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TRIP REPORT B - # 359-1 and 2

Travelers: Dr. Latifou Salami, INTRAH Consultant

Country Visited: Senegal

Date of Trip: March 23 - April 5, 1993

Purpose: To participate in a Child Survival Forum for public health officials from sub-Saharan Africa, March 29 - April 2, 1993.

Program for International Training in Health

PAC IIb

University of North Carolina at Chapel Hill
Chapel Hill, North Carolina 27514 USA

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EXECUTIVE SUMMARY

From March 29 - April 2, 1993, INTRAH Consultant Dr. Latifou Salami was in Dakar, Senegal to participate in a Child Survival Forum for public health officials from sub-Saharan Africa. Dr. Salami, representing INTRAH, gave a keynote presentation on the integration of family planning with other elements of primary health care. The forum was organized by the Africa Child Survival Initiative-Combatting Childhood Communicable Diseases (ACSI-CCCD) and sponsored by CDC/Atlanta. Dr. Salami's travel and per diem were financed by CDC and his fee was paid from INTRAH central funds.

INTRAH Regional Director for Francophone Africa Mr. Pape Gaye briefed Dr. Salami and agreed on major points for him to highlight during his keynote address. Dr. Salami also consulted with UNICEF/Togo Health and Nutrition Project Associate Director Dr. Tony Musindé concerning the integration of FP into maternal health services.

More than 350 public health officials from 45 African countries attended the 5-day meeting, whose purposes were to strengthen the capacity of public health officials to improve the quality of life and child survival in Africa and identify constraints to improved child survival and maternal health in Africa.

Following presentations, discussions and debates, participants identified the following findings from 12 years of experience with child survival programs in sub-Saharan Africa:

- Child health problems in sub-Saharan Africa have been identified and strategies to address them have been developed.

- During the 1980's there was strong political support throughout the world for child survival initiatives and activities. This support yielded encouraging results, including a reduction in the child mortality rate.

- Child survival programs should be integrated with PHC to promote efficiency and an increased chance of sustainability.

- Coordination of child survival and maternal health (safe motherhood) programs at the national, regional and local levels remains an important challenge.

Two sessions focussed on family planning, chaired by the Director of Family and Mental Health of the Cameroon Ministry of Public Health Dr. David Awasum. The first session was conducted by Dr. Salami who described the constraints to FP service access as a result of unnecessary medical barriers, and the importance of developing national FP service policies and standards as a means to reduce medical barriers.

During the second session, the presenter shared lessons learned from operations research on integrating FP into MCH and primary health care programs.

Findings and recommendations included:

- This was the first CCCD meeting in which family planning was a major theme alongside combatting childhood communicable diseases. The integration of FP into child survival strategies should be promoted and encouraged.

- One of the most discussed and debated issues was implementation strategies to achieve integrated maternal health, child health and family planning service delivery. Participants raised questions about integration throughout the forum.

- There was a high level of interest among participants about the role of national FP service policies and standards in reducing medical

barriers to FP service access. Development and dissemination of these service guides should be among the key strategies for reducing service access barriers.

Dr. Salami briefed in Dakar with Mr. Jean Roy, Coordinator of the ACSI-CCCD Project at CDC/Atlanta.

SCHEDULE OF ACTIVITIES

March 15-16	Briefed with Mr. Pape Gaye, INTRAH Regional Director for Francophone Africa.
March 17	Met with Dr. Tony Musindé, UNICEF/Togo Health and Nutrition Project Associate Director.
March 17-18	Prepared the first draft of the paper.
March 22	Revised the first draft of the paper with Mr. Gaye.
March 23	Arrived in Dakar.
March 24	Briefed with Mr. Jean Roy, Coordinator of the ACSI-CCCD Project at CDC/Atlanta.
March 25-27	In his capacity as Director of Training Planning and Research Department at the Ministry of Health and Population in Togo, Dr. Salami participated in the workshop on health information systems.
March 27-28	Finalized the presentation.
March 29	Opening session of the forum, presided by Mr. Assane Diop, Minister of Health, Senegal, and Mr. G. Monekosso, WHO Regional Director.
March 29-April 2	Attended forum at the Hôtel Méridien Président in Dakar.
April 2	Closure of the forum, presided by Mrs. N'Dioro N'Diaye, Minister of Social Affairs and Women Promotion.
April 5	Returned to Lomé.
April 8	Debriefed at INTRAH/Lomé with Dr. Aliou Boly, Training and Training Materials Officer, and Mr. Bongwélé Onanga, Evaluation and Supervision Specialist.
April 24	Debriefed at INTRAH/Lomé with Mr. Gaye.

