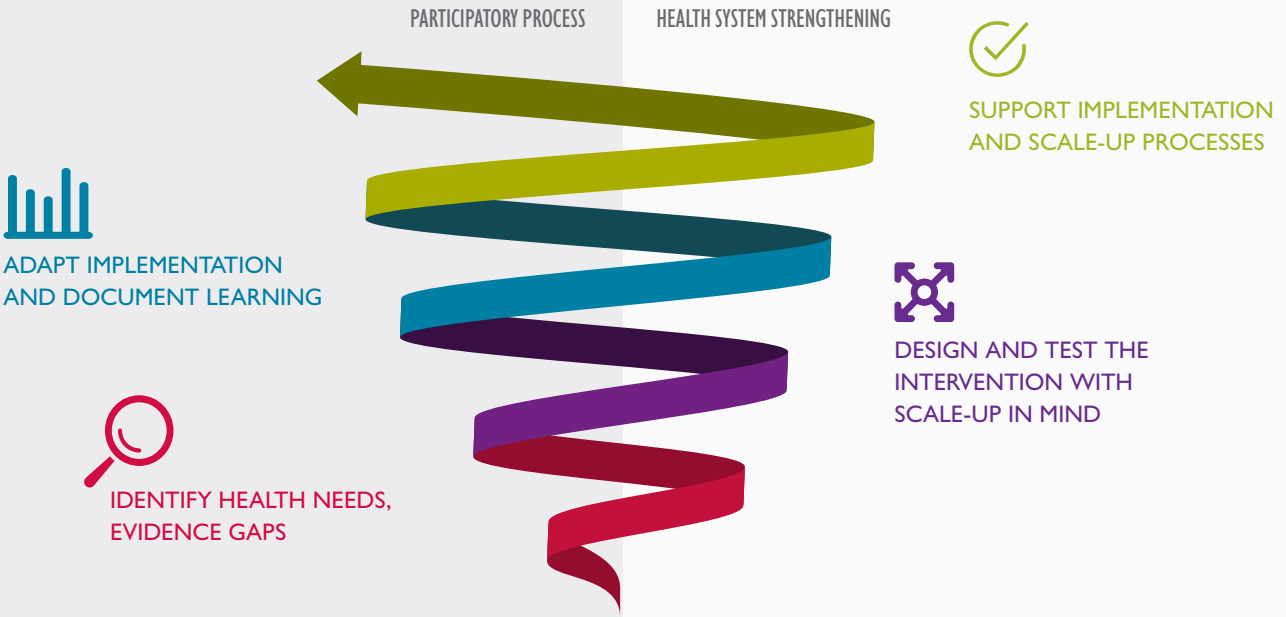
Planning for the Scale-Up of Postabortion Family Planning for Adolescents and Youth in Senegal

FIGURE 1: EVIDENCE TO ACTION PROJECT CYCLE



Between September 2018 and July 2019, Pathfinder International's Evidence to Action (E2A) Project, with support from USAID and in close collaboration with IntraHealth International's Neema Project, supported Senegal's Ministry of Health and Social Action (MSAS) to implement and plan for the scale-up of the "Postabortion Family Planning for Adolescents and Youth (PAFP-AY)" intervention. Utilizing the four steps of E2A's project cycle depicted in figure 1 above, this technical brief describes the different stages in planning for scale-up as well as the key results we achieved.[1]

STEP 1: IDENTIFY HEALTH NEEDS AND EVIDENCE GAPS

Postabortion family planning (PAFP) has always been a key element of postabortion care (PAC) and provides a powerful rationale for PAC services. In practice, however, treatment of complications is usually the sole focus, and family planning is often neglected.[2] The findings of the 2001 USAID global evaluation report, situational analyses in Latin America and the Caribbean, and country action plans from Bolivia, Kenya, and Senegal, as well as lessons learned from five PAC focus countries including Senegal, identified barriers for postabortion family planning at various levels, including national, facility, provider, and client levels. For instance, at the facility level, barriers to postabortion family planning services fall within two categories—(1) guidelines, staffing, and patient education materials and (2) contraceptive methods.[3-4] Senegal introduced PAC to regional hospitals in 1997 and expanded it to health centers in 2003

1 For more information, read E2A's full report: e2aproject.org/fr/publications/afpac-senegal-rapport

2 Curtis C, Huber D, Moss-Knight T, Postabortion Family Planning: Addressing the Cycle of Repeat Unintended Pregnancy and Abortion, International Perspectives on Sexual and Reproductive Health, Volume 36, Number 1, March 2010.

