



MAQ Bulletin

Maximizing Access and Quality of Services

Issue No. 2, February 1996

ESA Countries Take Action

From the Chair of JHPIEGO's MAQ Task Force

Two years have passed since many of you gathered in Harare, Zimbabwe, for the East and Southern Africa (ESA) workshop to launch the Maximizing Access and Quality (MAQ) initiative. Among the most notable achievements reported in 1995 are more than 30 changes in policies, practices and strategies in four ESA countries (Botswana, Kenya, Uganda and Zimbabwe).

By January 1995, when the first issue of the *MAQ Bulletin* for East and Southern Africa was published, much progress had already been made toward achieving the MAQ action plan objectives you documented at the February 1994 workshop. Owing to a variety of innova-

tive followup activities designed and conducted by leaders like yourselves, significant changes in reproductive health policies, guidelines and protocols have been made. Building on the favorable policy environment for reproductive health, you have turned the written document into action by training and delivering services according to new national standards.

JHPIEGO, with support from HHRAA/SARA, continues to follow your progress with great interest. This bulletin is intended to serve as a record of your many successes, to provide workshop followup and evaluation information, and to disseminate new information in the field of reproductive health.

Sandra de Castro Buffington, Chair
JHPIEGO Maximizing Access and Quality Task Force



Uganda Nurse Trainers Learn New FP Curriculum Skills:

Uganda nurse trainers prepare to train service providers in new inservice FP curriculum skills. Pictured is Perpetua Otim, Family Planning Association of Uganda, working with Zimbabwe National Family Planning Council trainer "Busi" Moyo and Morehouse School of Medicine consultant Linda Windham, in Lweza, Uganda, September 1995.

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Botswana Update

Revised Guidelines Await Official Approval

Botswana's family planning leaders have made tremendous strides in removing medical barriers identified at the 1994 ESA regional MAQ workshop by revising the



Family Planning General Policy Guidelines and Service Standards. (See issue no. 1 of this bulletin for highlights of measurable changes in Botswana's guidelines.) Botswana's revised policy guidelines are currently in the Permanent

Secretary's office, where approval is imminent.

Training Curricula Consistent with Guidelines

The impact of Botswana's revised policy has reached the training arena: Botswana's inservice training curricula have been revised using the new guidelines as a framework. Master trainers have transformed the new policy into action by clarifying and utilizing the guidelines during inservice training.

Couple Years of Protection Increases 50–100%

Evaluations conducted at two delivery sites (one where master trainers are assigned and one where the first group of newly trained participants provide services) indicate a

significant (50–100%) post-training increase in couple years of protection delivered at these facilities (personal communication, Health and Population Advisor, USAID/Botswana). ♦



Informed trainers are the link between updated FP policy and improved service delivery. (Left to right) Brenda Smuts (RN, South Africa), Mr. Erastus Njeru and Dr. Wangari Kuria (University of Nairobi lecturers), and Dr. John Nyamu (Marie Stopes ob/gyn intern trainer) attend Clinical Training Skills course, in Nyeri, Kenya, March 1995.

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Kenya Update: Results of the 1994 ESA MAQ Workshop

At a December 1994 policy guidelines workshop in Naivasha, Kenya, technical experts presented contraceptive technology updates (CTUs) to representatives from the Ministry of Health/Division of Family Health, the University of Nairobi, Department of Ob/Gyn and Kenya's ESA regional MAQ delegates. Following the CTUs, the Kenyan *National Family Planning Policy Guidelines and Standards for Service Providers* were revised to reduce barriers to quality family planning (FP) services and to expand reproductive health services for women and adolescents.



Measurable Changes in Policies, Procedures and Programs

Client restrictions reduced

- All restrictions related to age have been removed, making contraceptives available to adolescents.
- Parity is no longer a determinant of eligibility for IUDs and DMPA.
- Voluntary surgical contraception is available to all women of reproductive age. Spousal consent is no longer required.
- Contraceptive eligibility has been revised to reflect WHO criteria for a variety of medical conditions (see WHO Update, pp. 4–6).
- New guidelines provide more detailed information on: benefits and limitations of all methods; where services can be obtained.

New methods introduced

- New section on emergency contraception has been added.
- Lactational amenorrhea method has been added as a natural method.

Counseling and management policies improved

- Sections have been added to guidelines on the management of common side effects.
- Guidelines now include sections on reproductive health areas: sexually transmitted diseases (STDs), cervical cancer, antenatal care and safe motherhood.

- Increased emphasis on postabortion family planning; method-specific guidelines now indicate methods suitable for postabortion clients.