LIST OF ABBREVIATIONS

ACSI	African Child Survival Initiative
CCCD	Combatting Childhood Communicable Diseases
CDC	Centers for Disease Control
PHC	Primary Health Care

I. PURPOSE OF TRIP

The purpose of the trip was to participate in a CDC/Atlanta-sponsored Child Survival Forum for public health officials from sub-Saharan Africa in Dakar, Senegal, from March 29 to April 2, 1993.

The purposes of the forum were to

- strengthen the capacity of public health officials to improve the quality of life and child survival in Africa; and,
- identify constraints to improved child survival and maternal health in Africa.

II. ACCOMPLISHMENTS

A. Dr. Salami participated in the 5-day forum which was organized by the ACSI-CCCD and sponsored by CDC/Atlanta. Participants (an estimated 350 persons) drew on 12 years of experience with child survival programs in sub-Saharan Africa to discuss and debate lessons learned.

B. Dr. Salami, representing INTRAH, gave a keynote presentation on the integration of family planning with other elements of primary health care. Dr. Salami described constraints to FP service access as a result of unnecessary medical barriers, and the importance of developing national FP service policies and standards as a means to reduce medical barriers.

C. Briefings and debriefings were held with INTRAH/Lomé staff and Mr. Jean Roy, the Coordinator of the ACSI-CCCD Project with CDC/Atlanta.

III. BACKGROUND

In March 1993, ACSI-CCCD project representatives contacted Mr. Gaye about presenting a paper on family

planning at a forum on Africa's progress in child survival, to be held from March 29 to April 2, 1993, in Dakar.

Four hundred public health professionals working in child survival and family planning programs in sub-Saharan Africa were expected to participate in this forum.

Because of Mr. Gaye's unavailability at the time of the forum, INTRAH proposed that Dr. Salami represent INTRAH at the forum.

IV. DESCRIPTION OF ACTIVITIES

A. Preparation

Preparation was done in two phases, one in Lomé and one in Dakar.

In Lomé, Dr. Salami conducted the following activities:

- briefed with Mr. Gaye on major points to highlight during the keynote address;
- reviewed relevant documents available at INTRAH/Lomé;
- met with Dr. Musindé of UNICEF/Togo concerning the integration of FP into maternal health services; and
- prepared and reviewed the draft paper with INTRAH/Lomé staff.

In Dakar, the Dr. Salami clarified the scope of work and expectations during a briefing with Mr. Roy, and finalized preparation of the presentation with Dr. Awasum.

B. Keynote Address on Family Planning

The family planning session was held on April 1, from 8:30 to 10:30 and began with Dr. Salami's presentation.

The session was chaired by Dr. Awasum, Director of the Directorate of Family and Mental Health at the Ministry of Public Health in Cameroon.

V. FINDINGS AND RECOMMENDATIONS

1. **Finding**

This was the first CCCD meeting in which family planning was a major theme alongside combatting childhood communicable diseases.

Recommendation

The integration of FP into child survival strategies should be promoted and encouraged.

2. **Finding**

There was a high level of interest among participants about the role of national FP service policies and standards in reducing medical barriers to FP service access.

Recommendation

Development and dissemination of these service guides should be among the key strategies for reducing service access barriers.

APPENDIX A

Persons Contacted/Met

APPENDIX A

Persons Contacted/Met

CDC

Mr. Jean ROY, Coordinator of the ACSI-CCCD Project, CDC/Atlanta

Mr. Stanley FORSTER, CDC/Atlanta

Mr. Bradley HERSH, CDC/Burundi

Mrs. Kathleen PARKER, CDC/Atlanta

INTRAH/Lomé

Mr. Pape GAYE, Regional Director

Dr. Aliou BOLY, Training and Training Materials Officer

Mr. Onanga BONGWÉLÉ, Evaluation and Supervision Specialist

Others

Mrs. Veronique LAWSON, Ministry of Health/Benin

Dr. Tony MUSINDÉ, Health and Nutrition Project Associate Director, UNICEF/Togo

Dr. David AWASUM, Director of Family and Mental Health of the Cameroon Ministry of Public Health

APPENDIX B

Objectives and Schedule of the Forum

ANNEXE D

GENERAL PURPOSE

To strengthen the capabilities of African decision makers and health professionals to improve the quality of life and child survival in Africa

To assist African nations in their efforts to decrease morbidity and mortality due to immunizable diseases, malaria, diarrheal diseases, acute respiratory infections, and other communicable diseases

To share proven techniques on creative and innovative approaches to maternal health and child survival

To identify constraints and future challenges to Child Survival and Maternal Health in Africa

To revitalize commitments to Child Survival and Maternal Health in Africa

SPECIFIC OBJECTIVES

To gain knowledge on technical updates on EPI, CDD, ARI, malaria, HIV and other emerging priorities

