MAQ Bulletin

Maximizing Access and Quality of Services

Issue No. 1, January 1995

HHRAA/SARA/JHPIEGO ESA Workshop Follow-Up Activities

The Proceedings of the East and Southern Africa (ESA) Regional Workshop: *Improving Quality of Care and Access to Contraception: Reducing Medical Barriers* (featuring highlights of the five-day workshop, six country action plans, preworkshop medical barrier questionnaire results, and workshop evaluation) were distributed to all delegates and cooperating and donor agency representatives in September 1994. An additional 500 copies were produced in October 1994 for distribution worldwide.

A six-month follow-up questionnaire was sent out in September 1994 to the 44 delegates who attended the East and Southern Africa MAQ workshop. This was the first in a series of three follow-up questionnaires that will be distributed to the ESA MAQ workshop delegates. The purpose of these questionnaires is to gather delegates' assessments of the workshop's programmatic impact over the 18-month period following the workshop. To date, ten of the 44 six-month follow-up questionnaires have been returned to JHPIEGO: three from Botswana; one from Kenya; one from South Africa; three from Uganda; two from Zimbabwe. HHRAA/SARA and the JHPIEGO MAQ Task Force look forward to hearing from the remaining 34 delegates. **The following are highlights of responses to these questionnaires.**

What was the workshop's primary objective?
(response highlights)

- To assist delegates to identify the barriers to family planning (FP) access in their countries and plan strategies for removing the barriers
- To share information in order to improve the quality of FP programs and the quality of care
- To improve quality in training services

Was the workshop's primary objective met?
(ten respondents)

60% felt that the workshop's primary objective was **totally** met.

40% felt that the workshop's primary objective was **somewhat** met.

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From Medical Barriers to MAQ

Since 1992, USAID has provided guidance to the international family planning community to reduce medical barriers defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception."[1]

In 1994, USAID shaped a broader, more comprehensive initiative called Maximizing Access and Quality (MAQ) which will focus on strengthening the following key areas:

- Client–Provider Interaction
- Management–Supervision
- Technical Competence–Guidance
- Policy, Advocacy, Communication and Education (PACE) ♦

[1] Shelton JD, Angle MA, Jacobstein RA. Medical barriers to family planning. *The Lancet*; 340:1334-35, 1992.

HHRAA/SARA

In 1992, the Africa Bureau of USAID awarded a project contract to the Academy for Educational Development (AED) to assist the Bureau's Sustainable Development Division (formerly Health and Human Resources) in the implementation of its Health and Human Resources Analysis for Africa (HHRAA) Project. This project contract has been designated Support for Analysis and Research in Africa (SARA). SARA's role in the HHRAA project is to provide research management and technical support, disseminate research and analysis findings and encourage linkages with African experts and institutions. JHPIEGO's Research and Evaluation Office has organized several population and reproductive health activities through the SARA project, including the East and Southern African regional workshop, *Improving Quality of Care and Access to Contraception: Reducing Medical Barriers*, held in Zimbabwe in February 1994. ♦

From the Chair of JHPIEGO's MAQ Task Force

"IN HARARE, WE HAVE JOINTLY CREATED THE NUCLEUS OF WHAT IN THE FUTURE MAY BECOME A LARGE FRATERNITY OF DYNAMIC AND VISIONARY HEALTH PROFESSIONALS." O.A. Ladipo, Closing Session, East and Southern Africa Regional MAQ Workshop

Nearly one year ago, from January 30–February 4, 1994, many of you formed delegations of policy makers, health care professionals, and advocates for women's reproductive health from six countries (Botswana, Kenya, the Republic of South Africa, Tanzania, Uganda and Zimbabwe) and gathered in Harare, Zimbabwe, to address the Maximizing Access and Quality (MAQ) initiative at the regional and national level. For five labor-intensive days, you worked in both plenary and small group sessions to identify medical barriers (both to specific contraceptive methods and to service delivery) and to identify solutions to those barriers. You returned to your home countries with country action plans in hand, prepared to champion the MAQ initiative at the national and local levels.

Much has been accomplished since the meeting in Harare. National MAQ events, such as a national medical barriers workshop in Zimbabwe and two family planning leadership conferences in Botswana, have been held. Revisions are being made to Botswana's Family Planning General Policy Guidelines and service standards according to the latest technical information. In Zimbabwe, a national medical barriers task force has been formed and medical barriers have been identified for revision of family planning service guidelines, procedures and policies. Many more MAQ events are planned. For example, Kenya's National Family Planning Service Delivery Norms, scheduled for review this year, will be revised and used to update training curricula and increase training quality at district training centers.