3 Cobb L et al., Global evaluation of USAID's postabortion care program, Washington, DC: USAID, 2001.

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by building the capacity of health providers in the management of postabortion complications and counseling and provision of voluntary family planning, providing support for service reorganization to ensure availability of contraceptives in the PAC treatment room, and ensuring supportive supervision. The decentralization of services from tertiary hospitals to health center and health post levels has been successful in increasing the uptake of PAFP. As matter of fact, from 2003 to 2005, PAC services, which had previously been provided only in tertiary hospitals, were instituted in rural and urban health centers and health posts in Senegal. In just two years, the proportion of women who received contraceptive counseling before leaving the facility increased from 36% to 78%. Although baseline data on postabortion contraception acceptance was lacking, 56% of women who visited the facility for PAC received a method before going home in 2005—an impressive rate in the context of West Africa.[5] However, these early successes were not sustained. A multi-country evaluation, conducted by E2A in four West African countries that participated in the Virtual Fostering Change for PAC program showed that, between 2008 and 2012, Senegal had the highest number of PAC clients, the lowest counseling rate, and the lowest rate of contraceptive uptake.[6] Although there is lack of data on PAFP among young PAC clients, evidence suggests that among PAC clients, 79% of the cases of complications of induced abortion are experienced by girls between 14 and 24 years of age.[7] This represents an opportunity to provide PAFP to young people that, nationally, only account for 8.7% and 20.1% of contraceptive prevalence rate for adolescents 15–19 years and young people 20–24 years, respectively.[8]

STEP 2: DESIGN PAFP-AY WITH SCALE-UP IN MIND

Together, E2A and the Neema project supported Senegal's MSAS in strengthening PAFP by adapting a PAFP model that was originally tailored to adolescent girls and young women in Togo to the Senegalese context. The Togolese model had already been piloted and scaled up with support from E2A. This model was primarily intended to improve providers' attitudes toward adolescents and young clients, and integrate gender considerations into skills development to provide voluntary adolescents- and youth-responsive PAFP. The Ministry of Health in Togo subsequently institutionalized the PAFP training package.

In Senegal, with technical support from the Neema project, the PAFP-AY model was introduced in three health facilities in the Diourbel medical region.

PAFP-AY is defined as an initiative to increase counseling and the voluntary use of contraceptive methods among all PAC clients, with a tailored approach of caring for adolescents and young women. PAFP-AY is the Senegalese adaptation of a combination of the Postabortion Family Planning High Impact Practice (HIP)[9] and the Adolescents-Friendly Contraceptives Services HIP enhancement.[10]

PAFP-AY IMPLEMENTATION STRATEGIES IN SENEGAL

- Support MSAS in the provision of adolescent and youth responsive PAFP services.
- Support MSAS in documenting and disseminating the results of the model.
- Support MSAS in planning for scale-up of PAFP-AY.

KEY ACTIVITIES FOR PLANNING SCALE-UP

- Establish a fully equipped and operational scale-up resource team.
- Apply ExpandNet tools at different stages of the implementation.
- Develop a roadmap for the scale-up planning process.
- Develop of a scale-up strategy.

The three pilot sites—(1) Matlaboul Fawzaini National Hospital Center in Touba, (2) Mbacké Health Center, and (3) Ndamatou Public Health Facility—were known for their high volume of PAC clients in the Neema project area, as was evidenced by the baseline situational analysis. The package of activities for this intervention included:

- Establishment of a scale-up resource team, oriented on the WHO/ExpandNet scale up tools.
- Adaptation of the Togolese adolescent- and youth-responsive PAFP training materials to the Senegalese context.
- Capacity-building for frontline workers on voluntary PAFP for adolescents and youth.
- Development of facility action plans following facility assessments.
- Sustainable support of facility action plan implementation for strengthened PAFP within PAC.

