STRENGTHENING POSTABORTION FAMILY PLANNING IN GUINEA

Sustained Technical Assistance

BACKGROUND

Countries in Francophone West Africa have long worked to overcome the challenges related to implementing and scaling up reproductive health services, including providing the complete package of services included in postabortion care (PAC).[1] To help address these issues, an assessment[2] of the progress made by several West African countries, including Guinea, was conducted and presented at a conference called *Best Practices to Scale up PAC for Lasting Impact* in Saly, Senegal, in 2008. At this meeting, participants, policymakers, and program managers drafted action plans detailing strategies for strengthening postabortion family planning (PAC-FP) services in their respective countries based on the evidence presented[3] regarding each country's needs.

In Guinea, prior to and after the 2008 Saly meeting, Jhpiego and its country representative provided technical leadership and resource mobilization, including incorporating a Standards Based Management and Recognition (SBM-R) approach to improve the quality of service delivery under Jhpiego's Access to Clinical and Community Maternal, Neonatal and Women's Health Services – Family Planning (ACCESS-FP) Program. Prior to intervention, the communal medical centers (CMCs) in Guinea were poorly equipped with few trained staff to provide PAC-FP services.

A Virtual Fostering Change Program platform was adapted for PAC (VFCP for PAC) as a follow-up to countries participating in the 2008 conference in Saly, Senegal. The VFCP for PAC is an internet-based, interactive learning program that was used to teach teams about the application of the fostering change methodology as well as skills to help draft and refine action plans initiated at the 2008 meeting to strengthen PAC programs, namely emergency treatment of abortion complications, postabortion FP, and community empowerment through community mobilization. During the VFCP for PAC process, action plans were revised and participants were trained on leadership and management skills.

Guinea's action plan was created to address several key service delivery components:

- Reorganization of services
- Trainings
- Supply chain management for FP commodities and manual vacuum aspiration (MVA) kits
- Financing
- Leadership, governance, and management

Reorganization of services included ensuring a separate PAC roomwhere PAC servics and FP methods could also be accessed.

Training included training staff on the provision of PAC services using performance standards during counseling and supervision to ensure quality care, and training providers in treatment, FP counseling and services, and infection prevention.

Improving **supply chain management for FP commodities and MVA kits** included activities such as ensuring continuous availability of contraceptives at the PAC unit adn creting a stock management system.

Financing involved preparing a budget for expansion of services.

Leadership, governance, and management included establishing a national PAC program to ensure long-term sustainability of integrated services.

Throughout the VFCP for PAC implementation process, Guinea's action plan, initiated at the 2008 meeting, was further refined. The Guinea team selected three CMCs—Ratoma, Miniére, and Matam in Conakry—as the pilot sites for the action plan implementation. Change agents (CMC senior health facility management champions) selected from each facility were responsible for working with the team members who attended the 2008 Saly meeting to implement activities

About E2A

The Evidence to Action For Strengthened Reproductive Health Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services.

Awarded in September 2011, this five-year project is led by Pathfinder International, in partnership with the African Population and Health Research Center, ExpandNet, IntraHealth International, Management Sciences for Health and PATH.

outlined in the action plan. Following site selection, a situational baseline needs assessment for PAC-FP service delivery was conducted at each site. Service providers participated in several training sessions organized by Jhpiego that focused on emergency obstetric and neonatal care, performance standards, and FP counseling and services.

In 2012, USAID/Washington provided funding to the Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) Project to conduct an assessment of the implementation of the action plans refined under the VFCP for PAC. The E2A Project, a USAID-funded project designed to support the strengthening of FP and reproductive health service delivery, conducted a four-country assessment of action plan implementation in Burkina Faso, Guinea, Senegal and Togo. The goal of the assessment was to highlight successes achieved to date as well as to identify the processes needed to strengthen and scale up PAC-FP services. The assessment findings for Guinea are presented in this brief.

ASSESSMENT METHODOLOGY

In late 2012, E2A conducted interviews and focus group discussions with Guinea Ministry of Health (MoH) staff who participated in the VFCP for PAC. For this assessment, data collection included a total of: (1) eight key informant interviews from Saly meeting team members, senior health facility management champions, and policymakers; (2) three focus group discussions with service providers from the CMCs of Matam, Miniére, and Ratoma; and (3) a review of PAC patient registers from these facilities.

RESULTS

Reorganization of PAC Services

Reorganization of services was a major component of overall PAC services, and a great deal of progress was made to achieve this objective in the three pilot facilities in Guinea. Each of the facilities was able to move forward significantly in operationalizing the reorganization of services by *creating separate PAC rooms,* despite challenges related to room availability, the limited availability of contraceptive products (initially available only at the FP unit or pharmacy), and access to an adequate number of trained staff.