Health and Human Resources for Africa (HHRAA)/Support for Analysis and Research in Africa (SARA) and JHPIEGO's MAQ Task Force congratulate all of you on your many successes. We are very pleased to send you this first of three issues of the *MAXIMIZING ACCESS AND QUALITY (MAQ) BULLETIN* for East and Southern Africa. Included in this issue are highlights of in-depth follow-up interviews conducted with workshop delegates in Botswana and Zimbabwe, results of a six-month workshop follow-up questionnaire, and MAQ success stories from East and Southern Africa and from other regions of the world. We hope that you will share news of these successes with your colleagues to encourage further endeavors. Also included, as a technical update, is an article describing the World Health Organization's new classification system for the initiation of selected contraceptive methods which can be adapted for use in individual country settings.

We hope that you will make this your bulletin. Your suggestions for future *Bulletin* articles are most welcome. ♦

Sandra de Castro Buffington, Chair
JHPIEGO MAQ Task Force

HHRAA/SARA/JHPIEGO ESA Workshop Follow-Up Activities

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Are workshops of this kind an effective means of helping health officials improve the quality of their family planning programs? (ten respondents)

80% responded that these regional workshops are a very effective means of helping health officials improve the quality of their FP programs.

20% responded that these regional workshops are a **somewhat** effective means of helping health

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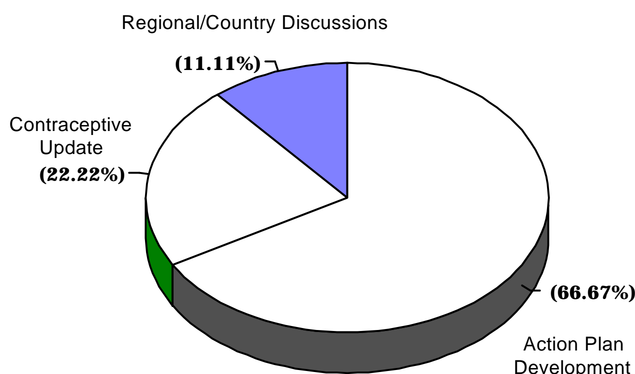
officials improve the quality of their FP programs.

How could the effectiveness of future regional MAQ workshops be increased? (response highlights)

- Follow-up workshops could be conducted to allow countries to share their experiences in removing the barriers.
- Countries further along in implementation could serve as role models and inter-country discussion could be improved.
- Country-level workshops could be conducted.
- Prior to workshops, each country group could prepare a document of their perceived problems.
- ESA regional workshop proceedings could be widely distributed.



The most useful aspects of the workshop

What was the most useful aspect of the workshop? (nine respondents)

66% indicated the development of specific action plans to address barriers to improved FP services in their countries.

22% indicated the update on contraceptive information.

11% indicated the opportunity to discuss issues with others in the country/region.

Which of the workshop reference materials were of most interest/relevance to colleagues upon returning home? (nine respondents)

- JHPIEGO's *PocketGuide for FP Service Providers* was selected nine times.
- FHI's *Injectables* Module was selected seven times.
- FHI's *Network* was selected one time.
- Eight delegates selected presenter materials. Norplant presenter materials were selected five times as being of interest/relevance and each of the other presenter materials listed (oral contraceptives, IUDs, injectables, barrier methods, and voluntary sterilization) were selected twice.

How many times have delegations met to discuss action plans and strategies for implementation since the workshop?

Delegations (or sub-groups) have met anywhere from one to three times to “more than 3” times since the end of the ESA regional workshop in February.

Are action plans developed still reasonable and/or appropriate given the resources available?

(ten respondents)

80% responded yes.

10% responded no.

10% responded do not know. ♦

In-Depth Workshop Follow-Up Interviews

In-depth workshop follow-up interviews in Botswana and Zimbabwe recently have been conducted to assess progress made toward country action plan objectives formulated during the ESA MAQ workshop in Zimbabwe. Similar interviews will be conducted in Kenya, Tanzania, South Africa and Uganda. The following are highlights of achievements made toward action plan goals in Botswana and in Zimbabwe.

Botswana

In September 1994, **two family planning leadership conferences** were held in Gaborone and Francistown for a total of approximately 175 participants, including policy makers, district health leaders from the Ministry of Health, local governments and private institutions. The following members of the ESA MAQ workshop Botswana delegation took part in these national-level conferences: Dr. A.A. Hogewoning, Ms. L.G. Mogapi, Ms. N. Mokgautsi, Ms. K.M. Motswaledi and Ms. P. Mudongo, Dr. J.K.M. Mulwa .

