

*Celebrating Mother and
Child on the Fortieth Day:
The Sfax, Tunisia.
Postpartum Program*

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Quality/Calidad/Qualité, a publication of the Population Council, highlights examples of family planning and reproductive health programs that are providing unusually high quality care. This series is part of the Council's Robert H. Ebert Program on Critical Issues in Reproductive Health and Population, which, through scientific and practical efforts, seeks to improve and expand the scope and quality of reproductive health care. The philosophical foundation of the program, and of this series, is that women and their partners have a fundamental right to respectful treatment, information, choice, and follow-up from reproductive health care providers. The pamphlets reflect one of the four main thrusts of the program: enhancing the quality of family planning programs.

Projects are selected for documentation in the *Quality/Calidad/Qualité* series by an Advisory Committee made up of individuals who have a broad range of experience within the field of reproductive health and are committed to improving the quality of services. These projects are making important strides in one or more of the following ways: broadening the choice of contraceptive methods and technologies available; providing the information clients need to make informed choices and better manage their own health care; strengthening the quality of client/provider interaction and encouraging continued contact between providers and clients; making innovative efforts to increase the management capacity and broaden the skills of service providers at all levels; expanding the constellation of services and information provided beyond those conventionally defined as "family planning;" and reaching underserved and disadvantaged groups with reproductive health care services.

None of the projects documented in the series is being offered as a model for replication. Rather, each is presented as an unusually creative example of values, objectives and implementation. These are "learning experiences" that demonstrate the self-critical attitude required to anticipate clients' needs and find affordable means to meet them. This reflective posture is exemplified by a willingness to respond to changes in clients needs as well as to the broader social and economic transformations affecting societies. Documenting the critical choices these programs have made should help to reinforce, in practical terms, the belief that an individual's satisfaction with reproductive health care services is strongly related to the achievement of broader health and population goals.

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*Celebrating Mother and
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Postpartum Program*

by Francine Coeytaux

*Introduction and Afterword by
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INTRODUCTION

For years the prevailing attitude of most postpartum family planning services has been that women will be favorably disposed to contraceptive use immediately after the birth of a child—that after the experience of childbirth, with all its discomforts, women will be highly motivated to avoid another pregnancy, labor and delivery. They have also supposed that women cannot be depended upon to return for family planning services and, therefore, should be “captured” while still in the hands of the medical establishment.

In fact, both of these assumptions are unrealistic. In the first case a focus on contraception alone neglects at least two concerns that mothers have in the immediate postpartum period, which supersede their potential interest in avoiding an additional birth: the well-being of the *current* baby and the mother's own immediate health needs. Some of the most pressing issues for mothers in the immediate postpartum period involve how to solve breastfeeding and weaning problems. Research shows that virtually all women intend to breastfeed and value its health benefits for the child. Paradoxically, however, breastfeeding is frequently unsuccessful and rarely practiced exclusively, even among mothers in developing countries. This is partly due to poor information and partly due to medical/institutional obstacles raised within the health care system itself, such as separation of mother and baby, bottle-feeding by hospital staff, misinformation from health care professionals, and provision of formula samples to mothers. In addition, pressure by health workers to practice contraception immediately following delivery frequently acts to further discourage mothers from continuing to breastfeed.

A program that broadens the concerns of postpartum health care beyond the narrow focus of contraception would be able to respond to the new mothers' needs in a more meaningful way, while at the same time ascertaining the most appropriate timing and kinds of family planning services for this group. Unfortunately, even when services do attempt to address mothers' concerns, they are often hampered by a lack of knowledge among health professionals about breastfeeding and contraception during lactation.

The second assumption, that the immediate postpartum period is the only time women can be reached, since they will not return for medical services after childbirth, is disputed by the facts. Well-run programs that provide desired services are a magnet for clients, as shown in the case study that follows. In addition, although more women in developing countries are delivering babies in hospitals, their hospital stays are so short (often 6-12 hours), that attempts to provide meaningful contraceptive services in that context simply are not feasible.

In addition, when women do return for family planning services, they may be faced with new obstacles. Program administrators often burden health providers with unnecessarily restrictive protocols so that many women who want family planning cannot be served. This may have serious consequences for both mothers and their children, since many women in developing countries will need to initiate contraception at some point during lactation in order to avoid a subsequent, closely spaced birth.

To sum up, postpartum programs historically have suffered from the following inadequacies: 1) the failure of health professionals to learn about and take into account mothers' concerns in the design of postpartum services; 2) lack of knowledge by health professionals about breastfeeding; 3) inadequacy of contraceptive advice and services specifically for lactating women; 4) lack of coordination between child health and family planning services; and 5) failure to design service packages that offer health care to mothers and children at the same time (well-child immunization, breastfeeding support, contraceptive services for mothers).

The following case study of the Fortieth Day Postpartum Program in Sfax, Tunisia demonstrates some successful, new approaches to providing appropriate health care for mothers and children in the postpartum period.



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Background

Sfax, the second largest city in Tunisia with a population of approximately 400,000, is located on the Mediterranean Sea, approximately 270 kilometers south of Tunis. A bustling industrial fishing port, the urban landscape quickly gives way to orchards of olive trees. Known as the "capital of the South," Sfax is an important urban center, serving people from the rural border of the Sahara as well as those from the north who come for trade and services.

Tunisia's major medical school is located in Sfax and the University's Teaching Hospital serves as the primary referral point for all of southern Tunisia. Another service that draws people to the city from the surrounding area is the Maternal and Neonatal Hospital of Sfax. At this 136-bed hospital, called the *Centre de Maternité et Neonatologie de Sfax*, an average of 30-40 deliveries take place each day, or approximately 11,000 births per year, representing 65 percent of all of the births in the region. Only 25 percent of women in the region of Sfax deliver at home, without professional

assistance (as compared to a national rate of 33 percent home deliveries). The remaining 10 percent deliver in various rural health centers and private clinics.

In 1983, in an effort to promote family planning and provide well-baby care, the Maternal and Neonatal Hospital of Sfax implemented an innovative postpartum program that scheduled a follow-up visit for every mother and child, 40 days after birth. The program immediately proved to be very successful in getting women to return for follow-up, and by 1987 hospital records indicated that 82 percent of the women who had delivered in the Sfax Maternity that year had returned for their postpartum visit. The success of the program is primarily attributable to two important factors incorporated in its design: 1) the appointment is for *both* the child and the mother, providing services for each at the same time and in the same place, and 2) the appointment is scheduled on the fortieth day after delivery, a day that has both cultural and religious significance for the Tunisian mother and child.