To acquire state-of-the-art information and examples of approaches for policy and strategy development to respond to these emerging priorities

To learn about numerous implementation experiences (failures and successes) attempted in efforts to achieve Goals for Children and Development in the 1990s

To hear reports of country efforts in planning, implementation and evaluation relating to the emerging child survival priorities

CONTINUING MEDICAL EDUCATION

The Centers for Disease Control and Prevention is accredited to sponsor continuing medical education for physicians by the Accreditation Council for Continuing Medical Education. Category 1 for Continuing Medical Education (CME) credits for physicians are being offered for designated sessions by the Centers for Disease Control and Prevention. These credits are intended for physicians who have responsibility for planning, directing, or coordinating public health activities.

Criteria for awarding CME credits include attending the sessions, as documented by submitting the session evaluation forms contained in the conference registration packet. A maximum of 62 credits are available to participants who turn in completed evaluation forms at the end of the designated sessions.

Validation of earned CME credits will be sent to participants following the conference.

ACSI-CCCD

Africa's Progress in Child Survival

L'Etat d'Avancement de la Survie de l'Enfant en Afrique

29 March - 2 April, 1993

Dakar, Senegal

Conference Schedule

	8:30 am - 9:00 am KEYNOTE SESSION	9:00 am - 10:30 am PLENARY	11:00 am - 12:30 pm PLENARY	2:00 pm - 3:30 pm PLENARY	4:00 pm - 5:30 pm PLENARY
Monday March 29	I Welcome Session Senegal USAID CDC Objectives of the Meeting	II Health of the African Child - Progress and Challenges	III Health and Survival of the African Child	IV Use of Data	V Improving and Maintaining the Quality of Primary Health Care Services
Tuesday March 30	VI Integrating Care of Ill Child (WHO)	VII Diarrhea	VIII Acute Respiratory Infection	IX Malaria	X Sick Child
Wednesday March 31	XI Prevention (CDC)	XII Immunization		XIII Epidemiology at Work	XIV Malaria Initiative
Thursday April 1	XV Family Planning	XVI Safe Motherhood and Family Planning	XVII Optimal Infant Feeding	XVIII HIV/STD/TB Prevention and Control	
Friday April 2	XIX Community Implementation (UNICEF)	XX Community Partnerships	XXI Financing Primary Health Care	XXII Implementing District Level Strategies	XXIII Visions for the Future

APPENDIX C

Keynote Address on FP in Sub-Saharan Africa

ANNEXE 6

ASCI - CCCD

L'ETAT D'AVANCEMENT DE LA SURVIE DE L'ENFANT EN AFRIQUE

DAKAR 29 MARS - 2 AVRIL 1993

LA PLANIFICATION FAMILIALE EN AFRIQUE SUBSAHARIENNE

BILAN SOMMAIRE

PAR DR LATIFOU SALAMI, CONSULTANT

INTRAH

PROGRAMME INTERNATIONAL POUR LA FORMATION
EN MATIERE DE SANTE

BUREAU REGIONAL POUR L'AFRIQUE FRANCOPHONE

LOME-TOGO

PLAN

INTRODUCTION :

Problèmatique de l'offre de service de PF

CONTRAINTES

* Liées au concept

* Liées à la technologie

APPROCHE DE SOLUTION :

DEFINITION ET DEVELOPPEMENT DE POLITIQUE ET STANDARDS DES SERVICES DE PF

* Principes directeurs

* Contenu

RESULTATS :

CONCLUSION / PERSPECTIVES

INTRODUCTION

Un nombre de plus en plus important d'etudes effectuees dans les pays en developpement demontrent que l'age de la mère, le rang de naissance et l'espacement entre les naissances sont liés à la sante et à la survie de l'enfant La plupart de ces etudes comme on a pu le voir au cours des différents exposés issus des enquêtes démographique et de santé suggerent que la mortalité infantile et juvenile peut être réduite par :

* la diminution du nombre de naissances se produisant moins de deux ans apres une naissance precedente ,

* la diminution du nombre d'enfants nés de meres très jeunes ,

* la diminution du nombre d'enfants nés de femmes en mauvais état de santé ;

* la diminution du nombre de naissances de rang elevé.

Actuellement on estime que si toutes les femmes qui disent ne pas vouloir de grossesse utilisaient une méthode contraceptive efficace, les taux de mortalité maternelle et infantile seraient réduits de 25 à 40%.

Mais l'observation de la situation en Afrique subsaharienne où l'on note les taux les plus élevés de mortalité infanto juvenile et de mortalité maternelle fait ressortir une faible prévalence contraceptive, surtout dans les pays francophones

Pourtant plusieurs facteurs semblent indiquer la possibilité d'une acceptation plus large des méthodes contraceptives modernes .

