

Study Title:

Investigating the major reasons for Implant discontinuation and impact on future use of family planning among women in Mashonaland East and Matabeleland North Provinces, in Zimbabwe.



August 2017



Acronyms

CLIC	Client Level Information Centre
CPR	Contraceptive Prevalence Rate
GOZ	Government of Zimbabwe
IFPS	Improved Family Planning Services
LARC	Long Acting Reversible Contraceptive
MoHCC	Ministry Of Health and Child Care
OR	Outreach
PSZ	Population Services Zimbabwe
PSZ-SC	Population Services Zimbabwe Static Clinic
SF	Social Franchise
ZDHS	Zimbabwe Demographic Health Survey
ZNFPC	Zimbabwe National Family Planning Council

Table of Contents

Acronyms	ii
Table of Contents	iii
List of Figures	v
List of Tables	v
1. INTRODUCTION	1
1.1. Background to the Study.....	1
1.2. Zimbabwe Family Planning Context	2
1.3. Rationale of the Study.....	2
1.4. Purpose of the Study	4
1.5. Main Objectives	4
1.6. Specific Objectives	4
1.7. Study Questions	5
2. LITERATURE REVIEW	5
3. METHODOLOGY	10
3.1. Study Design.....	10
3.1.1. Desk Review	10
3.1.2. Quantitative Methods.....	10
3.1.3. Qualitative Methods.....	11
3.2. Methods of Data Collection, Sampling and Recruitment	12
3.2.1. Study Population, Sites and Sampling	12
3.2.2. Recruitment of Participants.....	13
3.2.3. Training and Collection of Data.....	13
3.2.4. Data Analysis	13
3.2.5. Stages in the Study	14
3.2.6. Ethical Considerations	15
4. RESEARCH FINDINGS	17
4.1. Key Findings.....	17
Key Finding 1: Study Recruitment.....	17
Key Finding 2: Socio- demographic Characteristics.....	18
Key Finding 3: Family Planning Service Needs and Use	21
Key Finding 4: Household Decision Making.....	23

Key Finding 5: Counselling	25
Key Finding 6: Implant Discontinuation.....	27
5. RECOMMENDATIONS	38
6. CONCLUSION.....	41
REFERENCES	42
RESEARCH TEAM	43

List of Figures

Figure 1: Study Stages	15
Figure 2: Age of Husband/Partner	20
Figure 3: Source of Implant Information for the First Time	21
Figure 4: Mode of Transport and Time Spent to Access Implant Services	22
Figure 5: Source of Implant Insertion by Province	22
Figure 6: Husband's Level of Education vs Knowledge of Family Planning.....	24
Figure 7: SE Remembered by Clients during Counselling	25
Figure 8: Remedial Action Advised to Clients	26
Figure 9: Reasons for Removals of Implants – Community Perceptions	28
Figure 10: Reasons for Implant Removals by Clients	29
Figure 11: Side Effects by Age Group.....	29
Figure 12: Duration of Implant Use.....	33
Figure 13: Cross Tabulation of Side Effects and Duration of Use.....	35
Figure 14: Duration of Wait before Implant Removal.....	36
Figure 15: FP Uptake after Implant Removal	36

List of Tables

Table 1: Districts Visited by Province	12
Table 2: Distribution of Respondents by Province and District	17
Table 3: Type of Facility and Supporting Organisation.....	18
Table 4: Socio-demographic characteristics of clients, by province.....	18
Table 5: Husbands/spouse and FP support	24
Table 6: Reason for removal by age groups	30
Table 7: Type of Side Effects Experienced	32
Table 9: Reason for Removal and Duration of Implant Use.....	34

1. INTRODUCTION

1.1. Background to the Study

At the global level, evidence confirms that improving women's reproductive health and rights also contributes immensely to improving their socio-economic well-being. Where women's socio-economic status improves, the incidence of unplanned pregnancies and abortions also declines. There is no gainsaying that modern contraception has a huge contribution to the health and well-being of women and families, especially given that it also reduces maternal and infant mortality and morbidity (Guttmacher Institute 2014; Cleland et al 2012; Stover & Ross 2010). More so, it was proven that where women have access to contraception, their labour productivity also increases given that apart from increasing women's opportunities to participate in the workforce, health outcomes specifically for women also increase. The savings in disposable income that are generated in preventing unintended pregnancies affords women an opportunity to invest and ultimately improving their quality of life. (Guttmacher Institute 2014:7). Conversely, unwanted or mistimed pregnancies, high maternal and infant mortality and morbidity, unsafe abortions, limited productivity, poverty, high fertility, and poor socio-economic outcomes are direct product of limited or lack of access to family planning services and inconsistent provision of quality service (Guttmacher Institute, 2014). In Sub-Saharan Africa, there is high need to improve reproductive health, increasing access to long-term reversible contraception, reducing high maternal and infant mortality and morbidity, poverty, unplanned pregnancies among adolescents and young women as well as addressing the high unmet need for family planning. In order to achieve Sustainable Development Goal 3¹ (Good Health and Well-being) improving reproductive health and meeting women's contraceptive needs is crucial. Countries that have managed to achieve the Millennium Development Goals (MDGs) in regards to improving maternal health, reducing child mortality and eradicating poverty (Williamson et al, 2009) focused on meeting the contraceptive and other reproductive health needs of women. Also, in order to achieve SDG 1², it is vital that the reproductive health of women is improved as well as ensuring that women have access to comprehensive sexual and reproductive health care.

¹ The Sustainable Development Goal 3 - ensure health lives and promoting well-being for all at all ages – has the following relevant targets by 2030: reduce the global maternal mortality ratio to less than 70% per 100,000 live births (3.1); end preventable deaths of newborns and under-five children (3.2); ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.

² End poverty in all its forms everywhere.

1.2. Zimbabwe Family Planning Context

In Zimbabwe 67% of married women are using a method of family planning (ZDHS, 2015). Only 1% married women are using traditional methods of family planning whilst 66% are using modern methods of family planning. Whilst the most popular methods of family planning in Zimbabwe are the pill. Sixty-one percent of married women who are using any method of family planning are on the pill, Implants and Injectables are at 14% apiece. Of the married women who are using any method of family planning, six percent (6%) are using the male condom and one percent (1%) are sterilised (ZDHS, 2015). However, it should be acknowledged that the contraceptive prevalence rate (CPR) increases with age. In Zimbabwe, it reaches a highest at the age of 35-39 years, being 73%, though there is a decline to 56% among women aged 45-49 years. Further, the CPR is higher with an increase in household income from 63% in the lowest wealth quintile up to 73% in the highest wealth quintile. Thus, in Sub-Saharan Africa, Zimbabwe has one of the most successful family planning programmes (Ngome and Odimegwu, 2004) given an increase trend in CPR from 1984 to date (Sharan et al, 2010). Also, there has been a notable decrease in the unmet need for family planning which is currently 10% from 19% in 1994 (ZDHS, 2015).

In Zimbabwe, a number of organisations provide a full range of FP services to include the Ministry of Health and Child Care (MoHCC), Zimbabwe Family Planning council (ZNFPC), Population Services International (PSI), Population Services Zimbabwe (PSZ) and a number of council and privately owned health facilities. Review of service national data on FP reveals that PSZ is the biggest provider of Implants in Zimbabwe.

1.3. Rationale of the Study

The ZDHS Report (2015) notes that the use of contraception among married women in Zimbabwe has increased to 67% from the previous 59% reported in the ZDHS report (2010-2011). Also notable is the use of Implants, which has increased from 3% in the previous ZDHS to 10% in the current ZDHS (ZDHS, 2015). Thus, an increase in the use of Implants has contributed to an increase in the CPR. Nevertheless, behind these achievements, are notably high numbers of removals. According to the Population Services Zimbabwe (PSZ) Improving Family Planning Services (IFPS) 2016 Quarter 1 Report (January – March), against a total of 9, 839 insertions that were done in the Outreach and Social Franchise (SF) service delivery channel, and a total of 4, 293 Implants removals were done during the same

period.³ The second quarter report⁴ (April – June), notes that compared to a total of 9, 405 Jadelle insertions that were done, 4, 368 Jadelle removals were also carried out. During the same period, a total of 989 Implanon were inserted and 31 Implanon removals were recorded. Expressing removals as a percentage of the insertions would translate removals in the first quarter to 44% and 46% in the second quarter. Nonetheless, statistically, this would be inaccurate given that at face value, these removals cannot be proportionate to the insertions that were carried out during the same periods. Even so, the PSZ Client Level Information Centre (CLIC) data base provides a more accurate picture of the major reasons for Implant removals specifically focusing on the Outreach (OR) service delivery channel and the PSZ Static clinic (PSZ-SC). The CLIC database shows that out of the 707 Implant removals that were carried out in both the OR and the PSZ-SC, between July 2016 to August 2016 and January 2016 to August 2016 respectively, 59% of the reasons were either method related (side effects) or method failure related. Taken separately, method related reasons (side effects) and method failure reasons contributed 56% and 3% apiece. Thus, method related reasons (side effects) and method failure related reasons had the largest contribution. Against this backdrop, it is also interesting to note that the other reasons for removals, which are desire to become pregnant (17%); family planning method switch (21%); partner disapproval (1%) and replacing-method expiry (2%), combined, contributed 41% to the total number of Implant removals, which is 19% lower than the method related reasons (side effects) and method failure reasons combined. Furthermore, initial analysis of CLIC indicates that only 37% of removal clients, excluding those who discontinued due to wanting to become pregnant, took up another method of FP on the same visit as their removal. Thus, there is strong evidence justifying the need for carrying out the study.

Further, a Joint Quality Assessment Report (May, 2016) for Mashonaland East Province carried out by the Zimbabwe National Family Planning Council (ZNFPC), PSZ, Population Services International (PSI)⁵ and the Ministry of Health and Child Care (MoHCC), notes that at the health facility, in some measure, the reasons for Implant removals include, lack of capacity to manage post insertion side effects among service providers, especially prolonged vaginal bleeding and limited number of service providers trained in post insertion side effects management. At the client level, similarly with the CLIC data presented above, the report notes that the known reasons are desire for pregnancy; expiry of the method; partner

³ PSZ IFPS 2016 Quarter 1 Report

⁴ PSZ IFPS 2016 Quarter 2 Report

⁵ It should be noted that PSI did not send a representative for the joint assessment

disapproval. A specific method related reason in this context is that Implants have higher rates of failure when taken in conjunction with certain ART or TB regimens. There have been some reports by front line providers where women have fallen pregnant whilst using an Implant and being on ART.

Thus, against this backdrop, the study will produce evidence on the availability of Implant post insertion care to manage side effects or lack of it thereof, at the health facility level. The study will also disaggregate reasons for Implant removal according to the various possible causes at client level which are side effects; desire for pregnancy; expiry of the device as well as partner disapproval. In addition, it will also be the rationale of this study to determine how the use and discontinuation of the Implant affects future use of contraceptives.

1.4. Purpose of the Study

The study seeks to establish the major reasons for Implant discontinuation, future use of contraception and make context specific recommendations that will improve the quality of family planning service delivery in direct relation to the established reasons for discontinuation.

1.5. Main Objectives

- To determine the major reasons for Implant discontinuation.
- To understand future use of contraception among women who discontinued using Implant.
- To recommend post Implant insertion care strategies that increase client's satisfaction with the method.