How It All Began

Constantly searching for ways to improve the family planning program of Sfax and better serve its clients, Mme. Fatma Gargouri, the regional coordinator of the *Office National de la Famille et de la Population* (ONFP)—the national family planning program—was seeking to insure that all women who were interested in preventing or delaying their next pregnancy begin practicing contraception as soon after delivery as appropriate. She recognized that the maternity hospital in Sfax could be an ideal setting for such an endeavor: Having a large number of women of child-bearing age assembled in one place would be a perfect opportunity to inform and educate them about family planning. But informing women about family planning was not enough. They also needed to have ready access to services.

Postpartum education services existed (and continue to be provided) in almost every hospital in Tunisia, run and staffed by the ONFP. Under the ONFP program, health educators have been assigned to work within the maternity hospitals, talking to the women delivering at the hospital about contraceptive options. Follow-up, however, has been minimal because the hospital staff tend to view the delivery of contraceptive services as the responsibility of the family planning program. This viewpoint is reinforced throughout most of the country by the fact that family planning and pediatric services are located in buildings separate from the maternities. The center in Sfax is an exception. It is one of four hospitals in the country housing obstetrical, gynecological and pediatric services under the same roof. A whole floor in each of these four hospitals is now reserved for family planning services.

Physical proximity alone, however, did not bridge the gap between the various services. The staff of the maternity continued to consider family planning someone else's responsibility, and the family planning staff's attitude was: "Now that you have delivered the baby, give us the client." As a result,

each program was targeting women for their respective services only, completely overlooking women's overall needs. Mme. Gargouri felt strongly that to be successful, a new program would have to fully integrate the delivery of family planning services into the hospital's regular services, working toward the point at which hospital personnel would consider it their proper role to provide family planning information and prescribe contraceptives.

Such a model necessitated a team spirit and a willingness for all involved to consider and meet the needs of both the mother and child in a comprehensive manner. The program therefore, could not have gotten off the ground without the interest and commitment of Drs. Ahmed and Saida Rekik, a husband and wife team of physicians, who are Professors at the University Teaching Hospital and Chairs of the Pediatrics and Obstetrics-Gynecology Departments of the Maternal and Neonatal Center. The idea to include well-baby care along with postpartum care for the mother came from Dr. Ahmed Rekik, the pediatrician, who felt strongly that the mother's reproductive health and the spacing of births directly benefit the child as well as the mother. Soon his wife, Dr. Saida Rekik, in charge of the obstetrics and gynecology department at the hospital, was on board. Both recognized, from their differing perspectives, the practical possibilities of treating the mother and the infant as a synergistic pair, the *couple mere-enfant* (mother-child couple).

What emerged was a new approach to postpartum services at the hospital. Women would be invited to come back on the fortieth day after birth to a separate clinic within the hospital where services for both mothers and infants would be provided at the same time and in the same location. While women previously had been invited to come back for a family planning consultation at their convenience, the new program would not only capitalize on a date that had a meaning for the mother and would easily be remembered (see the section that follows), but perhaps more important, would respond



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to the mother's concern for her child's health, a concern that is often more pressing to her than her own needs.

Once the support of the department chairs was assured, actual implementation could begin. Mme. Gargouri and the Drs. Rekik became a team of three and began to work towards establishing a service in the Maternity which would integrate delivery and postpartum care of the mother, including family planning, with care of the infant. By early 1983, the "fortieth day consultation visit" had been established and the program was in full gear. In that year, 60 percent of the women delivering at the Maternity came back for their postpartum visit; by 1987, the percentage had increased to 83.

The Significance of the Fortieth Day

In most Muslim cultures, a rest of 40 days after delivery is considered essential for the convalescence of the mother and the development of the infant. During this period, the mother is carefully protected. She does not leave her home and is relieved of all household responsibilities, except that of

tending to her newborn infant. She is surrounded by her family who care for her, making her herbal teas to help her sleep and special dishes high in iron, glucose and protein to help her regain her strength. Broths with poached eggs; and cereals with dried raisins, eggs, caraway seeds and sugar or carob; fava beans and dried figs are just a few examples of the types of dishes that are traditionally reserved for postpartum women. The new mother is not supposed to bathe during this period, taking sponge baths instead, nor is she permitted to have sexual relations.

The fortieth day marks the end of this postpartum period of convalescence. Then, according to tradition, the mother may resume her household responsibilities and appear in public. Her first venture outside the house is usually to the local *hamman* or public bath. Only after this cleansing ritual can she resume sexual relations. For the infant, the fortieth day represents the beginning of a new stage of development. Now the baby has established a diurnal cycle of sleeping at night and being awake during the day (referred to in French as the *rythme nyctemeral*) and has reached an age when parental fears that the infant may not sur-

vive are greatly reduced. Now the baby is also expected to be able to sit upright, and, to symbolize this developmental achievement, a special infant seat called a "baby-relax" is made for the infant (see photo below).

Traditionally, a celebration is held on the fortieth day as well, marking the end of the mother's convalescence and the beginning of a normal routine for both mother and child. Family and friends gather, and pastries and sweets made especially for the occasion are enjoyed by all. The infant is placed for the first time in the "baby-relax" and introduced to the many children who come to eat the candies, dried fruit and nuts, and to welcome their new sibling and friend.

Today, the degree to which these traditions are adhered to in Tunisia varies by region and by family. Practices range from a strict adherence to the prohibitions, principally in the rural regions of the country, to minimal compliance among some urban dwellers. Yet, regardless of actual postpartum practices, the fortieth day itself is still celebrated throughout the country.

By linking the follow-up visit with this significant day, the Sfax Center has managed to incorporate the postpartum visit into the day's observances. (As this timing is meaningful to the family, the date is easily remembered. Most women do return exactly 40 days after delivery; those whose fortieth day falls on a Sunday are told to come the following Monday.)