- Premièrement, le desir d'espacer les naissances est déjà fortement ancré dans la plupart des pays subsahariens

- Deuxièmement, la méthode traditionnelle employée pour espacer les naissances, à savoir un interdit quasi-général des relations sexuelles pendant une période variant de 3 mois à 3 ans après l'accouchement selon les sociétés, a tendance à être appliquée avec moins de rigueur

En conséquence les couples pourraient donc être à la recherche d'autres moyens d'assurer un espacement des naissances convenable.

Mais ces méthodes sont sous le poids de nombreuses contraintes socio-culturelles et aussi institutionnelles

CONTRAINTES

Au début des années 80, si les programmes de lutte contre les maladies de l'enfant ont bénéfice d'un environnement favorable caractérisé par la reconnaissance de l'ampleur du problème de santé des enfants, par l'engagement important à tous les niveaux et l'adhésion de la population, il n'en est pas de même pour les programmes de planification familiale qui ont connu une situation plus difficile et même conflictuelle.

*** Liées au concept :**

Contrairement aux autres programmes de soins de santé primaires, la planification a été perçue comme synonyme de limitation des naissances entraînant une résistance à tous les niveaux, du décideur au prestataire, et par ricochet aux utilisateurs potentiels.

Grâce aux actions conjuguées des organisations internationales, des bonnes volontés, et des associations privées pour la promotion de la planification familiale soutenues par l'IPPF, et les organisations multilatérales et bilatérales progressivement un consensus s'est dégagé autour de concept mieux accepté sur le plan culturel:

* Concept d'Espacement des Naissances ;

* Concept de Naissances Désirables.

Ces actions ont été renforcées par différentes conférences internationales qui ont alors mis l'accent sur le concept de Maternité Sans Risque.

*** Liées à la technologie nouvelle** :

L'apparente complexité de la technologie contraceptive a abouti à l'édification de standards hautement restrictifs

Ce qui va avoir pour conséquences :

* une **médicalisation excessive de la prestation** des méthodes contraceptives,

* une instauration de nombreuses barrières que **Shelton et col ont appelé les barrières médicales.**

* une disponibilité réduite des méthodes contraceptives modernes limitant en conséquence l'accessibilité

Et en fin de compte ces contraintes ont abouti à une **marginalisation de la planification familiale** par rapport aux autres activités de survie de l'enfant.

C'est dans cette situation que INTRAH a commencé ses projets de formations du personnel oeuvrant dans le secteur de la santé.

CONTRIBUTION DU DEVELOPPEMENT DES POLITIQUES ET STANDARDS DES SERVICES A LA REDUCTION DES BARRIERES A L'ACCES AUX SERVICES DE PF

Dans sa recherche permanente d'offrir des prestations de service de planification familiale de qualité et accessible à la population, INTRAH programme international pour la formation en matiere de santé, de la faculte de médecine de l'Universite de la Caroline du Nord, parallèlement à son programme de formation, et par l'intermédiaire de son bureau regional d'Afrique a mis l'accent sur l'assistance des pays en matiere de **définition et de développement de politique et standards des services de planification familiale.**

PRINCIPES DIRECTEURS

L'engagement d'un pays à définir une politique et des standards des services de planification familiale offre l'opportunite .

* de reactiver la prise de conscience sur l'ampleur des problèmes lies à la fécondité elevée et aux grossesses à hauts risques ,

* de poser les bases pour l'amélioration consensuelle de la qualité des services de planification familiale

* et de faciliter simultanément l'accès à la PF par le développement d'une meilleure interface avec les utilisateurs.

Cela passe par .

- l'établissement dans chaque pays d'un cadre de reflexion et d'action pour la promotion de la planification familiale et par l'elaboration d'un document qui sert de cadre de reference pour le developpement des services de planification familiale.

- l'implication des autorités administratives et leur engagement explicite ;

CONTENU :

Dans son contenu le document de politique et standards des services donne des reponses claires aux questions fondamentales inherentes a la prestation des activités preventives en général, de planification familiale en particulier

Pourquoi le service ? les raisons de l'offre de service

Elle permet de répondre au concept de planification familiale tel qu'il est admis dans le pays

Actuellement dans tous nos pays la planification familiale est encouragée d'abord en tant que moyen d'ameliorer la sante des femmes et des enfants. Et est reconnue comme un droit fondamental du couple et de l'individu ,

Faire quoi ?

Elle amène à recenser toutes les composantes de la planification familiale ,

Elle doit recenser toutes les méthodes admises dans le pays et proposer les differentes approches

Pour qui ?

