Evidence to Action for Strengthened Family Planning
and Reproductive Health Services
for Women and Girls Project

Postabortion Care:

Assessment of Postabortion Care Services in Four Francophone West Africa Countries

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About E2A

The Evidence to Action 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 leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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Acronyms

ATBEF	Association Togolaise pour le Bien-Etre Familial
CA	Cooperating Agency
CEFOREP	Centre Régional de Formation, de Recherche et de Plaidoyer en Santé de la Reproduction
CHR	Regional Hospital (Centre Hospitalier Regional)
CHU	University Hospital (Centre Hospitalier Universitaire)
CHU-YO	CHU Yalgado Ouedraego
CM	Medical Center (Centre Médical)
CMA	Medical Center with Surgical Unit (Centre Médical avec Antenne Chirurgicale)
CPR	Contraceptive Prevalence Rate
CSPS	Centre de Santé et de Promotion Sociale
CHW	Community Health Worker
DNPL	National Pharmacy and Labs Management/Central Pharmacy (Direction Nationale de la Pharmacie et du Laboratoire)
DSF	Division of Family Health (Division de Santé Familiale)
DWB	Doctors Without Borders
E2A	Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls
EmOC	Emergency Obstetric Care
ENSP	National School of Public Health (École National de Santé Publique)
FGD	Focus Group Discussion
FIGO	Federation of International Gynecologists and Obstetricians
FP	Family Planning
IBP	Implementing Best Practices
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KI	Key Informant Interview
LARC	Long-acting reversible contraceptive
LMS	Leadership, Management and Sustainability
MDGs	Millennium Development Goals
MNCH	Maternal Newborn and Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
OB/GYN	Obstetrician/Gynecologist
PAC	Postabortion Care
PNA	National Supplying Pharmacy (Pharmacie Nationale d'Approvisionnement)
PNP	Policies, Norms, and Protocols
PRH	Population and Reproductive Health
PSP	Primary Care Facility (Poste de Santé Primaire)
RESPOND	Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services
RH	Reproductive Health
SBM-R	Standards Based Management and Recognition
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
USAID	United States Agency for International Development
USP	Peripheral Care Units (Unité de Soins Périphérique)
VFC	Virtual Fostering Change
VFCP	Virtual Fostering Change Program
WHO	World Health Organization

Executive Summary

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 the postabortion care service delivery model. To help address these issues, an assessment of the progress made by several West African countries 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 services in their respective countries based on the evidence presented regarding each country's needs.

In 2012, the United States Agency for International Development, Washington, provided funding to the Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project to conduct an assessment of the implementation of the action plans refined under the Virtual Fostering Change Program for postabortion care. The assessment was conducted 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 postabortion care family planning services.

The assessment methodology involved a three-pronged approach which included: a desk review, qualitative key informant interviews, and focus group discussions, and a review of quantitative data from health facility registers. The focus group discussions and register reviews were carried out within the target facilities identified in each country's action plan.

Senegal was the first country to be assessed. Over the course of two weeks, key informant interviews and focus group discussions with individuals who had been involved in the development and implementation of the action plan, as well as reviews of postabortion care client registers at two of the targeted facilities were conducted. Overall, the findings within the country suggested that while there had been some success in terms of community mobilization, significant challenges remained regarding availability of family planning methods at point of postabortion care treatment and recording client data in the postabortion care registers.

Guinea was the next country visited. As in Senegal, key informant interviews and focus group discussions with individuals who had been involved in the development and implementation of the action plan, as well as reviews of postabortion care client registers at three of the targeted facilities were conducted. Of the four countries included within the assessment, the Guinea team was able to make the most progress in terms of achieving its action plan objectives, particularly regarding the creation of separate rooms for integrated postabortion care and family planning services at the point of treatment in the selected health facilities. This success was due in no small part to the sustained technical assistance the country received from an implementing partner agency. Although the gains made by the Guinea team should not be diminished, it is worth noting that sustained technical assistance played a large role in the country's postabortion care family planning achievements.

In Togo, key informant interviews and focus group discussions with individuals who had been involved in the development and implementation of the action plan, as well as reviews of postabortion care client registers at four of the targeted facilities were conducted. The facilities visited ranged in the progress that had been made regarding the action plan, with one facility completely unable to implement and others at varying stages of progress. Findings conveyed that while family planning counseling and uptake for postabortion care clients showed some improvement, there was a consistent challenge of ensuring that these clients received a method before leaving the health facility. This challenge was traced to the separation of the postabortion care treatment and family planning units.

Burkina Faso was the final country visited for the purposes of the assessment. As with the other three countries, key informant interviews and focus group discussions with individuals who had been involved in the development and implementation of the action plan, as well as reviews of postabortion care client registers at three of the targeted facilities were conducted. Again, progress in this country was limited, with providers and policymakers citing lack of support and funding to implement activities. Furthermore, policymakers stressed that the action plan process did not allow them to harmonize activities with their own national policies and strategies.

Overall findings within the four countries suggest that while some progress has been made implementing postabortion care services within targeted health facilities, much work remains to be done in order to maintain the achievements and overcome continuing challenges. This work will require dedicated efforts by all those involved including health providers, policymakers, and partners.

1. Introduction

Countries in Francophone West Africa have long worked to overcome the challenges related to implementing and scaling up reproductive health (RH) services, including providing an integrated package of postabortion care (PAC) services. The Evidence to Action (E2A) project, a United States Agency for International Development (USAID)-funded project designed to support the strengthening of family planning (FP) and RH service delivery, conducted a four-country assessment of the PAC action plan implementation in Burkina Faso, Guinea, Senegal, and Togo. The goal of this assessment was to highlight successes achieved to date and challenges as well as to identify the processes needed to strengthen and scale up PAC-FP services in the four countries. This report highlights findings from this assessment, and makes recommendations for further service strengthening and service delivery for PAC-FP services.

1.1 Background

Unintended and/or unplanned pregnancy is the primary cause of induced abortion. Of the approximately 210 million pregnancies that occur annually, nearly 80 million are unintended.[1] Furthermore, of the approximately 35 million induced abortions that occur annually, 20 million are unsafe (i.e. performed by unskilled workers and often under unsafe conditions). Unsafe abortions result in nearly 67,000 deaths annually, representing 13% of all pregnancy-related maternal deaths.[1] In addition, morbidity is an even more common consequence of unsafe abortion than mortality. It has been estimated that the prevalence of infertility and long-term reproductive tract infections as a consequence of unsafe abortion corresponds to 2% and 5%, respectively, of women of reproductive age.[2]

In 1995, it was estimated that 78% of all abortions took place in the developing world; this proportion increased to 86% in 2008, while the proportion of all women of reproductive age who live in the developing world rose from 80% to 84% in the same period. Globally, the estimated annual number of abortions rose moderately in Africa and Asia, and slightly in Latin America, while it fell slightly in Europe and North America.[3] It is noted that there continues to be inadequate accessibility to FP services and counseling prior to and during PAC, as well as a paucity of evidence on women seeking repeated abortions due to unintended pregnancies. A comprehensive review of 24 studies in 14 countries revealed that, on average, 19% of women receiving PAC had a previous induced abortion ranging from 2% (Egypt) to 72% (Russia).[4]

Another distressing and alarming global trend in the magnitude of *unsafe* abortions has also recently surfaced: there were an estimated 43.8 million abortions that occurred in 2008, as compared to 41.6 million in 2003.[3] In 2008, more than 97% of abortions in Africa were unsafe.[3] West Africa[a] had an estimated abortion rate of 28 per 1,000 women[5] with abortion-related mortality ratio of 80-100 deaths per 100,000 live births in Eastern, Middle, and Western Africa.[1]

It is widely acknowledged that availability and consistent, correct use of contraceptives to avoid pregnancy would result in an estimated 25-35% decline in maternal mortality.[6] However, many West African countries, including Burkina Faso, Guinea, Senegal, and Togo, are characterized by high maternal deaths, high total fertility rates, low contraceptive prevalence rates, and high unmet need for FP, as well as high proportions of adolescent childbearing (Table 1).

[a] Countries include Benin, Burkina Faso, Cape Verde, Ivory Coast, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.

Table 1: Maternal Mortality Ratios (MMR), Contraceptive Prevalence Rates (CPR), Unmet Need, and Adolescent Fertility Rates by Country

Country	MMR (per 100,000 live births)	CPR	Unmet Need	Adolescent Fertility Rate (births per 1,000 women aged 15-19)
Burkina Faso	300[1]	15%[3]	24%[3]	117[6]
Guinea	610[1]	7%[3]	24%[5]	131[6]
Togo	300[2]	13%[4]	41%[4]	88[6]
Senegal	370[1]	12%[4]	29%[4]	53[6]

1. WHO, "Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and World Bank estimates," accessed August 2, 2013, http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf.
2. WHO, "Cause-specific mortality and morbidity: Maternal mortality ratio by country," accessed July 29, 2013, http://apps.who.int/gho/data/node.main.MATMORT?lang=en.
3. Institut National de la Statistique et de la Démographie (INSD) and IFC International , Enquête Démographique et de Santé et à Indicateurs Multiples 2012 (EDSBF-MICS IV), accessed August 2, 2013, http://www.measuredhs.com/pubs/pdf/FR256/FR256.pdf.
4. Population Reference Bureau, "World Population Data Sheet 2012," accessed June 26, 2013, http://www.prb.org/pdf12/2012-population-data-sheet_eng.pdf.
5. Institut National de la Statistique et de la Démographie (INSD) and IFC International , Enquête Démographique et de Santé et à Indicateurs Multiples 2012 (EDS-MICS), accessed April 8, 2014, http://dhsprogram.com/pubs/pdf/FR280/FR280.pdf.
6. Population Reference Bureau, "The World's Youth: 2013 Data Sheet," accessed April 22, 2014, http://www.prb.org/pdf13/youth-data-sheet-2013.pdf.

The main goal of PAC is to reduce maternal mortality and morbidity due to abortion complications. In addition, high-quality PAC services avert repeat unplanned pregnancies and the cycle of repeat abortions through provision of counseling and contraceptive services at the time of and location where emergency treatment of abortion complications is offered, as well as before the patient is discharged from the facility.

1.2 PAC Service Delivery Models

Prior to 1994 in most countries, abortion complications were traditionally treated in hospital settings with the primary aim of reducing maternal mortality and morbidity by treating hemorrhage and sepsis—the emergency obstetrics 'curative' paradigm.[7] Recognizing the critical importance of including FP and other RH services in the context of PAC services, in 1994, the global community introduced a PAC package that included emergency treatment for postabortion complications, FP services, and links to other RH services. In 2002, this package was expanded by the PAC Consortium[b] to five essential elements: (1) community and service provider partnerships; (2) counseling; (3) treatment; (4) FP and contraceptive services; and (5) reproductive and other health services.[8] USAID modified this model in 2004 to a three-component model: (1) emergency treatment; (2) FP counseling and services (and where human and financial resources exist, sexually transmitted infection (STI) evaluation and treatment and HIV counseling and/or referral for testing); and (3) community empowerment through community awareness and mobilization.[9] This provided a more holistic approach to improving women's health by combining the curative with the preventive and promotive paradigms of public health (Figure 1).

[b] IntraHealth, Ipas, Jhpiego, Pacific Institute for Women's Health, Pathfinder International and USAID/Washington

Figure 1: The USAID Postabortion Care Conceptual Model

The High Impact Practice brief, *Postabortion family planning: strengthening the FP component of PAC*[10] presents evidence on the importance of strengthening the FP services and counseling component of the PAC services package. There is strong evidence from several pilot studies that reorganizing services to provide postabortion FP counseling and contraceptives at the same time and location as treatment improves the uptake of postabortion FP and reduces repeat unintended pregnancies.[11-13] Evidence from these studies culminated in a consensus statement underscoring the significant role of FP as a key component of PAC.[14] Furthermore, evidence shows that the following components also contribute to the sustainable provision of postabortion FP; these components include the reorganization of services so that FP counseling and services can occur at the point of treatment and prior to discharge from the facility, male involvement in FP counseling, the provision of free contraceptives, and use of mid-level providers.[14]

There is little documentation as to what process(es) are needed to reorganize services so that postabortion FP can occur at the point of treatment in different country contexts. Some of these processes may include changes in service delivery guidelines; changes in how PAC clients are triaged; changes in job descriptions; co-location of FP methods and equipment in the recovery room or treatment room; necessary meetings with heads of the obstetrician/gynecologist (OB/GYN), chief nurse, and outpatient FP departments, among others. In other words, there is scant evidence to illustrate what preliminary processes are needed to ensure the sustainable strengthening of postabortion FP counseling and services at point of treatment and before the PAC clients are discharged from the facility. There are also few studies on the cost of strengthening postabortion FP in facilities.[15]

At the country level, there are a whole range of challenges that prevent effective implementation of postabortion FP, the major service in the second component of USAID's PAC model (Figure 1). These range from lack of policy and guidelines at the point of treatment to implementation barriers at the health facility. For instance, vertical organization of curative and FP services, a lack of appropriate FP training for health care providers providing PAC services, as well as weak health systems (such as health

management information system registers in the PAC unit that exclude FP services), limited data utilization, and logistics, to name a few.