The scale-up objective was an integral part of the PAFP-AY implementation strategy. Deliberate efforts to ensure that the project activities integrated planning for systematic scale-up included:

Setting Up and Orienting the Scale-Up Resource Team

ExpandNet's conceptual framework,[11] identifies a scale-up resource team (RT) as "individuals and organizations that seek to promote and facilitate wider use of an innovation." Senegal's RT comprised actors and institutions that facilitated the implementation and promotion of PAFP-AY to enable its adoption at different levels of the MSAS. The RT was established at the start of the project in September 2018 and was composed of 10 members, representing

4 Curtis C, What the community is telling us about their needs in PAC: Synthesis of Phase I community action plans from Bolivia, Senegal, and Kenya, presentation at Moving Forward with Postabortion Care: Lessons Learned from Five Postabortion Care Focus Countries, Mar. 18, 2008, Washington, DC.

5 Curtis C, Decentralization of postabortion care services in Senegal and Tanzania, Global Health Technical Briefs, Washington, DC: USAID, 2007.

6 Fariyal F. Fikree, Stembile Mugore, and Heather Forrester, Strengthening Postabortion Family Planning in Senegal, Maintaining and Enhancing Postabortion Care Services, Washington, DC: Evidence to Action.

7 Soumah M. et Al, Groupe pour l'Étude et l'Enseignement de la Population, 2010-2014.

different entities of the MSAS (Division of Family Planning, Division of AYRH; Division of Maternal and Neonatal Health; Community Health Unit; Diourbel medical region; districts of Touba and Mbacké), as well as partners such as Neema project, E2A, and ExpandNet. E2A facilitated capacity building for the RT on ExpandNet/WHO tools and concepts, including (1) the scale-up systematic framework[12] and (2) the *Beginning with the end in mind*[13] tool. By referencing the latter, the RT developed a roadmap that guided implementation and follow up of planned activities.

Documenting the PAFP-AY Implementation Process

The main purpose of this documentation was to identify the types and levels of improvement needed to strengthen the quality of PAFP care and provide evidence to support scale-up. The documentation focused on determining the potential of scaling up PAFP-AY using ExpandNet's *Beginning with the end in mind*[14] tool and assessing the level of ownership for institutionalization by health system actors.

STEP 3: ADAPT IMPLEMENTATION AND DOCUMENTING LEARNING

Adapting the innovation to the context of its implementation and documenting it for continuous learning are important steps to increase the likelihood of success during scale-up, with implementers engaged in ongoing reflection from the beginning of the pilot phase.

For Senegal's PAFP-AY project, the major adaptation involved the tools used to build frontline workers' capacity to provide adolescents- and young people- responsive PAFP, including addressing providers attitude. Understanding "innovations that build on existing social organization partners, values, and social traditions are more likely to be adopted and sustainable,"[15] the implementing actors thought it was relevant to review a number of tools in order to adapt them to the socio-cultural context of Senegal. The providers recognized the importance of the PAFP training content and observed a match between this content and the results of the situational analysis in the Diourbel region. They expressed that the trainings resulted in positive changes in their day-to-day work.

KEY ROLES OF THE PAFP-AY RESOURCE TEAM IN SENEGAL

- Advocacy within MSAS and other partners for optimal conditions for PAFP-AY implementation
- Documentation of the PAFP-AY implementation
- Resource mobilization
- Identification of core elements to be scaled up
- Selection of PAFP-AY extension sites

A Fawzaini provider testifies:

"I tended to consider PAC clients regardless of age. In Touba, many girls are married around the age of 13, so they sometimes are not aware of their pregnancy. This training especially helped me to know how to talk to adolescents and young people."

