



# STRENGTHENING POSTABORTION FAMILY PLANNING

## IN TOGO

### Mobilizing Resources



#### 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).<sup>1</sup> To help address these issues, an assessment<sup>2</sup> of the progress made by several West African countries, including Togo, 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<sup>3</sup> regarding each country's needs.

The 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 to strengthen PAC services, 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.

During the VFCP for PAC implementation process, the action plan for Togo, initiated at the 2008 meeting, was further refined. Four health facilities—CHR Tsévié, CMS Kévé, CMS Adidogomé, and the Togolese International Planned Parenthood Federation (IPPF) affiliate *Association Togolaise pour le Bien-Etre Familial* (ATBEF)—were initially selected to implement the revised action plan activities.<sup>3</sup> However, the action plan team lacked funding and associated resources to implement the range of activities. USAID/Washington responded to these challenges by providing \$40,000 for training and technical assistance to Togo, which was organized and implemented by EngenderHealth's Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) Project. Trainings were conducted in early 2010. Trainees were health providers from either the Division of Family Health (DSF) or one of the four selected sites.

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

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

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 program. The E2A Project 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 Togo are presented in this brief.

#### ASSESSMENT METHODOLOGY

In early 2013, E2A conducted interviews and focus group discussions with Togolese staff who participated in the VFCP for PAC. For this assessment, data collection included a total of: (1) twelve key informant interviews with the 2008 Saly meeting team members, senior health facility management champions, and policymakers; (2) four focus group discussions with service providers from the regional teaching hospital (CHU Kara) and three facilities (CHR Tsévié, CMS Kévé, CMS

#### 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, Intra-Health International, Management Sciences for Health and PATH.

<sup>3</sup>ATBEF was one of the four action plan facilities, but was excluded from this assessment as it is an NGO-run facility, and largely funded by IPPF. Although ATBEF offers PAC services, its implementation of the action plan was somewhat limited, and the challenges it faced were very different from the other three government-managed sites. In addition, the assessment team opted to collect data from a fifth site, CHU Kara, which was not an action plan facility. It was included because the chief obstetrician participated at the Saly workshop. CHU Kara is a large referral center and teaching facility in northern Togo that participated in implementing PAC action plan activities and therefore provides useful insights into providing PAC services in Togo.

Adidogomé); and (3) a review of PAC client registers in three of the facilities (CHU Kara, CHR Tsévié, and CMS Kévé).

**Reorganization of services** called for improvements such as creating a separate PAC room and ensuring FP counseling and methods were available at the point of treatment.

**Training activities** included training all providers on PAC so that they would be able to maintain continuous service provision.

Activities related to **supplies and commodities** included ensuring a constant supply of FP methods in the PAC unit, as well as ensuring night shift staff in the maternity ward had a regular supply of contraceptives available.

Organizing monitoring systems, including reviewing statistics within the PAC register, were intended to improve **health information systems**.

The need for **financing** was addressed through activities that included advocating to the government, development partners and the community for resource mobilization, as well as increasing the government contribution for the purchase of contraceptives.

**Leadership and management** activities included regular supervision as well as ensuring coordination activities at chosen health facilities and organizing monthly meetings between the health facilities and the national PAC team.

## RESULTS

### Reorganization of PAC Services

The reorganization of PAC services mandates provision of emergency treatment for abortion complications, FP counseling, and method provision at point of treatment. Togo's action plan centered upon two key components: (1) the creation of a separate room where clients could receive both emergency treatment for abortion complications and FP counseling;

and (2) FP method provision at the point of treatment.

*The creation of a separate PAC room* was one of the greatest challenges faced by the health facilities offering PAC services. Although one of the four facilities was able to establish a separate PAC room, that facility also used the room for post-surgical dressings and other low-tier medical services. Another facility was able to petition for a gynecological table, but was unsuccessful in obtaining funds to create a separate PAC room. These facilities were therefore unable to provide PAC services despite having all other necessary components, including trained personnel, a functioning MVA kit, and contraceptives. All other facilities that were able to provide PAC treatment did so in the delivery unit of the health facilities, which providers agreed limited privacy and confidentiality for the women receiving care. The inability to create a separate room for PAC patients was routinely traced back to lack of funds and limited infrastructure, particularly in the smaller facilities which had little space.

*Ensuring provision of FP methods at point of treatment*, a second important component of the reorganization of PAC services, also faced challenges, though facilities planned and negotiated alternate approaches. One facility was initially equipped to offer all methods to PAC clients in the PAC unit, but stopped providing all methods because, as a service provider remarked, the methods were expiring before being used. In an attempt to address this challenge, the facility began offering oral contraceptive pills to all PAC clients with the option to visit the FP unit to receive other methods.