As a result of these two conferences, policy makers and managers from both the northern and southern parts of the country came to consensus on a wide variety of revisions to the Botswana Family Planning General Policy Guidelines and service standards, including removal of most of the barriers that were identified by the Botswana delegation at the ESA regional MAQ workshop in Zimbabwe.

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Agreed Changes to Botswana Family Planning Policy Guidelines

Age and parity restrictions removed
- Age and parity restrictions will be removed for all reversible methods.

Inappropriate contraindications removed
- Method-specific contraindication checklists will be revised/updated per USAID's guidance document.

Process hurdles decreased
- Process hurdles will be decreased by reducing the unnecessary requirements for physical exams, laboratory tests and revisit schedules per USAID's guidance document.

Oral Contraceptives (OCs)
- Community-based distribution of OCs by family welfare educators prior to physical exam was approved for six months (up from one month).

IUDs
- Trained nurses and physicians will be able to insert IUDs both interval and postpartum (change in the physician-only rule).
- Training strategy approved for immediate post-partum IUD insertion, even after caesarian section.
- IUD training will include STD/HIV risk assessment, diagnosis and treatment.

Norplant®
- Upon completion of the preintroduction trial currently under way, midwives will be trained in Norplant insertion and removal.

Tubal Ligation (TL)
- Standardized approach to informed choice and consent approved (reversed the prevalent practice of routine TLs under general anesthesia on women undergoing a third caesarian section).
- A training strategy for minilap under local anesthesia was developed to replace the “Cape to Cairo” incision under general anesthesia.

Next Steps

Botswana's Family Health Division will appoint a committee to review and ratify the agreed changes in the policy guidelines. The new, revised guidelines will be used to revise the family planning procedures manual. Pre- and in-service **training curricula** will be harmonized with the new policy norms. Beginning in January 1995, the new in-service family planning curriculum will be used for Ministry of Health (MOH) training. The **new training approach** will be competency-based and participatory to replace the classroom, didactic approach. ♦

Zimbabwe

In July 1994 a **national medical barriers workshop**, organized by the Zimbabwe National Family Planning Council (ZNFPC) with USAID, was held for 20 participants. All sectors were invited (including provincial medical officers, provincial nursing officers, Ob/Gyn lecturers, MOH, ZNFPC) to revise service guidelines and IEC materials. At this meeting, a **medical barriers task force** was formed. The task force has met three times since the national meeting to highlight existing barriers in family planning documents and to list recommended revisions.

From November 7–18, 1995, 18 participants attended a workshop sponsored by the ZNFPC in Harare to review national policy and service delivery guidelines and to incorporate changes recommended by the medical barriers task force. The following key documents were reviewed and revised: service delivery guidelines, clinical procedures manual, clinical training manual, CBD procedures and CBD training manual, the IUD/GTI reference manual, trainer's notebook and participant handbook. Final editing to these manuals, under the supervision of the ZNFPC's Chief Training Officer and Chief Nursing Officer, is ongoing and will be completed by the end of January 1995.

Agreed Changes to Zimbabwe Family Planning Service Guidelines, Procedures and Policies

Process hurdles reduced
- Physical examination is required for new family planning (FP) clients on the first visit only (used to be required annually as a prerequisite for receiving FP methods).

Provider limitations decreased
- Trained provider (physician/nurse/midwife) can provide any reversible method (reversed the physician-only rule).

Oral Contraceptives (OCs)
- Disbursement of OCs should be as follows: *Clinic*: three packets at initial visit; 12 cycles (up from three cycles) at follow-up. *CBD*: three packets at initial visit; six cycles (up from three cycles) at follow-up. *Depot Holder*: three packets at initial visit; six cycles (up from three cycles) at follow-up. *Youth Centre*: three packets at initial visit; six cycles (up from three cycles) at follow-up.

IUDs
- No backup method necessary as IUD is effective

upon insertion (reversed recommendation that backup method be used for seven days).

- IUDs can be inserted or removed at any time in a woman's menstrual cycle, as long as pregnancy is ruled out by history and vaginal exam (reversed practice of insertion/removal only during menses).
- A six-week checkup postinsertion is the only return visit necessary if no problems/complaints.

Voluntary Sterilization (VS)

- Age and parity should not be limiting factors in the provision of VS services. Critical factor is thorough counseling to rule out indicators of possible regret.

