



THE FRANCOPHONE MAQ SUBCOMMITTEE BECOMES LESS FORMAL AND MORE FLEXIBLE

In July 2000, the Francophone MAQ Subcommittee was launched in Dakar, Senegal. Since that time this subcommittee has moved toward a less formal and more flexible structure that can mobilize efforts, as needed, to respond to current access and quality issues in West Africa. Francophone MAQ Subcommittee members have recently participated in the following regional meetings: the Francophone Regional Postabortion Care Conference in Dakar (March 2002) and the Dual Protection Workshop conducted by the Family Health and AIDS Project in Yamoussoukro, Ivory Coast (August 2002). This issue of the MAQ Bulletin provides reproductive health updates, highlights activities of the Francophone MAQ Subcommittee and the global MAQ initiative, and explores new ways to expand access to high quality family planning and reproductive health services for women and their families in West Africa.

FRANCOPHONE AFRICA GUIDELINES SURVEY

BACKGROUND

The development and implementation of national guidelines for family planning and reproductive health (FP/RH) have been important components of USAID's Maximizing Access and Quality (MAQ) Initiative in Francophone West Africa. FP/RH guidelines have been developed in the following nine Francophone West African countries: Benin, Burkina Faso, Cameroon, Guinea, Ivory Coast, Mali, Niger, Senegal and Togo. At the 1999 regional MAQ conference in Dakar, Senegal, a team from each of these countries reported where they were in terms of guidelines development and produced action plans for next steps in the guidelines implementation process. Since the launch of the Francophone MAQ Subcommittee in July 2000, the Francophone MAQ initiative has built upon guidelines development and implementation and is now focusing on



Photo by Chris Davis, JHPIEGO

In March 2002, Francophone MAQ Subcommittee members met in Dakar after the Francophone Regional Postabortion Care Conference.

Francophone MAQ Subcommittee members Judith Collins and Lucas Mbofung with Nicole Buono, USAID, at the Dual Protection Workshop held in Yamoussoukro, Ivory Coast, August 2002.



Photo contributed by Lucas Mbofung, Ministry of Public Health, Cameroon



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finding the most effective ways to integrate sexually transmitted infection (STI)/HIV/AIDS prevention into FP/RH programs.

It should be noted that in West Africa, national FP/RH guidelines are referred to as policies, norms and protocols (PNP). Policies (also called norms or standards) specify the minimum levels of acceptable performance for each component of FP/RH services offered. Policies/norms/standards apply to systems (e.g., a standard range of services expected to be found at various levels, by type of provider; or standard equipment) or to providers (e.g., the type of basic or inservice training/qualifications needed to provide specific services). Protocols (also called procedures) give step-by-step instructions for performing each FP/RH job to attain a minimum level of acceptable service provision.

DESK REVIEW

In October and November 2001, four USAID cooperating agencies (Family Health International, IntraH/PRIME, JHPIEGO and the Population Council) conducted desk reviews that examined the integration of STI/HIV/AIDS services in the PNP in four West African countries (countries W, X, Y and Z). Findings from the desk reviews were shared with the respective national Ministries of Health.

FINDINGS

Although the PNP documents in all 4 countries (WXYZ) contain STI/HIV/AIDS information, opportunities to include some additional important information on this subject were missed. (SEE TABLE 1.)

PROVIDER FOLLOWUP INTERVIEWS

In 2002, members of the Francophone MAQ Subcommittee developed a questionnaire for use in conducting in-depth interviews with providers at healthcare facilities. The draft questionnaire was pretested in two West African countries. Based on results of the pretest, the questionnaire was adapted to the local country context. In June 2002, the questionnaire was reviewed and approved by the Western Institutional Review Board (WIRB). Following WIRB approval, local consultants began using the finalized questionnaire to conduct interviews with doctors, nurses and midwives in the same four West African countries that were included in the desk review.

Findings from these interviews will help us determine whether the protocols are accessible and useful to providers. (For example, is a copy of the protocols available at the facility? Are the protocols easy or hard to use?) The interview questions will also help us to determine whether STI/HIV/AIDS services are successfully integrated in the protocols. (For example, do providers use the protocols in their daily work to provide STI/HIV/AIDS services? How do providers use the protocols to provide these services?)