1.6. Specific Objectives

- To determine the major reasons for Implant discontinuation amongst clients;
- To ascertain the timing of Implant removals among clients;
- To assess clients' knowledge of the possible side effects of Implants ;
- To find out clients' perceptions on the choice and use of Implants as a family planning method;
- To establish the capacity of family planning service providers at the health centres to offer post – Implant insertion care;
- To identify context specific strategies that can be adopted to improve the quality of family planning.

1.7. Study Questions

- Why do clients discontinue using Implant? What are the negative and positive aspects involved in deciding to discontinue? What role does the social network play in decision making?
- How long do clients use the Implant before they decide to discontinue? At what point in time do they reach a decision to discontinue?
- After discontinuation with Implant use, what are women's future decisions about contraceptive use? Do they switch to another method?
- Are there available post-Implant insertion care systems in place? Are clients able to access services if they decide to discontinue using Implant? Do service providers have capacity to provide post-Implant insertion care?
- What context specific strategies can be adapted to the quality of family planning?

2. LITERATURE REVIEW

Review on literature is divided into two main segments, with the first segment focusing on the major factors influencing the uptake of long acting reversible contraceptives (LARC) and the second reflecting on research evidence on satisfaction and continuation of LARC methods.

Factors influencing uptake or non-uptake of long acting reversible contraceptives

If used properly, LARC methods have proven efficacy given that they do not require daily user compliance. Thus, continued use of LARC methods has the potential of reducing the rates of unplanned and unwanted pregnancies (NICE, 2005). Although LARC methods are suitable for women of all age groups, including young people who are at high risk of teenage pregnancy and teenage unsafe abortion (Stevens-Simon et al., 2001, Lewis et al 2010), or as an alternative to tubal ligation for women who do not desire to have any children (Kane et al, 2009, Haimovich, 2009). Nevertheless, in spite of these advantages for women, LARC methods remain less popular than what is desired and a significant proportion of research has been investigating why LARC methods have remained unpopular, resulting in low uptake despite sufficient documentation articulating their benefits.

Other research has also shown that access to these methods of contraception remains narrow despite the noted benefits and efficacy (NICE, 2005; Wellings et al, 2007). The high cost of Implants is a momentous barrier to individual women in most parts of the world (Wellings et al, 2007), but this is not the case in the underserved rural population in Zimbabwe where contraceptives are provided free of charge through the donor funded outreach programme or are charged at minimal costs in government of Zimbabwe (GoZ) owned and council owned health facilities. Research has also shown inconsistencies in the access to contraceptives across different services (Wellings et al, 2007). Owing to lack of self-confidence among service providers in inserting Implants, there is always less probability that providing Implants would be suggested in general practice consultations as opposed to being recommended in specialist sexual and reproductive health services (Wellings, 2007). Thus, health service providers are highly likely to provide the pill as contraception rather than Implants (Wellings et al, 2001); Williams, et al, 2009). Regardless of efforts made to promote the use of LARC methods, decision making for contraception is often skewed towards using the pill as the ‘normal’ method to avoid pregnancy (Williamson et al, 2009:168). Among the young women who participated in the Williamson et al study (Williamson et al, 2009:168), none of the young women expressed the desire or anticipation of using any LARC method.

Owing to an information gap, about what can be regarded as ‘alternative methods of contraception’ may also influence the possibility of LARCs being overlooked or rejected (Rose et al, 2011). Further, informal discourses where women engage and get information from friends, family and peers on family planning and sexual and reproductive health also influences women’s choice of contraception (Williamson et al, 2009; Kuiper et al, 1997). Also, there is a connection between contraception and self-identity. There is a perceived relationship between contraception and sexual behaviour where women are less likely to decide on using methods that they are not familiar with due to concerns about future fertility and the possibility of experiencing side effects such as uterine bleeding or break bleeding (Kuiper et al, 1997). Other studies revealed that women are discouraged to adopt long acting methods given that the phrase ‘long acting’ had implications for future fertility (Glasier et al, 2008). Personal values and beliefs also influence decision towards choice of contraception (Cheung and Free, 2005).

Making investigations on the inconsistent use of hormonal contraception, Cheung and Free (2005), found out that some women were not disturbed by side-effects as long as this

contributed towards delaying child bearing (Cheung and Free, 2005). On the flip side, other women discontinued use due to side effects, whilst others deliberately ‘manipulated contraception’ in order to produce the desired side-effects such as menstrual control (Cheung and Free, 2005). Thus, this is a reflection on the desire and intention for one to exercise control over their own bodies. “...what they deemed ‘control’ was variable and dependent on personal values. Bodily control could be non-pregnancy, predictable bleeding, lack of monthly bleeding, or ‘natural’ state, when no hormones are added to the body’ (Cheung and Free, 2005). These phenomena were also discovered by Kuiper et al (1997), who found out that ‘for Implant users, the methods allowed them to assert control over their futures, while for many others the Implant threatened control. Thus, both the selection and the rejection of a method were viewed as affirmations of control’ (Kuiper, 1997:170). Thus, there is a relationship between physical functioning of the body and experiences with personal beliefs and values and choice of contraception.

Experiences with LARC determining satisfaction, toleration and reasons for removals

Studies examining the continuation rates of LARC methods are few (Smith and Reuter, 2002). Nevertheless, satisfaction with contraception is determined by a number of factors. Sangi Haghpeyker et al (2000) study on the range of factors that influenced women’s satisfaction and their continued use of LARC revealed they got satisfaction from using Norplant due to its perceived ‘convenience, effectiveness and ability to free them from the everyday worry of pregnancy and pregnancy prevention’. Other women also stated that use of LARC gave them freedom to a ‘fuller and more enjoyable sex life’. (Sangi-Haghpeykar et al, 2000:98). However, Wong et al (2009), distinguishes satisfaction from tolerance. After making comparisons between IUCD and other Implants, Wong et al discovered that whilst the satisfaction rate of IUCD was higher being 74.3% than that of other Implants which was 57.5% It was also revealing that women who were not satisfied with the other Implants were however prepared to continue with the method (Wong et al, 2009).

Thus, in some cases the perceived benefits outweighed the side effects. Women attribute the side effects to ‘their bodies getting used to this new hormone and perceived the benefits offered by the method to be greater than the inconveniences of menstrual irregularities (Sangi-Haghpeykar et al, 2000:105). The majority of women who express satisfaction with Implants have long-term personal career goals and regard the Implant as a tool to achieving these goals (2000:101). Women in this category are willing to tolerate side effects in

exchange for control over their reproductive lives (Sangi-Haghpeykar et al, 2000). Also, Sangi-Haghpeykar et al (2000), note that despite reports on side effects in the first year of use of Implants, compliance with LARC was shaped by the users' attitudes towards hormones and their bodies, as well as the desire to avoid pregnancy. Blumenthal et al (2008) note that the first six months of using LARC methods are characterised by bleeding irregularities.

Nevertheless, not all women are prepared to tolerate the side effects of Implants, with irregular bleeding as the main reported side effect of Implants (Power et al, 2007; NICE, 2005). In the main, this is cited as the major reason for removal (Wong et al, 2009; Jeffreys and Clark, 2012). It is estimated through research that 64% of women decide on having Implants removed due to irregular or unpredictable bleeding (Harel et al, 1996). Rai et al (2004), noted 60%, whilst Lakha and Glasier (2006) approximated removals due to PV bleeding to be 62%. Nonetheless, irregularities in bleeding are not the only reasons discovered. Other factors identified are weight gain (41%) and increased headaches (Harel, 1996:118), as well as mood changes (Lakha and Glasier (2006). However, there is no evidence to on the reasons why these effects are tolerated by other women yet for others there is prompt discontinuation. Investigations have been done to determine women's attitudes towards future contraceptive use upon discontinuation of LARC. What has been reported is that the majority of women who switch from LARC opt for short term methods of contraception (Lakha and Glasier, 2006). This is challenging given the high failure rate associated with short-term contraceptives such as the pill and male condoms.

Concluding the Review

There is compelling evidence revealing that the decision on the choice of contraceptive is complex and requires contextualisation within a framework of varying factors. Practical issues noted include lack of sufficient information on contraceptives as well as distresses around the invasiveness nature of the Implant procedures. Some of the issues are cultural, for instance, well documented resistance towards 'alternative methods of contraception and general fear associated with possible side-effects. There are also social factors based on interpersonal interaction between young women with their peers and family members. Lastly, focus should also be given to the individual woman in view of what she desires for her body, her future aspirations in relation to her expectations from a particular method of contraception. Thus, the dynamics around satisfaction, tolerance and reasons for removals of Implants can only be adequately comprehended taking into consideration the social, cultural

and individual control over the reproductive body as well as the women's varying previous experiences with contraceptives.

This review has noted that the main reasons for deciding on removing Implants are intolerance with side effects particularly perennial vaginal (PV) bleeding. In view of the context where the study will take place, Mashonaland East and Matabeleland north, perennial bleeding is not tolerable due to a number of reasons depending on the differentials in the statuses of women. First, married women may face the challenge of men with deeply entrenched traditional and religious beliefs regard PV bleeding not only as a deprivation of their conjugal rights, but also as a bad omen or a curse on the woman due to infidelity. Since these issues may fuel domestic violence, women would also feel safe and preserve their matrimonial home by discontinuing using Implant as a method of family planning⁶. Secondly, Mashonaland East is a hub of commercial sex work and the majority of commercial sex workers would consider PV bleeding as having a negative effect on business. These women would rather discontinue Implant use if it comes with these side effects. Nevertheless, this presents an opportunity to learn more and understand better the balance between tolerating side effects whilst continuing with the Implant and deciding to have the Implant removed. In addition there is also room to understand how side effects may also affect the future in view of contraceptive choices for women. Against this backdrop, this proposed study has been developed to offer an understanding on what influences the women choices for contraceptives. It will thus focus on individual, social and cultural factors as well as health facility related issues, as an endeavour towards locating patterns within the complex processes involved in the individual choices for contraceptives. More so, apart from analysing the discontinuation of LARCs, the study also investigate the effect of discontinuation on future choices for contraceptive.

⁶ CESHR Reports on Sex Workers

3. METHODOLOGY

3.1. Study Design

A mixed methods study design that combines literature review and analysis of existing service data, qualitative and quantitative methods was adopted for this study, whilst it focuses on a sub-set of family planning clients who took Implant as a family planning method to understand phenomena around Implant removals in the selected sites, in view of any of the reasons informing the rationale of the study. In light of the objectives and the questions of the study, desk review, qualitative and quantitative research methodologies are espoused in the study. This ensures triangulation of findings in order to produce a wealth of data.

3.1.1. Desk Review

Secondary data that include aggregated (without personal identifiers) family planning client registers and other relevant documents from the Ministry of Health and Child Care, Population Services International, Populations Services Zimbabwe and the Zimbabwe National Family Planning Council were reviewed as part of the desk review process of secondary data in order to complement data collected from the questionnaires, key informant interviews and in-depth interviews. Document review also included separate monitoring and evaluation reports and operational research and related assessment carried out by the above mentioned organisations. Further, mystery clients⁷ report that are routinely conducted by PSZ as well the Client Exit Interviews were also referred to in order to gather relevant data on the thoroughness of counselling conducted for Implant clients. Specific recommendations in these documents were linked to the findings of the study in order to understand where they were implemented and the challenges of implementations thereof.

3.1.2. Quantitative Methods

3.1.2.1. Survey

A survey was used as a systematic attempt to collect data from individual respondents in order to describe and explain phenomena around Implant removals in a quantitative manner. A questionnaire designed for the study captured data on health facility proprietorship; respondent's demographics such as age, age of their partners; religion; number of children; level of education and occupation and their partners' occupation among other relevant data.