Elle doit définir la population cible en général et en particulier identifier les groupes à hauts risques

Par qui ? Où ? Quand ? Comment ?

Quelles categories de prestataires ? peuvent faire quoi ? et ou ?

Quel est le niveau minimum de performance acceptable?

RESULTATS :

Depuis 1987, INTRAH, par l'intermediaire de son bureau regional pour l'Afrique, a prete son assistance à 8 pays d'Afrique au Sud du Sahara (Botswana, Burkina Faso, Cameroun, Cap Vert, Niger Tanzanie, Togo, Ouganda) pour l'élaboration et la dissémination des politiques et des standards nationaux des services de planification familiale

Pour evaluer le niveau des contraintes liees à la prestation de service de planification familiale dans un pays, INTRAH a retenu 10 indicateurs des barrieres medicales à l'accès aux services de planification familiale

1 Un large choix de methodes est-il disponible ?

2 Le nombre de cycles de CO distribues à chaque visite est-il limité ?

3 La distribution non medicale de CO est-elle permise ?

4 L'acces aux injectables est-il soumis à des conditions restrictives d'age et de parité ?

5 Le consentement marital est-il exigé pour les méthodes réversibles ?

6. L'accès aux services de PF est-il admis pour les adolescents

7. Les examens de laboratoire sont-ils systématique ment demandés ?

8. Les examens pelviens sont-ils obligatoires pour obtenir la contraception hormonale ?

9. L'allaitement maternel est-il reconnu comme methode d'espacement des naissances ?

10 Quelles catégories de personnels sont autorisées

On dispose maintenant d'abondantes publications qui justifient la suppression de nombreuses barrieres medicales telles que celles enumérées plus haut

Si l'on prend l'exemple du TOGO, en 1987 lors du premier recensement des besoins en formation, les 10 barrières que vous avez sous les yeux ont ete observees et documentees Pour l'autorisation maritale, elle devait non seulement être signée par le mari, mais en plus le personnel poussait le vice jusqu'à exiger la carte d'identite du mari

La dissemination du document de politique et standards des services de planification familiale permet de

* promouvoir une image positive de la planification familiale ,

* sensibiliser et d'améliorer les connaissances des prestataires et des non prestataires ;

* élaborer ou de reviser les differents protocoles et fiches operationnelles en usage ;

* harmoniser l'attitude des prestataires de services

* responsabiliser les utilisateurs des méthodes contraceptives ,

* faciliter la décentralisation et la délégation des prestations de méthodes contraceptives ;

* réduire les barrieres médicales

L'evaluation des resultats de la reduction des barrières concrètement obtenus au niveau de 6 pays fait ressortir .

* BOTSWANA	5/8	ont fait l'objet de reduction significative ,
* BURKINA :	8/10	" " " "
* CAMEROUN	9/9	" " " "
* TANZANIE	6/8	" " " "
* TOGO .	10/10	" " " "
* OUGANDA :	5/6	" " " "

CONCLUSION

Le développement et la diffusion des politiques et standards des services constituent un mécanisme important pour réduire les barrières médicales, tout en maintenant la qualité des services et faciliter l'accès aux services de planification familiale.

Les changements importants observés sur le plan institutionnel et sur le plan de l'attitude du personnel de la santé ouvrent des perspectives nouvelles quand l'intégration des activités de santé maternelle et infantile et planification familiale.

Les activités de santé maternelle et infantiles apparaissent comme les meilleures portes d'entrée pour augmenter l'utilisation des méthodes modernes de contraception. Il s'agit de redéfinir au niveau des centres de soins périphériques ou de premier contact:

* le paquet minimum d'activités nécessaires

* les principes directeurs organisationnels

* les outils de gestion de cas de façon à y intégrer les questions sur la planification familiale.

Ces changements ouvrent également des perspectives nouvelles dans le cadre du développement de la santé communautaire.

Aussi la décennie 90 promet-elle d'être marquée par l'accélération de l'expansion des services de planification familiale en **Afrique subsaharienne pour que** se réduisent sensiblement la mortalité maternelle et infantile.

Je vous remercie.