The Time of Delivery

From the day of delivery, the link between the infant's health and that of the mother is stressed. Immediately after giving birth, every woman who delivers at the Maternity is examined by a gynecologist and visited by a pediatrician who examines the infant at her bedside. The pediatrician encourages the mother to breastfeed and informs her of the fortieth day consultation, describing the benefits of the visit for both her health and that of the child. For the mother the staff stress:



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- the importance of ensuring that she has healed properly from the delivery,
- the need for her to recover her strength and nutritional status,
- the value of breastfeeding and how to avoid difficulties, and
- the role of contraception as a means to space pregnancies.

The child is checked for any anomalies and congenital birth defects that may not have been detected immediately at birth.

The woman is also seen by a social worker who repeats what the pediatrician has said and covers in more depth the topics of breastfeeding and the importance of contraception. The social worker gives the woman an appointment card, inviting her to come back to the center in 40 days, and outlines the threefold purpose of the visit: 1) to assure her own good health, 2) to check up on the health of her child, and 3) to assist her in choosing a family planning method should she desire one. (The appointment

card also contains the number of the woman's medical chart to assist in pulling her file upon her next visit.)

The fortieth day consultation is also promoted through the use of audio cassettes routinely played in the maternity ward. These specially designed tapes contain ten minutes of popular traditional music and eight minutes of messages about the importance of breastfeeding, basic child care practices, and information about the fortieth-day consultancy visit. The background music consists of songs about childbirth including the traditional cry, the *you-you*, that is made by the attendants during a birth at home. Because the hospital setting deprives women of this spontaneous expression of joy and relief upon delivery, these sounds of collective support have been incorporated into the tape.

Interspersed amid the songs are messages of congratulation and advice about breastfeeding, hygiene of both mother and infant, nutritional needs of a lactating mother, and the desirability of spacing a subsequent pregnancy to ensure the health of mother and child. Available contraceptive methods are then described followed by an invitation to return 40 days later for a check-up.

Hospital staff report that the audio cassettes are very popular and that women often request that the tapes be played again and again. Many women say they enjoy listening to the music and wish there were more tapes.

The Fortieth Day Consultation

On the fortieth day, the new mother returns to the Center, going to the special ward set aside for the consultation. The space has been arranged so that pediatric care is provided on the same floor as, and in conjunction with, the gynecological and family planning services. The mother and child unit, the *couple mere-enfant*, are seen by a pediatrician and a midwife consecutively.

The value given the closeness of mother and child is seen in the crib provided in the

women's examination room. By keeping the infant beside her during her examination, the mother feels more secure, and does not experience the anxiety many women feel when they do not know where their infants are and how they are faring. This seemingly small detail is mentioned by many women as one of the attractions of the service. They contrast this to other hospitals, with labyrinths of long corridors that they find overwhelming and frightening.

The first of the *couple mere-enfant* to be seen is the infant, who is given a complete examination by a pediatrician. One type of screening that is regularly provided is a hearing test. This service is provided in coordination with the Association of Deaf-Mutes, whose headquarters are located in Sfax. (The association was asked to participate because of the relatively high prevalence of congenital hearing problems in the region, one of a number of problems attributed to the high incidence of marriages within extended families in the region. The population of Sfax is particularly conservative, tending to try to retain inheritances within the family, and keeping very

much to themselves with little exposure to outsiders.)

During the course of the examination, vital protection provided by immunizations is discussed, as is the sequence of visits and their timing. Referrals are then made to local health centers for the child to receive the remaining immunizations. (The infant receives a BCG vaccination at birth but is not given another vaccination on the fortieth day because the timing of the visit does not coincide with the schedule prescribed by the Ministry of Health.) Mothers are also strongly encouraged to continue breastfeeding their infants. Breastfeeding techniques are discussed with those mothers reporting difficulties, and the correct preparation of infant formula is explained to those who are not nursing. A slow weaning process is recommended, including mixed feeding. During the consultation with the midwife, the mother's own nutrition is discussed. Popular sayings such as "A well watered tree bears good fruit" or "Feed the stomach and the eye will grow" are used to stress the importance of good nutrition for the nursing mother. The importance of iron in the



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mother's diet is highlighted and dishes traditionally prepared for the nursing mother that are high in iron content are recommended.

Services for the mother include a gynecological exam and a discussion of any

specific health problems she may have. The spacing of births is brought up at this time as an important means for recovery and good health of the mother, and for the mental and physical development of the infant.

Family Planning Services

Family planning services are readily accessible in most parts of Tunisia, provided free of charge by the ONFP. Contraceptive services are provided in all health centers and hospitals and by mobile units and mobile clinics, which serve rural areas devoid of health facilities. *Animatrices*, female family planning educators, work in the communities making home visits and keeping family planning centers informed of any woman requiring particular attention or follow-up. According to the 1983 Tunisian Contraceptive Prevalence Survey conducted by the Institute for Resource Development/Westinghouse, 42 percent of the women of reproductive age in Tunisia were practicing contraception and 34 percent were using a modern method. The two most commonly used methods in 1983 were the IUD and tubal ligation. Abortion is legal and available through the national family planning program.

Contraceptive methods available at the Maternal and Neonatal Center of Sfax include tubal ligations, IUDs, and spermicides. While oral contraceptives are avail-

able, they are rarely prescribed (due to staff concerns which are described below). All of the methods are available during the fortieth day visit except tubal ligations. Women who choose this method, and are prepared to stay overnight, can have the procedure scheduled for the following day. (Because tubal ligations are performed under general anesthesia, the women are required to stay overnight and to have fasted.) In general, however, appointments are made for either a return visit to the Sfax Center to undergo the procedure, or for a visit to the family planning center closest to the woman's home. In the latter case, a health educator employed by the ONFP informs the local center of the woman's interest, and a follow-up visit is made to her home by an outreach worker prior to her appointment for the procedure.

The hospital starts the woman on a contraceptive method, but follow-up care and supplies are provided by the local family planning centers. Each client is given a referral slip with an approximate date for her next visit. At the end of each month, copies of these referral slips are distributed to the respective centers.



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Results

The postpartum program has achieved a high return rate and timely promotion of the use of contraceptives. Of the 9,240 women who delivered in the Sfax Maternity in 1987, 83.2 percent (7,686) came back to the center for their postpartum visit. This is an increase from 73.3 percent in 1986 and from 60 percent in 1983. Of the 7,686 women who returned for the postpartum visit in 1987, 55.6 percent (4,277) accepted a family planning method during that visit, and all were informed about the methods available and the family planning services nearest to their domicile.