1.3 PAC-FP Pilot Program Implementation in Francophone West Africa

Between 2002 and 2008, a consortium of international and regional partners[c] organized a series of conferences and workshop to address these PAC service delivery deficiencies. The consortium established the "PAC Initiative for the Francophone Africa Committee" to address the programmatic issues of increasing access to and quality of PAC services in Francophone Africa, conduct operations research (Burkina Faso and Senegal), and advocate for FP services and counseling during PAC based on research conducted in the region.[16] The main objectives of the Initiative were to:

- Create a favorable policy environment to introduce and extend PAC services;
- Evaluate, document, and disseminate in Francophone Africa principal lessons learned in implementing PAC services in the region and globally; and
- Encourage South-to-South exchange of technical expertise and experiences in creating and scaling up PAC services.

The Initiative hosted a four-day conference in Dakar, Senegal (March 2002), organized by nongovernmental organizations (NGOs) and USAID cooperating agencies (CAs) in collaboration with the World Health Organization (WHO). High-level representatives from Benin, Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Ghana, Guinea, Haiti, Madagascar, Mali, Niger, Rwanda, Senegal, and Togo attended. The technical content of the conference focused on three main themes:

- Knowledge and skills of health care providers;
- Integrating PAC services into national RH programs; and
- Policy and advocacy.

The major outcome of the conference was the development of country-specific action plans focusing on interventions to strengthen PAC services.[16]

The Francophone PAC Initiative Committee Secretariat then assessed the progress made in the implementation of these action plans and presented the results at the January 2003 annual meeting of the Society of African Gynecologists and Obstetricians in Bamako, Mali.[16] This was subsequently followed with a progress meeting in Cotonou, Benin, in 2004, with the designated country-specific "focal point" persons. While Burkina Faso, Guinea, and Senegal reported some progress, the other Francophone West African countries were in early phases of their advocacy and/or introduction stages. All Initiative countries faced challenges in implementing their action plans.[16]

In 2007, under the auspices of WHO and the USAID PAC Working Group, the Population Council conducted a situational analysis of the progress of the PAC Initiative in Burkina Faso, Guinea, Mali, Niger, Senegal, and Togo. The objectives of the analysis were to:

- Assess the national situation concerning PAC services;
- Describe the process of introduction, integration, and decentralization of PAC services;
- Analyze the successes and obstacles in the process of introducing PAC services; and
- Recommend key steps to strengthen the introductory process.

The study identified that the countries were in different stages of development regarding the implementation of FP programming at point of treatment.

[c] Consortium members included – CEFOREP, USAID projects (Advance Africa, FRONTIERS, POLICY, PRIME, and SARA), international organizations (EngenderHealth, Family Care International, Ipas, JHPIEGO and Population Reference Bureau), development partners (USAID and SIDA), and WHO.

The findings from the situation analysis were disseminated at a *Conference for the Dissemination of Results of the PAC Evaluation in Six West African Countries and Introduction of Best Practices to Scale up PAC for Lasting Impact,* in Saly Senegal in 2008.[17] USAID's office of Population and Reproductive Health co-sponsored this meeting with WHO/Implementing Best Practices Initiative (IBP) and with support from the USAID missions. Country teams consisting of USAID mission staff, Ministry of Health (MOH) staff, and selected individuals from bilateral partners in Burkina Faso, Cameroon, Guinea, Niger, Rwanda, Senegal, and Togo participated. Participants' representation included: MOH policymakers, CAs supporting in-country PAC and FP, WHO, USAID, OB/GYNs, members from the Nurses and Midwives Council, pre-service education schools, and women's groups.

Country teams shared the status of PAC-FP services in their countries in response to six questions that had been sent to them before the meeting. During the meeting, each country developed an action plan to strengthen PAC-FP; these were developed on the basis of findings from the situational analysis and status of PAC-FP in their countries. The action plans were refined at the country level after meetings with other stakeholders or during the Virtual Fostering Change Program (VFCP).[18] The VFCP is an Internet-based blended learning program that is divided into seven modules (two phases) that guides teams through the change process and enables participants to develop plans to introduce and scale-up a best practice. The VFCP is facilitated by change management and clinical training experts. The VFCP modules, modified for PAC-FP, included an introduction to the Fostering Change approach, development of an action plan for implementation, and the processes involved in the implementation as described in the action plan (Box 1).

Box 1: The Seven Modules of the VFCP for PAC

1: Introduction to Leading and Managing Change

2: Defining the Need for Change I: Identifying the Desired State

3: Defining the Need for Change II: Identifying the Challenge and Measurable Result

4: Planning for Best Practice Introduction and Scale-up I: Selecting the Change Agent, Choosing a Best Practice

5: Planning for Best Practice Introduction and Scale-up II: Planning to Implement and Monitor the Introduction

Introductory Period: Implementation of the action plans they developed during the first five modules of the VFCP.

6: Going to Scale with Successful Change Efforts I: Evaluating the Introduction and Selecting a Scale-up Strategy

7: Going to Scale with Successful Change Efforts II: Selecting a Scale-up Strategy and Developing an Action Plan

Source: Report on VFCP for PAC Teams in Francophone Africa, 2010.

Each team selected three to four rural and urban target facilities in which to implement the action plan, including Senegal (two hospitals and one health center), Guinea (three health centers), Togo (one hospital, two health centers, and one clinic), and Burkina Faso (one hospital and three health centers). Burkina Faso, Guinea, and Togo identified one PAC focal point person/champion who was an OB/GYN, midwife, or medical assistant at each facility level.

USAID supported technical assistance and funding for implementation of the action plans through CAs. EngenderHealth supported Togo and Burkina Faso, conducting two training workshops for providers on PAC, infection prevention, and FP updates. Jhpiego supported Guinea, particularly training of providers and supervision. IntraHealth supported Senegal. In Senegal, ChildFund continued to support community empowerment through awareness and mobilization for PAC.[18]

With USAID funding, the Leadership, Management and Sustainability Project lead by Management Sciences for Health (MSH) facilitated the strengthening of the FP component of PAC services as a demonstration/introduction project using the VFCP approach.[18] During the first phase of the VFCP for PAC, most of the teams communicated to their MSH facilitators that they were facing human resource and funding challenges that prevented the implementation of their action plans (May 2009). The USAID/Washington PAC Working Group therefore made a decision to provide funding to four of the five country teams (Burkina Faso, Guinea, Mali, and Togo). However, a six-month delay in funding prevented countries from scaling up programs initiated in phase one of the VFCP for PAC.[19]

In 2012, USAID/Washington provided funding to the E2A project to conduct an assessment of the implementation of the action plans refined under the VFCP. 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.

Through desk reviews and interviews with individuals who were directly or indirectly involved in the program either as implementers or facilitators (Jhpiego, EngenderHealth, IntraHealth, MSH, WHO/IBP, and USAID) in the four Francophone West Africa countries, this assessment serves as an exploratory study to determine what worked and what did not work in the development and conduct of the scale-up approach, and the implementation of the intervention package at the country level. The assessment compares lessons learned across the countries, but is not designed to draw inferences or make generalizations regarding the process and outcome of the VFCP approach or the implementation of the action plans. However, the assessment results provide valuable insights into challenges and successes in scale-up of PAC, a proven high impact practice.

The study will increase our understanding of the extent to which the VFCP approach for PAC facilitated the implementation of the action plans, the extent to which the reorganization of PAC services facilitated the uptake of FP methods, the factors that facilitated or constrained the effective implementation of the scale-up approach, and institutional/facility sustainability. By understanding the factors that facilitated or hindered the reorganization of PAC services, the study will contribute to efforts to improve the reorganization of PAC services at point of treatment, particularly with respect to counseling and uptake of FP methods. The assessment can inform strategies to introduce PAC-FP counseling and services at point of treatment by health care providers in other countries.

2. Methods

Burkina Faso, Guinea, Senegal, and Togo were purposely selected for this assessment to provide broad experience in strengthening PAC-FP in relation to other components of USAID's PAC conceptual model, status of PAC programs, implementation at different levels of health facilities (hospitals and health centers) in urban and rural settings, availability of funding and technical assistance, and level of participation in the VFCP.

E2A conducted the assessment in each country's target facilities, identified in each respective country action plan. In the event that the package of services described in the action plan was introduced in other facilities in the region or beyond, the assessment included these additional facilities to evaluate the quality of FP services. Furthermore, as the introductory phase for the implementation of the action plan was concluded March 19, 2010, the assessment, conducted over a six-month period (September 2013 – February 2014), investigated the sustainability of the implementation package in the target facilities.

The assessment methodology involved a three-pronged approach: desk review, qualitative key informant interviews (KIs), and focus group discussions (FGDs), and a review of quantitative data from the facility registers, all described in detail below.

2.1 Desk Review

The desk review was a comprehensive analysis of the available literature (grey and published reports) on the process employed by the selected countries to develop and implement their action plans. The desk review included a review of VFCP country-level progress and final reports, country action plans, the USAID PAC strategy, the final report of the VFCP for PAC program, and other relevant documents and publications. The status of the PAC program, with a special focus on strengthened postabortion FP service delivery at baseline (prior to implementation of the action plans) and endline (March 2010), was studied to ascertain whether FP counseling and services were offered at the same time and location as treatment of abortion complications/emergency obstetric services. The comprehensive review guided development of the discussion guides and semi-structured interview tools for the qualitative assessment and facilitated the identification of stakeholders at the MOH, key staff directly and indirectly involved in the implementation of the action plans, heads and staff of facilities/OB/GYN units, and other relevant stakeholders, including country CA staff and VFCP facilitators/change management specialists.

2.2 Key Informant Interviews

The KIs were designed to elicit information on the factors that contributed to success, as well as the challenges and barriers that hindered the implementation of the action plans. E2A interviewed country team members and key stakeholders from the MOH, PAC-FP focal point persons/champions at the target facilities selected by the country team for implementation of the action plan, and NGOs and CAs that participated in the VFCP and who were directly involved in the development and/or implementation of the action plans, irrespective of whether they were working in the same position or had transferred to a different position at the time of the assessment. In addition, telephone and Skype KIs were conducted with six global stakeholders, including USAID, WHO/IBP Secretariat, implementing partners, and CAs (IntraHealth and EngenderHealth), who supported PAC-FP at country level in the four countries, and facilitators of the VFCP from MSH and Jhpiego. Among those not interviewed were country team members who were never involved in implementation of the action plan after the 2008 Saly meeting, or otherwise not available for an interview (Table 2).

Table 2: Key Informant Interviews Conducted in Each Country

Country	Country Team Members*	MOH Policy Makers	Facility PAC Focal Point Persons/ Champions	Development Partners and Cooperating Agencies**	Target # of KIs	Total # KIs Achieved
Senegal	8/14	3	2	-	10	13
Guinea	4/7	-	3	1	10	8
Burkina Faso	5/5	1	2	3	10	11
Togo	4/4	3	4	1	10	12
Total	**21**	**7**	**11**	**5**	**40**	**44**

**Number country team members interviewed/total number who attended 2008 Saly meeting*
***Included WHO RH Officers*

2.3 Focus Group Discussions

FGDs were conducted at the three health facilities selected in Senegal's action plan (two hospitals and one health center); three in Guinea (three health centers); five in Togo (two hospitals, two health centers, and the Association Togolaise pour le Bien-Être Familial (ATBEF) clinic); and four in Burkina Faso (one university teaching hospital and three health centers). A total of 90 service providers participated in the FGDs: Senegal (15), Guinea (18), Togo (27), and Burkina Faso (30) (Table 3).