REFERENCES

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ASCI - CCCD

ETAT D'AVANCEMENT DE LA SURVIE DE L'ENFANT

DAKAR 1 AVRIL 1993

LA PLANIFICATION FAMILIALE EN AFRIQUE SUBSAHARIENNE

BILAN SOMMAIRE

INTRAH

PROGRAMME INTERNATIONAL POUR FORMATION EN MATIERE DE SANTE

BUREAU REGIONAL POUR L'AFRIQUE FRANCOPHONE LOME TOGO

CONTRAINTES
A LA PRESTATION DE SERVICE DE PF

LIEES AU CONCEPT

* LIMITATION DES NAISS
* ESPACEMENT DES NAISS
* NAISSANCES DESIRABLES

* MATERNITE SANS RISQUE

LIEES A TECHNOLOGIE

* MEDICALISATION
* BARRIERES MEDICALES
* DISPONIBILITE/ACCESSIBILI

==> MARGINALISATION

POLITIQUE ET STANDARDS DES SERVICES
PRINCIPES DIRECTEURS

✓ PRISE DE CONSCIENCE COLLECTIVE

✓ AMELIORATION CONSENSUELLE QUALITE DES SERVICES

✓ FACILITATION DE L'ACCES AUX SERVICES

Assistance d'INTRAH en ce qui concerne les politiques et standards nationaux de PF:

- Botswana
- Burkina Faso
- Caméroun
- Cap Vert
- Niger
- Tanzanie
- Togo
- Ouganda

INDICATEURS DE BARRIERES MEDICALES

- EVENTAIL DE METHODES DISPONIBLES
- CATEGORIES DE PERSONNEL AUTORISEES
- CONSENTEMENT MARITAL
- ACCES DES JEUNES A LA CONTRACEPTION
- CRITERES D'ELIGIBILITE AUX INJECT
- NOMBRE DE PLAQUETTE CO AUTORISEE /VISITE
- DISTRIBUTION NON-MEDICAL DE CO
- EXAMEN DE LABO SYSTEMATIQUE
  EXAMEN PELVIEN OBLIGATOIRE

INTRAH

Effets du développement de politiques de services de PF sur les barrières médicales documentés dans 6 pays

Barrières médicales	Botswana	Burkina Faso	Cameroun	Tanzanie	Togo	Ouganda	Change-ment
C.O. non-cliniques	n.b.	+	+	DNA	+	DNA	3/3
Nb de C.O. distribués	+	+	+	+	+	+	6/6
Allaitement maternel comme méthode de PF	0	0	+	n.b.	+	n.b.	2/4
Age et parité pour les injectables	+	+/-	+	+	+	+	6/6
Eventail étendu de méthodes	n.b.	0	n.b.	+	+	DNA	2/3
Tests de laboratoire	0	+	+	0	+	+	4/6
Examens du pelvis exigés	0	+	+	0	+	0	3/6
Consentement conjugal	+	+	+	+/-	+	+	6/6
Consentement parental	+/-	+	+	+/-	+	+	5/6
Expansi n des types de personnel	+	+	+	+	+	DNA	5/5
Changement	5/8	8/10	9/9	6/8	10/10	5/6	Change-ment

+ = réduction significative de la barrière médicale réalisée à travers le développement d'une politique des services de PF

0 = aucune réduction de la barrière médicale réalisée à travers le développement d'une politique des services de PF

+/- = barrière n'existait pas systématiquement avant le développement de la politique des services de PF, et par conséquent l'amélioration est négligeable

a.b. = aucune barrière n'existait avant le développement de la politique des services de PF

D.N.D. = données non disponibles pour l'état de base (souvent dû aux contradictions parmi les sources des données)

APPENDIX D

Abstracts from Other Presentations Given During Seminar on FP

PAYNE Lola

Project Coordinator, MotherCare, Lagos, Nigeria

Promotion of Policy in the Provision of Maternal Services

Background: Approximately 500,000 women die each year from causes related to childbearing. Ninety percent of these mortalities occur in the developing world and are typical of the high maternal mortality ratios (MMR) in West Africa. Nigeria has an estimated MMR of 800 - 1500 deaths per 100,000 live births. The Federal Ministry of Health and Social Services (FMOHSS), in response to this severe crisis, invited MotherCare/JSI, a centrally funded A.I.D. project, to joint them in a strategy designed to strengthen the quality of maternal care services. To this end, the state-level interventions are focused on upgrading and expanding the role of the clinical midwife and promoting community awareness of and a response to the problems and complications which arise during pregnancy and puerperium.

Methods: The project, through the FMOHSS, initiated a series of policy meetings and activities for policy makers, government officials, health professionals and women's organizations to stimulate their awareness of the severity of the problem and to seek their participation in and endorsement of the strategy. The project also created technical and policy committees at the state level to provide oversight and direction to the state projects and to serve as conduits for policy change. Seminars for physicians were also added to the project to ensure their consensus for the expanded role of midwives. The registration body for midwifery education and the medical obstetrical society have been involved in the project since its inception.