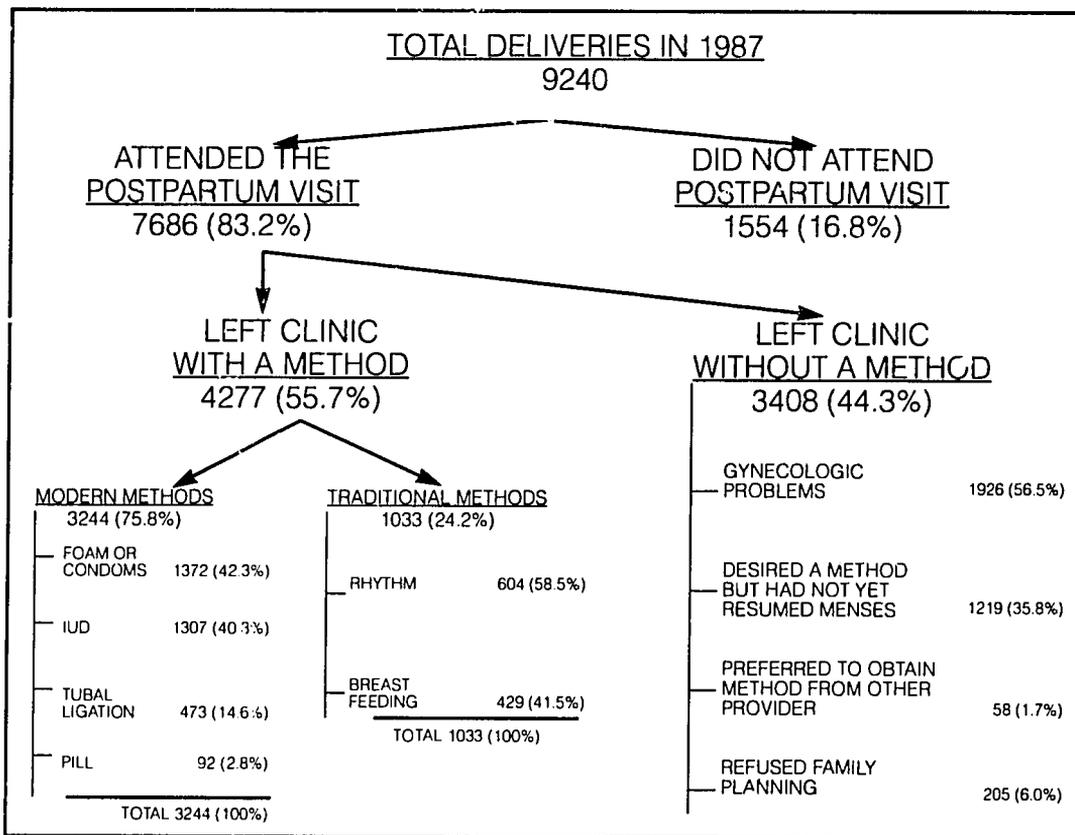
Improving Quality of Services

Intent on improving the program, in early 1988 the staff began to look for ways to increase impact and coverage. At first, emphasis was placed on establishing a system to find and interview the women who had not returned for the fortieth day visit (16.8 percent of the women who had delivered at the Maternity in 1987). This in itself

proved to be a tedious task; further, actually contacting the women in their homes would be time-consuming and costly. As a result, and given the already high return rate, the staff decided to concentrate on making services more effective for the great majority of women who do utilize the service.

Of particular interest was the effectiveness of the postpartum visit in providing women with contraceptives. Based on service statistics for 1987, clients were separated into those who had accepted a method during the fortieth day visit and those who had not. These two groups were further broken down according to the method they had chosen or the reason they had not been given a method (see figure on page 12).

A number of useful observations emerged from this analysis. The first was that approximately half (44.3 percent) of the women left the clinic without a method. The obvious question was, "Why?" The reasons could be broken down into three categories: 1) women who had been diagnosed as having gynecological problems (considered by the program to be contraindications for contraception), 46.3 percent; 2) women who



expressed interest in practicing contraception but, nonetheless, left without a method, 48.8 percent; and 3); those who were not interested in practicing contraception, 4.9 percent.

In fact, only a small number, 205 women, actually refused a method (equal to 2.7 percent of all the women who attended the clinic for a visit and 6 percent of those who left without a method). This implied that the acceptability of birth spacing was quite high among this population. But if refusal to practice contraception was so low, what accounted for the remaining 3,204 women who left the center without a method? The answers to this question provided some concrete recommendations on ways to increase women's interest in postpartum contraception.

Gynecological contraindications accounted for a significant majority of the women not given a contraceptive method. These problems included generalized discharge (in 72.6 percent of the cases), cervi-

cal inflammation (25 percent), and physical problems such as an abnormal uterus (2.4 percent).

Because an IUD or a tubal ligation is contraindicated for women exhibiting signs of infection, and since at the present time the center has neither laboratory equipment available for testing of reproductive tract infections nor drugs for treatment, the protocol at the Sfax Maternity is to refer for treatment all women who request a family planning method but who are suspected of having a vaginal infection. These women are generally given a prescription for antibiotics and are instructed to go to the nearest family planning clinic for a follow-up examination and a method two weeks later. Those who prefer to come back to the center for follow-up are provided with a note that gives them priority to be seen right away, without waiting, when they return.

In view of the finding that over half of the potential family planning users were being sent home without a method, the

need to reevaluate these procedures became clear. Two immediate suggestions were made. The first was to dispense spermicides and condoms to women while they are being treated for infection, placing particular emphasis on the role these methods can play in reducing the spread of infections. Before this, foam and condoms were given only to those women who specifically requested them.

