

MAQ Bulletin

Maximizing Access and Quality of Services

French version, Issue No. 1, October 1996

From the Chair of JHPIEGO's MAQ Task Force

Many of you met in Ougadougou, Burkina Faso, from March 12–17, 1995, for a very significant conference called the *Regional Conference on Increasing Access and Improving the Quality of Family Planning and Selected Reproductive Health Services in Francophone Sub-Saharan Africa*.¹ During the six days of the conference, 126 participants—including health professionals, jurists, government agency representatives, population experts, journalists, religious leaders, representatives of women's groups and sociologists—attended sessions to update knowledge on contraceptive methods and to address laws, practices and protocols that create barriers to access and quality of reproductive health (RH) services. You shared information and openly discussed issues of gender, harmful traditional practices, sexually transmitted diseases (STDs) and AIDS. Delegates from 10 francophone Africa countries—Benin,

Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Madagascar, Mali, Niger, Senegal and Togo—returned home with draft action plans that outlined practical strategies that would improve selected RH and family planning (FP) services in their home countries.

West Africa has been and continues to be a leader in the initiative to increase contraceptive range and access. For example, Senegal and Mali introduced Norplant® implants as an available method and increased its accessibility by permitting midwives, as well as physicians, to insert and remove the implants. Mali was a ground breaker in increasing adolescents' access to contraception by allowing this age group to use Norplant implants—provided they were counseled. You and your colleagues have reached many milestones toward increasing access to contraception and improving the quality of RH care in your region. Cameroon, Ghana, Guinea, Mali, Senegal and Togo have developed or updated their reproductive health service delivery guidelines. In addition, Benin has committed resources to update its guidelines. In October 1995, an infection prevention (IP) conference—the first of its kind in West Africa—sensitized decision makers and key service providers to the importance of IP in RH/FP service delivery and set in action national IP policies that will be implemented in Guinea, Mali, Niger and Senegal.

The purpose of this *Bulletin* is to document these achievements, to disseminate your success stories so that others may benefit from the progress you have made, to provide you with contraceptive technology updates, and to lend encouragement as you continue your efforts to increase access to contraception and improve the quality of RH care.

We are very pleased to send you this first of three issues of the French version of the *Maximizing Access and Quality (MAQ) Bulletin*. We hope you will make this your bulletin. Your suggestions for future *Bulletin* articles are most welcome.

*Sandra de Castro Buffington, Chair
JHPIEGO MAQ Task Force*



Anne Pfizer

Mali Hosts IP Conference, First of Its Kind in West Africa: Members of the Niger delegation (Mlle Mariama Amadou, Dr. Maimouna Kane, Mlle Agak Fatima Male, Prof. Hamadou Ousseini and Prof. Alio Sabo) meet to develop a policy document for infection prevention. Also pictured is Dr. Seydou Ousmane Diallo, representative from the World Health Organization in Mali.

¹ This conference was organized by FHI, JHPIEGO and INTRAH. For copies of the conference proceedings, please contact FHI (Family Health International), PO Box 13950, Research Triangle Park, North Carolina, 27709 USA. Fax: (919) 544-7261.



MAQ Followup Questionnaire Results

(collected and submitted by INTRAH)

A MAQ francophone conference followup questionnaire was sent in August 1995, 5 months post-conference, to 76 participants (54 delegates, 16 Technical Committee members and 6 USAID HPNOs). The purpose of the questionnaire was to determine the extent to which participants had implemented their country action plans. The following are highlights of responses received from 56% of participants surveyed from all 10 countries represented at the conference:

- 58% reported that the most significant objective of the conference—to improve service accessibility and quality—was met to a great extent
- 75% of country plans received official endorsement, primarily from heads of FP divisions

- 81% of the action plans or selected activities have been integrated into a national 5-year Maternal and Child Health (MCH)/RH/FP plan or strategy, particularly removal of access and quality barriers, with 77% reporting the consistency of the plan with current national objectives as a major factor in implementation
- 80% of respondents have become more professionally active in advocating changes in FP/RH policies, programs and practices

However, 50% of respondents cited funding shortages as a major barrier in attempting to implement their country action plans, with half of these respondents coming from countries where USAID has closed its missions.