FP services expanded

- Community-based distribution workers can provide an initial 3-month supply of combined oral contraceptives (COCs) and a 6-month resupply.
- Ninety new dispensaries were designated as FP service delivery points.

Measurable Changes in Strategies

Simultaneous changes in curriculum

- Curriculum for nurses has been updated concurrent with the FP guidelines. Inservice curriculum now includes reproductive health issues.

Youth programs expanded

- Youth counseling increased subsequent to the workshop; youth clinics have been established at colleges, universities, the Family Planning Association of Kenya and the University of Nairobi. A “Young Adult Clinic” is being pilot-tested. ♦

Uganda Update: Results from the 1994 ESA MAQ Workshop



The seven Ugandan ESA MAQ workshop delegates served as advocates for change by establishing the following country action plan objectives: improve provider competence, strengthen the FP component of health workers' preservice curricula, update and formulate guidelines and policy, and introduce a user charge for services.

Measurable Changes in Policies, Procedures and Programs

Sustainability increased

- A user charge has been implemented in some facilities for some FP services, including provision of condoms, OCs and surgical contraceptives. ♦

Update: WHO Eligibility Criteria



The January 1995 issue of the *MAQ Bulletin* featured an article on a classification system developed by a scientific working group at the World Health Organization (WHO) in Geneva, Switzerland, in March 1994, to provide guidance to policymakers, family planning program managers and the scientific community in updating eligibility criteria for the initiation of selected methods of contraception. In May 1995, a second scientific working group meeting was held and a final report produced.¹

The 1995 report includes eligibility criteria for **both initiation and continuation** of a wide range of family planning methods: low-dose combined oral contraceptives (COCs), combined injectable contraceptives (CICs), progestin-only pills (POPs), depot medroxyprogesterone acetate (DMPA),

The 1995 report includes eligibility criteria for both initiation and continuation of a wide range of family planning methods.

norethindrone enanthate (NET-EN), Norplant[®] implants (NOR), emergency contraception (emergency contraception pills and emergency use of IUDs), copper intrauterine devices (Copper IUDs), the levonorgestrel IUD (LNG-IUD), female and male sterilization, natural family planning methods (NFP), calendar method, coitus interruptus, barrier methods and lactational amenorrhea.

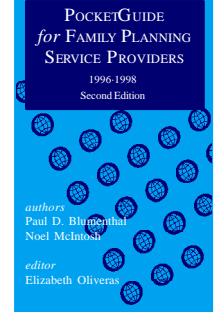
Eligibility criteria tables have been revised and expanded. For example, criteria for use of low-dose COCs (i.e., those containing $\leq 35\mu\text{g}$ of ethinyl estradiol) in clients with hypertension have been revised and more clearly delineated.

¹ World Health Organization (WHO). 1995. *Improving Access to Quality Care in Family Planning. Medical Eligibility Criteria for Initiating and Continuing Use of Contraceptive Methods*. WHO: Geneva. (The final report, which contains complete tables and reference citations, is expected to be published and distributed in early 1996. You may obtain this report from the Unit of Family Planning and Population, Family and Reproductive Health, World Health Organization, Avenue Appia, 1211, Geneva 27, Switzerland.)

² Blumenthal PD and N McIntosh. 1996. *PocketGuide for Family Planning Service Providers*, 2nd ed. JHPIEGO Corporation: Baltimore, Maryland, USA.

³ Technical Guidance Working Group. 1994. *Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting, Volume 1: Combined Oral Contraceptives, Progestin-Only Injectables, Norplant[®] Implants, Copper-Bearing Intrauterine Devices*. USAID: Washington, DC.

Harmonized PocketGuide: The soon-to-be-published second edition of JHPIEGO's *PocketGuide*² has been harmonized with WHO's medical eligibility criteria and with USAID's Technical Guidance Working Group document.³



Guidelines for Use of COCs in Clients with Hypertension

The following simplified guidelines, adapted from the WHO report, may be applied in situations where clinical experience is limited, such as in community-based services:

- Women with mild hypertension ($<160/100$) may use COCs; however, close blood pressure monitoring is recommended.

Low-dose COCs should *not* be used if the following conditions are present:

- History of hypertension where blood pressure can not be evaluated (excluding hypertension in pregnancy)
- Blood pressure $\geq 160/100$

Summary tables have been updated and expanded to include additional family planning methods. For example, criteria listed in **Table 1** (page 5) apply for STDs.

In a **new section on voluntary sterilization**, conditions or circumstances relevant to the timing of the procedure or selection of the facility where the procedure should be performed have been defined according to four categories, as shown in **Table 2** (page 5).