The second suggestion was to make oral contraceptives more readily available. Hesitancy to prescribe the pill is based on two beliefs: 1) that less educated women will not remember to take the pill regularly, thus making it an ineffective method for them; and 2) that because of the extensive medical follow-up required by pill users (according to the perception of many Tunisian health providers), the method is not safe for use by rural women. Also many Tunisian providers are still very wary of the contraindications of oral contraceptives, such as hypertension, and would rather prescribe one of the other methods. This attitude reflects the ONFPs general bias against the prescription of oral contracep-

tives and is illustrated by the low prevalence of use of the method in Tunisia: only 5.3 percent of the contraceptive users interviewed for the 1983 Contraceptive Prevalence Survey (CPS) relied on the pill, and less than half obtained pills from an ONFP facility. Pills are generally dispensed at the Sfax clinic only when a woman insists on having them.

Concerns regarding the safety of oral contraceptives are particularly acute when it comes to breastfeeding women. Unfortunately, this situation is exacerbated by the fact that low-dose, progestin-only oral contraceptives, compatible with breastfeeding, are not readily available in Tunisia. Thus, for the moment, the Sfax Center will not provide pills to lactating women. Staff are considering ordering low-dose oral contraceptives so they can begin to test their acceptability. Successful use, combined with training to recognize when these pills should be prescribed, would be the best way to convince staff of their safety and efficacy.

The second major reason women left the clinic without a method (35.8 percent) was that they had not yet had a return of



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menses. According to the medical protocol, IUDs can only be inserted during menses (to facilitate insertion and to ensure that the woman is not pregnant). To the limited extent that they are available, oral contraceptives also are given only once menses has resumed, again to assure that the woman is not pregnant. Therefore 1,219 women who wished to adopt contraception were told that they needed to have resumed menstruation in order to obtain a method, and were referred to the nearest family planning clinic.

The need for such a strict protocol for a program that sees a woman only 40 days postpartum, when she is extremely unlikely to be pregnant, was discussed by the staff at length. While such a conservative approach regarding the assurance of nonpregnancy may be necessary in the context of the national program, which serves remote rural areas with mobile teams that provide services only periodically, application of the same protocol for women who have just delivered and are breastfeeding is inappropriate.

One exception to this protocol is for women who request an IUD and say they have not resumed sexual relations. However, this still leaves the women who are most at risk of an unwanted pregnancy, namely, those who have resumed sexual relations, unprotected.

A change in protocol is, therefore, being considered that would allow the insertion of the IUD and prescription of appropriate oral contraceptives for breastfeeding women on the fortieth day, whether or not menstruation or sexual relations have resumed. The benefits of these changes would include: 1) being able to meet the contraceptive needs of a significant number of women who presently are not being served; 2) reducing fears of pregnancy for women who may be at greater risk of unplanned pregnancy (given that they have resumed sexual relations); and 3) reducing the overall costs of contraception to client and provider. (Under the present system, women who do turn out to be pregnant are given an abortion and then have an IUD inserted.)

As a result of these discussions, a new protocol regarding women who request an IUD and have not resumed menstruation is now in place. The women are now given a pelvic exam and asked to return to the center a week later. If the uterus has not enlarged, ruling out a possible pregnancy, an IUD is inserted at that time. This procedure was the compromise reached between the medical directors, who feel the need to strictly adhere to the medical protocols, and other staff who want to reduce the obstacles faced by women who want to use an IUD. However, the requirement for a woman to return a week later may be an unnecessary inconvenience for the client, as well as exposing her to the risk of conceiving during that week. It is hoped that, with time, and after determining just how many women actually are pregnant, further changes can be made to provide the method during the fortieth-day visit.

The other two reasons women left without a method were because they preferred to obtain their family planning care from another provider (1.7 percent) or they were not interested in family planning (6.0 percent). Since the program could do little to reduce these numbers, the staff was pleased to discover that so few women fit into these categories.

An analysis of the women who *did* receive a method also confirmed the strikingly low percentage of pill users (2.8 percent of the women opting for a modern method were prescribed oral contraceptives). This reflected the provider bias previously discussed more than client preference, as informal queries by service providers indicate that many women would choose oral contraception as a method if it were available, including women not presently being served or those now using rhythm or breastfeeding alone.

This evaluation of the postpartum program proved very helpful in identifying for staff various ways in which they could improve both the quality and output of their program at little additional cost. The challenge now is to implement the recommen-

datations made and, subsequently, evaluate their contribution to client satisfaction and use of the services.

Other Aspects of Quality Services

The staff would like to improve other aspects of the program as well. One area of concern is the clinic's reception of men. Presently, no services exist for husbands or other men who accompany women and infants to the clinic. The ones who come—and there seem to be a significant number of them—tend to wait outside the center, conversing amongst themselves.

Each man's interest in being included in the visit may vary. The following are a few responses men gave when asked whether they would like to be involved:

"We are made to feel like strangers."

"This is women's stuff and we should not mix in."

"We are pushed aside. . ."

"From the way we are treated one would think that this doesn't concern us."

"I would like to hear what the doctor says (about the pediatric consultancy) but only my wife is allowed in."

The staff are thinking about ways to welcome men and to somehow include them in the service.

Improving the atmosphere of the reception area is another goal of the staff. Currently, it is too stiff and formal. At the entrance to the ward, a large open space is presently unused because the women prefer to wait in a small room further back, which is more private and less drafty (in popular culture, babies are rarely taken out of the house at this age in order to protect them from drafts). The result is that the small room is often crowded with women, and its size and location interfere with clinic flow. Therefore, a number of ways to make the large front room more inviting are being discussed, including: dividing the space with movable partitions, which could either be made of colorful local cloth or covered with bright, informative posters; and, the construction of low benches covered with pillows on which the women could sit. Such benches are typical of traditional Tunisian



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architecture and are particularly comfortable for women as they breastfeed because they can sit cross-legged, a position they cannot assume on the narrow wooden benches presently found in the large waiting room.

Finally, the staff wish to establish an improved management information system. Under the current system, every visit a woman makes to the hospital during a specific pregnancy, be it for prenatal care, delivery, or postpartum care, is recorded on a single chart, thus facilitating continuity of care. However, because a new chart is opened for every pregnancy, it is not possible to easily follow an individual woman's history over the years, something that would be very useful both for better continuity of care and for evaluating the impact of the family planning program and providing follow-up care to women considered at risk.

Although the records have been designed for computer analysis (they are precoded and could be processed easily), to date the center has not had the necessary equipment or analytical capabilities to computerize its record-keeping system. The establishment of such a computerized management information system is one of the

improvements the Center is planning to make.