Information provided by healthcare providers during these interviews will be shared in each country with the Ministry of Health. It is hoped that the findings from these interviews can be used to improve future FP/RH protocols. Findings from this study may guide us in developing new ways to make the protocols more accessible to providers at all levels of the healthcare

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MAQ BULLETIN

Maximizing Access and Quality of Services

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TABLE 1: STI/HIV/AIDS CONTENT IN THE PNP OF FOUR FRANCOPHONE WEST AFRICA COUNTRIES

Content	Country			
	W	X	Y	Z
Information concerning client-focused prevention				
Counseling about risk assessment	✓	✓	✓	✓
Counseling for prevention (addressed to all clients)	✓	✓	✓	✓
• Focusing on women	✓	✓	✓	✓
• Focusing on adolescents	✓	✓	✓	
• Focusing on men				✓
Male condoms listed as a method that should be regularly available at the clinic	✓	✓	✓	✓
Demonstration of the use of the male condom recommended	✓	✓	✓	✓
Female condom listed as a method that should be regularly available at the clinic				✓
Demonstration of the use of the female condom recommended				✓
Dual protection (addressed to all clients)	✓		✓	✓
Inform clients that contraceptives other than condoms do not provide protection against STIs and HIV/AIDS	✓	✓	✓	✓
Information, education and communication (IEC) materials about prevention (addressed to all clients) should be available at the clinic	✓	✓		✓
Prevention focusing on service providers				
Use of gloves during pelvic examinations	✓	✓	✓	✓
Use of gloves for drawing blood	✓	✓	✓	
Disinfection of equipment (specula, gloves)	✓	✓	✓	
Information on ways to protect service providers from needle sticks	✓	✓	✓	
Information on the prevention of STI/HIV/AIDS transmission during labor and childbirth			✓	
Voluntary counseling and testing				
Offer counseling, tests and/or referral for voluntary testing as part of FP/RH services	✓	✓	✓	✓
Offer counseling, testing and treatment of STIs for partners	✓	✓	✓	✓
Provide guidance to staff on the client-centered approach to counseling	✓	✓	✓	✓
Mother-to-Child Transmission				
Counseling, during FP/RH visits, on breastfeeding options				
Counseling, during FP/RH visits, on mother-to-child transmission of STIs/HIV/AIDS				

system. For example, we may be able to articulate some best practices for disseminating guidelines and orienting/training providers in the use of the guidelines. We may be able to create new job aids that will make the protocols easier to understand and use on the job. If we are able to make the protocols more accessible to providers, we will be better able to ensure that high quality healthcare services reach the clients who need them. ♦

gions in the country were involved in the study, producing a sample of 100 providers. The 21 sites surveyed were:

- Referral maternities (2)
- District hospital maternities (3)
- Type II integrated health centers (4)
- Type I integrated health centers (4)
- Community integrated health centers (4)
- Urban community maternal and child health centers in Niamey (4)

NIGER: PRELIMINARY RESULTS OF THE SURVEY OF PROVIDERS' USE OF STI/HIV/AIDS PROTOCOLS

**BY DR. ARZIKI SOULEY
AND M. ALIO SABO**

INTRODUCTION

In 1998, Niger, like certain other countries of the sub-region, was instructed to develop documents for Reproductive Health (RH) Policies, Norms and Procedures (PNP). These documents were to be disseminated to various categories of healthcare institutions in the country.

PURPOSE OF THE SURVEY

The purpose of this survey was to evaluate providers' use of the protocols and to collect their opinions and suggestions on the content and format of the protocols.

IMPLEMENTATION OF THE SURVEY

This survey pertained only to physicians, midwives and nurses. Data collection took place between 16 July and 9 August 2002. A total of 21 health institutions from 4 re-



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At the conclusion of the survey, we had been able to interview only 62 providers, in the following categories: 10 physicians (4 men, 6 women), 26 midwives (26 women), 26 nurses (9 men, 17 women). The reason for the smaller number is that some had not gone back to their posts, some were on vacation and others were attending seminars during the time we visited their institution.