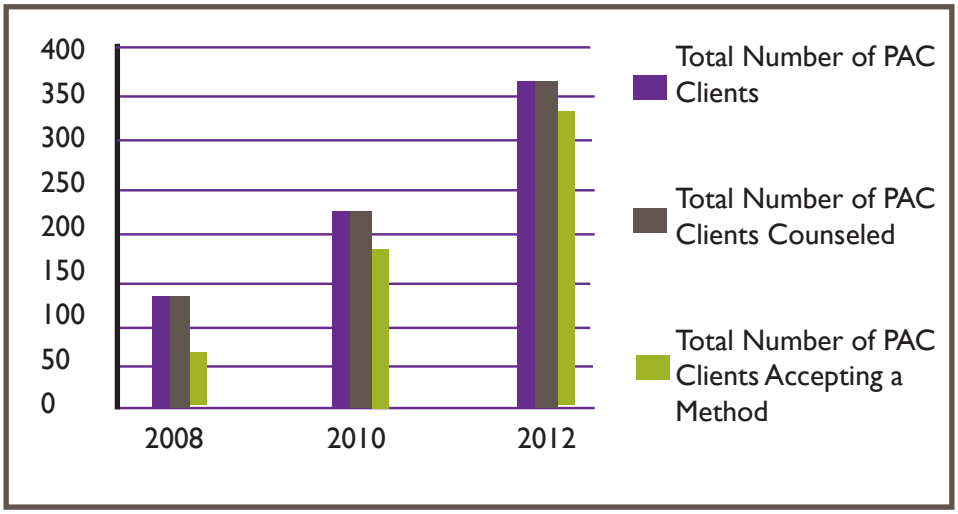
> *"…the first thing that the action plan has allowed (…for us …) to achieve is make available the room."*
>
> **- Midwife (focus group discussion)**

Senior health facility management champions reported that they had made great efforts to *ensure FP method availability at point of treatment* for PAC clients. According to respondents, although contraceptives including condoms, oral pills, injectables, and intrauterine devices (IUDs) had been available at the FP unit and pharmacy in each CMC facility, ensuring availability of contraceptive methods at the PAC unit required that the facility pharmacist allow access to the products. As a result of facility champions negotiating with the FP unit and pharmacy, contraceptives were made available in the PAC unit. Unfortunately, despite this achievement and committed donor support for provision of equipment and supplies, stock-outs occurred not only at the PAC unit, but throughout the facility as well, preventing clients from accessing a full range of methods.

> *"Even though DWB (Doctors without Borders) has been ensuring the supply with contraceptives, it happens that stock-outs pose serious constraints."*
>
> **- Senior Health Facility Management Champion**

In order to gauge progress in this area, this assessment included gathering PAC statistics at three facilities (CMC Ratoma, CMC Miniére and CMC Matam) offering PAC services. In 2008, 142 PAC clients were seen at the selected facilities; all of them (100%) received FP counseling and 46% (n=65) accepted a FP method. Following the completion of the VFCP for PAC program, the implementation of the action plan was associated with an increase in both the number of PAC clients and those who had accepted a FP method. Overall, the number of PAC clients increased by 163%, from 142 (2008) to 374 (2012), with all clients (100%) being counseled on FP methods. The number of PAC clients accepting a method increased from 46% in 2008 (65/142) to 82% in 2010 (196/238) to 94% in 2012 (351/374) (see graph).

PAC-FP Client Register Statistics from CMC Ratoma, CMC Miniére, and CMC Matam, January – June 2008, 2010, and 2012



Cost to PAC Client

Cost of methods was another issue related to client acceptance, especially regarding long-acting reversible contraceptive methods. Examination of facility registers shows a rising acceptance of IUDs as a client method choice between 2008 and 2012. Implants were introduced in Guinea in 2011, and service statistics show uptake in only one facility; one health provider suggested this may be occurring since implants are more expensive than other FP methods.

Training of Service Providers

Service providers, including obstetricians, were trained in the provision of PAC, and even staff who did not attend the trainings received on-the-job training. Service providers from one facility commented that some staff had not been trained, and combined with staff turnover this had resulted in declining numbers of skilled service personnel, which had limited the facility's ability to meet client demands. While expressing appreciation for the previous training program, senior policymakers advocated for continuing the training programs, especially training the untrained workers.