Moving in Other Directions

On the national level, this program is being looked at by the ONFP as a possible prototype for postpartum services. In addition, the national family planning program would like to see the postpartum services decentralized, thus allowing women to go to health centers closer to their homes. For example, when it was discovered that a number of women who were not returning to the Center for their postpartum consultation were instead going to a clinic run by the National Social Security system (which provides health services to 33,000 employees of affiliated private enterprises), an effort was made by the family planning staff to establish a program similar to the one at the Sfax Maternity at this clinic. Family planning services were initiated, using ONFP personnel, and operate alongside the pediatric services. A gynecologist was later recruited. As is frequently the case, personal ties played a role in this innovation: The Director of the clinic just happened to be the sister of Mme. Gargouri and the pediatricians, students of Dr. Ahmed Rezik.



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Sfax Center

Lessons Learned

- 1. Delivering contraceptive services to women at an appropriate time is a key element of a successful postpartum family planning program.** In Tunisia, by the fortieth day following birth, women are ready to think about contraception; they have completed their postpartum recovery period, and the infant is well established.
- 2. The linking of the appointment date to a day that has cultural significance was crucial to the program's success.** Not only does it serve as a reminder, but it also corresponds to the women's sense of timing in terms of their own and their child's health needs.
- 3. The program's focus on the couple *mere-enfant* has multiple benefits,** including: a) motivation for the mother to return for follow-up care for both herself and her infant; b) improvement of postpartum and infant care; and c) increasing birth spacing and the practice of contraception. Early on, the increasing numbers of women attending the program indicated to the staff the extent of the unmet demand for integrated postpartum infant health care and contraception.
- 4. Increasing the choice of methods available to lactating, postpartum women is necessary and could both help meet more individual women's needs as well as increase contraceptive coverage.**
- 5. Those providing care need time to become comfortable with a new service.** In many cases, territorial feelings about who is responsible for each task will need to be overcome. In the case of the Sfax Maternity, had it not been for the commitment of the heads of both the gynecological and pediatric departments, the program would probably not have been able to overcome many of these obstacles. But that commitment, coupled with the apparent success of the program and its popularity with the clients, has done much to motivate the staff.
- 6. Commitment to the women's well-being and their right to space births,**

combined with a commitment to the welfare of infants, can increase staff motivation to adopt innovative and comprehensive quality services.

When asked how to establish similar programs elsewhere, Mme. Gargouri's and the Rekik's advise that the first necessary ingredient is a firm commitment from all of those involved, particularly the administra-

tors, to an integrated approach that responds to women's own sense of timing and considers the totality of the mother's concerns: the well-being of her infant, her personal health, and her ability to control her fertility. While it doesn't hurt to have the head of the pediatric unit married to the head of the obstetrics and gynecology department, this is not, they hasten to add, absolutely necessary.



Rafik Staali

AFTERWORD

The story of the Fortieth Day Postpartum Program in Sfax, Tunisia suggests, in rough paraphrase of Tolstoy's comment that happy families are all alike, that successful clinics have important similarities. Among the attributes of the program are two that stand out particularly.

First is the striking cultural relevance of scheduling postpartum visits on the fortieth day after birth, a day that has special meaning for mothers and new babies in an Islamic culture. Happily this day correlates well with the usual western medical recommendation of a "six-week" postpartum visit. The result is a date that mothers can easily remember and, because it is already associated with an important postpartum event involving both mother and baby, one that makes sense to them.

While other cultures may not have exactly similar observances during the postpartum period, it is certainly possible to follow the general principle that the timing of appointments and services must "make sense" to the population being served. As noted in the introduction, it is in this respect that postpartum services for contraception have so often failed; the offerings being urgent, frequently made one or two days following birth—a time when mothers may be least interested in thinking about preventing pregnancy or, for that matter, about resuming sexual relations.

Experience has shown it makes little sense to offer women contraceptive services when they are still recuperating from the immediate experience of childbirth. It makes a good deal more sense, as one can judge from the impressive acceptance of services at the Sfax Maternity, to offer these services at a later point, when mothers are beginning to re-establish the normal rhythm of their marital lives.

A second important aspect of the Sfax program is the fact that services are integrated. "Integration" here refers not only to the fact that two types of services are

offered in the same location (i.e., postpartum health care and family planning), but also to *the integration of services for two clients: mother and baby*. This is perhaps the most important innovation of the Sfax program. Once again, it makes the service provision strategy logical from the point of view of the consumer. Since a mother with a newborn child will have to take the child with her when she goes for services for herself, it is much more convenient to be able to obtain all health services at the same time and in the same place. The mother no longer has to wonder where to leave her baby, who will take care of the baby, or whether the baby is welcome at the clinic. In addition, the program has created a double incentive for service utilization: Mothers want to check on the health of their babies as well as use the health care services themselves.

In this sense, again, the Sfax program has created a service that is logical and congruent with the needs of mothers. It is no surprise, then, that the service is well accepted by mothers. One fact that should not be overlooked in attempts to advocate the Sfax model, however, is that the "double" integration was facilitated by the fact that a major medical institution, with a wide range of medical services already on the premises, undertook the innovation. It would be more difficult for a family planning program to attempt such an integration of both maternal and child health services under one roof. This argues, perhaps, for increasing awareness among the existing, heavily utilized maternity services of the need for postpartum family planning and for simultaneous access to care for mothers and newborns.

Despite the success of the Sfax program, notable problems remain that are characteristic of those experienced by postpartum programs around the world. Some of these problems seem particular to the type of systems created in this program,

such as a record-keeping system that is "pregnancy-based" rather than "woman-based." This means that every pregnancy has its own category, and a woman who has two or three pregnancies will have two or three charts that are not linked in the record-keeping system.

Other difficulties arise from the rigid medical norms regarding postpartum provision of contraception. Some of these norms are related to attempts to avoid providing contraceptives to women who are already pregnant. They ignore, however, a good deal of basic biological information about the risks of pregnancy to lactating women in the early postpartum period. These risks have been demonstrated to be extraordinarily low. A program that insists a woman must resume menses before she can be given certain types of effective contraceptives is, in fact, increasing the risk of an unplanned pregnancy among its clients.