Plans have been made to conduct in-depth interviews with the delegates to determine the extent to which the MAQ initiative has contributed to strengthening RH programs in the region. Highlights of these interviews will be included in upcoming issues of the French version of the MAQ bulletin. ♦

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This bulletin was produced by JHPIEGO, an affiliate of Johns Hopkins University. JHPIEGO, a nonprofit organization dedicated to improving the health of women and families in developing countries, works to increase the number of qualified health professionals trained in modern reproductive health care, especially family planning.

The *MAQ Followup Questionnaire Results* article was contributed by INTRAH (Program for International Training in Health). INTRAH is a nonprofit organization whose mission is to assist countries in various stages of development transition to improve the development and delivery of essential reproductive health services through better preparation and utilization of human resources.

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New User-Friendly Service Delivery Guidelines are a “First” in Senegal

In early June 1996, Senegal’s first FP service delivery guidelines (SDGs) were approved by the Ministry of Health. The guidelines were drafted by a comprehensive



working group of representatives from all Senegalese FP partners including Ministry officials, training institutions and schools, and private sector service provider

organizations. As the first family planning SDGs ever written in Senegal, their development represents a notable milestone towards achieving FP services that are standardized to provide maximum access and quality for Senegalese women and men.

Highlights of Senegal’s New Guidelines ²

Who can provide services

- Nurses, midwives and physicians can provide IUD and Norplant implants services. ³

Unnecessary physical examinations reduced

- Pelvic exams will only be required for women seeking the IUD or minilaparotomy.

Client restrictions reduced

- All methods will be available to unmarried and/or nulliparous women.

Services standardized

It is hoped the SDGs will ensure standardized and effective infection prevention (IP) practices and reduce inconsistencies in FP services. For example, the guidelines specify that:

- 3 packets of pills can be provided to oral contraceptive clients at the first visit

In the past, instructions regarding resupply of pills as well as the timing of return visits for other contraceptive methods have been inconsistent. The new SDGs have established the return visit intervals shown below in **Table 1**.

After field testing a variety of guideline formats to determine the most user-friendly and appropriate way to present this new material to service providers, the guidelines will be printed and disseminated first by means of a national launch at the end of 1996, and then at regional level seminars for service providers. The guidelines, which are currently written as two documents, *Family Planning Policies and Norms* and *Protocols for Family Planning Services*, will be integrated into curricula, supervisory checklists, FP clinic forms and IEC materials. ◆

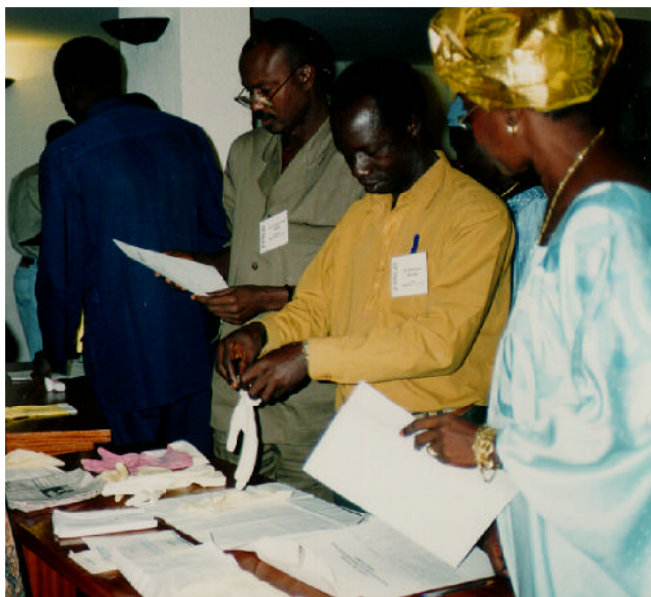
Table 1. Return Visit Intervals Specified in Senegal Guidelines

Contraceptive Method	First Return Visit	Subsequent Visits
Oral contraceptives	2 months ^a	every 3 months
Norplant implants	1 month	3 months, then every 6 months
Injectables	DepoProvera: 3 months	DepoProvera: every 3 months
	Noristerat: 2 months	Noristerat: every 2 months
IUD	1 month	6 months, then 1 year
VSC	1 week	

^a Women are given 3 packets of pills but asked to return when beginning the 3rd packet (i.e., at the end of 2 months) for resupply.