AREAS OF SPECIALIZATION

There is no one exact area of specialization. Most of the providers surveyed (84%), offer the following services:

- Family planning
- Antenatal consultations
- Newborn consultations
- Maternity (supervision of labor, delivery and postpartum care)
- Obstetrics and gynecology
- STIs
- HIV/AIDS
- Immunization

PROFESSIONAL EXPERIENCE

The providers surveyed had between 2 and 23 years of professional experience in RH, with the majority having between 5 and 10 years. Most of the providers interviewed, however, had between 10 months and 2 years of service in their present position.

TYPES OF FAMILY PLANNING SERVICES OFFERED

All the providers offer all types of FP services but some, such as the maternal and child health center and referral maternity nurses, provide these services less frequently. Services offered are: intrauterine devices (4,8%), injectables (8,2%), combined oral contraceptives (100%), progestin-only contraceptives (100%), male condoms (100%), female voluntary surgical contraception (6,5%), emergency contraception (25,8%), Lactational Amenorrhea Method—LAM (100%).

TYPES OF STI/HIV/AIDS SERVICES OFFERED TO WOMEN

All the providers offer STI/HIV/AIDS services daily, to both women and men. Services offered are: group or individual education on STIs (100%), clinical examination for STI screening (100%), STI diagnosis and treatment (100%), voluntary counseling (88%), dual protection (100%).

DISSEMINATION OF THE PROTOCOLS

A total of 10 of 21 health institutions have a copy of the RH norms and procedures that were published in 1998. The institutions, however, use other publications for reference: syndromic management strategies (1994 and 1998 versions), FP protocols and technical data sheets (1993), flip chart on AIDS and the family (2001), standards for obstetrical and neonatal emergency

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FORESKIN AND HIV

Question: What is it about the foreskin that might increase risk of HIV transmission?

Answer: The interior side of the foreskin has a mucosal surface, which is more susceptible to trauma than the tougher skin of the penile shaft or the glans. Moreover, the foreskin contains high levels of HIV target cells (such as Langerhan's cells). Indeed in a recent *in vitro* study of 14 foreskins, investigators from Chicago found that foreskin mucosal tissue had a 7-fold greater susceptibility to HIV-1 than cells in cervical tissue under the same conditions. Lastly, the presence of a foreskin appears to increase risk of ulcerative sexually transmitted diseases such as chancroid and herpes, which are strong co-factors for HIV infection.

Thus there appears to be good biologic plausibility to the epidemiologic finding that male circumcision reduces risk of HIV infection.

References:

1. Estrada CR et al. Biologic mechanisms of HIV infection of human foreskin: implications for transmission. Presentation at the American Urological Association, May 2002.
2. Szabo R, Short R. How does male circumcision protect against HIV infection? *BMJ* 2000; 320:1592-1594.
3. Moses S, Bailey RC, Ronald AR. Male circumcision: Assessment of health benefits and risks. *Sex Transm Infect* 1998; 74:368-73.

This "Pearl" was prepared by Dr. James D. Shelton, Senior Medical Scientist, Office of Population, United States Agency for International Development (USAID), the week of 10 June 2002.

MAQ PEARL



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care (Morocco 2000), emergency obstetrical care modules (Niger 2002), Essentials of Contraceptive Technology (2000).

These 10 institutions have data sheets following a dissemination (a reading of the document followed by explanations). Eighteen providers from these institutions were interviewed. Thirteen had been trained in the use of the protocols and 5 providers had been indoctrinated by their trained colleagues. All training courses (with dissemination) took place in 2002. All the trained providers had put the protocols into practice. Of those who did not have the protocols and who had not been trained (44 providers) only 7 had heard about the protocols.