⁷ A mystery client (MC) is when a trained person (usually a community member), poses as a client, visits a health facility, without the service provider knowing that they are carrying out research, and then report (by completing a survey or through an interview) on their experience.

Other data collected included timing and reasons for Implant discontinuation; respondents and their partners knowledge about family planning; experience with counselling at the time of insertion; respondent's knowledge about side effects and previous attempt done by respondents to manage side effects if and when they were experienced. Information on household decision making; social support; domestic violence; HIV status; ARV and TB drug use was also collected. The latter questions were asked in regards to whether clients had their ARV use adequately assessed at the time of insertion of the Implant. This was particularly important for clients who experienced a method failure and got pregnant.

3.1.3. Qualitative Methods

In-depth interviews and key-informant⁸ interviews were used in the study in order to explore the issues and gain in depth and rich data on phenomena around Implant discontinuation among women in Mashonaland East and Matabeleland north provinces. The qualitative aspect of the research seeks to understand and interpret the information about the “human side” of an issue, meaning “behaviours, beliefs, opinions, emotions and relationships” (Khan and Shaikh, 2013).

3.1.3.1. In-depth Interviews

Interviews were conducted with service providers and health workers as key informants using an interview guide. The focus of the in-depth interviews was to understand the reasons why women reached a decision to discontinue particularly taking into cognisance both the negative and the positive aspects thereof. Data was collected on how the identified factors influence decisions about discontinuation, also in view of the probable risks and benefits associated with reasons for discontinuation. In spite of the identified reasons for discontinuation due to unpleasant experiences with Implant or any other reasons mentioned by the respondents, the in-depth interview attempted also to find out why regardless of the unpleasant experiences, some women still decide on continuing with using Implant as a family planning method. The in-depth interview also attempted to find out the existence of barriers that may prevent women intending to discontinue using Implant to access the services. Further the focus of the in-depth interviews was to determine the influence of social networks such as the husband; mother-in-law; friends; service providers; community based health workers; parents and religious leaders have on making decision on family planning in

⁸ The interview guide will be conducted with various key stakeholders to include MoHCC staff, PSZ, PSI, ZNFPC was designed with the intention of gathering information from key individuals involved in the design and implementation of the study.

general and Implant use and discontinuation in particular. Whilst the above mentioned data was collected from both key informants and respondents, in addition, key informants were asked specifically on their capacity to manage side effects and the challenges that they face in managing Implant side effects and post-insertion service provision in general. Finally, the in-depth interview also endeavoured to elucidate as a cognitive sense, the feeling associated with discontinuation, the possible effects and future use of any other type of contraception.

3.2. Methods of Data Collection, Sampling and Recruitment

3.2.1. Study Population, Sites and Sampling

3.2.1.1. Quantitative survey

The study utilised probability sampling procedures for the quantitative survey. A probability sample is likely to be representative of the larger population from which it is drawn (Fisher, A et al 1983). Multi-staged sampling was adopted, to ensure that the larger population is represented. The study population was first divided into two (2) clusters: Mashonaland East and Matabeleland North Province. Each cluster was further divided into different clusters as shown in Table 1.

Table 1: Districts Visited by Province

Name of province	Districts visited
Mashonaland East province	Chikomba; Goromonzi; Hwedza; Marondera; Mudzi; Murewa; Mutoko and Uzumba-Maramba Pfungwe.
Matabeleland North Province	Umuguza, Hwange, Nkayi, Tsholotsho, Bubi, Lupane

Respondents were drawn from the sites in the districts with highest rates of Implants insertion and removals according to the HMIS statistics of 2016. All married women of reproductive age 18-49 years who ever received and had removed an Implant from the sites were eligible to be recruited to participate in the study. Women who declined to take part in the study were excluded from the study. The overall sample size was 328 across both types of sites.

3.2.1.2. Qualitative sampling

The sampling for the in depth interviews was purposive. For the key informant interviews one service provider at one of the health centres in the district was selected for interview. For in depth interviews with clients, again a purposive sampling approach was taken, from clients

who were not selected for a quantitative survey, one client from each health centre was selected for the in depth interviews.

3.2.2. Recruitment of Participants

Recruitment of clients was done at the health facilities that offer Implants insertion and removal. Family planning registers were used to identify clients who had their Implants removed in the period under review. Systematic random sampling was then used to pick clients who would participate in the study.

3.2.3. Training and Collection of Data

Six experienced data collectors drawn from the MoHCC, ZNFPC and PSZ were engaged and trained to collect the data for this study. The training focused on how to engage clients and establish rapport; adherence to research ethical principles, particularly voluntary participation, informed consent and privacy during the interviews, data collection procedures particular focus on questioning techniques as well as ensuring that the data collectors have an appreciation of the rationale of the study and what it aims to achieve. The data collectors were also trained on how to discuss sensitive issues that may come up during interviews – such as domestic violence. The training included referral practices, in the case of distress (to a health provider or the PSZ toll free call centre) and also in the case of reported domestic violence (to Musasa Project).

3.2.4. Data Analysis

3.2.4.1. Quantitative Data

Quantitative data was analysed using SPSS and Microsoft excel to run descriptive statistics in order to determine the measures of central tendency as well as cross-tabs. Based on the survey questionnaire, the following variables were analysed in view of the purpose, the objectives and the study questions health facility proprietorship; respondent's demographics such as age, age of their partners; religion; number of children; level of education and occupation and their partners' occupation among other relevant data. Other data that was summarised using descriptive statistics, include timing and reasons for Implant discontinuation; respondents and their partners knowledge about family planning; experience with counselling at the time of insertion; respondent's knowledge about side effects and previous attempt done by respondents to manage side effects if and when they were

experienced. Household decision making; social support; domestic violence; HIV status; ARV and TB drug use was also analysed.

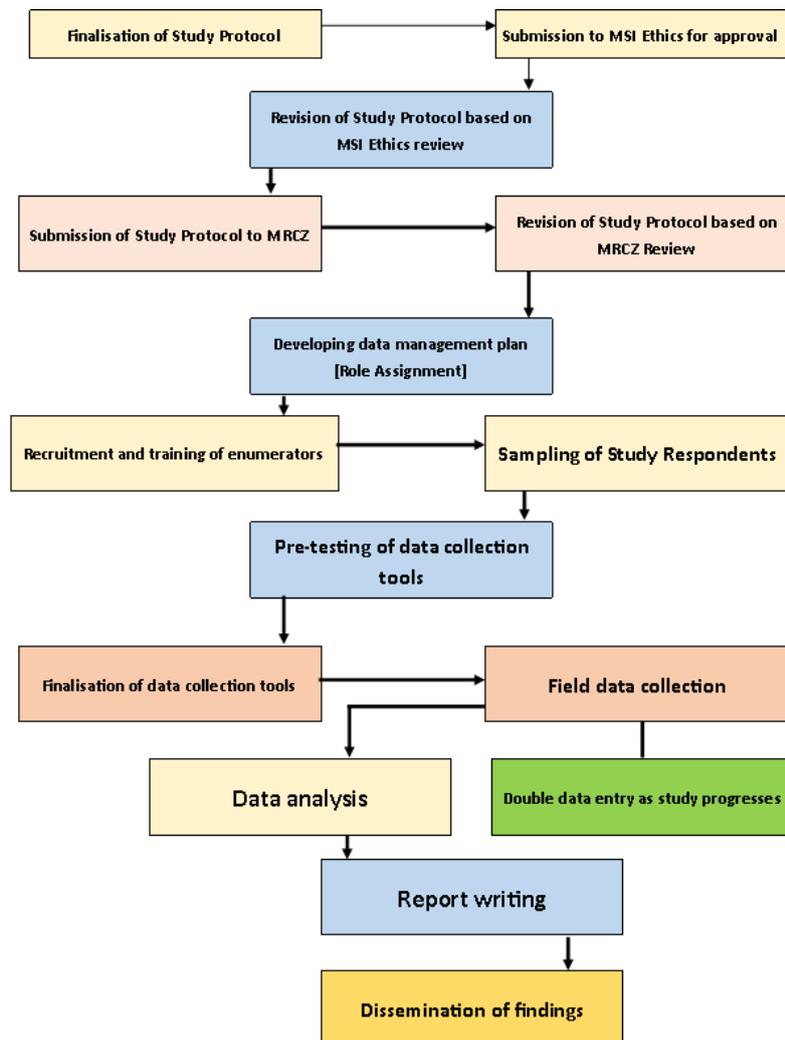
3.2.4.2. Qualitative Data

Thematic data analysis was adopted. In-depth interviews with key informants and client's material including digital audio recordings and field notes were fully transcribed and translated from vernacular to English language. A team of selected study researchers repeatedly read the transcripts in order to have sufficient comprehension of experiences, perspectives and the views of study participants. This primary analysis was critical for the adequate appreciation of issues and meanings that was condensed into categories as part of the coding process (Hoggart et al, 2013). Codes and emerging issues were discussed and clustered into sub-categories and major categories. Categories were then abstracted into sub-themes and ultimately into major themes.

3.2.5. Stages in the Study

Figure 1 shows the stages followed during the planning and implementation of the study.

Figure 1: Study Stages



3.2.6. Ethical Considerations

3.2.6.1. Ethical Approval

Field clearance were sought from the relevant authorities such as the Ministry of Health and Child Care; local government authorities; traditional leaders and the police prior to entering study sites and engaging with the study participants. The study tools were pre-tested at selected sites in order to determine the appropriateness of the questions' validity and the tools reliability.

3.2.6.2. Informed Consent

Data collectors would give verbal introduction to the potential respondent whom they took through the written consent form and obtained their consent and signature. Confidentiality was maintained at all times to ensure that the rights and welfare of each respondent would be

protected. Respondents were taken through the purpose of the study, as well as the risks and the benefits associated with their participation. Further, respondents were reminded that they have the right to refuse responding to questions or to opt out of the interview session and that this would not affect their right to access services in future, from any of the service providers.

3.2.6.3. Confidentiality Protection

Several measures were put in place to protect confidentiality and anonymity of respondents. This includes conducting interviews in total privacy and not collecting respondent individual identifiers on the questionnaire or interview guide. Where respondent's contact information and names were collected, they were stored separately from questionnaires and interview guides in order to avoid linking their unique ID to their individual personal information.

3.2.6.4. Conflict of Interest

There was no conflict of interest, as the research was conducted with the intention to find out the reason for the widely reported high number of Implants removals that are occurring in Zimbabwe. PSZ, UNFPA and ZNFPC all have a shared interest to better understand this issue in order to improve service provision to women receiving Implant insertions and removals.

4. RESEARCH FINDINGS

4.1. Key Findings

Key Finding 1: Study Recruitment

The Implant removals study was carried out in two provinces namely Matabeleland North and Mashonaland East. The two provinces were selected based on service statistics which indicated high incidences of Implant removals for the year 2016. A total of 328 participants from six districts in Matabeleland North and eight districts in Mashonaland East provinces were interviewed for the study. Table 2 shows participants distribution per province and district.