Table 3: Focus Group Discussions Conducted in Each Country

Country	Number of Facilities	Target Number of Facilities	Total FGD Participants
Senegal	3	3	15
Guinea	3	3	18
Togo	4	4	27
Burkina Faso	4	4	30
Total	**13**	**14**	**90**

FGDs were conducted with all cadres of service providers in maternity and PAC units at each of the health facilities selected by the country teams for implementation of the action plans. These included OB/GYNs, medical officers, nurses, midwives, auxiliary nurses, and maternity assistants who were providing PAC, FP, and maternity services before, during, and after implementation of the action plans.

Attempts were made to recruit at least two health care providers with the same designation to enable good representation of the different health care provider cadres that provided the PAC-FP services. Each FGD was convened at a venue where there was unlikely to be interruption or excessive noise interference and was convenient to participants. Each discussion lasted between an hour and a half and two hours, and consisted of six to ten participants of various cadres. Discussions commenced with introductions and clarifications about the purpose and procedures of the focus group. Participants were briefed on the need for confidentiality and were asked to participate through an informed consent process which outlined the investigators' commitment to confidentiality.

E2A's regional consultant facilitated the FGDs. Prior to the FGDs, each participant was requested to complete an FGD attendance form to provide his or her name, professional designation, and length of time he or she had been providing PAC and/or FP services at the facility. Participants were assured of confidentiality, right to withdraw from the FGD, and to decline to respond to any questions. Identification numbers were allocated to each participant, which were matched with the names/designations on the FGD participant attendance form for reference during data analysis.

Each FGD was facilitated with a guide that contained questions on a range of topics related to their role in the implementation of FP services and counseling including completing the PAC registers, challenges that they faced in the process of performing their FP service and counseling roles, and whether the data/results of the FP service provision were discussed at the regular maternity ward meetings. All FGDs were audiotaped; country resource persons also took notes during the discussions.

2.4 PAC Registry Data Review

Service data were reviewed to assess PAC service delivery performance over time both before (2008); during (2009–2010) and after (2011–2012) the implementation of the action plan. PAC registers were reviewed to determine number of clients receiving PAC services, profiles of PAC clients (age, parity), and FP counseling and method uptake. A checklist was created to ensure a standardized approach for review of the service data in all four countries.

2.5 Data Collection Instruments

The qualitative data collection instruments consisted of one FGD guide (service providers) and five KI guides, including: (1) country resource persons and focal point persons/champions at target facilities; (2) MOH policymakers; (3) CAs and development partners; (4) VFCP facilitators; and (5) global stakeholders. The FGD guides were pre-tested at one facility in each country and necessary corrections were made (KI and FGD guide: http://www.e2aproject.org/publications-tools/pac-fp-assessment-tools-english.html).

2.6 Data Collection

Field visits were conducted by a core assessment team consisting of local country resource persons, a regional consultant, and E2A staff. Visits took place for 10 days in each country to conduct KIs, FGDs, and review the PAC registers (2008–2012). Country resource persons from each country were recruited to assist in the field work. Recruitment of these country resource persons was based upon past experience in conducting qualitative studies, ability to relate to the target group, and data-transcribing skills. A regional consultant was hired to conduct interviews and FGDs, train note takers, and provide oversight for the study. E2A staff participated in field activities to ensure high-quality data.

Country resource persons in consultation with the core assessment team scheduled the KIs and FGDs, reviewed the list of interviewees, and clarified roles and expectations. E2A staff assisted in reviewing service statistics at the facility level and other related documents at the district and/or central offices.

During the field work, E2A staff collected the notes, transcripts, and/or audio recordings and stored them in a safe place.

2.7 Data Management and Analysis

Country resource persons and transcribers transcribed the data, as applicable. FGDs and KIs were conducted in French and transcribed verbatim into Microsoft Word. No names were included in the transcription; each speaker was identified by gender, number, provider cadre (OB/GYN, medical officer, nurse, etc.), and length of service at the facility. All transcriptions were translated into English and reviewed.

The FGD and KI data were analyzed using content analysis. The KI and FGD transcripts for each country were read and re-read several times and recurring themes were identified. The major thematic areas, cross-cutting all four countries, were: reorganization of PAC services, training, supply chain management, and policy and guidelines. The PAC-FP registry data were analyzed for six-month (January to June) time periods: 2008 (before); 2010 (during), and 2012 (after) the implementation of the action plan. Data from the KIs and FGDs were triangulated and supported by service statistics, where relevant, to provide a holistic description of the processes, challenges, and barriers to the implementation of the PAC-FP action plans at the policy and service provision levels.

2.8 Ethical Considerations

E2A obtained ethical approval from the appropriate ethics review boards in the United States and Burkina Faso; Guinea, Senegal, and Togo did not require formal submission to their respective ethical review boards. After obtaining approval, data collection took place. The Reproductive Health Directorate of the MOH in each country wrote to appropriate facility management offices to inform them of the assessment and review of the PAC registers. The E2A core team also met with the facility managers to formally apprise them of the assessment prior to data collection. The KI respondents and FGD participants were briefed on the objectives of the assessment, their roles and rights, and they were assured of confidentiality. The KIs and FGDs were conducted only after all participants had given consent.

2.9 Limitations of the Study

A major limitation of this study is the non-representativeness of the sample due to the qualitative design of the study. Qualitative research involves the collection, analysis, and interpretation of data that yield rich, context-specific data, not easily reduced to numbers. However, qualitative research quality is heavily dependent on the individual skills of the interviewer, and is more easily influenced by the researcher's personal biases and idiosyncrasies than quantitative research. Rigor is more difficult to maintain, assess, and demonstrate with qualitative data.

In addition, analysis of the data involved transcribing recorded interviews and discussions into French, and then translating the French transcripts into English. As a result of this process, some of the richer contextual data may have been lost in the process of transcription and translation. Finally, much of the data collected were retrospective in nature concerning training, meetings, and events that happened since 2008; thus, information given to us by respondents regarding events which took place over the past decade may be incomplete, altered, or not well recalled.

3. Results

This chapter conveys information on what worked and what did not work when PAC-FP action plans were implemented in Burkina Faso, Guinea, Senegal, and Togo. The results for each of the four countries are structured based on the thematic areas included in each country's action plan. These include:

- Reorganization of services;
- Trainings;
- Supply chain management;
- National policy, norms, and protocols (PNP); and
- Community empowerment through community mobilization.

In addition, a section on country feedback elucidates the opinions of senior government personnel, service providers, and program managers for strengthening PAC services. Information gleaned from the KIs, FGDs, and client register reviews describes the current status of PAC services in the pilot facilities. Thereafter, the conclusion section presents an analysis of results from the four countries and distils factors that contributed to programmatic success or barriers for effective implementation. Given the major focus in these countries on achieving Millennium Development Goal (MDG) 5 related to improving maternal health, these findings are critical in assessing PAC status and its contribution to maternal health.

3.1 Burkina Faso

Burkina Faso has an estimated population of 15.7 million, with close to 50% younger than age 15. While during the past 12 years (2005-2012) there has been significant improvement in infant mortality rate and maternal mortality ratio, indicators for female education, fertility rates, CPR, and unmet need have shown only slight improvements. The infant mortality rate has declined substantially from 81 to 65 deaths per 1,000 live births, and the maternal mortality ratio has declined from 700 to 300 deaths per 100,000 live births. The total fertility rate (TFR) has remained relatively stagnant—6.2 (2005) to 6.0 (2012). The CPR for modern methods increased from10% in 2005 to 15% in 2012, with concomitant five percentage point decline in unmet need. The substantial declines in infant mortality rates and maternal mortality ratios indicate the positive impact of improvements in child health service delivery, including immunizations and emergency obstetric and newborn care implemented during the past decade (Box 2).

Box 2: Selected Socio-demographic Indicators

Indicator	Value
Population size (in millions)[1]	15.7
Under 15 years of age[1]	49%
Infant Mortality Rate per 1,000 live births[1]	65
Maternal Mortality Ratio per 100,000 live births[2]	300
Total Fertility Rate (TFR)[1]	6.0
TFR Urban	3.9
TFR Rural	6.7
Contraceptive Prevalence Rate, modern methods[1]	15%
Unmet need[1]	23.8%

Data Sources:

[1] Institut National de la Statistique et de la Démographie (INSD) and IFC International, Enquête Démographique et de Santé et à Indicateurs Multiples 2012 (EDSBF-MICS IV), accessed August 2, 2013. http://www.measuredhs.com/pubs/pdf/FR256/FR256.pdf .

[2] WHO, "Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and World Bank estimates," accessed August 2, 2013 http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf.

Abortion is illegal in Burkina Faso, except when it is necessary to save the life of a woman and in cases of rape, incest, or fetal impairment.[5] The most recent estimate of the abortion rate was 25 abortions per 1,000 women aged 15-49 years (2008).[3] The same study noted that 32% of all pregnancies were unintended, of which 31% ended in induced abortion, indicating the high level of unmet need and its fatal consequences.[3] Among the maternal health services available, PAC services have improved, but greater investments are needed to sustain these achievements. Postabortion services are provided at district, regional, and teaching hospitals, while FP is available at all levels of health care.

3.1.1 Background

The health care system in Burkina Faso is hierarchical and structured in several layers, with health posts [*Poste de Santé Primaire* (PSP)], and dispensary and RH units [*Centre de Santé et de Promotion Sociale* (CSPS)] serving as the primary health care (PHC) units. The secondary facilities at sub-district and district levels are the *Centre Médical* (CM) and *Centre Médical avec Antenne Chirurgicale* (CMA), with tertiary level facilities at regional [*Centre Hospitalier Regional* (CHR)] and national levels [*Centre Hospitalier National* (CHN)] including university hospitals [*Centre Hospitalier Universitaire* (CHU)].[20-21]

In 1998, the *Projet de Recherché Operationnelle et d'Assistance Technique en Afrique II*, Jhpiego, the Division of RH at the MOH, and Burkina Faso's Chapter of the Reproductive Health Research Network (CRESAR) introduced a pilot PAC project to study the feasibility of providing PAC services (manual vacuum aspiration (MVA), FP counseling and provision of or referral for other RH services, and community mobilization for PAC) in a hospital maternity ward[17] at CHUs in Ouagadougou and Bobo Dioulasso. During the pilot intervention, PAC equipment and MVA kits were supplied by UNFPA and Jhpiego respectively, and CRESEAR constructed and equipped the FP unit, which included equipment and supplies for female sterilization.[17] Pre-intervention data indicate that 30% of PAC clients were counseled at the point of emergency PAC treatment, of which 57% accepted a contraceptive method. Post-intervention data illustrate a rise both in the percentage of PAC clients counseled (82%) and clients who accepted a method (83%).[17] Based on these results, PAC was included in the PNP for Emergency Obstetric Care (EmOC), emphasizing counseling, infection prevention, links with RH services, and use of MVA to treat incomplete abortion. PAC services were subsequently scaled up, and as of 2007, PAC services were available in the CHUs, 13 CHRs, and 46 CMAs. PAC services were included in the annual district planning, national PAC-specific registers were printed, and PAC activities were integrated with other services and in the training curricula of the National School of Public Health (*École National de Santé Publique*).[22] UNFPA, Jhpiego, and Ipas, recognizing the inadequacy of PAC services, provided some assistance (training of health providers and MVAs kits) to address the situation.

In 2008, findings from the Population Council's 2007 PAC assessment study[17] were shared with six participating countries (Burkina Faso, Guinea, Niger, Rwanda, Senegal, and Togo) at the 2008 regional meeting in Saly, Senegal.[22] Key findings from this study identified several facilitating factors for the successful introduction and scale-up of PAC-FP as well as challenges and barriers. Participants were oriented to the VFCP and invited to participate in a year-long follow-up program as a means of providing technical assistance as the country teams finalized and implemented their draft action plans (Annex – Virtual Fostering Change Program for Postabortion Care).

The Burkina Faso team drafted an action plan that they modified with additional co-opted team members, including senior facility management champions, prior to and during its implementation (2008-2010). The five team members were senior policymakers from the MOH, a senior obstetrician, and a WHO representative. The action plan included activities related to the reorganization of PAC services, supply chain management to improve contraceptive security, and community awareness. The VFCP roll-out in Burkina Faso was successful, though active participation of the country team members was a significant challenge. Only two country team members that participated in the Saly meeting continued

with the VFCP roll-out, in addition to the three new teams members who were recruited. The implementation process was also challenged by poor communication with the VFCP facilitator, as well as inadequate human and financial resources (Annex – Virtual Fostering Change Program for Postabortion Care).