USE OF THE PROTOCOLS

- 89% (16 of 18) know that there is information about STIs and HIV/AIDS in the RH norms and procedures document.
- In 50% of the institutions, there has been no formal discussion of the protocols with the other health workers.
- 72% (13 of 18) have read the information about STIs and HIV/AIDS as often as once a week to at least once a month.
- 83% (15 of 18) have used the protocols when providing services; frequency of use ranged from daily (33%), to at least once a week (46,5%), and at least once a month (20,5%).
- 100% of the providers believe that they benefit from use of the protocols.
- Other sources of information frequently used are: radio/television, particularly for HIV/AIDS and FP
- 100% consider the protocols appropriate
- The protocols most frequently used were:
 - Family planning
 - STI/HIV/AIDS
 - Obstetrics and technical data sheets
 - Infection prevention

FORMAT OF THE PROTOCOLS

- 100% of those interviewed found the information understandable
- 100% found the information on the following topics to be complete:
 - STIs/HIV/AIDS
 - Condoms
 - Syndromic management
 - Syphilis

COMMENTS AND SUGGESTIONS

Almost all of the providers found the content appropriate but there are problems concerning a syndromic management strategies document that is used every day and on which all supervision, monitoring and cost recovery practices are based. This document also deals with STIs and obstetrical and gynecological complaints. As for format, the providers interviewed requested, above all, that the pages be laminated to make the document sturdier.

INFORMATION SEARCH

- Search for STIs/HIV/AIDS information (how to protect oneself)
 - 65,5% found the correct answers when using the document
 - 34,5% did not find the correct answers
 - 55,5% found the correct answers easily
 - 39% had difficulty finding the correct answers or did not find them in the document because they had not mastered use of the document or did not even know where to look for the information
- Search for STI/HIV/AIDS information (advice to give someone to enable the person to protect himself/herself)
 - 65,5% found the correct answers
 - 34,5% did not find the correct answers
 - 44,5% easily found the correct answers in the document
 - 44,5% found the correct answers with difficulty or did not find them because they had not mastered the use of the document

RECOMMENDATIONS AND COMMENTS

Changes to make in the format of the protocols

- Laminate the pages
- Use heavier paper

Comments and supplementary questions

- Dissemination of the protocols was limited.
- At times only one provider in an institution receives training.
- There is only one copy of the document for all the staff.
- The dissemination methodology is not appropriate and the training time is too short (3 to 5 days).
- The document concerning syndromic management strategies is an obstacle to the use of other reference documents such as the protocols.

RECOMMENDATIONS

- Disseminate the documents throughout the entire country.
- Train all providers working in the area of RH in healthcare institutions.
- Make two copies of the protocols available to Type II integrated health centers.
- Take the RH protocols into account when supervising and monitoring.
- Improve the dissemination methodology with case studies, information searches, etc.
- Lengthen the training time. ♦

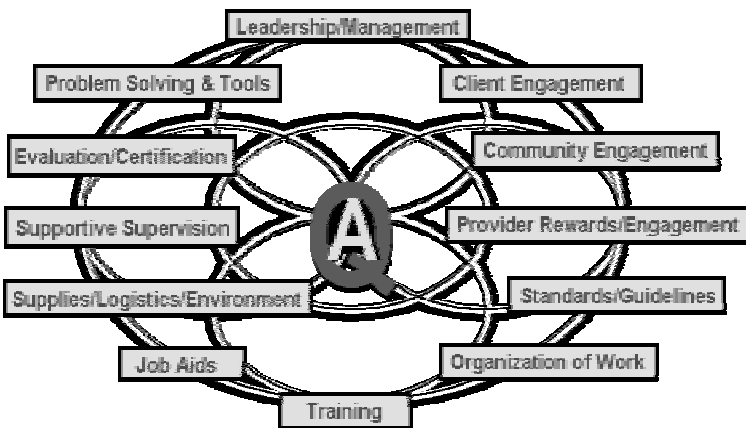


MAXIMIZING ACCESS AND QUALITY (MAQ) IN FAMILY PLANNING AND RELATED REPRODUCTIVE HEALTH SERVICES: THE MAQ EXCHANGE

WHAT IS THE MAQ EXCHANGE?