Another Mbacké provider shares:

"PAFP-AY has changed our approach to the care of adolescent girls and young people. They are vulnerable service users that need understanding and discretion. Prior to the PAFP-AY training, we used to take up to eight days postabortion before offering contraception. After the training, they are provided with care immediately postabortion to allow them [to] leave the facility with a family planning method."[16]

Another key to optimizing a scale-up effort is to evaluate the implementation of the pilot phase. Therefore, in addition to documenting the quantitative results of the voluntary PAFP-AY care, E2A also documented the implementation process. Documenting actions taken in implementing the PAFP-AY, as well as the challenges encountered, helped determine recommendations for adaptations to the intervention as it moves to scale. The methodology used in this documentation was intended to identify changes as they occurred. In addition to collecting routine data on the performance of each facility, the changes reported also related to initiatives taken by health facility managers and staff to facilitate implementation.

8 Enquête Démographique et de Santé Continue (EDS-Continue) 2017, Agence Nationale de la Statistique et de la Démographie (ANSD) Dakar, Sénégal, The DHS Program ICF Rockville, Maryland, USA, Septembre 2018.

9 fphighimpactpractices.org/briefs/postabortion-family-planning/

10 fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/

11 Ibid.

12 Ibid.

13 World Health Organization (WHO)/ExpandNet, " Beginning with the end in mind: Planning Pilot Projects and Other Programmatic Research for Successful Scaling Up" (Geneva: 2013).

14 WHO/ExpandNet, "Nine steps for developing a scaling-up strategy" (Geneva: 2011).

15 WHO/ExpandNet, "Aiming for the Goal from the Start: Planning Pilot Projects and Other Programmatic Research for Successful Scaling Up" (Geneva: 2013).

QUANTITATIVE RESULTS

Data on service delivery were collected by each facility's maternity ward managers during monthly data monitoring visits using monitoring sheets developed for this purpose. Another level of data quality assessment and data analysis were performed by the health district and Neema project staff.

The following parameters of PAC clients were monitored age, postabortion FP counseling, and type of contraceptive method chosen.

Table 1: Distribution of PAC Clients by Facility

STRUCTURES	CLIENT LOAD 3 months data before implementation, June–August 2018	PERCENTAGE 3 months data prior to implementation, June–August 2018	CLIENT LOAD 9 months of implementation	PERCENTAGE 9 months of implementation
FAWZAINI	72	15.4%	214	17%
MBACKE	66	14%	190	15.1
NDAMATOU	332	70.6%	853	67.9
Total	**470**	**100%**	**1257**	**100%**

From November 2018 to July 2019, a total of 1,257 postabortion cases were reported at the three sites. The Ndamatou facility received the highest number of PAC clients—nearly 68% of cases with an average of four PAC clients per day. All three facilities showed similar client load trend as reported by the baseline assessment data.

FP Counseling for PAC Clients

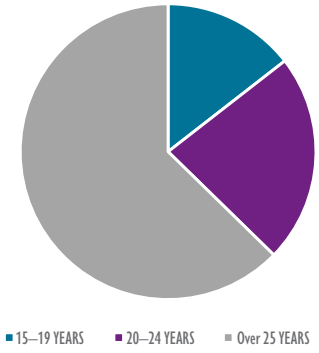
On average, at the end of the intervention period, four out of five clients received counseling on the benefits of FP and the different contraceptive methods on the same day that the PAC was performed. It should be noted that performance of counseling varied from site to site—at 99.5%, 83%, and 76.6% at the Mbacké Health Center, the Ndamatou Health Center, and the Fawzaini Health center, respectively. An age analysis showed that only 37% (n=172) of 15–24-year-olds received FP counseling at the three implementation sites.

Trends in PAFP use

After receiving FP counseling, an average of one in four of all clients opted for a FP method—28.3%, compared to 16% before the start of the project. When comparing the results at the three sites, performance differed, particularly at the Mbacké Health Center, which had a contraceptive method adoption rate of 78%, compared to Fawzeyni and Ndamatou, which had adoption rates of 50% and 12%, respectively. Further analysis reveals that 21% of clients under 25 years of age adopted a FP method in the immediate postabortion period. Although this seems low, it should be noted that, during the baseline situational analysis, no women under 25 years of age had adopted a FP method post abortion.