Throughout the VFCP for PAC implementation process, Burkina Faso's action plan was further refined (Box 3). However, the action plan team lacked funding and associated resources to implement the full range of activities. USAID Washington responded to these challenges by providing US$40,000 for training and technical assistance to Burkina Faso, which was organized and implemented by EngenderHealth's Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) project from 2009 to 2010. In 2009, a member from RESPOND's technical support team visited Burkina Faso to hold preliminary meetings with the country team, including supervision and site assessments of the facilities included in the action plan. During this visit, the team ascertained that there were service providers offering PAC services (using MVA for treatment of complications), who had no training in FP and vice versa. Although the action plan activities were originally planned for only two facilities (CHU Yalgado Ouedraego [CHU-YO] and CMA Sector 30), the activities were eventually implemented in four facilities (CHU-YO, CMA Kossodo, CMA Pissy, and CMA Sector 30). In 2010, RESPOND facilitated a workshop to strengthen best practices related to PAC and PAC-FP. Twenty participants, including doctors and midwives from CHU-YO and CMAs Kossodo and Pissy, were trained in the treatment of abortion complications, infection prevention, and FP counseling during PAC.[23]

Box 3: Burkina Faso Action Plan

Reorganization of services:

- Creating separate PAC room
- Ensuring FP counseling and methods were available at the point of treatment

Supply chain management:

- Procurement of supplies
- Creating a stock management system to include supervision of stock reports

Training:

- Training on both MVA and FP counseling and services

Community awareness:

- Community health workers to use behavior change communication and information, education, and communication materials to improve health promotion activities

The vague objectives and activities and associated target indicators that were not clearly defined in the action plan made implementation and measuring progress difficult; no baseline assessments were conducted and target indicators were not set. For example, activities such as improving FP counseling and services in two (unspecified) sites for 24 hours/7 day coverage through division of tasks and supervision, developing a culture of excellence by reinforcing facility personnel's competencies at two sites, and training of 15 providers were articulated in the action plan without defining specific activities and/or indicators to measure progress. There is scant documentation that describes the implementation of Burkina Faso's action plan.

3.1.2 Data Collection

In early 2013, E2A conducted KIs and FGDs with staff in Burkina Faso who had participated in the VFCP for PAC. For this assessment, data collection included: (1)12 KIs with Saly meeting team members, senior health facility management champions, and policymakers; (2) 4 FGDs with service providers from the teaching hospital at CHU-YO and the CMAs of Sector 30, Pissy, and Kossodo; and (3) a review of PAC client registers (CHU-YO, CMA Sector 30, and CMA Kossodo). PAC statistics for CMA Pissy

were not recorded for the January- June 2012 period. The data from the review of client registers therefore excludes CMA Pissy due to incomplete information.

3.1.3 Findings

The findings describe the achievements, challenges, and barriers for the effective implementation of the action plan activities to strengthen FP counseling and services for abortion clients. The results are organized around the key themes of reorganization of services, trainings, supply chain management, national PNP, community awareness, and country feedback in order to provide a holistic assessment of the current status of PAC package of services in the respective facilities.

Reorganization of PAC Services

Reorganization of PAC services to ensure curative services and preventive FP counseling and services at the point of treatment was operationalized in all facilities with some success, addressing 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 in integrating these services. Challenges related to a complete reorganization of services have continued, specifically for a dedicated PAC room. Despite efforts by trained staff to establish an exclusive PAC room, respondents at some facilities mentioned that some senior management staff did not agree with having a dedicated room, and it was therefore impossible for the space to be created. One midwife described the challenges in this way:

> "*I would say that in relation to the postabortion care room, I did everything possible to get a room during the construction of the new maternity. When I found one and thought of making it an MVA room, I discovered to my great surprise that it was turned into a screening room.*"

FGD: CMA Kossodo, Midwife

Another significant challenge mentioned by respondents was the physical separation of PAC services, the FP unit, and the facility pharmacy in different locations within a facility.

Facilities were also challenged to ensure FP method provision at the point of treatment, although, according to the patient register data, all PAC clients were counseled in 2012 (Graph 1). Providers and policymakers were aware of the need for women undergoing postabortion treatment to receive an FP method of choice. The UNFPA RH program officer advocating for a comprehensive PAC package of services remarked that "*a woman who comes to postabortion care should leave with a contraceptive method*."

An FP unit offering counseling and services during normal working hours was functioning in all four facilities, although clients had to go to the facility pharmacy to purchase their prescribed contraceptives. Providers mentioned that this created a barrier for clients, given that after receiving MVA treatment and FP counseling, clients would then be given a prescription for their chosen method and directed to the facility pharmacy to purchase it, before having to return to the provider to have the method administered, or to come back the next day. Providers were very aware that this created a significant barrier for women. As one provider explained:

> *"Making family planning service available for postabortion care would avoid loss of cases; when ladies that we send away following care are asked to come back the following morning, we are not sure if they do come back for family planning or to their office visit a week later. Making available an on-site planning service would fix this problem in a better way."*

FGD: CHU-YO, Midwife

Service providers reported that facilities struggled to provide a range of methods at the point of treatment and were only partially successful, with oral pills remaining the most common method of choice (Table 4). For example, at the CHU-YO facility, the senior management champion explained that since the facility was only in operation during normal business hours, and clients would have to travel to another distant location to obtain an FP method, CHU-YO began offering oral pills to try to ensure that clients received some FP method before leaving, "…*we limited this option to pills, since they are the most simple to give out."* Information from another facility shows that, at first, both short-acting and long-acting methods were offered, though more recently, only oral pills were recorded (Table 4).

Myths and misconceptions surrounding certain FP methods, particularly long-acting ones, also challenged method uptake. Specifically with regards to the IUD, there were mixed impressions from clients ranging from: "*they think that the implanted device will migrate to their heart*" (CMA Sector 30, Senior Management Champion) to "*they claim that anything that comes in contact with the cervix causes cancer*"(FGD: CHU-YO, Midwife). Despite these fears, providers and policymakers recognized the necessity for advocating for long-acting reversible contraceptives (LARCs) as well as the associated challenges, including the need for training, task-sharing, and ensuring the availability of supplies. As one senior policymaker described:

> "…*the long-term methods pose a challenge in regard to the technicality it needs to apply. You need to frequently do incisions, have sterile equipment, and have a certain skill level to put the IUD in place or to insert a Norplant.*"
>
> Senior MOH Policymaker

Overall, some progress has been achieved for offering FP counseling and services despite myths, misconceptions, and the availability trained staff and FP supplies 24/7 at the point of treatment (Graph 1 and Table 4).

PAC Client Register Maintenance

The MOH prints and distributes PAC registers to target health facilities. The registers are kept in the PAC room. Senior policymakers and service providers agreed that although the information is recorded, heavy workloads sometimes prevent information from being recorded immediately during service provision, indicating that data quality issues may exist. One midwife explained that, *"….we have registers, but they are under-utilized because of lack of staffing, since we do many things at the same time" (*FGD: CMA Kossodo, Midwife).

Senior policymakers and service providers also described data utilization as a gap within PAC services. One respondent explained, "*the rate of completeness and promptness is very good in Burkina, but if there was a challenge, it would be in the use of information for decision-making*" (RH Program Officer/UNFPA). Documenting the contribution of abortion to maternal deaths was of particular concern. A senior policymaker described the situation this way:

> "*We have the figures* (… for maternal deaths…), *but that doesn't amount to a detailed evaluation that would tell us the contributing element in abortions to the number of deaths so that we could see the decrease in relation to what we used to know.*"
>
> Senior MOH Policymaker

PAC Client Register Data

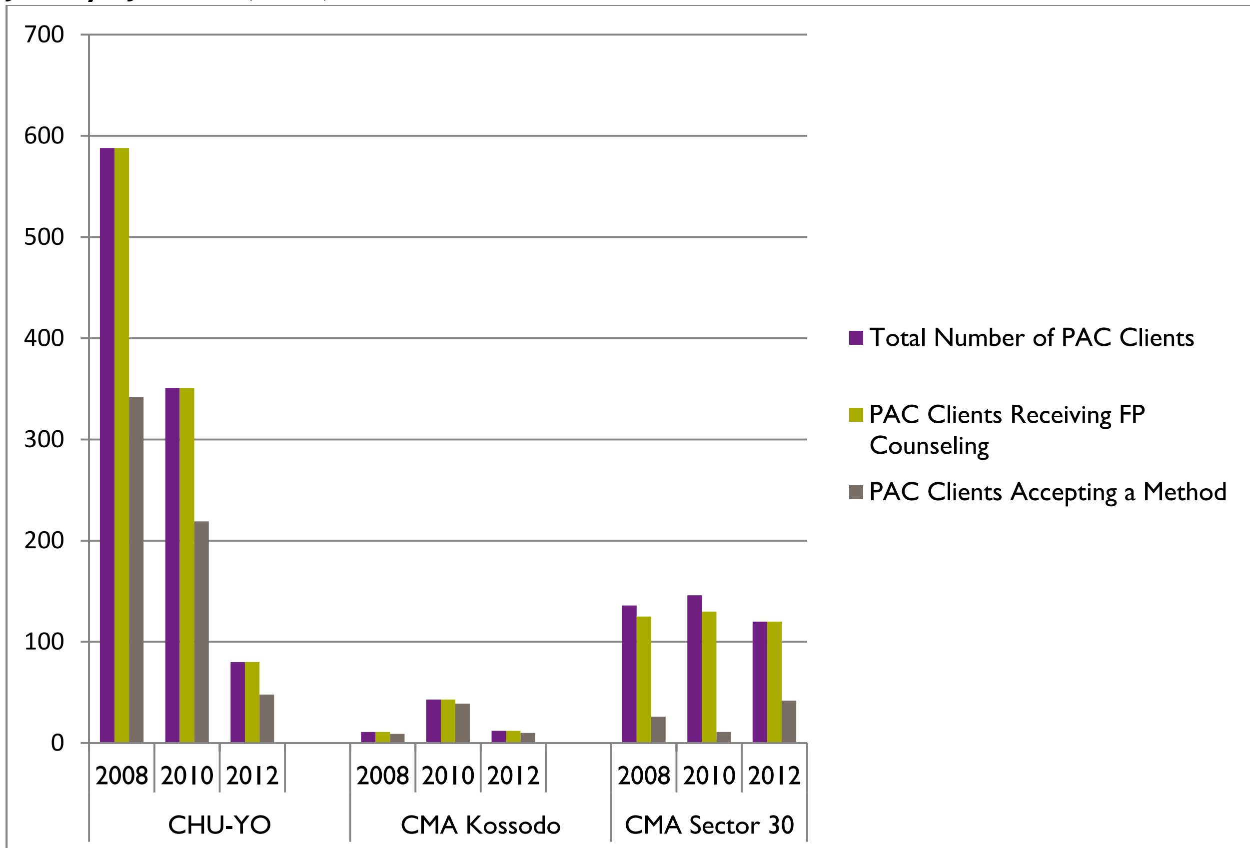
Statistics compiled from the formal PAC client registers at the four target facilities (CHU-YO, CMA Kossodo, CMA Pissy, and CMA Sector 30) for the January-June period in 2008, 2010, and 2012 were analyzed in order to gauge progress in FP uptake among PAC clients. However, data were not recorded in the PAC register at CMA Pissy for the January-June 2012 period. Therefore, results are presented

for only CHU-YO, CMA Kossodo, and CMA Sector 30. At the three facilities, the total number of PAC clients decreased by 71% (from 735 in 2010 to 212 in 2012). Variations among the facilities showed the largest decline in the number of PAC clients at CHU-YO, with much smaller declines in CMAs Kossodo and Sector 30 (Graph 1).

Service statistics from the PAC registers also indicate that between 10% and 20% of PAC clients were young people under age 20. While those interviewed did not express the need to address the special needs of youth, they did express awareness of the availability of youth-friendly services among service providers.

> "*We take care of contraception here, and then we refer them to Sector 15, where there are midwives more adapted to the particulars of cases dealing with young women* (… <20 years…)."
>
> FGD: CMA Sector 30, Obstetrician

Graph 1: PAC-FP Client Register Statistics from CHU-YO, CMA Kossodo, and CMA Sector 30, January – June 2008, 2010, and 2012



Contraceptive Methods: Availability and Uptake

Nearly all PAC clients were counseled, though fewer accepted a method during the study period—377 in 2008 and 100 in 2012. However, in CMA Sector 30, the number of FP acceptors nearly doubled from 26 (2008) to 42 (2012) (Graph 1).