The MAQ Exchange is a means of engaging USAID and its partners in a dialogue around programmatic best practices in reproductive healthcare service delivery, with a particular focus on family planning. It is a product of the MAQ Initiative, which for several years has combined the efforts of USAID, CAs and host country partners in documenting and applying state-of-the-art methods to improve access to and the quality of reproductive health services.

The MAQ Exchange is not training. Rather, it is a process of sharing the wealth of new information, data and lessons learned on improving access and quality. This facilitates strategy development for application in your existing programs. The process begins with a needs assessment. The centerpiece activity is a 3- to 4-day interactive and results-oriented workshop conducted by a team of master trainers with relevant technical and programmatic expertise. In the course of the workshop, the mission and its partners draft action plans using the Synergy of Interventions framework. This process equips the mission and its partners to implement a set of prioritized and realistic activities.



SYNERGY OF INTERVENTIONS

WHAT IS THE CONTENT OF A MAQ EXCHANGE?

The MAQ Exchange curriculum is made up of the following modules and can be tailored to the specific needs of host country programs and USAID missions.

- MAQ Key Concepts
- Barriers to Access and Quality
- Service Delivery Guidelines
- Contraceptive Technology Update
- Infection Prevention



DEMAND FOR MALE CIRCUMCISION

Question: I can see that there might be some health benefit from male circumcision, but is there significant demand for it from men?

Answer: Yes, several studies from Africa at least, indicate that demand for circumcision among uncircumcised men is substantial. Interestingly, the demand appears to be largely for reasons of “hygiene,” cleanliness and prevention of local infections/sexually transmitted infections and not particularly for reduced risk of HIV specifically. Female partners also appear to support circumcision for similar reasons.

References:

1. Soori N et al. Dynamics of male circumcision practices in Northwest Tanzania. *STI* 2001; 28:214-8.
2. Bailey RC et al. The acceptability of male circumcision to reduce HIV infections in Nyanza Province, Kenya. *AIDS Care* 2002; 14:27-40.
3. Kebaabetswe P et al. Male circumcision: An acceptable strategy for HIV prevention in Botswana. Unpublished manuscript (Also Abstract accepted for 2002 Barcelona AIDS Conference.)
4. Fritz K et al. The feasibility of adult male circumcision for HIV prevention in Zimbabwe. (Submitted)

This “Pearl” was prepared by Dr. James D. Shelton, Senior Medical Scientist, Office of Population, **United States Agency for International Development (USAID)**, the week of 3 July 2002.

MAQ PEARL

- Client-Centered Communication: The Client, the Provider, and the Community
- Dual Protection
- Family Planning and HIV/STI Service Integration
- HIV/AIDS Prevention
- Postabortion Care
- Adolescent Reproductive Health
- Provider Perspective
- Organization of Work
- Performance Improvement
- Quick Investigation of Quality
- Logistics/Supply Management
- New Strategies for Supervision
- Leadership
- Community Defined Quality
- Antenatal Care
- Normal Labor & Childbirth
- Transfer of Learning

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WHO WILL BENEFIT FROM THE MAQ EXCHANGE?

Mission staff, public and private sector partners, and other donor agencies can all participate, share and benefit. The ultimate beneficiaries will be the men, women and children of the host country.

HOW WILL YOU BENEFIT FROM A MAQ EXCHANGE?

- By receiving an update on the most recent evidence-based best practices in FP/RH service delivery

- By discussing ways to apply MAQ principles and practices effectively within your country program
- By sharing lessons learned and expertise among your colleagues
- By developing a shared vision and strategy for improving access to and the quality of RH service delivery programs in your country
- By utilizing the MAQ Exchange package of extensive resources, which includes reference materials, publications, training curricula and specific tools to improve service delivery. ♦

FIRST SUB-REGIONAL LEVEL MAQ EXCHANGE HELD IN HONDURAS

From 22 to 26 April 2002, the first sub-regional MAQ Exchange was held in Tegucigalpa, Honduras. Seventy-five participants from Honduras, Guatemala, El Salvador, Nicaragua, and the Dominican Republic attended the Exchange, including representatives from the public and private sectors, NGOs, and USAID missions. The technical agenda for the workshop was determined by a needs assessment, which pointed to priority technical areas (e.g., access barriers, adolescent reproductive health, contraceptive security, antenatal and postnatal care, medical eligibility criteria for contraceptive use, com-