The lack of appropriate contraceptive pills within the program for nursing mothers highlights a problem that has been virtually universal in the postpartum approach to family planning. Almost all descriptions of postpartum family planning services demonstrate a peculiar blind spot with regard to the issue of lactation. This well may be a result of medical biases. Much technical advice provided to family planning programs comes from clinicians educated in developed countries where lactation has been less universal and of shorter duration than in developing countries. On the whole, the number of lactating women who request family planning is a much smaller percentage of the entire family planning clientele in developed countries than in the developing world. In developing countries, an overwhelming majority of women who come for postpartum family planning are nursing mothers.

Nursing women require specific advice as to timing and type of contraception, so as not to interfere with or shorten lactation. Yet, such considerations are almost always absent from informational

materials, from program design, and from contraceptive choices. This lack of logic with regard to a very salient characteristic of many, if not most, of the potential users creates a basic mismatch between the services offered and the needs of the clientele. If contraceptive service policies are adjusted to meet the needs of lactating women, a larger proportion of women can be served. This includes better alignment of program norms with scientific information about the relationship between lactation and fertility and the low probability of pregnancy in the early postpartum period. As programs reflect better appreciation of women's physiology and behavior in the postpartum period, mothers will have more reason to perceive services as logical, responsive and comprehensive.

The contraceptive needs of new mothers also could be better met if the program itself had the capacity to diagnose and treat the large number of women presenting with vaginal discharge, rather than referring them for treatment. Such a service would allow the significant number of women who do want contraception to be given an appropriate method, instead of being forced to go elsewhere for treatment and then return at a later date, risking the possibility of an unplanned pregnancy in the interim. In addition, such a service would more effectively meet the health needs of the women by screening for common infections and prescribing the appropriate treatment.

In the long run, other clinics and programs can learn much from the aspects of the Sfax program that are associated with high utilization rates and good acceptance of family planning. The general principles of cultural relevance and a logical constellation of services are well illustrated. In addition, the story of Sfax illustrates a common gap in the service provision of many postpartum family planning clinics: the neglect of the needs of breastfeeding women. By addressing this issue in the future, another substantial proportion of postpartum women will be both better served and better able to make use of the existing health care services.



UNICEF/J. Isaacs

Appendix

Listed below are some publications specifically related to providing family planning services to breastfeeding women.

"Breast-feeding and Fertility Regulation: Current Knowledge and Program Policy Implications." *Bulletin of the World Health Organization* 61, 3, 1983: 371-382. Report of the WHO/NRC joint Workshop and Programme Policy Meeting on Breast-feeding and Fertility Regulation, Geneva, February 1982.

"International Planned Parenthood Federation. *Breast Feeding, Fertility and Contraception*. (London: IPPF, 1984).

Millman, Sarah. "Breastfeeding and Contraception: Why the Inverse Association." *Studies in Family Planning* 16, 2, 1985: 61-75.

The Population Council. *Contraception During Breastfeeding: A Clinician's Sourcebook*. (New York: The Population Council, 1988).

World Health Organization. *Patterns of Breast-feeding, Child Health and Fertility*. Prepared for WHO regional workshop on breast-feeding and fertility: proceedings and report, Kandang Kerbau Hospital, National University of Singapore, December 10-14, 1984.

World Health Organization. *Breastfeeding and Fertility: A Simplified Methodology for Community-Based Calculations of the Proportion of Mothers at Risk of Conception by Breast-feeding Status*. Prepared by the MCH Working Group on Breast-feeding and Fertility, Maternal and Child Health Unit, Division of Family Health (Geneva: WHO, 1987).

World Health Organization. *Breastfeeding and Child Spacing: What Health Workers Need to Know*. Programme on Maternal Child Health and Family Planning. (Geneva: WHO, 1988).



Résumé en Français

Ce numéro de *Quality/Calidad/Qualité* est consacré au programme du planning familial en période post-partum opérant au Centre de Maternité et Néonatalogie de Sfax (Tunisie). Ce programme, développé conjointement par l'Office National de la Famille et de la Population (ONFP) et le personnel de la Maternité, a été une réussite du fait qu'un nombre exceptionnel des mères soient retournées à la Maternité pour la visite, six semaines après l'accouchement. Ce taux élevé est premièrement dû à deux aspects du programme. Primo: le programme prodigue des soins pour le couple mère-enfant au même lieu et le même jour. Ceci répond au souci de la mère pour la santé de son nouveau-né, souci qui passe avant ses propres besoins.

Secondo: le rendez-vous est pris pour le quarantième jour après l'accouchement, car ce délai prend sa signification aussi bien dans la tradition que dans la religion. Dans la culture musulmane, le quarantième jour marque la fin de la convalescence de la mère. Ce même jour, elle reprend ses responsabilités familiales et peut apparaître en public pour la première fois après l'accouchement.

Pendant la visite du quarantième jour, un pédiatre procède à l'examen général du nouveau-né. La vaccination en temps opportun est discuté avec la mère. Il lui est également conseillé d'allaiter son nourrisson au sein. En ce qui concerne la mère, un examen gynécologique suivi d'une discussion sur divers problèmes de santé—y compris la santé reproductive—lui sont prodigués.

L'espacement des naissances est discuté et les services du planning familial sont offerts comme étant bénéfiques à la santé maternelle, assurant ainsi le développement physique et mental de l'enfant.

Le Centre de Sfax offre des services tels que les ligatures des trompes, les DIUs, et les spermicides. Bien que disponibles, les contraceptifs oraux sont rarement prescrits. Toutes les méthodes sont disponibles à la visite du quarantième jour, sauf la stérilisation volontaire qui peut être opérée à partir du lendemain de la visite.

La cliente est informée du centre de planning familial le plus proche pour le suivi et la procuration des moyens contraceptifs.

Sur les 9.240 femmes qui ont accouché à la Maternité de Sfax en 1987, 83,2 pour cent d'entre elles sont retournées pour la visite en période post-partum. Parmi celles qui sont retournées, 55,6 pour cent ont accepté une

méthode du planning familial pendant la visite. Dans le but d'améliorer davantage la qualité des services, le Centre de Sfax compte modifier sa politique afin qu'un plus grand nombre de femmes acceptent une méthode pendant la visite du quarantième jour.