Several service providers and policymakers reported that quality of care for PAC services had been improved, in large part due to Jhpiego's training on the SBM-R approach. One senior policymaker felt that this approach to providing PAC services contributed to the reduced rate of complications for PAC clients. Respondents also recognized improvements in compassionate care and acknowledged that PAC patients were being treated in a more humane and caring way by providers. A senior policymaker mentioned that this training program has since been discontinued.

National Guidelines

At the national level, a senior policymaker reported the formal approval of guidelines for "the integration of PAC-FP into university programs" as a notable achievement. Despite these successes, some challenges remain, such as creating a national PAC program, as mentioned by a respondent.

Leadership, Governance, and Management

Respondents mentioned that several of the action plan's leadership, governance, and management activities had been successfully implemented, including advocating to the on-site pharmacies regarding availability of contraceptives at point of PAC treatment. Respondents attributed much of the progress achieved with strengthened PAC service delivery to the involvement of Jhpiego, but called for greater investment by the MoH to ensure long-term success.

Country Feedback on Implementation of Action Plan

MoH staff (senior policymakers and health providers) provided insights and suggestions to ensure continuation of the progress and to address some of the barriers that continue to stand in the way of even greater success. Acknowledging that facility champions were able to successfully negotiate to ensure method accessibility in the PAC unit while at the same time recognizing lack of consistent contraceptive availability, respondents suggested a supply chain management system that better forecasts needs and reduces the incidence of supply interruption at the facility level. Reducing clients' cost of all FP methods, particularly long-acting ones, was also proposed as a strategy to ensure increased FP uptake.

Senior MoH staff proposed continued training, both in-service and pre-service, on PAC services to achieve national coverage (in addition to trainings on Jhpiego's SBM-R approach to improve quality of care). Senior MoH staff recommended establishing national reproductive health policies, strategies, and guidelines for PAC service delivery, as well as ensuring appropriate financing for national coverage through line budget inclusion in the national health budget to strengthen PAC-FP from a health systems perspective.

Overall sustainability needs to be ensured for PAC services to continue to be provided nationally. Jhpiego has been able to work closely with the MoH and pilot facilities in Guinea to support the introduction and scale-up of PAC services. However, in order for sustainable success to be achieved, greater investments need to be made by the government with support from technical partners and donor agencies.

> *"…is this very, very good coordination BY the MoH, not with the MoH, but very much BY the MoH. The MoH is in charge of doing it. We should make sure that ultimately the MoH is the one that is scaling up the activities, not to just keep having the NGOs doing it."*
>
> **- Cooperating Agency, Stakeholder**

CONCLUSION

The 2008 action plan was successfully implemented in the three facilities with sustained technical assistance by Jhpiego through facility-specific champions. This resulted in the establishment of separate PAC rooms, successful negotiation with the facility pharmacist to co-locate FP methods in the PAC units, and supportive supervision of maternal health service providers. Respondents mentioned the inclusion of PAC in national training guidelines for universities. Sustaining these achievements and scaling them up will depend on the MoH assuming a leadership role in national program implementation.

These results were presented at the *Inter-country Workshop to Disseminate the Results of the Postabortion Care Evaluation and the Introduction of Best Practices for the Development and Sustainability of PAC*, held in Saly, Senegal, October 7-11, 2013. The Guinea country team proposed strengthening PAC services by scaling up quality PAC services in all district hospitals and 5 percent of health centers. Strengthening community involvement and facilitating young people's access to PAC services in two districts were also proposed for action in the subsequent 18 months.

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Endnotes

[1] For the purposes of this report, the definition of postabortion care (PAC) is based on the USAID PAC service delivery model, which includes three components:
1. Emergency treatment for complications of spontaneous or induced abortion.
2. Family planning counseling and service provision; sexually transmitted infection evaluation and treatment; and HIV counseling and/or referral for HIV testing.
3. Community empowerment through community awareness and mobilization.

[2] Dieng T, Diadhio M, Diop NJ, Faye Y. Assessment of Progress of the Postabortion Care Initiative in Francophone Africa. Centre de Formation et de la Recherche en Santé de la Reproductions (CEFOREP), Frontiers in Reproductive Health (FRONTIERS), The Population Council, April 2008.

[3] Dissemination of Workshop Report: PAC (Postabortion Care) Assessment Results from Six West African Countries and Introduction of High Impact Best Practices for Scale-up in these Countries, October 20-23, 2008, Palm Beach, Saly Portudal, Senegal.

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Evidence To Action Project
1201 Connecticut Ave NW, Suite 700
Washington, DC 20036, USA
T: 202-775-1977
www.e2aproject.org
info@e2aproject.org

Pathfinder International
(Contact for this project after September 2016)
9 Galen Street, Suite 217
Watertown, MA 02472, USA
T: 617-924-7200
www.pathfinderorg