² Although there were no previous guidelines in Senegal as a baseline against which to measure the extent and range of the changes in service delivery that these new guidelines will bring, anecdotal information about formerly existing practices provides insight into the impact some of these changes will have on reducing barriers to contraceptive services.

³ Even before the guidelines were written, during the introductory phase of Senegal’s Norplant implants introduction program, Senegal granted official approval for nurses and midwives to provide Norplant implant services (see page 5, *Senegal and Mali: Ground Breakers in Norplant Implants Introduction*). Nurses and midwives were also allowed to provide IUD services before the guidelines were written.



Teresa McHenry

IP Conference Delegates Learn Appropriate Technique for Putting on Sterile Gloves: (Left to right) Col. Lamine Cissé Sarr from Senegal, Dr. Emmanuel Malano from Guinea, and Dr. Henriette Carvalho Kouyate from Senegal play a game of “IP Golf.”

Guinea, Mali, Niger and Senegal Create Guidelines to Prevent Infection

West Africa infection prevention (IP) conference, the first of its kind in the region, responds to need for IP sensitization

In October 1995, 38 West African decision-makers and key service providers representing Guinea, Mali, Niger and



Senegal were sensitized to the importance of IP in RH/FP service delivery. The conference, held in Bamako and organized by JHPIEGO in collaboration with the Malian Division of Family and Community Health and AVSC International, featured

both informational sessions and innovative hands-on learning activities. Session topics included *HIV/AIDS and Hepatitis in the Health Care Setting*, *Maternal Morbidity and Mortality Linked to Infection* and *Postinfection Infertility*. Hands-on activities included a handmade poster

contest, “IP Bingo” and “IP Golf” games in which participants learned essential IP techniques such as loading IUDs in the sterile package, recapping hypodermic needles, and putting on sterile gloves. The conference made it clear that IP is essential not only to the health of the client, but also to the health of all levels of clinic personnel including service providers, maintenance staff and laundry staff.

Delegates returned to their home countries with a draft IP policy document which they will incorporate into their Reproductive Health Service Delivery Guidelines. The cross-institutional partnership that was formed among delegates, who represented West African medical and nursing schools, Ministries of Health, and RH/FP programs, was considered crucial to the initial success of the conference and its potential for impact within the region.

Potentially harmful practices found in West African service delivery sites

- Blood on equipment and clinic walls
- Instruments and other soiled objects not correctly decontaminated
- High-level disinfection not correctly performed
- Service providers and maintenance staff not washing hands correctly and not wearing gloves correctly
- Service providers not wearing protective barriers and exposed to infections such as HIV or hepatitis B
- Improper handling of needles and sharps which could lead to infectious needle-stick injuries
- Skin not correctly prepped prior to surgery
- Flaming of material and instruments for disinfection instead of using correct boiling techniques
- Underutilization of steam autoclaves
- Poor usage of antiseptics and antibiotics
- Improper disposal of waste materials
- Service providers performing female circumcision—or not sensitizing the population about the harmful effects of this practice

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National IP guidelines will be implemented

All health personnel will be targeted for IP sensitization, including:

- RH administrators
- Service providers
- Clients
- Maintenance and laundry staff
- Community-based distribution workers

In addition:

- IP will be integrated into both preservice and inservice training curricula.
- The importance of handwashing and the use of protective barriers will be emphasized.

Policy documents for the four countries recommend inclusion of postabortion care in RH/MCH programs.

Harmful and unnecessary practices will be discontinued

Delegates agreed to put an end to the following practices that are either harmful or not cost-effective, such as:

- Shaving before surgery
- Flaming of instruments for procedures (boiling, to replace flaming, was recommended for high-level disinfection)
- Use of antibiotics for several days after surgery
- Female genital mutilation

Infection prevention committees will be established

All four countries will establish infection prevention committees. ◆

Senegal and Mali: Ground Breakers in Norplant Implants Introduction⁴

Both Senegal and Mali were “ground breakers” in maximizing access to quality FP services through their Norplant implants programs. Senegal was one of the first countries in Africa to grant official approval for midwives to provide services during the introductory phase of the program. Mali was one of the first countries in Africa to use available scientific data to obtain regulatory approval and introduce Norplant implants without a clinical trial, and to allow the use of implants by adolescents—provided they were counseled. ◆

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 and 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 complications of unsafe abortion among women presenting at health facilities.