See page 6 for **summary and main conclusions** of the WHO eligibility criteria.



Table 1. WHO Medical Eligibility Criteria for STDs

Condition	CIC	COC	POP	NET-EN DMPA	NOR	Copper IUD	LNG-IUD
STDs							
Current or within 3 months (including purulent cervicitis)	1	1	1	1	1	4	4
Vaginitis without purulent cervicitis	1	1	1	1	1	2 ^a	2 ^b
Increased risk of STDs (e.g., multiple partners or partner who has multiple partners)	1	1	1	1	1	3	3

^a Where background incidence of STDs is high, vaginitis may indicate STD.

^b Continued use of an IUD depends on the client's current risk factors for STDs and PID and her informed choice.

Note: Conditions affecting eligibility for use of each contraceptive method are ranked according to the following four categories:

- 1 = No restriction for use of the contraceptive method.
- 2 = Advantages of using the method generally outweigh the risks.
- 3 = Risks usually outweigh the advantages of using the method.
- 4 = Unacceptable health risk associated with using the method.

Table 2. WHO Voluntary Sterilization Categories

WHO Voluntary Sterilization Categories	Definitions	Examples
A(Accept)	No medical reason to deny sterilization.	Age < 35 (Clients of any reproductive age are eligible for voluntary sterilization.)
		History of deep venous thrombosis/pulmonary embolism
C(Caution)	Conduct procedure in a routine setting, but use extra preparation and precautions.	Nonvascular diabetes
D(Delay)	Delay procedure until condition is evaluated and/or corrected. Provide alternative temporary methods of contraception.	A current STD (including purulent cervicitis)
S(Special)	Undertake procedure in a setting where an experienced surgeon and staff, equipment to provide general anesthesia and other backup medical support are available. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Provide alternative temporary methods of contraception, if referral is required or there is otherwise any delay.	Coagulation disorders
		Chronic lung disease (relevant only for female sterilization)



WHO Medical Eligibility Criteria: Summary and Main Conclusions

- Many restrictions on the use of high-dose COCs (i.e., those containing a high dose of estrogen) do not apply to low-dose COCs.
- Eligibility criteria for progestin-only methods are different from those for combined estrogen/progestin methods. For example, use of COCs is more restrictive than progestin-only contraception for women with the following conditions: breastfeeding, hypertension, venous thromboembolism, stroke and complicated heart disease.
- Risk of STDs is the main factor restricting the use of IUDs. Most medical conditions are not contraindications for IUD use.
- Age alone is not a sufficient criterion for denying a woman any of the contraceptive methods.
- Irregular menstrual bleeding generally does not disqualify a woman from using any method.
- Unexplained vaginal bleeding should be evaluated before deciding whether or not a woman can use a method.
- Unless otherwise described in the WHO document, clinical and laboratory diagnostic tests are not considered mandatory for the safe use of the contraceptive methods reviewed as long as the client's history is taken correctly.

Complications of Unsafe Abortion in Africa: Translating Research into Policy, and Policy into Action

A *Monograph on Complications of Unsafe Abortion in Africa* was published in August 1995, as a collaborative effort among the Commonwealth Regional Health Community Secretariat (CRHCS) for East, Central and Southern Africa (ECSA), JHPIEGO, IPAS and the Academy for Educational Development. The monograph contains the results of a literature review on abortion in sub-Saharan Africa (SSA) covering the years 1980 to 1994 and primary data collection in three Commonwealth countries (Malawi, Uganda, Zambia). Recent data collected from the three countries specifically for this monograph confirmed, for the most part, the findings of the comprehensive literature review.

Findings

The high proportion of incomplete abortion patients among hospital gynecology admissions (up to 60% in some places) points to a significant public health problem. Hemorrhage and sepsis were identified as the two most common com-

plications of unsafe abortion among women presenting at health facilities.

Experiences with the use of manual vacuum aspiration (MVA) in SSA for treating abortion complications have been positive as measured by shorter lengths of hospital

The high proportion of incomplete abortion patients among hospital gynecology admissions points to a significant public health problem.

stay and a reduced need for a second evacuation; however, important research gaps exist, including how MVA services can be expanded to lower levels of the health system.

Very little information exists on the cost of treating abor-

continued on page 7

⁴ Johnson BR et al. 1993. Costs and resource utilisation for the treatment of incomplete abortion in Kenya and Mexico. *Social Science and Medicine* 36(11): 1443–1453.



tion complications. One study⁴ which compared facility costs of patients treated with MVA versus sharp curettage documented decreases of over 65% with the use of MVA. Researchers collecting primary data in Malawi estimated that the cost of treating one abortion patient with no serious complications was higher than the amount budgeted annually per capita for overall health care by the Malawi Parliament.