Next Steps

Revised training manuals will be pretested during an upcoming training course, during which additional changes will be recommended. Final revisions to family planning service delivery guidelines, procedures and policies will be reviewed and ratified by a committee of family planning experts by the end of May 1995. ♦

Upcoming ESA MAQ Events

Kenya Norms Revision: A five-day workshop for 20 key decision makers at the MOH, USAID and other cooperating agencies was held in November 1994 to review and revise Kenya's national family planning service delivery norms. The revised guidelines produced at this workshop will be used to revise training curricula and increase training quality at district training centers.

Mini-MAQ Workshops in Zimbabwe: JHPIEGO assistance has been requested by the USAID mission in Zimbabwe to conduct local-level workshops in collaboration with the ZNFPC. These workshops, modeled on the ESA regional MAQ workshop, will be held at the provincial level, beginning in mid-1995, to ensure sensitization of provincial-level policy makers and service providers to the MAQ initiative. ♦

New World Health Organization Classification System [2]

From March 7–11, 1994, a scientific working group of 26 reproductive health experts from 16 countries met at the World Health Organization (WHO) in Geneva, Switzerland, to review current clinical and epidemiological data on selected methods of contraception. As a result, the group has issued a draft report, *Improving Access to Quality Care in Family Planning. Eligibility Criteria for Initiating Use of Selected Methods of Contraception*, to provide guidance to policy makers, family planning program managers and the scientific community in updating the eligibility criteria for the initiation of low-dose combined oral contraceptives (COCs), progestin-only oral contraceptives, DMPA, Norplant implants and copper-containing IUDs. The final draft of this report will be printed and circulated widely in approximately one to two months.

All available clinical and epidemiological data were carefully reviewed to weigh the risk-benefit ratio of using each method in the presence of specific “conditions.” “Conditions” were defined as both a woman's characteristics (e.g., age, history of pregnancy) and known preexisting medical/pathological conditions (e.g., diabetes, hypertension). The presence of conditions affecting eligibility for use of a contraceptive method were ranked according to the following four categories:

1. A condition for which there is no restriction for the use of the contraceptive method
2. A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3. A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4. A condition which represents an unacceptable health risk associated with the use of the contraceptive method

Based on this classification system, a three-column table format was developed which classifies eligibility criteria for initiating use of specific methods. Column one of the table (see top of page 6) specifies the condition being considered.

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[2] World Health Organization (WHO). *Improving Access to Quality Care in Family Planning. Eligibility Criteria for Initiating Use of Selected Methods of Contraception: Combined oral contraceptives, Progestin only pills, DMPA, Norplant implants and Copper IUDs.* Draft Report. Geneva, WHO, November 1994.

Column two classifies the condition into one of the four categories described above ranging from one to four. Column three gives a brief rationale for the classification assigned.

These tables may serve as a guide to the service provider. For example, if a client presents with hypertension, malaria or sickle cell disease, and the initiation of low-dose COCs (containing $< 50\ \mu g$ of ethinyl estradiol) is being considered, the following table would apply:

CONDITION	CATEGORY	RATIONALE/COMMENTS
Essential Hypertension		
• Mild hypertension (< 180/105)	2	COC causes only small changes in blood pressure among non-hypertensive women. Primary concern is risk of underlying vascular disease and additional risk of thromboembolism.
• Moderate and severe hypertension	3	
• Vascular disease	3/4	The health risk/benefit ratio is dependent upon the severity of the condition.
Malaria	1	Not relevant for eligibility for this contraceptive method. No need for restriction of COC use.
Sickle Cell Disease	3	Women with sickle cell disease are at increased risk of thrombosis.

The working group also developed a table format that classifies eligibility criteria by condition for all of the methods considered. For example:

CONDITION	COC[1]	POP[2]	DMPA[3]	NORPLANT	IUD
Age	< 40 = 1 > 40 = 2	< 16 = 2 > 16 = 1	< 16 = 2 > 16 = 1	< 16 = 2 > 16 = 1	< 20 = 2 > 20 = 1
Parity					
• Nulliparous	1	1	1	1	2
• Parous	1	1	1	1	1
STDs: current or within three months	1	1	1	1	4
HIV/AIDS					
• HIV+	1	1	1	1	3
• High risk of HIV	1	1	1	1	3
• AIDS	1	1	1	1	3

[1] Combined oral contraceptive [2] Progestin-only pill [3] Depot-medroxyprogesterone acetate (injectable)

This WHO classification system is intended to be adapted for use at the country-program level. For example, the four-category classification system (see column one, opposite page), which would be appropriate for use where the necessary clinical judgment could be provided, may be simplified into a two-category (yes/no) system (see column three, opposite page) for use in situations where clinical judgment is limited, such as in community-based services.