Results: Although the project is still in the full implementation phase, support for this project has been apparent at all levels. Memos of Understanding, specifying the roles and responsibilities at national and state levels, have been signed with federal and state governments. To date, a national policy stimulated similar meetings in the two targeted states. Two state hospitals, selected as project training sites, have funded the upgrading of their antenatal, labor and delivery suites and have instituted management systems to support quality maternal health services. In addition, the two state ministries have now included line items in their budgets to sustain these interventions over the next year.

Conclusions: The road to policy change is a route full of curves and surprises. Participation and endorsement of national, state and local governments are necessary requisites to promote policy change. The effort to bring about this change demands credibility, perseverance, wit, rapport, patience and skills to continually stimulate and involve those in authority who will create and implement this change.

Future Challenges: A final national policy meeting will be held at the completion of this project in July, 1993. Recommendations and models will be presented for expansion in 1994.

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Policy Ethnography for Family Planning Policy Development, Abidjan, Cote d'Ivoire, 1991

Background: Cote d'Ivoire has the third largest growing population in the developing world and is traditionall considered a pronatalist country. This paper reports results from a 1991 ethnographic assessment, in the capital cit of Abidjan, of issues surrounding population policy at three levels: policy makers, service providers, and consumer Reported are results from two themes: the changing shape and role of the modern Ivoirian family (Theme I), an the role of the government, society, and the family in maternal health and birth spacing (Theme II)

Methods: Interviews with key informants, focus groups, and individual respondents, using a semi-structure interview guide, were the primary source of data collection. A purposive sampling strategy identified respondent who were most likely to contribute to accomplishing the study objectives. Respondents interviewed in Abidja included: 20 policy makers from the Ministry of Health, USAID, WHO and other non-governmental organization (Level I); 38 individual health workers (and others interviewed in 18 focus group discussions) from private an public health facilities (Level II); and 150 consumers in 25 focus groups composed of adolescent males and femal between the ages of 16-19, single males and females between the ages of 20-30, single males and females over th age of 30, and married males and females (Level III).

Results: Theme I: Two key factors were echoed throughout the three levels of the study: the extended family an family solidarity. At all three levels, the large extended family was the reported desired family form; however, th ideal did not preclude respondents' support for limiting the number of biologic offspring. Solidarity, the soci commitment to provide support for all members of one's extended family, is the second factor common across a three levels of respondents. Although respondents' statements suggest an acknowledgement of the limitations o modern, urban life, "solidarity" is still a concept that they would like to preserve. Theme II: At all three leve respondents agreed that although a mother is responsible for the health of the family, family planning decisio making results from a complex web of social relations. Respondents said that a woman's decision to limit fertilit is influenced by her mate and other members of her extended family. The government was considered responsib for providing technical assistance (staff, training, commodities), and service providers are needed to educate th population and to provide services. Disagreement between Levels I, II, and III occurred on the responsibility o consumers: Although respondents in Levels I and II were supportive of consumers paying for services, Level I respondents were not.

Conclusions: Studies of the proximate determinates of fertility suggest that when a woman's decision to lim fertility is influenced by others, family planning programs are resisted and fertility is likely to remain high. Howeve results from Thailand (Knodel et al 1984, 1987) suggest that each culture can find innovative ways to integra family planning with traditional values related to the family structure. The values expressed in the first theme o this study suggest the Thai results may be applicable for Cote d'Ivoire. Implications for program and polic development are three: there is support for coordinated family planning at all three levels of respondents; 2) the targ for family planning services should include fecund women, their mates, and members of their extended family; an 3) the extent to which the population will financially support a fee-based family planning service is uncertain an needs further assessment.

Future Challenges: The need to fully access and use data that expresses the sentiments and needs of the populatio when preparing populations policy and developing a program strategy is emphasized by the results in th ethnographic study. The challenge ahead lies in the successful integration to these findings into policy and progra development and evaluation activities.

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The Integration of Family Planning Services with Vaccination and Growth Monitoring Consultations in Burundi

Background: Burundi is the second most densely populated country in Africa and family planning (FP) is a national priority. Despite several years of health worker training, FP health education and the availability of contraceptive supplies at health facilities, the national annual contraceptive prevalence rate (CPR) is only 3%. In contrast, 92% and 79% of infants were vaccinated with DTP1 and measles respectively by one year of age in 1991.
A demonstration trial was designed to assess the potential of integrated service delivery to increase the CPR.

Methods: Nine government health centers (HCs) in the Sector of Muramvya (population 440283) were randomly designated as intervention or control HCs. A baseline census of women 15-49 years of age was conducted within a two-kilometer radius of all 9 HCs. At all HCs, a supervisor ensures that FP services are provided to women requesting them. At intervention HCs, he also ensures that FP services are provided to mothers when their infants are vaccinated and/or weighed for growth monitoring. Data are collected monthly to monitor the study.