The FP method of choice for PAC clients in all target facilities was oral pills. While oral pills were the only method accepted by PAC clients at CHU-YO in 2012, PAC clients accepted injectables, implants,

and IUDs in CMAs Kossodo and Sector 30 (Table 4). Information gleaned from the KIs and FGDs on method mix indicated that while oral pills were the most preferred method, injectables and implants were also preferred methods.

> "*Pills are more popular…women like injectables and the implants. They don't like the IUD much.*"
>
> CMA Sector 30, Senior Management Champion

> "*It is the oral method, the pills, because they want to easily become pregnant again later on.*"
>
> FGD: CMA Kossodo, Midwife

Table 4: Frequency Distribution of Contraceptive Method Uptake by PAC Clients from CHU-YO, CMAs Kossodo and Sector 30 (2008, 2010, and 2012 [January – June])

Method Type (%)	CHU-YO			CMA Kossodo			CMA Sector 30		
	2008	2010	2012	2008	2010	2012	2008	2010	2012
Abstinence	-	-	-	-	-	-	-	-	-
Condoms	1.2	-	-	-	2.6	-	-	-	-
Oral Pills	81.0	84.5	100.0	100.0	97.4	70.0	92.3	54.5	88.1
Injectables	9.1	7.8	-	-	-	20.0	7.7	27.3	4.8
Implants	3.5	5.0	-	-	-	10.0	-	18.2	4.8
IUDs	5.3	2.7	-	-	-	-	-	-	2.4
Tubal Ligation	-	-	-	-	-	-	-	-	-
TOTAL (n)	342	219	48	9	39	10	26	11	42

Cost of Postabortion Care

Respondents mentioned that in addition to an assigned PAC room, cost of FP methods was another barrier for PAC clients. One respondent described how donor agencies provide contraceptives for free to the government, but actual cost to the client is high since the government has a cost-recovery system. As a result of this system, even though contraceptives are subsidized, the issues pertaining to financial management are pervasive. It is important to note that obstetricians were not only cognizant of these issues, but recommended offering contraceptives free of cost to ensure that FP products are available at point of treatment, either at the PAC or FP units. One obstetrician described the challenge this way:

> "*….we need to understand that it is a payment problem, since we do not want midwives to handle money. The packet* (... of oral pills….) *is sold for 100 CFA.*[d] *To avoid this problem, we need to offer the family planning products for free. If we do so, the method would come directly to the units without passing by the pharmacy; pharmacy will carry only the inventory. This is the solution to the problem. If the woman has to stop by the pharmacy to buy her method, we lose her, but if I have it in my cabinet and hand it to her, it is a done deal. This would eliminate dropouts; it eliminates barriers. I'd say make family planning products free, not childbirth*"
>
> Obstetrician, CMA Sector 30

Another respondent explained that while the high cost of methods has remained a barrier for clients, there may be an opportunity in the future to work with the MOH on a solution. "*There is a need to review the cost of contraceptives. The Minister is very willing*" (RH Program Officer, UNFPA).

Supervision

A guide for integrated RH supervision was developed and implemented through the auspices of the MOH. The maternal health officer at WHO described the process this way:

> "*We have developed with UNFPA and the Ministry a guide for the integrated supervision of service providers in the reproductive health sector; this involves all service disciplines, including postabortion care.*"
>
> WHO, Maternal Health Officer

Included in Burkina Faso's action plan was the goal of developing "a culture of excellence" within activities (although specific activities to attain the culture of excellence were not mentioned). Service providers and key informants acknowledged that quality of care and quality assurance generally, and infection prevention in particular, were important facets of PAC management, particularly with regard to supervision. Service providers and policymakers noted that quality supervision, which helped to improve providers' skills, was needed to achieve positive outcomes. One midwife explained, "*we need proper involvement of our supervisors in postabortion care management*" (FGD: CMA Kossodo, Midwife). A similar sentiment was expressed by a senior policymaker who said, "*….in supervision, in watching people regularly, it reinforces, it reassures, and they acquire the skill. That is really the skill they will acquire*" (Senior MOH Policymaker).

Training of Service Providers

Providers at all of the health facilities benefited from trainings on PAC service provision. UNFPA collaborated with the MOH and implemented a program for strengthening pre-service training that included technical support and equipment to the skills laboratory for adherence to International Confederation of Midwives standards.

Both those who participated in the Saly meeting and those who joined the effort to strengthen PAC-FP services following the meeting emphasized the need for a two-pronged approach to improve pre-service and in-service training programs and address the immediate and long- term PAC training needs for midwives and doctors. One senior policymaker described the need this way: "*At least to have the integration of postabortion care always integrated in training curricula of midwives schools as well as medical schools*" (Senior MOH Policymaker, Doctor).

[d] At the time of the assessment, 100 CFA was equal to about $ 0.21 USD.

Although there were initial concerns about feasibility, including cost, technical support, and involving professional associations, all of these challenges were successfully addressed. One policymaker described the process this way: "*All parties, including gynecologists, were in agreement about adding postabortion care to the base training curriculum, so it was added"* (Senior MOH Policymaker, Midwife).

PAC-FP training modules have been included in both the pre-service and in-service training manuals, and there are many more trained personnel available to perform PAC services. This has been one of the greatest improvements to PAC within the country. As one respondent described:

> *"The achievements, I would say, are the critical mass of competent people on the ground who can handle postabortion complications. This has accrued to the point that I believe that at all levels we have the trained personnel to do the work."*
>
> WHO, Maternal Health Officer

Despite the success, barriers remain to ensuring the constant availability of PAC services. Some providers expressed the need for more training to ensure adequate numbers of trained staff to manage PAC cases and provide FP counseling and services, particularly after hours.

Supply Chain Management

A notable achievement of the action plan was the recognition that concerted efforts have been made to improve supply chain management for PAC supplies, including contraceptives. Service providers from one facility mentioned that they had received MVA kits on a regular basis, but other facilities didn't fare as well. As reported by a senior obstetrician and midwives at one facility, stock-outs of MVA kit items, particularly cannulas, as well as contraceptives and consumables continue, significantly limiting providers' ability to offer quality care to their PAC clients.

Stock-outs of popular FP methods also occurred and limited the full range of method choice for clients. One midwife described a scenario in which, "*in 2011, we went through a full year without implants. We had some women come to us with implants asking us to insert them, but we do not know where they got them*" (FGD: CMA Sector 30, Midwife). The logistics supply chain management system has received considerable attention from the MOH, with technical support from UNFPA, resulting in improved supply chain logistics at the central level. Stock-outs at the peripheral levels continue, especially for implants, due perhaps to high demand.

National Policies, Norms and Protocols

Given that PAC clients are at high risk of unintended pregnancy, FP counseling and services at point of treatment have been included in PNP. As one policymaker proudly explained, *"…when you look at the text of standards and protocols, the postabortion care section, there is family planning"* (Senior MOH Policymaker, Doctor). Despite the inclusion of PAC and FP within the PNP, implementation is hindered by low provider knowledge about protocols and guidelines.

Community Awareness

A key component of the action plan was the recognition of the need to raise community awareness about obstetric danger signs and enable timely referral to appropriate facilities when pregnancy complications arise. One respondent pointed out that in order to address these concerns, a community awareness program for obstetric emergencies (that included PAC) was implemented, which established management cells for obstetric emergencies at the village level. These village-based committees for obstetric emergencies used the orientation documents to raise community awareness. As one respondent explained:

"The instructions were mainly focused on information, communication with the community at the base level to provide them with information about the danger signs and the referral centers within the area."
WHO, Maternal Health Officer

These village-based committees also used information, education, and communication (IEC) materials and mass media, especially radio, to raise community awareness about maternal mortality and abortion, and encouraged community leaders to recognize the contribution of abortion to maternal mortality.

While acknowledging that progress has been made, concerns remain about continued programmatic activities for raising awareness, mobilization of community leaders, and clinicians' role in community involvement. One senior policymaker explained community-level challenges:

"…at this level, mobilization of leaders is still a challenge. We need to have this to easily engage communities. Many things depend on local leaders and their mobilization."
Senior MOH Policymaker

Country Feedback

Health providers and policymakers in Burkina Faso offered valuable suggestions for strengthening PAC-FP services and addressing the remaining barriers and challenges. Respondents, acknowledging the strengthened pre-service and in-service training modules for PAC-FP and trainings offered, proposed continuing the training programs to attain national coverage. As one senior policymaker explained:

"….we defined political commitment as a challenge. I think we are no longer confronted with that. On the political level and up to the highest level, the understanding about investing in a certain number of service providers, including postabortion care, to achieve results defined as priorities in Burkina, no longer needs to be demonstrated. There is strong commitment."

Given the growing demand for LARCs, particularly implants, respondents suggested conducting LARCs skills training, especially for implants. Both policymakers and providers were very aware that low uptake of long-acting methods could be associated with low provider ability to provide the

Box 4: Burkina Faso Key Findings

Reorganization of services:

- Some improvement in offering FP counseling and methods at the point of treatment
- Creating separate PAC room continues to be a challenge
- Physical separation of PAC services, FP unit, and pharmacy in same facility presents obstacles
- Reduce or make FP methods free for PAC clients
- Strengthen internal and external supervision

Supply chain management:

- Improvement in supply chain management and logistics at central level
- Stock-outs for MVA kits and FP methods (especially for LARCs) continue at facility level

Training:

- PNP includes section on FP services for PAC clients
- PAC-FP modules included in pre-service and in-service training manuals
- Many more trained service providers offering PAC-FP services
- Low provider knowledge about protocols and guidelines

PAC client registers:

- All PAC clients counseled
- 47% of clients left the facility with a contraceptive method

Community awareness:

- Some progress made in raising awareness of the contribution of abortion to maternal mortality
- Raising community awareness needs support

methods. As one senior management champion explained:

> *"We have attributed this to the lack of expertise in the IUD insertion technique. If a provider does not feel comfortable with applying a method, he would not suggest it. Such skill could enhance the prescription of this method."*
>
> CHU-YO, Senior Management Champion

Respondents were well aware of the challenges PAC clients have faced when trying to acquire a method after regular working hours due to the national cost-recovery policy for drugs. They recommended offering contraceptives free of cost to all clients and making contraceptives available at the PAC unit. They also proposed further investments in raising community awareness about maternal mortality and its associated causes by mobilizing community leaders through advocacy campaigns on the link between maternal mortality and abortion.

Senior policymakers raised concerns about the action plan created in Saly, citing uncertain funding sources, and its apparent lack of alignment with national plans and budget.

> "*The people who have asked you to prepare the plan of action, have they given you the money for its execution? You can't just come and say insert this plan in your programs. You really can't do it this way; it is not the right process."*
>
> Senior Policymaker

They proposed better alignment with national plans, rather than the creation of parallel plans that they said were unlikely to progress. As one respondent commented, "…..*you cannot just come and invent a parallel system. You need to help consolidate the existing one, improve it. A parallel system does not promise a future to the national one. It doesn't*" (CMA Sector 30, Obstetrician).

3.1.4 Conclusion

Burkina Faso has made progress in the quality of PAC-FP service provision by strengthening its pre-service and in-service training programs for PAC and including PAC in its national standards and protocols. Respondents suggested that investments need to be made that will allow contraceptives to be offered for free to all clients and ensure they are available to all PAC clients at the PAC unit so that they can receive their chosen FP method at point of treatment. Particular attention needs to be paid to the logistics of the supply management chain, and efforts need to be undertaken to work within existing national plans.

3.2 Guinea

Guinea has an estimated population of 11.5 million with over 40% under the age of 15. While infant and maternal mortality rates have significantly improved over the past decade, fertility and contraceptive prevalence rates have shown smaller improvements. TFR and CPR are relatively high—5.1 and 7% respectively. Maternal mortality ratios have declined substantially from 910 to 610 deaths per 100,000 live births, though Guinea has the highest maternal mortality ratio among the four countries in this assessment study. The substantial declines in infant and maternal mortality rates suggest the positive impact of improvements in child health service delivery, including immunizations and emergency obstetric and newborn care, implemented during the past decade (Box 5).