Table 2: Distribution of Respondents by Province and District

Province	District	Number Of Participants
Mashonaland East	Murewa	12
	UMP	6
	Mutoko	42
	Mudzi	49
	Wedza	17
	Marondera	5
	Goromonzi	15
	Provincial Total	178
Matabeleland North	Umguza	15
	Hwange	47
	Nkayi	9
	Tsholotsho	35
	Bubi	7
	Lupane	37
	Provincial Total	150
	Grant Total	328

The majority of facilities that participated in the study were MoHCC and PSZ supported sites. PSZ supported sites included sites where services are provided outside health facilities using medical tents. Thirty percent of the participating facilities were government health clinics and 29 percent were council clinics. Table 2 gives an outline of the health facilities.

Table 3: Type of Facility and Supporting Organisation

Type of Facility	Supporting Organisation					Total
	PSZ	PSI	Council	MoHCC	ZNFPC	
Government hospital	17	0	0	45	0	62
Government clinic	6	0	0	94	0	100
ZNFPC clinic	0	0	0	0	1	1
Council clinic	69	0	25	1	0	95
Mission clinic	0	0	0	1	0	1
Mission hospital	1	0	0	20	0	21
Private facility	43	1	0	4	0	48
Total	136	1	25	166	1	328

Key Finding 2: Socio- demographic Characteristics

Overall, 328 participants were interviewed from the two selected provinces. 178 clients were from Mashonaland East and 150 from Matabeleland North (Table 4).

Table 4: Socio-demographic characteristics of clients, by province.

Socio-demographic characteristics	Mashonaland East	Matabeleland North	TOTAL
	N = 178	N = 150	
Sex			
% Male	0	0	0
% Female	178	150	328
Age (years)			
20-24	7.3	11.3	9.1
25-29	18.5	16	17.4
30-34	29.2	28.7	29
35-39	23	28.7	25.6
40-44	13.5	8	11
45 +	8.5	7.3	7.9
Relationship Status			
% Single/never married	1.7	6	3.7
% Married	83.1	74	79
% Widowed	5.6	4	4.8
% Separated/divorced	9.6	16	12.5
Education level			
% None / non-formal	2.2	0	1.2
% Primary	19.1	28.7	23.5
% Secondary	62.9	62.7	62.8
% Tertiary or higher	15.7	8.7	12.5

Religion			
% Roman catholic	6.2	17.3	11.3
% Protestant	14	19.3	16.5
% Pentecostal	33.1	30	31.7
% Apostolic sect	35.4	30.7	33.2
% Traditional	5.6	0.7	3.4
% None	4.5	0.7	2.7
% Other	1.1	1.3	1.2

- **Sex and age of the respondents**

All study participants were women aged between 20 to 49 years. Implants removals were mostly conducted to women between the ages 25-39 years. A peak is seen at the age of 30-34 years at 29%. Only 9% of these women were youth between the ages of 20-24 years. Analysed by province, Matabeleland North had a slightly higher number of youth (11.3%) compared to Mashonaland East (7.3%). Women aged 45 years and above had the least number at 8%.

- **Marital status of study participants**

Family planning services are utilised mostly by married women and this is reflected in Table 3. Seventy-nine percent (79%) of women who came to have their Implants removed indicated that they were married and living with their husbands/ spouses or partners. Overall, only 4% of women reported that they were never married. Analysed by province, Matabeleland North had a slightly higher percentage of women who were never married at 6% compared to Mashonaland East at 2%

- **Religion**

Religion is known to have an impact on the decision of women to use family planning services. Some apostolic churches are well known for barring their members from using family planning while some denominations generally discourage use of family planning by women. Apostolic (33%) and Pentecostal (32%) were the most popular religions as indicated in Table 3. A proportion of 11% belong to the Roman Catholic. However, more women in Matabeleland North (17%) as compared to six percent from Mashonaland East belong to the Roman Catholic.

- **Educational status**

The majority of women (63%) who were interviewed attained at least secondary education. Overall, 13 percent of the study participants attained tertiary education status.

- **Number of living children**

Almost all the study participants (99.7 percent) had living children. Fifty-eight percent (58%) of the women interviewed outlined that they were planning to have children in the near future, 38 percent indicated that they no longer wanted to have children while 4 percent were not sure if they will have children in the future.

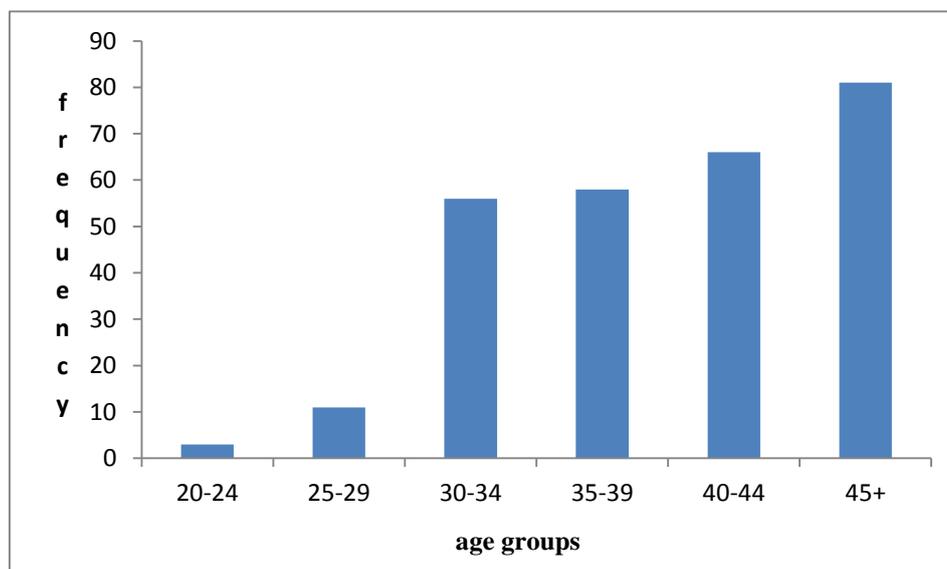
- **Age at First Marriage**

Majority of the women who were interviewed and remembered their age at first marriage were married in their youthful and adolescent age between 15-24 years. Only 15 percent were married after reaching the age of 25 years. Out of the total clients interviewed, 68% reported that they got married before reaching the age of 18 years which is now the legal age of marriage.

- **Age of the husband/partner**

Age of the husband can affect the fertility intentions of the spouse and therefore use of family planning. Out of the 328 women who were interviewed, 84% were able to remember the ages of their husbands/spouses and the majority of them indicated that their husbands/spouses were above the age of 45 years (Figure 2).

Figure 2: Age of Husband/Partner



- **Occupation**

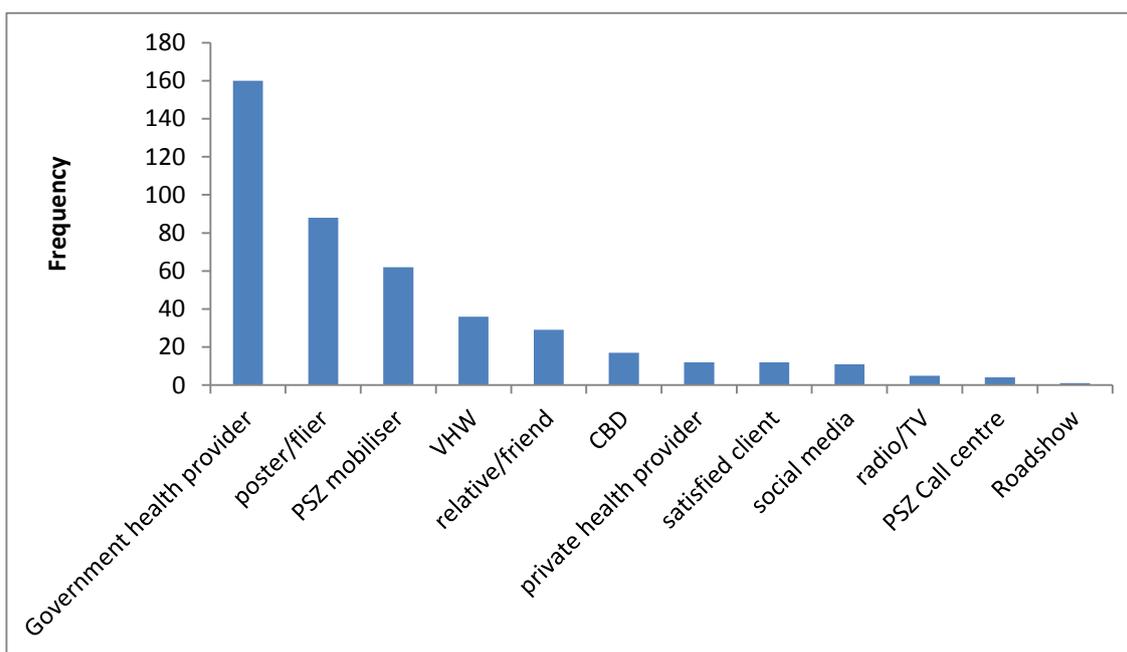
Thirty-eight (38) percent of the women who participated in the study indicated that they were unemployed and 51% of the women indicated that their husband/spouses were in paid formal employment.

Key Finding 3: Family Planning Service Needs and Use

- **Source of Implant information**

Half of the total clients interviewed (50%) indicated that they first heard about Implants from a government health providers. Government health providers were cited as the highest sources of information in the two provinces. The second most common source of Implant information on Implants are poster (27%) and PSZ mobilisers (19%). Figure 3 shows the sources of Implant information in absolute numbers.

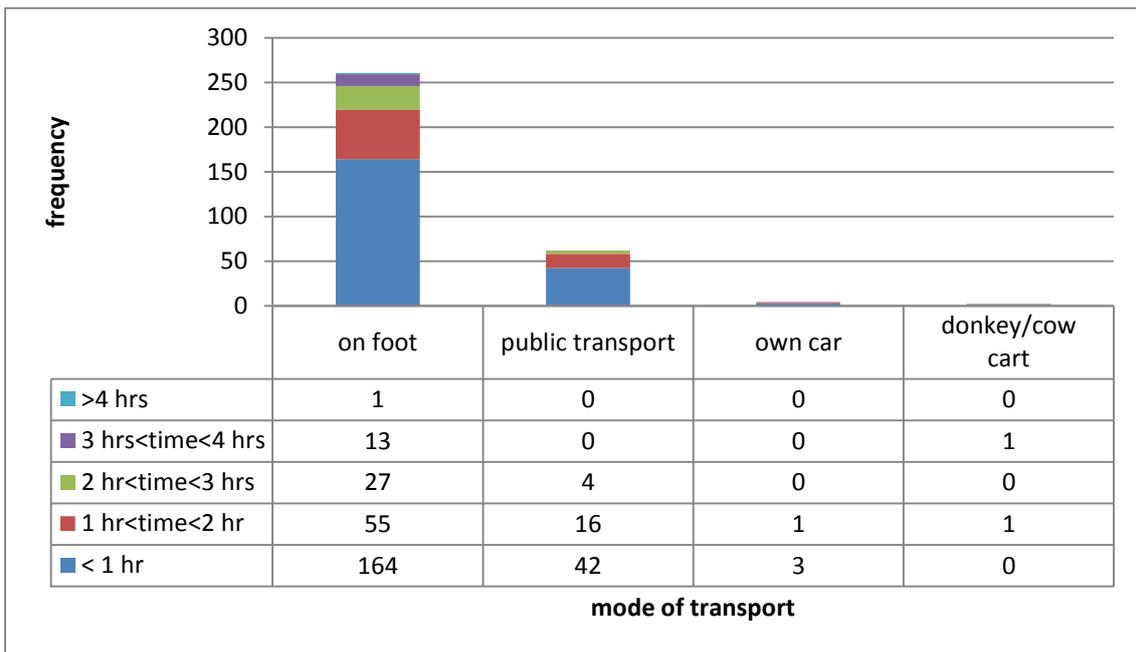
Figure 3: Source of Implant Information for the First Time



- **Mode of transport used**

Majority (79%) of the clients who came to receive the Implants insertion came on foot, 19% used public transport and a negligible number used own cars or the donkey cart. Most clients travelled from their homes to the service centres for less than an hour. However it is also noted that a significant number walked from two hours up to four hours in order to get the service as indicated in Figure 4.