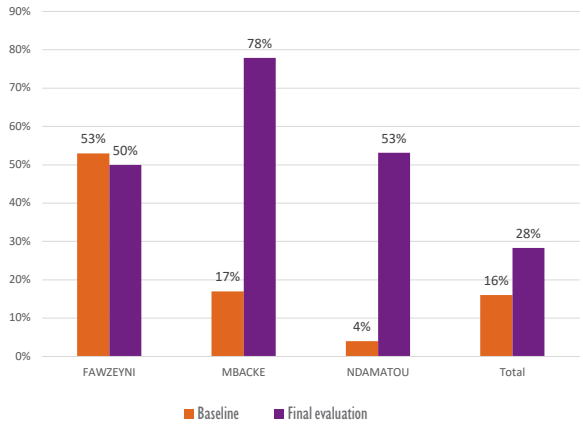
The most used methods are injectables, pills, and implants with a higher uptake of short-term methods among young people aged 15–24 (Figure 4).

Figure 2: Distribution of PAC Clients by Age



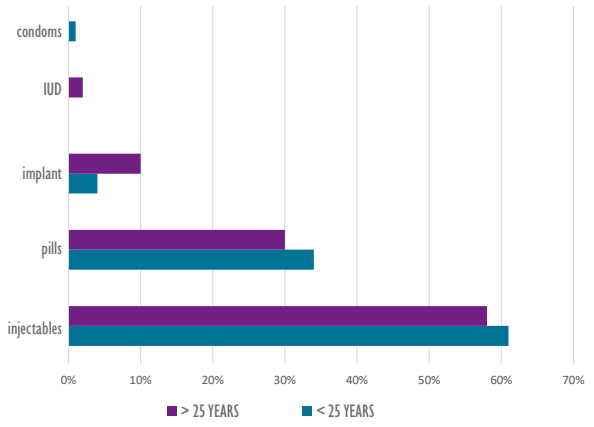
Adolescent/young clients, 15–24 years of age, represented over one-third of the total number of cases (n=465, 37%).

Figure 3: Evolution of the Postabortion Adoption of Contraception



16 fphighimpactpractices.org/briefs/postabortion-family-planning/

Figure 4: Method Uptake of Postabortion Clients, by Age Group



QUALITATIVE DATA

Data were collected through individual interviews and focus group discussion with frontline workers and other key informants. District and regional health managers shed light on several positive changes:

Providers' recognized the importance of good counseling as one of the best strategies for overcoming socio-cultural barriers preventing young women and adolescents from choosing a PAFP method.

A midwife provider comments:

"After the training, all the PAC clients I have managed have adopted a contraceptive method, because the counseling was well done. Women do not understand why they should take an FP method as part of PAC. Good counseling can help rectify rumors and explain to the woman and her family that within 11 days after abortion, she is at risk of becoming pregnant again."

The reorganization of services is an important mechanism for improving PAFP-AY care. The constant availability of contraceptives, the provision of new standardized registers on PAC, and the improvement of financial accessibility to PAC through reduction of the PAC user fee by half (from FCFA10,000 to FCFA 5,000) all facilitated greater accessibility to clients in need of PAC. Equally important was the continuous availability of PAFP as an integral part of PAC.

One provider shares this positive change:

"The changes that have been made have resulted in PAC clients now being attended to every day and at all times, even at night, if they want to adopt a contraceptive method. A register for PAC clients is in place, a fully individualized PAC room now exists, and all FP methods are available at the pharmacy."

Actors of the health system, including central-level program managers, regional and district health managers, and health providers took ownership of the PAFP-AY intervention in preparation for future scale-up. This ownership is evidenced by the participatory process that prevailed throughout the project, the mechanisms put in place for coordination and follow-up, and the regular collection and dissemination of information on the project. In addition to these actions led by the PAFP-AY RT, there were additional deliberate efforts made by some health facilities, themselves, to allocate financial resources for strengthening PAFP and PAFP-AY provision. For instance, the Mbacké health facility development committee decided to subsidize PAC fees from 10.000CFA to 5.000CFA, thus creating more opportunity for women and girls to financially access services. At the district level, careful attention was paid to the management of contraceptive supplies to facilities to avoid stock out.