Box 5: Selected Socio-demographic Indicators

Indicator	Value
Population size (in millions)[1]	11.5
Under 15 years of age[1]	43%
Infant Mortality Rate per 1,000 live births[2]	67
Maternal Mortality Ratio per 100,000 live births[3]	610
Total Fertility Rate (TFR)[2]	5.1
TFR Urban	3.8
TFR Rural	5.8
Contraceptive Prevalence Rate, modern methods[2]	7%
Unmet need[2]	24%

Data Sources:

[1] Population Reference Bureau, "World Population Data Sheet 2012," accessed June 26, 2013, http://www.prb.org/pdf12/2012-population-data-sheet_eng.pdf.

[2] Institut National de la Statistique et de la Démographie (INSD) and IFC International, Enquête Démographique et de Santé et à Indicateurs Multiples (EDS-MICS) 2012, accessed April 8, 2014, http://dhsprogram.com/pubs/pdf/FR280/FR280.pdf .

[3]WHO, "Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and World Bank estimates," accessed June 26, 2013, http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf.

Abortion is illegal in Guinea, except when it is necessary to save the life of a woman and in cases of rape, incest, or fetal impairment.[5] The MOH oversees eight regional health directorates, and each regional directorate oversees three to six health prefectures/communes. Conakry, the capital, is a special zone comprising five urban communes, each with a *Centre Médical Communal* (CMC) staffed by midwives, doctors, and gynecologists.[24] The CMCs in Guinea were poorly equipped with few trained staff to provide PAC services in the 1990s. The MOH, in 1999, introduced PAC services (MVA, FP counseling and services) in two hospitals and subsequently expanded to five regional hospitals.[25] Recognizing that concerted efforts need to be made to ensure PAC clients receive an FP method at point of treatment, Jhpiego provided technical and resource mobilization, including incorporating a Standards Based Management and Recognition (SBM-R) program to offer maternal and newborn services.The SBM-R approach helped 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.[26]

3.2.1 Background

In 2008, findings from the Population Council's 2007 assessment study[17] were shared with six participating countries (Burkina Faso, Guinea, Niger, Rwanda, Senegal, and Togo) at the Saly, Senegal meeting.[22] The study findings showed 10 prefectural hospitals not providing PAC services due to some being in rural remote areas; however these had been included as a priority for the National Program for Health Care Development. The major challenges to implementing PAC services were maintaining a pool of PAC trainers, irregular availability of contraceptives within the PAC unit and lack of IEC materials. The erratic supply of contraceptives was due to the fact that the national PNP for EmOC did not allow a hospital service to distribute its own medications.[17] It was under this context that the country team drafted their action plans at the meeting.[22] Participants at the 2008, Saly meeting were oriented to the VFCP and invited to participate in the year-long follow-up program as means of providing technical

assistance to each country team as they finalized and implemented the draft action plans developed at the meeting (Annex – Virtual Fostering Change Program for Postabortion Care).

Upon returning to Guinea, the country team members continued their deliberations on the draft action plan with technical support from the VFCP facilitators. During the VFCP for PAC implementation process, Guinea's country team was composed of the Saly country team and additional co-opted members (the designated 'change agents' at the three target CMC facilities—Ratoma, Miniére and Matam in Conakry[18]). Senior policymakers and obstetricians, WHO and country representatives (Jhpiego and Extending Service Delivery Project) comprised the country team. The activities described in the action plan represented a comprehensive PAC package of services (Box 6). Change agents (CMC senior health facility management champions), selected from each target facility, were responsible for working with the Saly team to implement activities outlined in the action plan. Following site selection, a 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. The VFCP roll-out in Guinea was successful, though active participation of the country team members was a significant challenge.[18] Communication with the VFCP facilitator/s remained a challenge, as did inadequate human resources. Jhpiego provided continuous technical support to the implementing team.

Box 6: Guinea Action Plan

Reorganization of services:
- Ensuring a separate PAC room where PAC services and FP methods could be accessed

Training:
- Training staff on the provision of PAC services— treatment, FP counseling and services, and infection prevention
- Using performance standards during counseling and supervision to ensure quality care

Supply chain management:
- Ensuring continuous availability of contraceptives at the PAC unit
- Creating a stock management system

Financing:
- Preparing a budget for expansion of services

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

The ACCESS-FP project progress report (2010) documents the implementation of the action plan activities,[26] specifically noting that external supervision occurred every two weeks to identify problems and provide solutions; facility staff were counseling PAC clients on FP using IEC materials, and change agents were personally involved in resupplying contraceptives to avoid stock outs in the facility, especially in the PAC treatment rooms. The main results included:

- Availability of contraceptives in the PAC units of the CMCs, specifically in Ratoma and Matam, where contraceptives were not available at the start of implementation; as of November 2010, the three CMCs had a continuous supply of contraceptives;
- Increase in the number of PAC clients, with all PAC clients having received FP counseling;
- Increase in the number of PAC clients who received a contraceptive method—from 44% prior to the implementation of the action plan to at least 60% during the implementation phase; and
- Use of performance standards by the coordination team and the local team, which solved 68% (15/22) of the complex problems identified during the baseline needs assessment analysis; marked overall performance improvement was noted at Ratoma and Miniére.

The challenges identified in the ACCESS progress report included retention of team members, inconsistent use of PAC performance standards for coaching, inability to maintain a functional

contraceptive supply system for PAC units, not implementing activities related to IEC as quickly as possible, and PAC services that were not always available 24 hours per day/7 days per week in the CMCs of Matam and Miniére. Supervision using PAC performance standards for coaching was not conducted as often as indicated in the action plan given the number of activities assigned to the change agents in addition to their regular workload.[26]

3.2.2 Data Collection

In late 2012, E2A conducted KIs and FGDs with MOH staff who helped draft and implement the action plan and with those who participated in the VFCP for PAC. For this assessment, data collection included: (1) eight KIs with Saly meeting team members, senior health facility management champions, and policymakers; (2) three FGDs with service providers from the CMCs of Matam, Miniére, and Ratoma; and (3) a review of their PAC patient registers.

3.2.3 Findings

The findings describe the achievements, challenges, and barriers to the effective implementation of action plan activities to strengthen FP counseling and services for postabortion clients. The results are organized around the key themes of reorganization of services; training of service providers; supply chain management; leadership, governance, and management; and country feedback. The findings provide a holistic assessment of the current status of the PAC package of services in the respective facilities.

Reorganization of PAC Services

CMC Miniére's senior management champion eloquently described that integrated curative and preventive PAC services are essential for maternal health, "…*contraceptive products were only available within the FP unit and not at the level of PAC. As a result, many patients never came back, for after counseling they were left without any suggestion for a method. In terms of FP, this lady is somehow a lost case.*" The head midwife from CMC Miniére remarked proudly that "*the first thing that the action plan has allowed (*…for us …*) to achieve is make available the room,*" while recognizing that additional actions including "*disseminate information on the existence of the room; ensure its accessibility and make available staff for provision of services*" were necessary measures that were also rolled out.

The three pilot facilities achieved considerable progress through the creation of a separate PAC room; supplies (MVA kits, FP-IEC materials and contraceptive supplies); and 24 hours per day/7 days per week availability of service providers who have been trained to conduct MVAs and provide FP counseling and services. Each of these 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 inadequate access to trained staff. The role of facility senior management and Jhpiego were imperative for the successful reorganization of services and decisions such as "*all patients having PAC would be brought to choose a FP method before they leave the unit*" (CMC Miniére, Senior Management Champion); ensuring the availability of contraceptives at the PAC room when FP commodities were only available either at the FP unit or pharmacy unit; and room allocation. This effective decision-making highlights the essential role of senior facility leadership and team work.

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 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 facility pharmacists allow access to the products. As a result of successful negotiations by the facility champions with the FP unit and pharmacy, contraceptives were made available in the PAC unit. Clients had access to a full range of methods and IEC materials. Wall charts and counseling kits were shown

displaying contraceptives that were available in the target facilities, illustrating that the decision to "*display all methods available in counseling kits*" (CMC Miniére, Senior Management Champion) was successfully implemented. The positive influence of effective FP counseling training was also brought up:

> "*By talking to patients after the training, you can be sure to give them useful information and help them choose a method. Most patients come with misperceptions and some wrong information; yet if they have access to the right information, they can be convinced and ultimately choose a method before they leave the facility.*"
>
> FGD: CMC Ratoma, Doctor

Service providers noted misconceptions about LARCs, specifically IUDs, as a barrier to long-acting method uptake. When asked about clients' acceptance of long-acting method, one provider explained the persistence of myths around these methods, such as that "*IUD can cause cancer*" (CMC Miniére Senior Management Champion). Efforts were made to dispel such myths both for the service providers and clients via training and improved counseling. One senior management champion explained the improvements that were achieved through these activities:

> *"…some considerable and regular sensitization among the personnel, by providing consistent explanation on the benefits of IUD, as a long-term method that not only prevents any fecundation but could cause no abortion, unlike what some members of the personnel believed and had been conveying."*
>
> CMC Miniére, Senior Management Champion

A review of PAC service statistics confirms this perceptible shift towards LARCs. In all three facilities, there was a documented increase in IUD uptake from 2008 to 2012. For example, CMC Ratoma IUD uptake increased from 15.4% to 21.8 % (Table 5).

PAC Client Register Maintenance

All three health facilities had PAC client registers for recording data, but service providers acknowledged poor record keeping. One provider commented that:

> "*…any patient coming for care was primarily presented to a midwife, and then after counseling she was taken to the doctor. But there was no record, no statistics, and patients could leave after receiving care*."
>
> FGD: CMC Ratoma, Midwife

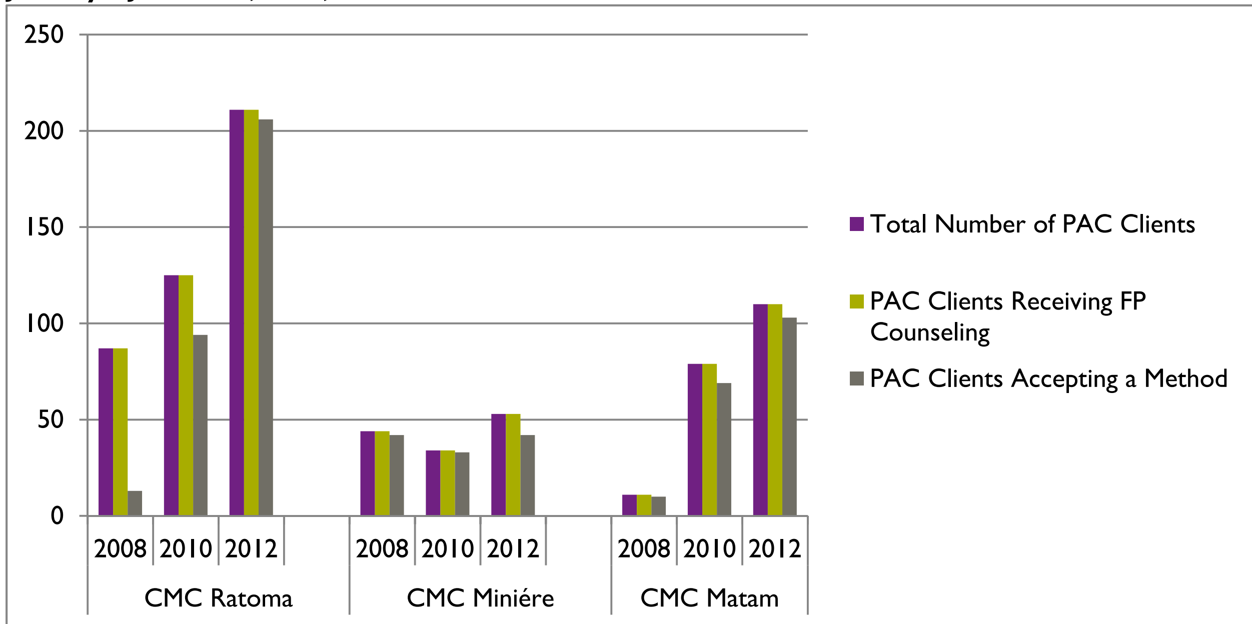
As service providers became aware of the challenges, record keeping improved, and there is good understanding of the value of record keeping. One senior management champion explained, "*registers and reports are regularly updated, and the personnel are punctual and they abide by the rules prescribed*" (CMC Miniére, Senior Management Champion).