In almost all facilities surveyed in the three monograph study countries, the providers noted that incomplete abortion patients were not using any modern method of FP when they became pregnant. In the literature reviewed, adolescents, in particular, did not use an effective method of contraception. This was true because, often, adolescents do not have access to FP services—which makes them a population particularly vulnerable to unsafe abortion.

Research literature on postabortion family planning services in SSA is virtually nonexistent, which probably reflects the lack of these services in general in the region. In fact, in the facilities surveyed, neither postabortion FP counseling nor FP methods were offered before discharge. Many of the providers surveyed, however, thought that FP information and services *should* be provided to abortion patients following the procedure.

In most ECSA countries, local laws restrict or prohibit women from obtaining safe, legal abortions. Providers surveyed in Malawi, Uganda and Zambia, however, were almost unanimous in their opinion that women will choose to abort and that providers will perform the procedure despite these laws.

Policy and Program Implications

In November 1994, study findings summarized in the initial draft of the monograph were presented with policy and program implications to officials attending the 22nd

Conference of Health Ministers held in Blantyre, Malawi. The final version of the monograph was presented and distributed at the CRHCS Directors' Joint Consultative Committee meeting in Nairobi, Kenya, in August 1995, where it was utilized to draft a regional action plan to address various aspects of the problem. Representatives of the Ministries of Health of the 13 ECSA countries and members of donor organizations including the World Bank and the United Nations Population Fund attended the meeting.

Next Steps

Policy and program implications of the research will be summarized in a shorter policy document to be shared with officials at a future CRHCS Conference of Health Ministers. In addition, the country reports are being further developed for country-wide distribution, and follow-on activities are being planned to facilitate the translation of regional postabortion care policy into action. ♦

Extension of the Pill-Free Period by Three Days in Oral Contraceptive Users.⁵



Abstract: The authors studied the effect of extending the 7-day pill-free interval between cycles to 10 days. One hundred seven healthy volunteers with confirmed ovulatory cycles were randomly assigned to treatment groups with one of three new, low-dose COCs: monophasic gestadene (MG) with ethinyl estradiol (EE), triphasic gestadene with EE or monophasic desogestrel with EE.

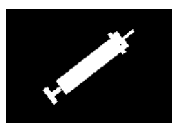
Although evidence of pituitary-ovarian recovery (increasing FSH and E₂ and follicular growth) during the extended pill-free interval was found, ovulation was **not** observed. (One patient on MG had ovulatory levels of progesterone in one cycle, but this was shown by ultrasound to be due to an unruptured luteinized follicle, not ovulation.)

⁵Lähteenmäki P et al. The Family Federation of Finland: Helsinki, Finland. (Abstract presented at the meeting of the Society for the Advancement of Contraception, Guatemala City, Guatemala, March 1995.)



Thus, although recovery of significant ovarian function appears to be common in COC users if the pill-free period is extended to 10 days, normal ovulation appears to be rare in this interval. Therefore, the risk of pregnancy for clients missing a pill early in the cycle or starting the pill a day or so late (beyond day 7) may not be as great as was formerly assumed. ♦

Cross-Sectional Study of Bone Density in Long-Term Users of DMPA⁶



Abstract: In 1991 Cundy et al (New Zealand) reported that long-term DMPA users (more than 1 to 2 years) experienced a significant loss in bone density. The design of that study was flawed, however, and variance in the measurements was very high (in many cases greater than the differences in the measured loss). Until this new (1995) paper was published there was no evidence to refute these findings. In the present cross-sectional study of long-term users of DMPA who were amenorrheic or only spotting for more than 1 year, spine and femoral neck bone density was measured and compared to that of an age-matched population of nonDMPA users.

Based on the preliminary results, the authors found no significant changes in spinal or femoral neck bone density (measured as 98–99.5% of that of the age-matched population). Because the youngest subject was 21, however, this study does not shed any light on the question of possible bone loss in DMPA users who are very young—ages 13 to 16. (This is the time period when the rate of bone deposition is greatest, and the potential effect of changes in bone metabolism also could be the greatest.) ♦



Updating Contraceptive Technology and Standardizing Skills: Ugandan preservice faculty Elizabeth Katende and Samuel Emajuma use anatomic model to update and standardize IUD insertion skills, in Kampala, Uganda, August 1995.

⁶Gbolade BA and RJE Kirkman. University of Manchester: Manchester, England. (Abstract presented at the meeting of the Society for the Advancement of Contraception, Guatemala City, Guatemala, March 1995.)



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