Une des possibilités serait de fournir des spermicides et des préservatifs aux femmes ayant des infections vaginales pour usage pendant la période de traitement. Ceci leur procure aussi bien une protection contraceptive, qu'une diminution de risque de propager l'infection.

Autre possibilité prise en considération est de mettre l'accent sur un usage plus étendu des contraceptifs oraux. Le personnel médical hésite à donner les pilules contraceptives aux mères qui allaitent, par crainte des effets sur le nourrisson. Jusqu'à présent, les contraceptifs à basse dose de progestine recommandés aux mères qui allaitent ne sont pas suffisamment disponibles en Tunisie. Si ces pilules l'étaient, le Centre de Sfax pourrait les incorporer dans le programme post-partum.

Une révision de la politique en matière d'insertion des DIUs est également à l'examen. En effet, ne peuvent se faire insérer des DIUs, lors de la visite du quarantième jour, que celles qui ont eu un retour des règles ou celles qui déclarent ne pas avoir eu de relations sexuelles. Supprimer de telles restrictions permettrait à un plus grand nombre de femmes à risques d'utiliser la contraception, évitant ainsi une grossesse imprévue.

Ce ne sont que quelques approches prises en considération par le Centre de Sfax afin d'étendre les choix offerts aux clientes post-partum. Ceci fait partie des activités d'évaluations continues à travers lesquelles le programme cherche les moyens de mieux répondre aux besoins des soins de santé reproductive de ses clientes.

Une traduction de cet article entier est disponible en français. Si vous voulez recevoir la traduction, écrivez à Ann Leonard, éditrice, *Quality/Calidad/Qualité*, The Population Council, One Dag Hammarskjöld Plaza, New York, NY 10017, U.S.A.

Resumen en Español

En esta edición de *Quality/Calidad/Qualité* se da información sobre un programa de planificación familiar postnatal que se lleva a cabo en el Centro Sfax del Hospital de Tunisia para Maternidad y Recién Nacidos. Este programa, desarrollado conjuntamente por el programa nacional de planificación familiar (ONFP) y por el personal de Maternidad, ha tenido extraordinario éxito en lograr que un mayor número de madres regresen después de seis semanas a su visita postnatal. El alto porcentaje de aceptación se debe primordialmente a dos aspectos de su estructura. Primero: el programa ofrece cuidado postnatal para ambos, madre e hijo, (la pareja *mere-enfant*) en el mismo sitio y el mismo día, satisfaciendo así la preocupación que tiene la madre por la salud de su hijo—preocupación que con frecuencia es más importante para ella que sus propias necesidades. Segundo: la cita se hace para el cuarentavo día después del parto; esta día tiene en Tunisia un significado cultural y religioso muy especial tanto para la madre como para el hijo. En la mayoría de las culturas musulmanas, el cuarentavo día marca el final del período de la convalecencia postnatal de la madre. En este día, ella puede regresar a sus responsabilidades domésticas y por primera vez aparece en público con su hijo.

En la visita del día cuarentavo el pediatra hace un examen completo del infante. La protección vital que proveen las vacunas y su aplicación oportuna, se discute con la madre; y a ésta se le ofrecen, además, el apoyo y la información necesarios para que amamante al hijo. Los servicios para la madre incluyen un examen ginecológico y una discusión sobre cualquier problema de salud o de reproducción que ella tenga. El período entre nacimiento y nacimiento se discute; y se ofrecen servicios de planificación familiar como medio importante para lograr tanto la recuperación y la buena salud de la madre, como el desarrollo físico y mental del infante.

El Centro Sfax provee la ligación de los tubos, el dispositivo intrauterino (DIU) y los espermicidas. Los anticonceptivos orales también están disponibles, pero se prescriben muy poco en el presente. Todos los métodos están disponibles en la visita del cuarentavo día, excepto la ligación de los tubos que puede hacerse tan pronto como al día siguiente. La mujer es referida al centro de planeación familiar de

su localidad para la continuación de servicios y los aprovisionamientos necesarios.

De las 9.240 mujeres que dieron a luz en la Maternidad del Centro Sfax en 1987, 83,2 por ciento regresaron a su visita postnatal. De las que regresaron, 55,6 por ciento aceptaron un método de planeación familiar durante su visita. En un esfuerzo para mejorar aun más la calidad de los servicios, el Centro Sfax está considerando algunos cambios que permitan ofrecer en el día cuarentavo un método contraceptivo a un número todavía mayor de mujeres que estén interesadas en ello.

Una posibilidad sería distribuir espermicidas y condones a las mujeres que tengan infecciones vaginales para que los usen mientras estén en tratamiento. Esto no sólo ofrecería protección anticonceptiva sino que ayudaría además a evitar que se extendiera la infección.

Otra de las posibilidades que se han considerado es dar disponibilidad más inmediata a los anticonceptivos orales. Las píldoras no se ofrecen con frecuencia en Tunisia debido a la justificada preocupación que existe acerca de los efectos que puedan tener en los infantes que se están amamantando. Hasta ahora, los anticonceptivos orales de sólo progestin en dosis bajas, apropiados para mujeres que estén amamantando, no han existido para disposición inmediata en Tunisia. Si estas píldoras pudieran lograse, el Centro Sfax consideraría su incorporación en el programa postnatal.

También se han contemplado cambios en las inserciones de los dispositivos intrauterinos (DIUs), las cuales ahora se permiten en el cuarentavo día sólo si la menstruación ha vuelto o si la mujer dice que sus relaciones sexuales no se han renovado aun. La eliminación de estas restricciones permitiría a un mayor número de mujeres que deseen protección anticonceptiva y que estén en peligro de concebir, lograr protección contra el riesgo de una preñez indeseada.

Estos sólo son unos pocos de los planes que el Centro Sfax está considerando en el presente para aumentar las opciones que puedan ofrecerse a las clientes en estado postnatal. Son, en efecto, una parte de la permanente evaluación de los servicios del programa; y es a través de esta evaluación que se buscan formas mejores de responder a la necesidad que tienen las clientes del Centro de protección para su salud reproductiva.

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Francine Coeytaux is a public health specialist with extensive experience in the development and evaluation of family planning and reproductive health programs in Africa and Latin America. An Associate of the Population Council, she has been responsible for the development of Council activities in Sub-Saharan Africa and the initiation of a new, worldwide program to address the problem of septic and incomplete abortion.

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