PAC Client Register Data

Statistics compiled from the formal PAC client registers at the at three facilities (CMC Ratoma, CMC Miniére, and CMC Matam) for the January – June period in 2008, 2010, and 2012 were analyzed in order to gauge progress in FP uptake among PAC clients. 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; oral pills and injectables were the methods of choice. 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, as well as those who had accepted a method. An FGD participant commented that "*when we started, we used to stay a whole week without having a single patient, but now we can have up to eight cases to deal with.*"

Service statistics document the rising trend in the number of PAC clients by163%, from 142 (2008) to 374 (2012) (Graph 2).

Graph 2: PAC-FP Client Register Statistics from CMC Ratoma, CMC Miniére, and CMC Matam, January – June 2008, 2010, and 2012



Contraceptive Methods: Availability and Uptake

The overall achievement in action plan implementation is implied by triangulating data related to the successful reorganization of services from KIs and FGDs with the statistics from the PAC client registers. A senior policymaker remarked on the "*escalation of the level of demand for PAC/FP services*" that was elaborated upon by a focus group participant ("*FP service is available round the clock,*" CMC Miniére, Midwife) and confirmed with the documented increase in PAC clients who accepted an FP method. For example, while all clients (100%) received FP counseling prior to and after action plan implementation, the proportion of PAC clients who accepted a method increased considerably from 46% (2008) to 94% (2012). While oral pills and injectables continued to be a method of choice, a steady rise in IUD acceptors in each of the three facilities was noted. For example, at CMC Matam, the number of IUD acceptors rose from 1 (2008) to 35 (2012) (Table 5).

Table 5: Frequency Distribution of Contraceptive Method Uptake by PAC Clients from Ratoma, Miniére, and Matam (2008, 2010, and 2012 [January – June])

Method type (%)	CMC Ratoma			CMC Miniére			CMC Matam		
	2008	2010	2012	2008	2010	2012	2008	2010	2012
Abstinence	-	1.1	1.9	-	-	21.4	30.0	-	19.4
Condoms	-	10.6	25.2	21.4	3.0	2.4	-	7.2	1.0
Oral Pills	76.9	38.3	38.3	16.7	33.3	7.1	50.0	52.2	18.4
Injectables	7.7	36.2	10.7	52.4	51.5	45.2	10.0	13.0	27.2
Implants	-	-	1.9	-	-	-	-	-	-
IUDs	15.4	13.8	21.8	7.1	12.1	21.4	10.0	27.5	34.0
Tubal Ligation	-	-	-	2.4	-	2.4	-	-	-
TOTAL (n)	13	94	206	42	33	42	10	69	103

Cost of Postabortion Care

Cost of methods, particularly long-acting methods, was another issue related to client acceptance. Examination of facility registers shows a rising acceptance of IUDs as a client method choice between 2008 and 2012 (Table 5). Implants were introduced in Guinea in 2011, and service statistics show uptake in only CMC Ratoma with a total of only four PAC acceptors (Table 5). One FGD participant commented that cost was a particular barrier to PAC clients accessing long-acting methods, saying, "*… besides, at 10,000 Guinean francs, implants are too costly, compared to other method"* (FGD: CMC Ratoma).

Supervision

Jhpiego's SBM-R approach articulated in Guinea's action plan was implemented with some degree of success. Several service providers and policymakers reported that quality of care for PAC services had 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 a reduced rate of complications among PAC clients. However, demand burden on service providers resulted in what one respondent referred to as, "*…the frequency and regularity of training indicated by the plan of action was not respected due to the many identified activities*" (Country Representative, Jhpiego).

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 regretted that this training program has since been discontinued.

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. Despite these achievements, challenges remained and 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 available 24 hours a day, 7 days a week, which had limited the facility's ability to meet client demands. The recognition that all service providers in the maternity department need to be trained for providing quality FP counseling and services was well articulated by a service provider:

> "*For in the provision of services, each one of us should be ready to replace an absent colleague, so that service provision does not become deficient simply because one worker is unavailable."*
>
> FGD: CMC Miniére, Obstetrician

While expressing appreciation for the previous training program, senior policymakers advocated for continuing the training programs, especially training the untrained workers.

Supply Chain Management

One of the several challenges Guinea faced in the implementation of PAC activities was maintaining a continuous supply chain for essential commodities including contraceptives, MVA kits, and medicines. A senior MOH official explained that while there has been progress made in gaining commitment for collaborative exchange between the family health and the central pharmacy units at the national level, there had unfortunately also been:

> *"…some rather poor collaboration between our Direction (Family Health/MCH) and DNPL (National Pharmacy and Labs Management/Central Pharmacy) in the purchase of contraceptives for the reduction of maternal and infant mortality.*"
>
> Senior Policymaker

Furthermore, despite 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*" (CMC Matam, Senior Management Champion).

When asked about challenges faced, a senior MOH policymaker and obstetrician remarked that it was difficult to "*…ensure uninterrupted supply with medicines and consumables*" (Senior Policymaker). Another service provider commented that there had been "*…difficulties in the effort to obtain the consumables needed and stock-outs"* (FGD: CMC Matam, Doctor). Furthermore, a PAC unit-based stock management system needed to be designed and implemented in order to "*…communicate the statistics created to the FP unit…*" remarked the Senior Management Champion at CMC Miniére.

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. At the national level, one 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. 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. "*Get political decision-makers involved with the support of a national budget. It matters to find our own resources*" (Senior MOH Policymaker).

Country Feedback

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.

Service providers also recommended greater emphasis on youth-focused programs. Over 30% of PAC clients attending the CMCs in each of the five years (2008- 2012) were youth under age 20. Reaching these young people with information about PAC and FP through such programmatic approaches as radio and television programs was identified as an important part of community outreach. One respondent advised that there was a need for *"IEC at all levels: schools, districts, rural radios, etc."* in order to reach people, particularly young ones, with PAC information (FGD: CMC Matam, Midwife).

Box 7: Guinea Key Findings

Reorganization of services:
- Created separate PAC room
- Strengthened supportive supervision (internal and external supervision)

Training:
- Trained staff on PAC and SBM-R
- Improved provider knowledge and quality of counseling
- Dispelled myths and misconceptions, especially for LARCs, among providers
- Included PAC in national training guidelines for universities

Supply chain management:
- FP commodities available at the PAC room
- Forecasting FP commodities needs at the facility level continues to be a challenge

PAC client registers:
- All PAC clients counseled
- All PAC clients left the facility with a contraceptive method; most preferred methods were IUDs, injectables, and oral pills

Financing:
- Creating a national PAC program with budgetary allocation remains a challenge

Leadership, governance, and management:
- Team work significantly improved at the facility level, including the facility pharmacy
- Continued need for technical and financial resources
- Continued need for a youth-friendly PAC approach

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 RH 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. As one respondent explained, the role of the MOH cannot be emphasized enough and the ultimate success of any activities is dependent on:

"…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, Global Stakeholder

3.2.4 Conclusion

The 2008 action plan was successfully implemented in the three facilities with sustained technical assistance from Jhpiego through facility 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.

3.3 Senegal

Senegal has an estimated population of 13.1 million; 44% of whom are under age 15. During the past decade, there has been some improvement in infant and maternal mortality rates, while the TFR, CPR, and unmet need for FP have only improved minimally. Maternal mortality ratios have fallen to an estimated 370 deaths per 100,000 live births—the second highest of the four countries studied. The TFR has remained relatively stagnant, around 5, while CPR for modern methods has slightly improved. PAC, including strengthening FP services at point of treatment, is a significant service delivery best practice to reducing maternal mortality and morbidity, early and short-spaced pregnancies, and unsafe abortion. Abortion is illegal in Senegal, except to save the mother's life. Postabortion services are provided at health centers, regional and teaching hospitals, while FP is available at all levels of health care (Box 8).

Box 8: Selected Socio-demographic Indicators

Indicator	Value
Population size (in millions)[1]	13.1
Under 15 years of age[1]	44%
Infant Mortality Rate per 1,000 live births[2]	47
Maternal Mortality Ratio per 100,000 live births[3]	370
Total Fertility Rate[2]	5.0
Contraceptive Prevalence Rate, modern methods[2]	12%
Unmet need[2]	29%

Data Sources:

[1] Population Reference Bureau, "World Population Data Sheet 2012," accessed August 26, 2013, http://www.prb.org/pdf12/2012-population-data-sheet_eng.pdf .

[2] Measure DHS, Enquête Démographique Et De Santé Rapport De Synthèse 2010-11, accessed August 26, 2013, http://www.measuredhs.com/pubs/pdf/SR192/SR192.pdf

[3]WHO, *Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and World Bank estimates* (Geneva: WHO, 2012).

3.3.1 Background

In 2008, findings from the Population Council's 2007 assessment study[17] were shared with six participating countries (Burkina Faso, Guinea, Niger, Rwanda, Senegal, and Togo).[22] Key findings from the study identified the following factors, which had facilitated the successful integration of PAC services in Senegal: incorporation of an integrated PAC model into the national PNP; considering PAC in annual district planning; standardized printed logbooks to record PAC data; training teams in regions where USAID and UNFPA provide support; training physicians and nurses in EmOC and PAC-FP.[17] At the meeting, additional facilitating factors supporting integration were highlighted by the country team—the gradual decentralization of PAC from hospitals to health centers and health posts; integration of PAC into all other RH services offered by the health facilities (avoiding stigmatization of abortion cases); consideration of PAC in maternal, newborn, and child health programs; subsidies from the national bank; and decreasing beneficiary costs by 80%.[22]

Participants were oriented to the VFCP at the Saly meeting and invited to participate in the year-long follow-up program as means of providing technical assistance to each country team as they finalized and implemented the draft action plans developed at the meeting. Senegal's action plan focused on: reorganization of services, cost of FP methods, training, supervision, supply chain system management, and community mobilization for PAC (Box 9). One global stakeholder described the process by which country teams chose their action plan items: *"for instance community involvement, community mobilization. Some of them decided to include it if they found it important. So, it is based on what is missing."* (Cooperating Agency, Global Stakeholder) (Annex – Virtual Fostering Change Program for Postabortion Care)

Upon returning to Senegal, the country team members continued their deliberations on the draft action plan with technical support from the VFCP facilitators. During the VFCP for PAC implementation process, Senegal's country team was composed of representatives from the MOH as well as *Centre Régional de Formation, de Recherche et de Plaidoyer en Santé de la Reproduction* (CEFOREP), WHO, and other NGOs. The 12 country team members from the 2008 workshop were not all the same participants who participated in the VFCP. Nine people participated in the VFCP from CEFOREP and the MOH.[18] In May 2009, Senegal's participation in the VFCP ended due to low participation. There is no documentation as to what happened with the action plan developed at the 2008 workshop in Saly, Senegal. Despite the fact that Senegal's country team had to end their participation in the VFCP for PAC, Senegal nevertheless has a mature PAC-FP program, which may provide useful insights into scaling up PAC-FP service delivery.

Box 9: Senegal Action Plan

Reorganization of PAC services:
- Ensuring FP counseling and methods are available 24 hours/7days a week at the point of treatment for PAC clients
- Creating job descriptions
- Adequately dividing duties for service providers and routine supervision

PAC client cost of FP methods:
- Ensuring free provision of the first supply of contraceptives

Training and supervision:
- Integration of the community component of PAC into the basic training curricula
- Establishing procedures for evaluating the curriculum to ensure health workers would be able to provide comprehensive PAC, specifically the community component

Supply chain management:
- Advocacy
- Guiding supply chain managers
- Ensuring availability of MVA kits
- Maintaining a supply system
- Management of FP products between the pharmacy and the processing unit

Community mobilization for PAC:
- Dissemination of PAC community mobilization in one district
- Advocacy through champions

3.3.2 Data Collection

In late 2012 and early 2013, E2A conducted KIs and FGDs with staff in Senegal who had helped to draft and implement the action plan at the 2008 workshop and with the early phases of the VFCP for PAC program implementation. For this assessment, data collection included: (1) 12 KIs with Saly team members, participants of the VFCP for PAC program, and policymakers; (2)3 FGDs with service providers from the regional hospitals of Thiès and Roi Baudouin and the Polyclinic maternity at the Aristide Le Dantec hospital in Dakar[e]; and (3) a review of PAC patient registers (Thiès and Roi Baudouin).

3.3.3 Findings

The findings describe the achievements, challenges, and barriers to the effective implementation of the action plan activities to strengthen postabortion FP counseling and services for postabortion clients. The results are organized around the key themes of reorganization of services, training of service providers, supply chain management, community mobilization for PAC, and country feedback that provide a holistic assessment of the current status of the PAC package of services in the respective facilities.