STEP 4: SUPPORT GEOGRAPHICAL SCALE-UP AND INSTITUTIONALIZATION OF THE PAFP-AY INTERVENTION

According to the ExpandNet methodology, "scale-up requires undertaking systematic planning on how tested pilot innovations can be implemented on a larger scale to achieve a wider impact."[17] In the Senegalese context, this systematic approach was initiated at the start of the pilot phase and was pursued throughout the implementation process, mainly through the establishment and capacity building of the PAFP-AY RT, the development of a roadmap outlining different actions to be implemented by the RT, and efforts to plan for systematic scale-up. As a flagship activity of the RT, and in line with the systematic planning mindset, the scale-up strategy development workshop was held and was attended by a wide range of actors, including the Diourbel Medical Region; the participating districts and facilities managers; representatives of the Family Planning, Adolescent/Youth Reproductive Health Division; the Mother and Newborn Health Divisions; the Community Health Unit (GEXCOM); and IntraHealth International, E2A, and ExpandNet expert. Using lessons learned from both the quantitative data analysis and the qualitative documentation outcomes, the RT drew from the WHO/ExpandNet *Nine steps for developing a scaling-up strategy* tool—to identify areas in need of improvement and actions required to enhance the scalability of PAFP-AY to other settings. As a result of this process, the Diourbel Medical Region decided to extend the approach to eleven additional service delivery points in the Bambey district and six health centers

17 WHO/ExpandNet, Nine steps for developing a scaling-up strategy, Geneva: 2011.

18 For more details on the PAGE plan, consult the full report: e2aproject.org/fr/publications/afpac-senegal-rapport/

in the Touba district, this time with the integration of a community component, while consolidating the gains made in the three pilot sites.[18] To ensure sustainability beyond the pilot phase, members of the PAFP-AY RT reached a consensus that their team's activities should be embedded in the national community health interventions scale-up committee.

The following recommendations were made to increase the potential for successful scale-up:

Adapt the intervention to the community context:
Despite the recognized effectiveness of counseling in helping adolescents and young women exercise FP method choice, it only represents a partial response to the socio-cultural barriers that prevent women, adolescents, and young women from accessing PAFP. To this end, the geographic extension phase of PAPF-AY would benefit from a well-contextualized community-based component. This community-based component would aim to create acceptance of and demand for FP through the development of a social and behavioral change strategy primarily targeting the key influencers of adolescent girls and young women.

Build local solutions for affordable care:
Financial inaccessibility continues to be a challenge in accessing PAC. However, in Mbacké, in-house efforts have been made to reduce service costs by ensuring active involvement of the health facility development committee. This example of the search for endogenous solutions could be used as a case study and replicated in geographic extension sites.

Monitor what's important:
To enhance sustainability of PAFP-AY, advocacy should be conducted for the integration of PAFP indicators into DHIS2 for better monitoring and decision making at all levels of the health pyramid.

Ensure careful selection of expansion sites:
The managers of the Mbacké Health Center seem more inclined to support the technical activities of the intervention than the hospital authorities, who have to deal with significantly greater administrative and financial responsibilities. This could justify the extension of the approach—toward health centers more than hospitals.

Diversify RT members with additional expertise:
The current PAPF-AY RT should be expanded to include potential partners and serve as a framework for planning, validating, monitoring, and mobilizing additional resources in order to support the expansion of the approach toward new sites.

Start the intervention with inclusive planning for scale-up:
In preparation for scale-up, organize a strategic planning workshop involving the actors from the PAPF-AY pilot phase, the managers of the future geographic extension zones, the current members of the RT, and other potential members of the RT.

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. E2A addresses the reproductive health care 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. E2A is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

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