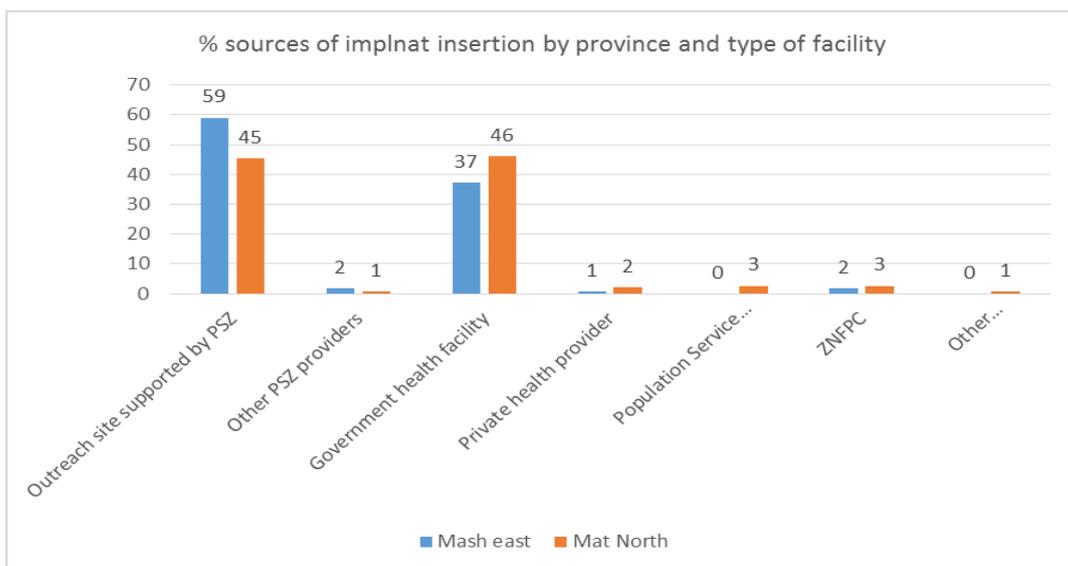
Figure 4: Mode of Transport and Time Spent to Access Implant Services



▪ **Source of Implant removed**

The major facilities/sites which experienced the most Implants removals were PSZ outreach (59 percent) and the government health facilities at 41%. In Mashonaland East the majority of Implants that were removed were inserted at PSZ outreach supported sites (59 percent) and government health facility at 37%. In Matabeleland North, the majority of the Implants that were removed were inserted at a government health facility at 46%. Figure 5 outlines the source of the Implant by province and by type of facility.

Figure 5: Source of Implant Insertion by Province



- **Previous experiences with Implants**

Besides the current Implant that was removed, 20 percent of the women interviewed reported that they had previously used another Implant with the 19 percent having used Jadelle and one percent (1%) having used Implanon.

Key Finding 4: Household Decision Making

Male involvement in family planning has always been a topical issue. The study sought to unpack and understand the dynamics of male involvement in relation to Implants use. Overall, the majority (89%) of the study participants indicated that their husbands/ partners support the use of family planning. Only seven percent (7%) indicated that their husbands/ partners do not support the use of family planning and the remainder of the clients were not sure on their husbands'/ partners' position. A greater majority of the clients (90%) indicated that their husbands/ partners were aware of the fact that they were using Implants. Analysed by province, there were more husbands/spouses in Matabeleland North (11%) who did not support FP compared to four percent (4%) in Mashonaland East.

In terms of decision making in relation to the uptake of Implants, most participants (50%) in the study reported making the decision by themselves without involving their husbands/ partners. Only 10 percent indicated that their husbands/partners made the final decision while 38 percent indicated that it was a mutual agreement as a couple.

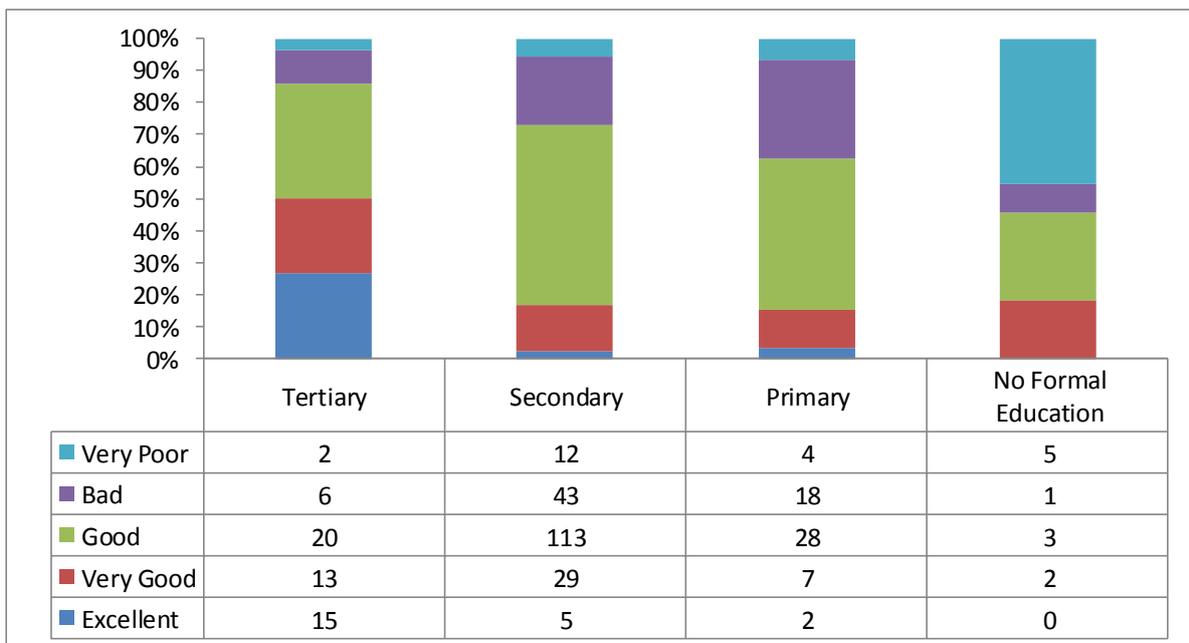
Table 5 shows the various views by women towards their husbands/ partners perceptions on the use of family planning. The majority of the study participants (70%) indicated that they think that their husbands/partners are well informed on FP issues. A significant proportion (22%) rated their partners/husbands as very good/ excellent when it comes to knowledge on LARC services.

Table 5: Husbands/spouse and FP support

Indicator	Percentage
Husband support use of FP	89
Husband/partner aware of the fact that one have been using Implant as an FP method	89
Wife making final decision to choose Implant as a family planning method	49.7
Percentage of women who thinks that husbands are well informed on Implants	70
Percentage of women who rate their partners/husbands as very good/ excellent when it comes to knowledge on LARC services.	22

The proportion of husbands/ partners with bad and very poor knowledge of family planning decreases with increasing level of education. Husbands with no formal education have the highest proportion with bad and very poor level of education. Only two (2) husbands with tertiary education were reported to have very poor knowledge of family planning and there was no husband with no formal education whose knowledge of Implants could be rated as excellent. Figure 6 outlines the husband level of education and knowledge levels of family planning.

Figure 6: Husband’s Level of Education vs Knowledge of Family Planning



Key Finding 5: Counselling

One of the major component in the provision of quality integrated family planning services is the quality of counselling and information given to clients. To establish this, clients were asked a number of questions including a retrospective understanding of what transpired when they visited the health facility for the insertion of the Implant. The questions were meant to understand the quality of counselling and information given to the clients before making a choice of the family planning method they preferred.

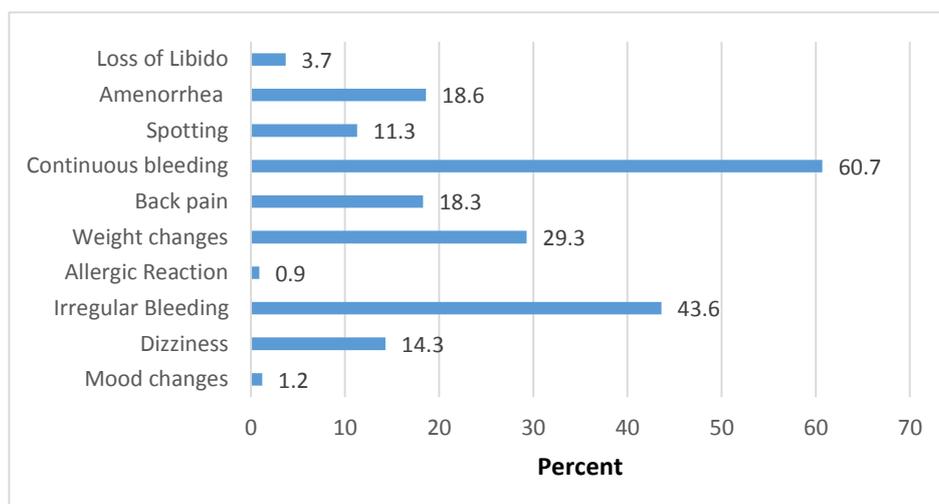
▪ Informed choice and coercion to take up Implants

Ninety-five percent (95%) of the clients indicated being informed on the various FP methods available during counselling before uptake of an Implant. Ninety-nine percent (99%) highlighted that the choice of method to use was not dictated by the health service provider but they had the option to choose the method they would prefer.

▪ Information of side effects

The purpose of comprehensive counselling and information dissemination before providing the actual service to the client is to ensure an informed decision and choice. Eighty-seven (87%) of the clients indicated that they were informed about potential side effects during counselling before uptake of the method. Among the highlighted side effects, continuous bleeding was the most remembered (61%) followed by irregular bleeding at 44 percent. Allergic reaction and mood changes were the least remembered side effects. Figure 7 shows the most reported side effects which the clients remembered being told during counselling on the day of Implant insertion.

