africa and elsewhere are sent home without a method and told to return at the onset of menses(2).

For clients who want oral contraceptives, however, an extra clinic visit is an unnecessary obstacle. Even if a woman cannot initiate pill use immediately, providers can supply one or more cycles to start later, along with a barrier method. This "advance provision" of pills, common in much of the world, is safe(3) and can reduce unwanted pregnancies while saving clients' time and money. In sub-Saharan Africa, however, we have noticed that family planning providers seem particularly resistant to advance provision of pills. Because part of this resistance arises from the perception that advance provision may somehow be dangerous to clients' health, we assessed pill-taking outcomes of "advance provision" clients and compared them with those of standard pill clients.

MATERIALS AND METHODS

We conducted prospective research in six clinics(Mugeka health centre, Kiambu hospital, Nyeri provincial hospital, Rongo health centre, Kisii district hospital, Homa Bay district hospital) in Kenya in 1997 to assess advance provision of combined oral contraceptive (COC) pills in a low-resource setting. We compared non-menstruating clients who were provided with pills to carry home for later use, with menstruating "control" clients who initiated pill use immediately. To ensure that women recruited into the study met all eligibility criteria for use of COCs, including those related to breastfeeding, the inclusion criteria in the study protocol specified that subjects had to be new, intermenstrual (between two normal menses) clients desiring oral contraception but with no precautions against COC use. For ethical reasons, we did not randomise because new, menstruating clients could not in good conscience be denied family planning for a month.

At the standard one-month pill re-supply visit, we compared the two groups on a variety of indicators of pill-taking success. As a proxy for continuation, we also compared the proportions returning for re-supply.

Table 1

Pill-taking outcomes, by client type

Indicator	Advance provision (n=20) n (%)	Control (n=280) n (%)	Relative risk*	95% CI
Experienced problems related to pill-taking	1 (5)	36 (13)	0.4	0.1 - 2.7
Extra spotting / bleeding last month	1 (5)	39 (14)	0.4	0.1 - 2.5
Forgot no pills last month	20 (100)	246 (88)	1.1	1.1 - 1.2
Told when to start taking first pack	20 (100)	280 (100)	–	–
Told when to return for re-supply	20 (100)	280 (100)	–	–
Knows what to do if forget to take the pill	20 (100)	269 (96)	1.0	1.0 - 1.1
Knows possible side effects: Headache	16 (80)	132 (47)	1.7	1.3 - 2.2
Knows possible side effects: Spotting	13 (65)	104 (37)	1.8	1.2 - 2.5
Knows possible side effects: Weight gain	14 (70)	90 (32)	2.2	1.6 - 3.0
Knows possible side effects: Nausea	1 6 (80)	204 (73)	1.1	0.9 - 1.4
Satisfied with method	20 (100)	266 (95)	1.1	1.0 - 1.1
Willing to recommend COCs to a friend	20 (100)	277 (99)	1.0	1.0 - 1.0

* Using control clients as the referent group for each comparison

RESULTS

Recruitment of clients for the "treatment" arm of the study was low because some providers considered advance provision dangerous, even on a research basis. Eventually, 48 non-menstruating clients were recruited and provided with pills to carry home and 629 "standard" pill clients agreed to participate in the study for comparison purposes.

After one month (the standard re-supply period) 20 of the 48 (42%) advance provision clients returned, versus 280 of the 629 (46%) in the control group. The re-supply rates were similar, but low, a fact attributed in part to the common practice in Kenya of switching to community-based services after one clinic visit.

Our outcomes of interest at one month included problems attributable to pill-taking, menstrual disturbances, counselling messages recalled, reported compliance, knowledge of side effects, and satisfaction (Table 1). Among those clients who returned for re-supply, those receiving advance provision of pills did no worse than, and often had superior outcomes to, their counterparts who started taking pills immediately after the clinic visit. The only significant differences between the two groups of clients occurred when advance provision clients demonstrated significantly better knowledge of certain side effects.

DISCUSSION

In developing countries, where the risks of incorrect pill use are dwarfed by the risks inherent in unwanted pregnancy, advance provision of pills makes good sense. Appropriate candidates for advance provision include amenorrheic and intermenstrual women for whom pregnancy cannot be ruled out, or who prefer to wait until their next menses to begin taking pills The potential impact of advance provision of pills is great. In Kenya, half or more of new family planning clients are not menstruating, and a third or more of these women are sent home without any method(4). While careful history-taking might rule out pregnancy for most of these women, some undoubtedly must wait for pills and would benefit from advance provision.

Although the small sample size in this study might suggest the need for further research, we feel our study adds to evidence worldwide showing that advance provision of pills is feasible and safe. Explicit mention should be made of advance provision of pills in national family planning guidance documents and training curricula throughout sub-Saharan Africa.

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