Results: The baseline contraceptive prevalence within a two-kilometer radius of intervention and control HCs was 4.8% and 11.6% respectively. From January-May 1992, prior to the start of the intervention, there was a mean of 12 new FP acceptors per month at each intervention HC and 18 at each control HC. After two months of implementation of the intervention (November and December 1992), there was a mean of 43 new acceptors per intervention HC per month and 21 per control HC per month.

Conclusions: The integration of FP and vaccination/growth monitoring services was effective during the first two months of partial implementation in increasing the number of new FP acceptors. The study is expected to last four years and final outcome measures will be vaccination coverage and contraceptive prevalence.

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Integration of FP Service Delivery in MCH and PHC in Burkina Faso

Background: With a population of 9.1 million inhabitants (estimated in 1990), Burkina Faso, an emerging coun with a high demand for family planning, is one of the poorest in the Sahel with an average income of $100. At same time, its population is expanding. Total fertility rate is 7.2 and the rate of natural increase is 2.8%. SEA has taken advantage of positive policy changes and USAID support to participate in initiating one of the m dramatic uptakes of family planning in Africa.

Methods: Building on operations research findings from the late 1980s, SEATS has assisted the Ministry of Hea to develop and implement a national family planning strategy, expanding services from Ouagadougou to the ent nation.

Results: Over the life of the project, SEATS will expend 2.1 million dollars in assistance to five organizatio providing over 200 thousand dollars in clinical equipment, training of hundreds of service providers, and provisi of a full range of SEATS technical assistance. SEATS assistance also includes the services of a Resident Advis Dr. Meba Kagone, a committed Burkinabe physician who is responsible for high level programming.

SEATS supports programs with five Burkinabe organizations, public and private, to provide youth progra upgrade and expand 149 clinical sites, introduce voluntary surgical contraception, introduce and develo community based distribution program integrate family planning into work-based health services, and creat national family planning training team. In addition to devising and implementing a national managem information system, technical assistance to the Ministry of Health includes the *Public Sector Integration Proj* which works to integrate family planning into 62 Maternal and Child Health clinics in rural and peri-urban are This expands on work initiated by the Columbia Operations Research Project, and coverage reaches approximat 80 percent of the population.

Conclusions: By the end of the project, approximately 75,600 Couple-Years of Protection will be generated. date, 50 clinics have received contraceptive technology and counselling training out of 136 clinics planned. fo of these have been equipped to provide services. The first voluntary surgical contraception (VSC) theater in Burk Faso has been established by SEATS, and training of the first Burkinabe physicians to provide VSC is comple

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Testing the Integration of Family Planning and Childhood Immunization Services in Togo

Background: The integration of family planning and other MCH services is an explicit policy of many West African countries that is not often operationalized in clinical services, even among programs that have a common target population. If an effective link can be demonstrated for joining family planning and immunization services, a step towards developing an effectively integrated family planning program will be taken. The Ministry of Health in Togo, with assistance from the Population Council's Africa OR/TA project and the Centers for Disease Control's CCCD project, conducted an operations research study that examined the effects of individually referring all EPI clients to the family planning provider during a childhood immunization consultation.

Methods: A quasi-experimental, two-group study design used a representative sample of eight test clinics and eight control clinics in two regions of Togo to examine the impact of individualized referral. The study collected two types of data: (1) a pre- and post-test exit interview survey with 1,000 women attending EPI services, (2) Monthly service statistics from family planning and EPI services were collected retrospectively, beginning nine months prior to the study and continuing through the study period. In the test clinics a special stamp was also added to the family planning services' daily log book that provided information on the number of women referred from EPI services as well as the total number of family planning clients who vaccinated their child during the study period.

Achievements/Results: The results of the study show that the number of new acceptors of oral contraceptives, injectables or IUDs increased significantly in the study's test group (from a pre-test average of 200 clients per month to an average of 307 per month during the study), yet remained relatively unchanged in the control group. Approximately fifty percent of the test clinics' new acceptors stated that they had been referred by the EPI provider. There wasn't any evidence of a negative impact on the EPI services, and a majority of the EPI providers reported satisfaction with the referral message at the close of the study.

Conclusions: The use of an unobtrusive referral message that linked family planning and EPI services was accompanied by an increase in both awareness of family planning services and the use of those services by EPI clients. These results present a compelling case for developing links between the EPI and family planning programs through the use of individualized referral.

Future Challenges: The study's results indicate the need to address the broader issue of the manner in which IEC activities are conducted in MCH/FP clinics in West Africa. The use of referral across MCH/FP services is a simple mechanism for achieving a better of measure of service integration that clearly needs to be examined more closely by MCH/FP program managers and clinical supervisors.