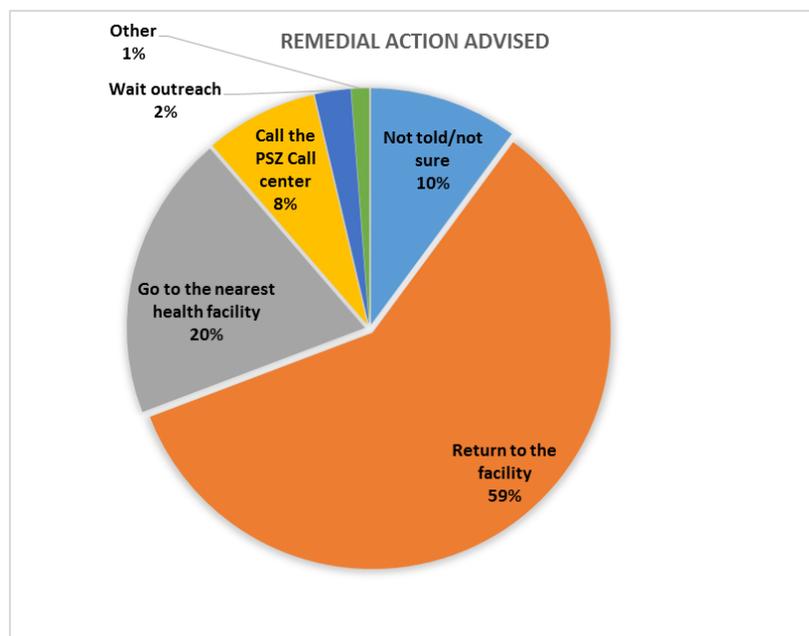
Figure 7: SE Remembered by Clients during Counselling



- **After care information during counselling**

The general health advice given to clients who come for any health services is that in the event of any discomfort or side effect, immediately visit the nearest health facility. Overall, the study showed that women were given clear instructions as to where to go if they experienced any problems related to the method use. Ninety percent (90%) of the clients indicated that they were told on what to do if they experience any side effect and seven percent (7%) indicated that they do not remember being told about what to do in case of side effects while 3% were not sure. However, given these scenarios and the 10% proportion of clients not aware of what to do, there is greater need to improve on the quality of counselling and information dissemination. This will help to improve on the uptake of the family planning services. Fifty-nine percent (59%) of the total respondents indicated that they were told to return to the health facility if they encounter any problems related to the use of the Implants. Twenty percent (20%) indicated that they were told to go to the nearest health facility and 8% remembered being told to call the PSZ call centre. Figure 8 shows the proportion of clients advised on remedial action by the service provider.

Figure 8: Remedial Action Advised to Clients



A greater proportion (86%) of the respondents reported that it was very easy for them to access treatment or management of any side effects from a trained health service provider whenever necessary. Asked further to indicate if it was easy to get in touch with health provider to have side effects managed, 86 percent of the respondents indicated that it was very easy for them. However, seven percent (7%) indicated that they would face a challenge of distance as it was too far, with another three percent (3%) indicating cost of user fees as the major challenge. Results from the key informant interviews conducted showed that the user fees are not standard and do vary by facility type and location. In most public facilities Implant insertion and removal is USD20.00 while ZNFPC facilities charge USD10.00 for insertion and USD15.00 for removal. This is different from PSZ outreach facility where the service is provided for free. Other PSZ facilities charge fees varying from USD5.00 to USD20.00. In this regard, clients prefer accessing family planning services from the PSZ outreaches but they indicated the challenge of the cost of removal of the Implant at another facility whenever the time of removal comes in the absence of PSZ outreach. The challenge with PSZ outreach is the turnaround time, where the respective team will return to the same facility after three months. The study also found out that 99 percent of the respondents indicated that they knew where to go if they want to have the Implant removed.

Key Finding 6: Implant Discontinuation

This section gives results on the Implant removal reason at community level and by clients who participated in the study. There were no significant differences when results were analysed by provinces, hence results presented outline the overall results combining the two provinces.

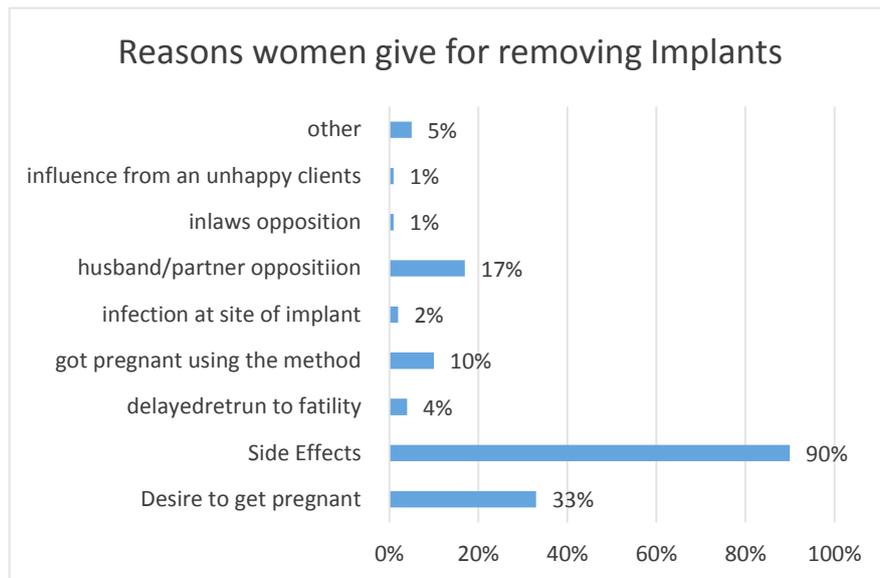
- **Type of Implants**

About 98 percent of the clients who participated in the study were using Jadelle and only two (2) percent were using Implanon. In absolute numbers, Implanon clients were only eight (8). As such, not much information can be obtained from cross tabulation by type of Implant. Thus, the results of this study are highly skewed towards Jadelle users.

- **Community Perception on Implants Removals**

After being asked on the community perception and reasons on why they remove Implants, the indications are that the majority (90 percent) of people in communities who remove Implants do so mainly because of side effects (Figure 9). The desire to get pregnant was the second most cited reason at 33 percent followed by husband opposition at 17 percent.

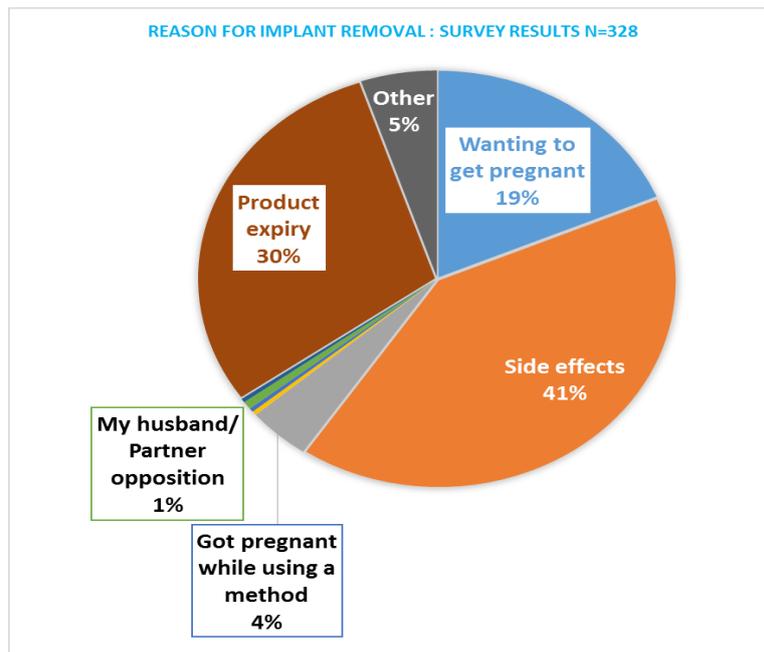
Figure 9: Reasons for Removals of Implants – Community Perceptions



- **Actual Reason for Implants Removal by Study Participants**

A relatively high proportion of the respondents (41%) indicated that the reason for removal of Implants was due to side effects (Figure 10). This is followed by product expiry at 30 percent while those who wanted to get pregnant constituted 19 percent of the total clients interviewed. Thus, a percentage total of 49% clients indicated that their major reasons for removal were due to product expiry and the desire to get pregnant.

Figure 10: Reasons for Implant Removals by Clients



▪ **Removal Reasons by Age Groups**

Twenty eight percent of respondents aged between 30-34 years and 31% of those aged between 35-39 years complained more about Implants related side effects as compared to the other age groups. Survey results indicated that clients aged above 40 years experienced less side effects as shown in Figure 11.

Figure 11: Side Effects by Age Group

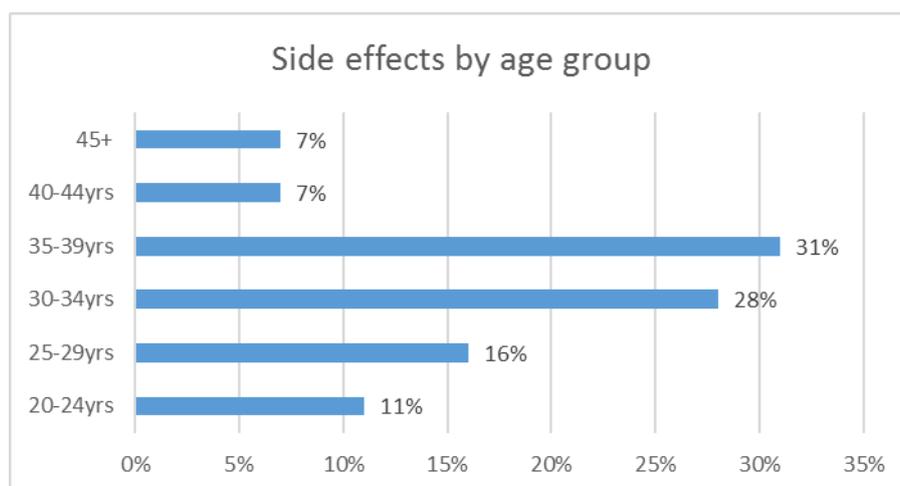


Table 6 highlights that for the clients who cited the desire to get pregnant as a reason for removal, 41 percent of them were aged between 30-34 years. As expected, the number decreases as the age of the clients increases. The greater proportion of clients who reported side effects were aged between 35-39 years.

Table 6: Reason for Removal by Age Groups

		20-24yrs	25-29yrs	30-34yrs	35-39yrs	40-44yrs	45+	Total
Wanting to get pregnant	Count	10	11	25	8	5	2	61
	percentage	16%	18%	41%	13%	8%	3%	100%
Side effects	Count	15	22	37	42	9	9	134
	percentage	11%	11%	28%	31%	7%	7%	100%
Got pregnant while using a method	Count	1	2	3	5	3	0	14
	percentage	7%	14%	21%	36%	21%	0%	100%
Absces/Infection at site of injection	Count	0	0	1	0	0	0	1
	percentage	0%	0%	100%	0%	0%	0%	100%
Drug Allergy	Count	0	0	0	0	0	1	1
	percentage	0%	0%	0%	0%	0%	100%	100%
My husband/ Partner opposition	Count	1	0	0	1	0	0	2
	percentage	50%	0%	0%	50%	0%	0%	100%
Peer influence	Count	0	0	1	0	0	0	1
	percentage	0%	0%	100%	0%	0%	0%	100%
Product expiry	Count	2	20	23	25	17	10	97
	percentage	2%	21%	24%	26%	18%	10%	100%
Other	Count	1	2	5	3	2	4	17
	percentage	6%	12%	29%	18%	12%	24%	100%
Total	Count	30	57	95	84	36	26	328
	percentage	9%	17%	29%	26%	11%	8%	100%

Of note, 14 clients indicated that they decided to remove the Implant because they got pregnant while they were using the method. A cross tabulation indicated that out of the 14 clients, 11 of them indicated that they were HIV positive and currently on ART. Two (2) of the clients were not willing to share their HIV statuses and one was HIV negative.