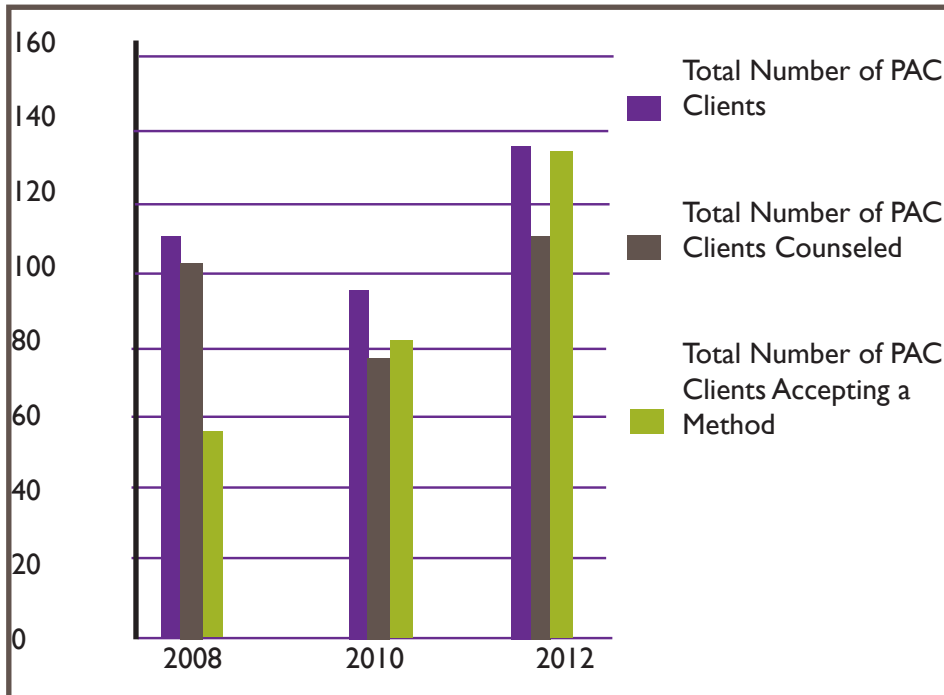
*"Integration [for offering PAC services] is easy... a woman has a problem, she comes, we help her and we propose a solution so it doesn't happen again and she accepts it."*

**- Senior Policymaker**

*Referral to Family Planning Clinic:* The separation of the PAC unit from the FP unit presented a barrier to clients, as all the health facilities visited had FP units that were only operational during normal business hours. Most clients receiving PAC treatment are discharged from facilities during weekends or otherwise outside of normal business hours, and without FP supplies available at point of PAC treatment, many clients were unable to obtain their desired method immediately. These clients were often directed to return to the facility to obtain their chosen FP method at their routine eight-day check-up, but there was no way to identify if these clients ever returned or accepted a method of their choice (likely due to being seen by a different provider at the eight-day check-up, and/or records that were not well maintained at follow-up).

In order to gauge progress in this area, E2A's assessment gathered PAC statistics at three facilities (CHU Kara, CHR Tsévié, and CMS Kévé) offering PAC services. Prior to the 2008 conference in Saly, Senegal, over a six-month period of time from January to June 2008, 110 PAC clients were seen at the selected facilities, and 56 of these PAC clients had accepted a method. The implementation of the action plans, following the completion of the VFPC for PAC program and trainings, was associated with an increase in the number of PAC clients and FP acceptors: overall, the number of PAC clients increased by 22% from 110 (2008) to 134 (2012). The number of PAC clients who received FP counseling was 93% (102/110) in 2008 and decreased to 84% (79/94) in 2010 and to 79% (106/134) in 2012. The number of PAC clients who had accepted a method increased from 51% (56/110) in 2008 to 100% (134/134) in 2012 (see graph on next page).

**PAC-FP Client Register Statistics from CHU Kara, CHR Tsévié, and CMS Kévé, January – June 2008, 2010, and 2012**



**Cost of FP Methods**

Facilities that were able to offer contraceptives at point of treatment, regardless of method type, charged clients the usual fee for the FP method. This additional cost to clients was another challenge that prevented the full realization of PAC services, which included FP at point of treatment. Oral contraceptive methods were often offered to PAC clients as an alternative strategy, as they are much less expensive than other long-acting methods such as implants and intrauterine devices. Although a client may have preferred a longer-acting method, many may not have had adequate funds to pay for the method upfront, particularly the most vulnerable clients who were most likely to need PAC and FP services.

**Training of Service Providers**

Before 2010, there had been provider trainings on PAC services, but treatment for PAC services had consisted primarily of digital and/or surgical curettage. In February 2010, EngenderHealth’s RESPOND Project conducted a training workshop series on PAC service delivery. Participants in the 2010 trainings included midwives, doctors, and medical assistants who were trained to perform MVA to treat incomplete abortion and to counsel on FP methods. Unfortunately, not all providers at the health facilities were able to attend the training, and staff turnover meant that it was sometimes not possible

to provide the full package of PAC services 24 hours a day. This lack of sufficient trained personnel hampered the ability of the health facilities to provide consistent PAC services, 24 hours per day, seven days per week.

**Supply of MVA Kits**

Health facilities also faced the challenge of ensuring adequate availability of well-functioning equipment and supplies during implementation of the action plan. While facilities were equipped with an initial MVA kit following the 2010 training, the DSF gave health facility providers clear instructions that they would be responsible for finding the resources to obtain replacements as the kits wore out. Many health facilities struggled to obtain new MVA kits to meet the growing demand for PAC services and to replace old equipment as it wore out; this resulted in difficulty maintaining enough operational MVA kits to provide safe and effective PAC treatment to patients over time.