CLASSIFICATION	WITH CLINICAL JUDGMENT	WITH LIMITED CLINICAL JUDGMENT
1	Use method in any circumstances.	Yes
2	Generally use the method.	Yes
3	Use of method not usually recommended unless other more appropriate methods are not available or acceptable.	No
4	Method not to be used.	No

For the future, WHO will collaborate with other international agencies to address medical criteria for **both initiation and continuation of all available contraceptive methods**, including levonorgestrel IUDs, NET-EN, combined once-a-month injectables, barrier methods, female and male sterilization, natural family planning, withdrawal, and emergency postcoital oral contraceptive regimen. ♦

MAQ in East and Southern Africa

ESA MAQ Workshop Delegate Elected Member of Parliament

Dr. Manto Tshabalala, a family planning leader in South Africa, has been elected as a Member of Parliament in the new South African government. Dr. Tshabalala, National Coordinator of the Progressive Primary Health Care Network, was a member of the South African delegation at the February 1994 ESA MAQ workshop in Zimbabwe. She will play a leadership role in maximizing access to and quality of family planning services in the new South Africa. ♦

Dr. Manto Tshabalala

MAQ in Other Regions

Turkish Clinicians Find Local Solutions

Clinicians in Turkey are working on a national standardization effort to reduce barriers to family planning services and training which involves the Ministry of Health and approximately half of the Turkish medical schools. Not only have constraints (that are commonly found in many clinical training sites) been identified , but some local solutions have been found. To compensate for the resource limitation of drapes, trays, and containers for sterilization, one trainer devised a cloth instrument pack (see photo, page 8), made of cotton material, with internal pockets that hold the IUD instruments, a flap that closes the pack, and a tie that fastens it for autoclaving and storage. When unfolded, this pack serves as a sterile drape on which to place the instruments, including a place for the speculum between insertions. To provide each client with an individual antiseptic container, clinical trainers are using readily available items such as disposable specimen containers, plastic yogurt cups and small metal Turkish tea saucers. This system of individualized local antiseptic containers eliminates possible cross-contamination among clients. Uterine sounds, which would have been considered unusable after only a few uses due to apparent corrosion, are

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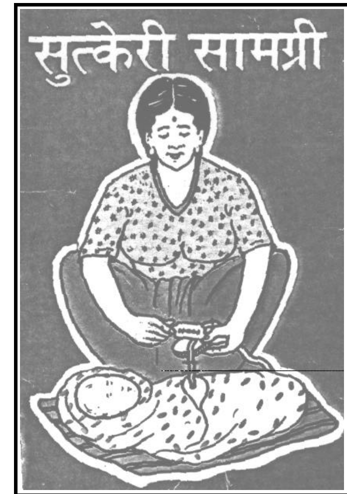
now easily cleaned and reused. The black coating on these instruments (caused by a deposit of calcium carbonate, in areas of Turkey where the water has a high calcium content) can be completely removed by soaking them in a vinegar solution and gently wiping them with a smooth cloth.

Cloth instrument pack

These are a few examples of innovative solutions developed by clinicians in Turkey that are inexpensive, practical, adaptable and locally feasible ways to maximize contraceptive access and improve the quality of family planning services. ♦

Nepali Birthing Kit Prevents Infection

Traditional birth attendants and midwives in Nepal are using a locally manufactured safe birthing kit that helps prevent the spread of infection during and after childbirth in home deliveries. The kit's contents, which are clean and sealed in plastic, include a small bar of soap, a coin-sized plastic disk on which to cut the umbilicus, a new razor blade, three pieces of string to tie the umbilicus, and a thin plastic sheet which can be spread under the mother during the delivery. In addition, the kit contains a set of step-by-step illustrated instructions that emphasize handwashing before and after the delivery and the wrapping of instruments and afterbirth in the plastic sheet for safe disposal. All of these are contained in a small cardboard box about the size of a deck of playing cards which is lightweight, easily carried in a pocket, inexpensive, and soon will be available in Nepali markets. Since the kit is modeled on traditional Nepali birthing practices (for example the plastic disk replaces a coin that would normally be used for cutting the umbilicus), it is readily accepted. This safe birthing kit is the product of an 18-month intensive social marketing research project by the Nepal Save the Children Alliance (funded by UNICEF and UNFPA, with technical assistance from PATH with USAID funding), which tested the kits in homes and in the marketplace. The first Nepali women's health micro-enterprise was organized to produce this kit. In its first few months, the group has produced over 30,000 kits to supply to local nongovernmental organizations (NGOs), and will soon be providing the kits to retailers in the market. ♦



Nepali birthing kit

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