▪ **Side Effects to Clients**

A total of 134 clients (41%) reported having had experienced side effects challenges which resulted in them making a decision to remove the Implants. Product expiry and desire to get pregnant reasons are not worrisome as side effects clients. As such, more analysis was done on the clients who reported removing the Implant because of side effects. The following issues were extracted from the subgroup of respondents who ever experienced side effects:

- The majority of the clients (50%) who experienced side effects indicated that they got the Implant from a government health facility. Forty-six percent (46%) indicated that they got the method from PSZ , while two percent (2%) indicated ZNFPC and another two percent (2%) indicated PSI as the source of the Implant

- Sixteen percent (16%) of the clients indicated that they had previously used Implants before. Of these, 67 percent indicated that they had removed their previous Implants because of side effects problems. Despite previously having challenges with side effects, they had another Implant inserted, hoping that this time they would not have any challenges with side effects
- Out of the 134 clients who indicated side effects as a reason for removal, 83 percent indicated that they were informed about the potential side effects before the uptake of the method and 93 percent indicated that they were informed on the available range of FP methods. Despite being informed on the side effects, they decided to have the Implant removed mainly because they realized that the side effects were proving difficult to manage.
- Most clients are being informed on what action to take if they experienced side effects. Eighty-eight percent (88%) of the clients who experienced side effects indicated that they were informed on what action to take if they experienced side effects. The majority (66%) remember being told to return to the facility and 24 percent indicated that they were told to visit the nearest health facility to seek help.
- Of the 134 clients, 88 percent indicated that they managed to get some side effects management which later proved to be temporary (only worked for a short period of time), hence the decision to have the Implant removed and citing side effects as the main reason. The study also revealed that 16 percent of the clients did nothing when they experienced side effects. The reason for not doing anything was mainly due to the expectations that the situation was going to improve.
- The majority (60%) of the clients who removed the Implant because of side effects switched to the contraceptive pills. They perceived the uptake of contraceptive pills with less side effects and hence the decision to opt for the pill.
- Seventy-eight percent (78%) of the clients who removed Implants due to side effects indicated that they had opted for the Implant because of the fact that it is long term while 15 percent indicated that it was easy to use.

- **Type of Side Effects**

Respondents who experienced side effects were asked further to outline the type of side effects experienced. Prolonged bleeding was the most common type of side effects experienced (66%). This is followed by irregular bleeding and headaches at 19 percent. Table 7 shows the type of side effects experienced.

Table 7: Type of Side Effects Experienced

Side effects type	Number	Percentage
Headache	25	19%
Mood changes	1	1%
Dizziness	20	15%
Irregular bleeding	25	19%
Allergic reaction	3	2%
Weight changes	21	16%
Back Pain	17	13%
prolonged bleeding	88	66%
Spotting	14	10%
Amenorrhea	3	2%
Loss of Libido	3	2%
Breast tenderness	8	6%
Total clients	134	100

A total of 134 clients indicated that they sought the removal of the Implant because of side effects related problems. Out of the total respondents, 88 clients (66%) indicated that they experienced prolonged bleeding making it the most cited reason for removal while 19% reported that they experienced irregular bleeding and headaches.

- **Side Effects Management**

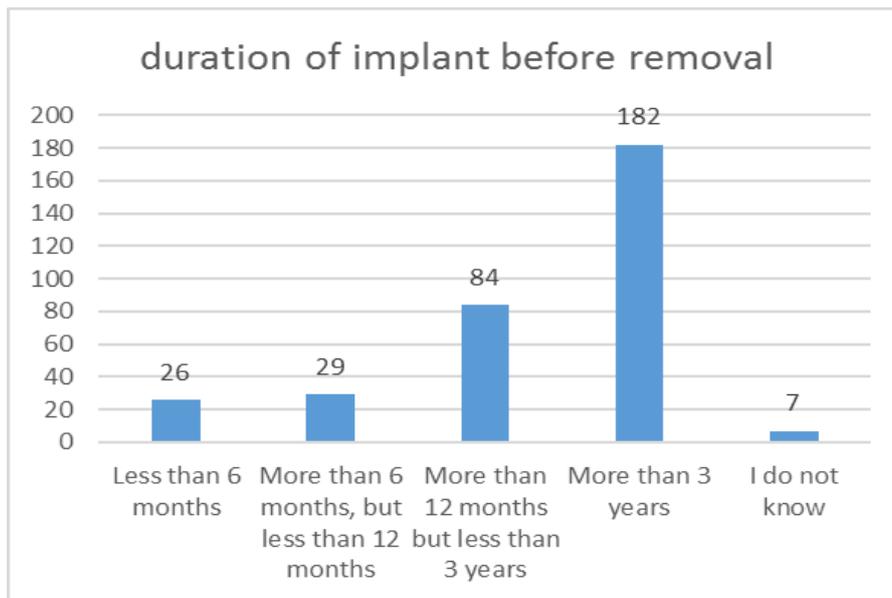
After experiencing side effects, the majority of the respondents (39%), indicated that they got help from the nearest local clinic. Twenty percent (20%) of the clients indicated that they did nothing while 10% went back to the local health facility and were assisted.

- **Duration of Implant Use**

About 56% of the respondents reported to have used the Implants for three years or more before having it removed. In-depth interviews with clients indicated that side effects

challenges were not confined to certain period during the Implant use. A client can have no problem in the first year of Implant use and have side effects in the coming years. Clients can also have problems of side effects soon after insertion and the challenges disappear in the coming years. Only eight percent (8%) of the clients (26 clients) had the Implant removed before six months after insertion. In total, 17 percent of the clients had an Implant removed before 12 months period (Figure 12).

Figure 12: Duration of Implant Use



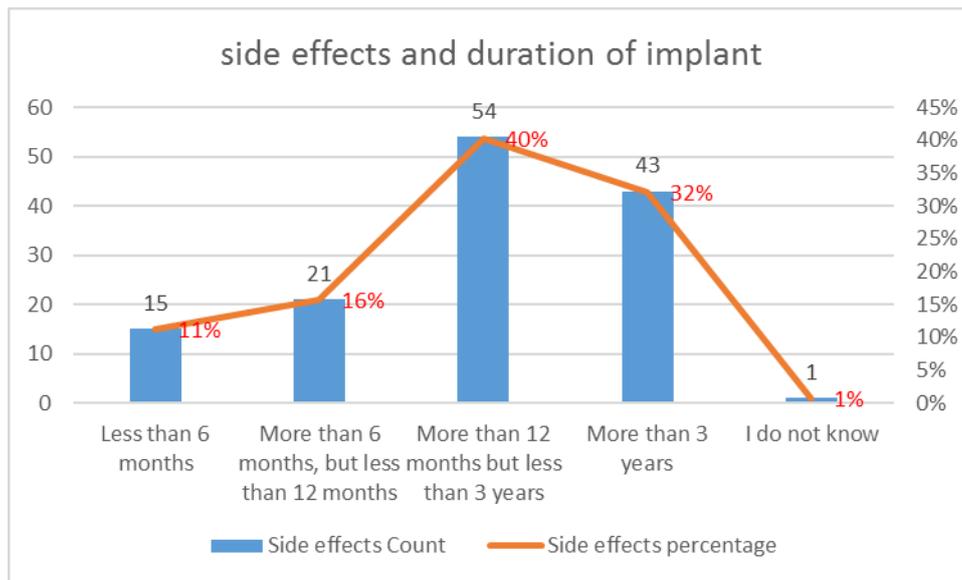
A cross tabulation of Implant use duration and reason for removal indicated that the majority (48%) of the respondents who removed the Implant due to the desired to get pregnant had used the method for more than three years. A total of 38% clients who removed the Implant due to the desire to get pregnant reported to have used the method for a period between 12 to 36 months. As expected, the majority of clients who removed because of expiry had used the method for more than three years. Table 8 shows that, very few clients (3%) who cited desire to get pregnant as a reason for removal had used the method for less than six months.

Table 8: Reason for Removal and Duration of Implant Use

	Less than 6 months	More than 6 months, but less than 12 months	More than 12 months but less than 3 years	More than 3 years	I do not know	Total
Wanting to get pregnant	2	6	23	29	1	61
	3%	10%	38%	48%	2%	100%
Side effects	15	21	54	43	1	134
	11%	16%	40%	32%	1%	100%
Got pregnant while using a method	5	0	1	6	2	14
	11%	16%	40%	32%	1%	100%
Abscess/Infection at site of injection	1	0	0	0	0	1
	11%	16%	40%	32%	1%	100%
Drug Allergy	1	0	0	0	0	1
	11%	16%	40%	32%	1%	100%
My husband/ Partner opposition	0	1	0	1	0	2
	0%	50%	0%	50%	0%	100%
Peer influence	0	0	1	0	0	1
	0%	0%	100%	0%	0%	100%
Product expiry	1	0	1	93	2	97
	1%	0%	1%	96%	2%	100%
Other	1	1	4	10	1	17
	6%	6%	24%	59%	6%	100%
TOTAL	26	29	84	182	7	328
	8%	9%	26%	56%	2%	100%

The results from the survey shows that for the majority of clients who removed Implants because of side effects, (40%) had used the Implant for more than 12 months but less than three years (Figure 13). This is followed by clients who had used the Implant for more than three years at (32 percent).

Figure 13: Side Effects by Duration of Use



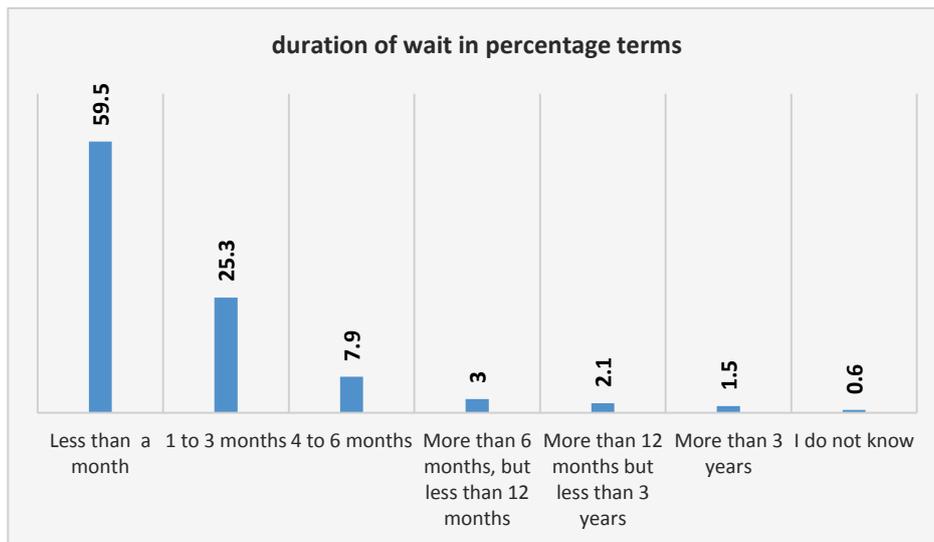
- **Removing the Implant**

The majority of the clients (90%) indicated that it was not difficult to find someone to remove the Implant whenever they wanted to, while 10% of the clients indicated that it was difficult to find someone to remove the Implant.

More than half of the respondents (59%) who indicated that it was difficult to find someone to remove the Implant, cited the unavailability of trained health service providers at their nearest health facility. Relatively significant proportions of 21% and 12% of the client indicated that exorbitant user fees and distance to access the nearest local health facility were respectively the major challenges limiting their desire to remove the Implant whenever they wanted.

The majority of clients (60%) indicated that they had to wait for less than a month to find someone who could remove the method while a total of 15% of the clients indicated that they had to wait for a period ranging from four months to 3 years to access removal services (Figure 14).