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⁴ Kerrigan M and L Gaffikin. 1996. *The Effect of Norplant® Implants Training on Increasing Access to Family Planning Services: the Senegal and Mali Experiences*. JHPIEGO Technical Report FCA-24. JHPIEGO Corporation: Baltimore, Maryland, USA.



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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 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.⁵

Very little information exists on the cost of treating abortion complications. One study⁶ 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. Often, adolescents do not have access to FP services—which makes them a population particularly vulnerable to unsafe abortion.

Research literature on postabortion FP 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 patients following the treatment of postabortion complications.

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 despite these laws, women will continue to seek abortions and providers will continue to perform them.

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. ◆

Update: WHO Eligibility Criteria

In March 1994 and May 1995, two scientific working groups met at the World Health Organization (WHO) in Geneva, Switzerland, to review the latest clinical and epidemiological data on a wide variety of contraceptive methods. As a result of these meetings, WHO produced a document that provides guidance to policymakers, FP program managers and the scientific community in updating eligibility criteria for **both initiation and continuation** of a wide range of FP methods, including: low-dose combined oral contraceptives (COCs), combined injectable contraceptives (CICs), progestin-only pills (POPs), depot-medroxyprogesterone acetate (DMPA),

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⁵ Greenslade FC et al. 1993. *Manual Vacuum Aspiration: A Summary of Clinical & Programmatic Experience Worldwide*. IPAS: Carrboro, North Carolina.

⁶ Johnson BR et al. 1993. Costs and resource utilisation for the treatment of incomplete abortion in Kenya and Mexico. *Social Sciences and Medicine* 36(11): 1443–1453.



WHO Medical Eligibility Criteria: Important Points

- For many medical conditions, there are no restrictions on using any of the contraceptive methods discussed.
- 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 heart disease with complications.
- 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.
- Risk of STDs is the main factor restricting the use of IUDs. Most medical conditions are not contraindications for IUD use.
- Persons at risk of STDs should be advised always to use condoms in conjunction with other methods.
- In general, as long as the client's history is taken correctly, clinical and laboratory diagnostic tests are not considered mandatory for the safe use of the contraceptive methods reviewed.

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norethindrone enanthate (NET-EN), Norplant[®] implants (NOR), emergency contraception (emergency contraceptive pills and emergency use of IUDs), copper intrauterine devices (Copper IUDs), the levonorgestrel-releasing IUD (LNG-IUD), barrier methods, female and male voluntary sterilization, natural family planning methods (NFP) including coitus interruptus and lactational amenorrhea. ⁷ ♦

Cross-Sectional Study of Bone Density in Long-Term Users of DMPA⁸



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.) ♦

⁷ World Health Organization (WHO). 1996. *Improving Access to Quality Care in Family Planning. Medical Eligibility Criteria for Contraceptive Use*. WHO: Geneva. (A French translation is being prepared. 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.)

⁸ Gbolade 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.)



Comparison Between Standard and “U” Techniques for Norplant Implants Removal⁹



Abstract: In this paper, Dr. Untung presented new data comparing the “U” technique with the standard removal method. These data indicated that with the “U” technique, the time for removal was less, fewer capsules were broken and there was less tissue trauma (i.e., fewer clients with postremoval hematoma: 2.44% versus 9.76%). A recently published

JHPIEGO technical report concludes that the “U” technique appears to be more easily learned by inexperienced, novice removers than the standard technique for implants removal. In addition, the “U” technique appears to offer significant improvements in speed and safety over the standard technique recommended by the manufacturer without any significant increase in cost. This technical report recommends that large-scale training programs should consider using the “U” technique as the removal method of choice when training new providers in implants removal. ¹⁰ (Investigators agree that correct insertion of the capsules is the single most important factor in making removal easy.) ♦

⁹ Praptohardjo U. Department of Obstetrics and Gynecology, Medical Faculty Diponegoro University, Dr. Kariadi Hospital, Semarang, Indonesia. (Abstract presented at the meeting of the Society for the Advancement of Contraception, Guatemala City, Guatemala, March 1995.)

¹⁰ Blumenthal et al. 1996. *Comparative Assessment of Norplant[®] Implants Removal Techniques: Indonesia*. JHPIEGO Technical Report FCA-22. JHPIEGO: Baltimore, Maryland, USA.



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