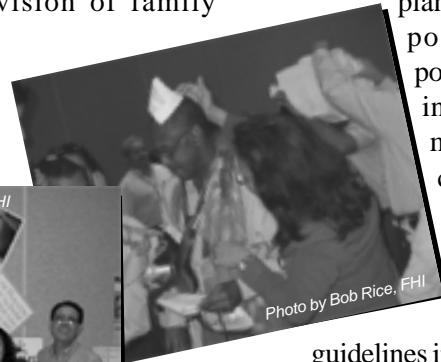
munity-defined quality, supervision, family planning and reproductive health service in-

ductive health service integration, HIV/AIDS and contraceptive technology updates). During the workshop, facilitators presented updates in best practices in priority technical areas and country teams developed action plans using a structured quality-improvement methodology.

Teams selected interventions that could be implemented within one year to address such problems as limited provision of family

planning services to postpartum and postabortion clients in hospitals, high maternal mortality caused by postpartum hemorrhage, limited use of standards and guidelines in labor and delivery and postpartum care in the public sector, and limited

preservice education for healthcare students in the area of reproductive/sexual health service norms and guidelines. The Honduras MAQ Exchange is the first in seed money support the action plans that were developed. Each country will submit a final proposal to receive \$15,000 to support its 1-year action plan. ♦





MAQ EXCHANGE HELD FOR THREE STATES IN NIGERIA

From 19 to 22 March 2002, a MAQ Exchange was held in Ibadan, Oyo State, Nigeria. The agenda for this 4-day workshop was based on the results of an in-depth performance needs assessment that had been carried out in the three participating states in December 2000. The Nigeria Exchange included technical updates on a variety of topics (e.g., access barriers, infection prevention, service delivery guidelines, client-centered communication, leadership and supervision, and reproductive health services integration). Fifty-five representatives from three states—Enugu, Bauchi, and Oyo—participated in this event. Participants included family planning/reproductive health service providers,

program managers, and supervisors from the public and private sectors and local nongovernmental organizations (NGOs). Three members of the Federal Ministry of Health co-facilitated the workshop. And, representatives from USAID/Nigeria's implementing partner agencies (CEDPA, JHU/CCP and EngenderHealth) took an active role in the Exchange. The last day and a half was dedicated to developing four distinct action plans—one for each of the three states and one for the Federal Ministry of Health. These action plans focused on issues such as ensuring effective management at all levels of the healthcare system, updating the reproductive health service delivery guidelines for use by providers, developing management information systems to maintain client records, including community outreach in family planning workers' job expectations, and orienting providers to better infection prevention practices. ♦



MALE CIRCUMCISION AND NATIONAL HIV INFECTION RATES

Question: Does the prevalence of male circumcision (MC) help explain why HIV is increasing rapidly in some countries, but not in others?

Answer: Probably so, though such cross-country comparisons are tricky and involve other factors. Notably, HIV has increased most rapidly in Eastern and Southern Africa where MC is uncommon (e.g., Botswana, Zimbabwe, Zambia, Malawi, Rwanda, Swaziland.) In contrast, although HIV probably originated in West Africa, HIV prevalence there tends to be much lower and MC tends to be very common.

Of course MC is very common in Islamic countries, and Islamic faith might also relate to lower behavioral risk of HIV. However, some countries are not predominantly Islamic but have high MC rates and comparatively low HIV (e.g., Philippines, Ghana, Benin, Nigeria, Liberia, Gabon, Madagascar).

In other countries the pattern seemingly doesn't support the argument. For example, Kenya has high overall circumcision and relatively high HIV (though HIV is notably high among the Luo, the only major ethnic group that doesn't practice circumcision). Latin America and Europe have low HIV even though male circumcision is not common.

Reference: Halperin DT and Bailey RC. Male circumcision and HIV infection: 10 years and counting. *Lancet* 1999; 354:1813-15.

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MAQ PEARL

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