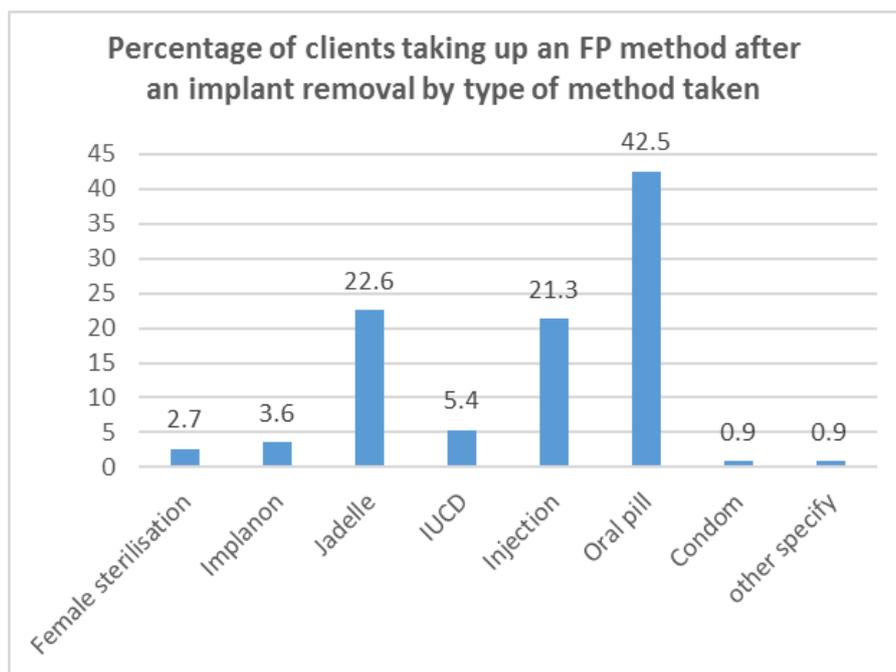
Figure 14: Duration of Wait before Implant Removal



▪ **Method Switch After Removal**

The study found out that 67% of the clients took another FP method after having an Implant removal. Figure 15 shows the type of FP method that was preferred by clients after having an Implant removal. The majority of the clients (43%) took up oral contraceptive pills. It was reassuring to note that 23% of the clients took up Jadelle as an FP method. Close to 3% took up a permanent FP method.

Figure 15: FP Uptake after Implant Removal



The type of FP method that the client opted for after an Implant removal varied significantly by reason for having the Implant removal. The majority of clients who cited side effects (60%) as the reason for removing Implant opted for oral contraceptives after the Implant removal. Those clients who cited product expiry (53%) as their reason for removal were re-inserted Jadelle as their FP method of choice. Seventy-six percent of the clients who had a removal and opted for another FP method managed to get their FP method of choice on the same day of removal while nine percent (9%) reported that they got the FP of their choice within one week after the removal.

Forty-nine (49%) percent of clients who did not take up an FP method after removal highlighted that they desired to get pregnant while 22% reported that side effects contributed greatly to their decision not to use any other FP method. Out of the total respondents who reported to have had Implant removal due to product expiry, 17% of them did not take up any FP method after that a removal.

Asked to comment on their experience on the use of Implants, the majority of clients (52%) outlined that side effects is the aspect that they did not like about Implants. Seventy-two percent (72%) indicated that they preferred Implants due to its long term effectiveness and 18 percent citing that it is easy to use. Sixty-one (61%) percent of the clients indicated that they would like to use the Implant again in future as a family planning method while 63% indicated that they are comfortable to refer a friend or relative for the service.

5. RECOMMENDATIONS

KEY FINDING	RECOMMNDATIONS	RESPONSIBLE
<p>Overall, side effects were cited as the main reason for having Implant removal. 30% of the clients cited expiry and 19% indicated the desire to get pregnant as the main reason for having an Implant removal.</p>	<p>There is need to ensure health service providers are capacitated in post insertion care of Implants. This will ensure effective management of side effects and increased uptake of LARCs</p>	<p>MoHCC and ZNFPC</p>
<p>Of the 134 clients, 88 percent indicated that they managed to get some side effects management which later proved to be temporary (only worked for a short period of time), hence the decision to have the Implant removed and citing side effects as the main reason.</p>	<p>There is need to look at the quality of side effects management being provided to ascertain effectiveness. If the management provided had proved to be effective, the clients would have probably not removed the Implant. Effective side effects management is therefore required and this can only be done by capacitating the health staff.</p>	<p>MoHCC and ZNFPC</p>
<p>78 percent of the clients who removed Implants due to side effects indicated that they had opted for the Implant because of the fact that it is long term while 15 percent indicated that it was easy to use. After experiencing side effects, the majority of the clients went back to take up a short term FP method. Yet, there are other long term FP methods like the IUCD that clients would have opted for. Twenty-two percent (22%) of clients who did not take up a post Implant method highlighted the fear of side effects. This increases their risk of pregnancy as they are still sexually active.</p>	<p>Capacitate service providers on post Implant removal counselling. Improved counselling is required to ensure that clients requiring to use long term methods are fully aware of the options available. (Giving respect to client choice)</p>	<p>All Family Planning service implementing partners</p>

<p>A total of 14 clients indicated that they removed the Implant because they fell pregnant while using the method. 11 of the clients indicated that they were HIV positive and currently on ART drugs while two of the clients were not willing to disclose their HIV statuses.</p>	<p>An operation study that collects data routinely on clients who get pregnant aggregated by their HIV status. This will ensure that over time, enough cases are gathered to make the analysis</p> <p><i>(Cases analysed for this indicator are few to make a conclusive analysis. However, the few cases point to a very interesting analyses which requires more cases to establish the drug interaction of Implants and ARVs.)</i></p>	<p>All Family Planning service implementing partners</p>
<p>20% of the clients who experienced side effects indicated that they did nothing to manage the side effects until they waited to have the Implant removed.</p>	<p>Future studies should explore reason for such behaviour from clients to enable proper action to be taken. Need to strengthen FP counselling by health service providers to encourage health seeking behaviour.</p>	<p>All health service providers</p>
<p>Ninety-five percent (95%) of the clients indicated being informed on the various FP methods available and 99% highlighted that the choice of method to use was not dictated by the health service provider but they had the option to choose the method they would prefer. Eighty-seven (87%) of the clients indicated that they were informed about potential side effects during counselling before uptake of the method. Among the highlighted side effects was continuous bleeding at 61 percent followed by irregular bleeding at 44 percent while allergic reaction and mood changes were the least remembered. The side effects were verbally given to clients during counselling.</p>	<p>While the majority of clients indicated that the counselling received was comprehensive, there is need to ensure that demand generation materials on FP side effects is readily available for reference. Most clients indicated that they were told on the side effects verbally but there is always the risk of forgetting. The demand generation materials distributed do not include information on potential side effects and are not in vernacular languages</p>	<p>ZNFPC to ensure availability of demand generation materials</p> <p>All implementing partners to sensitize FP service consumers</p>

<p>Ninety percent (90%) of the clients indicated that they were told on what to do if they experienced any side effects and 7% indicated that they did not remember being told about what to do in case of side effects while 3% were not sure</p>	<p>Given these scenarios that 10% proportion of clients were not aware of what to do, there is greater need to improve on the quality of counselling and information dissemination. Quality assurance visits to be increased and improve quality of service provision by MoHCC, ZNFPC and other implementing partners</p>	<p>All health service providers</p> <p>MoHCC and ZNFPC</p>
<p>More than half of the clients (59%) who indicated that it was difficult to find someone to remove the Implant, cited the unavailability of trained health service providers at their nearest health facilities. Proportions of 21% and 12% of the client indicated that exorbitant user fees and distance to access the nearest health facility were respectively the major challenges limiting their desire to remove the Implant whenever they wanted</p>	<p>Staffing levels at government health facilities should be capacitated to ensure that they adequately respond to the Implant client needs. The outreach team has a turnaround time of about three months. In their absence, the local health staff should be able to attend to clients without any challenges. There is also need to look at user fees as a barrier to management and removal of side effects.</p>	<p>MoHCC, ZNFPC and PSZ</p>

6. CONCLUSION

The study findings reveal that Implant removal is a problem in the two provinces. This concern has been expressed by the clients themselves and the key informants. It is important to understand why women are getting the inserted Implant removed. The causes of Implant removals identified will help the Government and other family planning implementing partners to understand why the removal rate is increasing and help to identify effective interventions to reduce these removals. This calls for interventions that are informed by the research findings, targeting the identified hotspots and groups. Consequences of Implant removals include the rise in unwanted pregnancies if clients do not opt for an alternative method. There is need to ensure that health service providers are capacitated in post insertion care of Implants to ensure effective management of side effects and increased uptake of LARCs. Effective side effects management is required and this can only be done by capacitating the health service providers. An operations research that collects data routinely on clients who get pregnant aggregated by their HIV statuses is required. There is need to strengthen FP counselling by health service providers to encourage health seeking behaviour. While the majority of clients indicated that the counselling received was comprehensive, there is need to ensure that demand generation materials on FP side effects are readily available for reference. There is also need to look at user fees as a barrier to management and removal of side effects.

REFERENCES

1. Alkema, L., Kantorova, V., Menozzi, C., & Biddlecom, A. (2013). National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *Lancet*, *11*; *381(9878):1642-52*.
2. Castle, S., & Askew, I. (2015). *Contraceptive Discontinuation: Reasons, Challenges, and Solutions*. New York: Population Council.
3. Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). *Family planning: the unfinished agenda*. Lancet.
4. Core Group. (2005). Countdown to 2015. A Decade of Tracking Progress for Maternal, Newborn and Child Survival: The 2015 Report. Mexico: Countdown to 2015: Maternal, Newborn & Child Survival; 2015 Oct.
4. Hall, S. . . (2012). The Health Belief Model Can Guide Modern Contraceptive Behavior Research and Practice. *Journal of Midwifery Womens Health*, *57(1):74-81*.
5. Khan, A., & Shaikh, B. . . (2013). “An all-time low utilization of intrauterine contraceptive device as a birth spacing method – A qualitative descriptive study in district Rawalpindi, Pakistan”, *Reproductive Health* 2013, *10(10)*. <http://doi.org/10.1186/1742-4755-10-10>
6. Smith, R., Ashford, L., Gribble, J., & Clifton, D. (2009). *Family Planning Saves Lives*. Report No. Fourth Edition. Population Reference Bureau. Washington DC.
7. UKaid and USAID. (2012, September). *London Summit on Family Planning*. London, United Kingdom: Presented at the London Summit on Family Planning.
8. Zimbabwe Demographic Health Survey (November 2016) ICF International
Rockville, Maryland, USA
9. Zimbabwe Demographic Health Survey. Zimbabwe National Statistics Agency - ZIMSTAT - and ICF International. 2012. Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland, USA: ZIMSTAT and ICF International

RESEARCH TEAM

Lovejoy Gamba – ZNFPC
Farai Machinga – ZNFPC
Onias Munamati – ZNFPC
Mercy Marimirofa – ZNFPC
Joyce Ndebele – ZNFPC
Caroline Tshuma – ZNFPC
Siphathisiwe Sibangiswani - ZNFPC
Brighton Muzavazi – MOHCC
Sibonile Nkala - MoHCC
Rudo Mhonde – UNFPA
Sunday Manyenya - UNFPA
Dadirai Nguwo – PSZ
Tafadzwa Gora – PSZ

Information Technology Specialist

Mr. Leonard Katova – ZimStat