**Monitoring and Evaluation - Use of Registers for PAC Clients**

There is currently no national standardized PAC register in Togo, but within the facilities that did maintain client registers, service providers modeled them on those presented during training workshops and viewed at the university teaching hospital in Lomé (CHU Sylvanus Olympio). Health providers and policymakers recognized good maintenance of PAC client registers as a challenge. The PAC registers were informal notebooks that inconsistently defined routine monitoring indicators (e.g., age, parity, number counseled, number of FP acceptors, etc.) at the three health facilities. One facility maintained no PAC register at all. In all cases, staff acknowledged barriers to maintaining a clear and consistent PAC client register. This inability to track client data prevented full monitoring and evaluation of postabortion treatment and FP service uptake and improvement of service delivery.

Besides maintaining the client register, *monitoring and evaluation* also suffered from resource challenges. While DSF staff were able to visit the four health facilities to monitor progress of PAC-FP implementation and assist with challenges in the early stages, as resources became less available, these visits eventually ceased. The DSF attempted to circumvent the inability to conduct field visits by identifying a DSF staff member who remotely monitored the program. This approach had its own set of challenges as the reports were irregular and not documented. Without sufficient monitoring, communication between the DSF and health facilities began to break down and problems with the integration process could not be communicated and solved, hindering efficient implementation of action plan activities.

**National Policies, Norms, and Protocols**

Aside from demonstrable results, one critical operational success of implementing the action plan was the inclusion of PAC into

*“I was trained to offer help to women in PAC, so it is really hard for me when a case presents itself and I can’t do anything for her due to lack of material. I feel embarrassed because I am competent, but due to space and material, I cannot practice. I did ask for these needs to be met, but did not get any responses; it is discouraging.”*

**- Senior Health Facility Management Champion**



EXPANDNET



the National Reproductive Health Policies, Norms, and Protocols (PNP) by senior policymakers at the DSF. Despite this achievement, policymakers recognized that simply including PAC as a component in the PNP for reproductive health was insufficient and more needed to be done to strengthen PAC services within Togo. One policymaker suggested the possibility of creating a five-year national PAC planning document incorporating PAC guidelines and training modules that the DSF could use for resource mobilization among a diverse donor group.

This publication was made possible through support provided by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development, under the terms of Award No. AID-OAA-A-11-00024.

The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

All brand names and product names are trademarks or registered trademarks of their respective companies.

*“I, as a planner, I would have liked a document, a ‘National PAC Plan,’ that I could submit to partners such as UNFPA, WHO, USAID, etc., for resource mobilization”*

- Senior Policymaker

### Country Feedback on Implementation of Action Plan

Togolese health providers and policymakers provided insights and suggestions to ensure continuation of the positive trend and address some of the barriers that continue to stand in the way of even greater success. Respondents suggested that more resources need to be mobilized to ensure the creation of a PAC room, or alternatively, a private space needs to be adapted for PAC clients within the health facilities. PAC clients also need to be able to access FP counseling and methods at point of treatment at any hour and on any day.

In-service and pre-service training on MVA use and counseling, and provision of FP methods should be offered to all maternity staff for emergency treatment of abortion complications and FP counseling and method provision. Service providers also proposed that FP methods be free for all clients in need; though at a minimum, FP methods should be made available and free for all PAC clients.

Respondents proposed the creation of a national PAC plan that meets the country's needs for strengthened PAC-FP services. This national plan would help policymakers advocate for funds specifically for PAC-FP service delivery needs. The creation of a national PAC register for use at health facilities would likely contribute to consistent and complete data recording and improve data utilization for decision making. Adequate resources for DSF staff to continue monitoring the health facilities was also proposed.

## CONCLUSION

Togo achieved considerable success in improving PAC services in the target facilities

by training and re-organizing PAC services as well as including PAC in national reproductive health PNP. Sustaining these achievements and scaling up PAC services should be pursued within existing DSF strategies or in cooperation with national reproductive health plans. To be successful, respondents suggested aligning PAC service activities with existing policies and guidelines, and strengthening monitoring and evaluation to ensure funds are allocated appropriately for national activities.

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 Togo country team proposed providing quality PAC services and strengthening monitoring and evaluation in several sites. In addition, in the subsequent 18 months, advocacy strategies for reinforcing the commitment of policymakers, partners, and community leaders, and raising community awareness for PAC services were proposed

### Endnotes

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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.

### Suggested Citation

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 Project, January 2014).

### Acknowledgements

The Evidence to Action (E2A) Project gratefully acknowledges the generous support of the US Agency for International Development (USAID) to the creation of this brief and the work it describes. This brief was developed with contributions from the following individuals: Amadou Moreau of the Global Research and Advocacy Group; Carolyn Curtis of USAID; and Linda Casey, Papa Fall, Bamikale Feyisetan, and Gwendolyn Morgan of E2A.

### 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.pathfinder.org