[e] Maternity services at the Polyclinic closed in early 2010 for renovation. Staff were transferred mainly to Gaspard Camara where the focus group discussion was conducted; the PAC client register was unavailable.

Reorganization of PAC Services

Reorganization of PAC services requires establishing a dedicated space to provide PAC services and ensuring the availability of service providers trained to conduct MVA and provide FP counseling and services at the point of treatment, 24 hours per day, 7 days a week. As a country with a more established PAC program, Senegal had already created separate PAC rooms to treat clients prior to the 2008 Saly meeting. Separate PAC room were available, and service providers had been trained to offer FP counseling and services to PAC clients as an integral component of PAC service delivery, as noted by policymakers and service providers. Respondents were aware that challenges remained for patients receiving dilation and curettage, as opposed to MVA, since FP counseling and services were not offered at the same time as treatment in the operating theater or recovery room for those clients. As one midwife described:

> "*FP counseling was systematic in PAC for ladies who received intrauterine suction, but not for the others who received other forms of care, for example, those receiving manual curettage in the delivery hall or in the surgical unit. The reason was that these ladies did not receive care through the same individual… Therefore, it was systematic for some of the women–those who underwent MVA –but not for others.*"
>
> FGD: Roi Baudouin, Midwife

In earlier years, a variety of FP methods had been made available in the PAC room without much difficulty, service providers noted. Both service providers and policymakers mentioned that following the introduction of the Bamako Initiative (cost-sharing for essential drugs including contraceptives) most FP methods were available only through purchase at the facility pharmacy. Service providers and policymakers believed that this process created a barrier for PAC clients who were required to leave the PAC room, go to the facility pharmacy to purchase an FP method, before returning for further counseling or FP product administration. As one service provider at the Thiès regional hospital commented, "*at our level, the only thing that we can ensure is offering MVA and prescribing antibiotics and iron, but we cannot guarantee if she has received an FP method or not*" (FGD: Thiès, Midwife).

Service providers were hindered in their ability to provide comprehensive services including FP methods at point of treatment as a matter of policy. In order for this to change, there would need to be changes made higher up to the policy as described here:

> *"…their (…FP commodities…) availability is the problem we face, so our challenge is to make products available within facilities…They go to the pharmacy, they go out, and they do not get the contraceptives…but we will change the policy…What we want is that if they do counseling, they provide contraceptives."*
>
> Senior MOH Policymaker

However, a senior MOH policymaker commented that it was possible to circumvent higher level policy decisions at the facility level by internal facility arrangements, though demonstrable leadership skills would be required: "*When I was there* (…. at a health facility….) *I went and collected contraceptives from the pharmacy. Those in charge can do that …*"

PAC services were also available at health centers, which resulted in a concomitant decrease in the hospital referrals, as described by one senior obstetrician, "*from now on, everything is done at the level of health centers and there are fewer and fewer referrals*" (Senior Obstetrician).

PAC Client Register Maintenance

Respondents commented that the MOH distributes officially printed PAC client registers to the health facilities along with record-keeping support. These PAC client registers include client statistics that

enable a number of widely accepted PAC indicators to be ascertained. Service providers mentioned that monthly records are compiled from the PAC registers and then submitted to the chief physician for reporting and procurement purposes. As one respondent explained, "*each month we prepare a report about our activities, and at the same time we express our needs to the chief physician* (….name….)*, to whom we submit these reports*" (FGD: Roi Baudoin, Midwife).

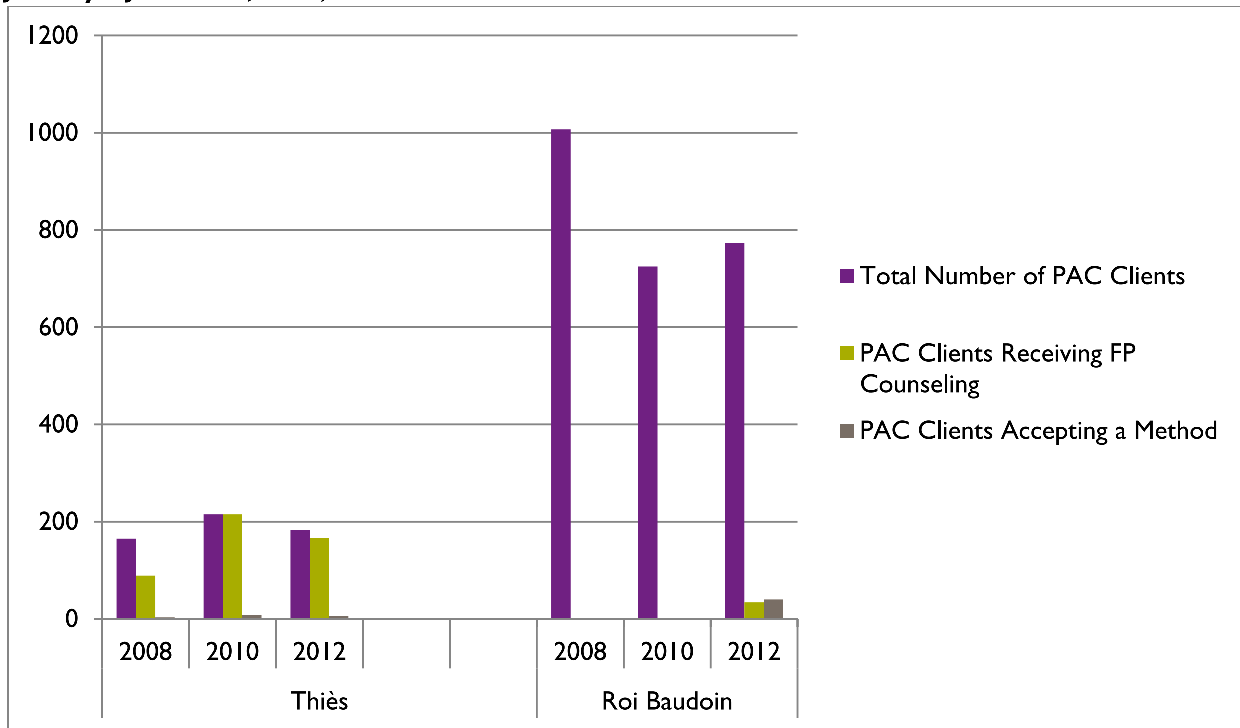
Despite some progress, record keeping continues to be a challenge, specifically recording FP counseling and uptake. Data gathered in a review of PAC client registers at Thiès and Roi Baudouin illustrate a substantial discrepancy between the large number of PAC clients and the significantly fewer number recorded as being counseled or accepting a method. Several reasons were cited by policymakers and service providers for this discrepancy, including staff transfers and lack of awareness among service providers about recording PAC-FP uptake. One midwife described the problem this way: "*That's the problem* (…loss of follow-up…)*; we have no means of verifying this and sometimes cases* (… FP acceptors…) *drop out*" (FGD: Thiès, Midwife).

PAC Client Register Statistics

Statistics compiled from the formal PAC client registers at the two regional hospitals (Thiès and Roi Baudouin) for the January- June period in 2008, 2010, and 2012 were analyzed in order to gauge progress in FP uptake among PAC clients. In 2008, 1,172 PAC clients were seen over a six-month period of time (January to June) at the selected facilities; declining to an average of 19% in 2010 (940) and 2012 (956). Data on number of PAC clients counseled and accepting an FP method were not recorded for Roi Baudouin in 2008 and 2010. Trends in FP counseling and method uptake for Thiès for the 2008 to 2012 study periods are reported. The total number of PAC clients who were counseled and who had accepted a method rose. Overall, the number of PAC clients counseled increased from 54% (89/165) in 2008 to 91% (166/183) in 2012. The number of PAC clients who accepted a contraceptive method increased from less than 2% (3/165) in 2008 to a little over 3% (6/183) in 2012. For the 2012 study period in Roi Baudouin, of the 773 PAC clients seen, a little over 4% were counseled and 5% accepted an FP method (Graph 3).

Service statistics from the PAC registers illustrate a high client load, especially in Roi Baudouin (1,007 in 2008 declining to 773 in 2012), though number of clients counseled (34 in 2012) and number accepting a method (40 in 2012) were much fewer, indicating perhaps that operationalization of FP counseling and services and/or record keeping were underlying challenges (Graph 3). The awareness that PAC connotes a package of services (care management and FP counseling and services) was well articulated by service providers, though record keeping for tracking FP uptake including method type among this client subset was a challenge. Providers were well aware of this issue and when asked about it, a senior obstetrician commented, "*not recording FP products following PAC; we need to raise the awareness of midwives about this issue.*"

Graph 3: PAC-FP Client Register Statistics from Regional Hospitals at Thiès and Roi Baudouin, January – June 2008, 2010, and 2012



Note:: Total Number of PAC Clients Counseled and Acceptors not recorded for Roi Baudouin (2008 and 2010); Numbers of FP acceptors for 2008 (n=3) and 2010 (n=8) for Thiès; PAC clients counseled and FP acceptors recorded for both facilities in 2012.

Contraceptive Methods: Availability and Uptake

The review of the FP service statistics for the 2008-2012 period indicates that although attempts were made for products to be available at the point of treatment, numbers counseled and method uptake were relatively low. The most accepted methods by clients were oral pills and injectables, indicating perhaps provider counseling and method availability at point of treatment (Table 6). While younger and/or primiparous clients were counseled for short-acting methods, older grand multiparous clients were counseled for long-acting methods. One midwife described the FP counseling this way:

> *"We are very aware that primigravida cherish pregnancy very much, so it is very difficult to convince them to use a method. But I recommend their taking even Depo or pills for three months, so we focus on these short-term methods in this group. However, the multiparous would like to avoid pregnancy, so we offer them the long-term methods."*
>
> FGD: Thiès, Midwife

Additionally, service statistics show low to no uptake of implants and IUDS prior to 2012, although the exact reasoning for this is unclear (Table 6). One country team member expressed concern that service providers in the PAC unit had not received training on long-term methods, saying, "*lack of training on long-term methods of FP. Patients having chosen IUD or Norplant/implants are referred to the FP unit*". This is perhaps a reason for hindering LARCs administration at point of treatment for PAC clients.

Table 6: Frequency Distribution of Contraceptive Method Uptake by PAC Clients from Thiès and Roi Baudouin (2008, 2010, and 2012 [January – June])

Method type (%)	Thiès			Roi Baudoin		
Year	**2008**	**2010**	**2012**	**2008**	**2010**	**2012**
Abstinence	-	NR	-	NR	NR	-
Condoms	-	NR	-	NR	NR	1
Oral Pills	67	NR	50	NR	NR	48
Injectables	33	NR	33	NR	NR	40
Implants	-	NR	17	NR	NR	5
IUDs	-	NR	-	NR	NR	3
Tubal Ligation	-	NR	-	NR	NR	3
TOTAL (n)	3	8[1]	6	NR	NR	40

NR = Not recorded
1: Method type not recorded.

Costs for PAC Service Delivery

One activity outlined in Senegal's action plan was to ensure free provision of the first contraceptive supply to PAC clients. This activity was difficult to implement given the challenges surrounding the cost-recovery strategy subsequent to the implementation of the Bamako Initiative (cost-sharing for essential drugs including contraceptives).

In earlier years, service providers pointed out that a variety of FP methods had been made available in the PAC room without much difficulty. Both providers and policymakers mentioned that following the introduction of the Bamako Initiative, however, most FP methods could only be purchased at the facility pharmacy. Service providers and policymakers believed that this process created a barrier for PAC clients who were required to leave the PAC room, go to the facility pharmacy to purchase an FP method, before returning for further counseling or FP product administration. Costs for contraceptives varied across facilities, though typically oral pills remained the least expensive option with LARCs being the most expensive, as reported by service providers. As one midwife described, "*all products are available only in the pharmacy. Three strips of pills cost 100[f] CFA; Depo costs 200 CFA; Jadelle and Norplant cost 500 CFA*" (FGD: Thiès, Midwife). However, at least in one facility, orals pills are offered at the point of treatment at no cost. A midwife at the Roi Baudouin facility explained, "…..*we made pills available and offered them for free so that at least patients would leave with a method*" (FGD: Roi Baudouin, Midwife). Despite these efforts, the separation of the PAC and FP units remained a persistent barrier to client uptake of a variety of FP methods.

[f] At the time of the assessment, 100 CFA was equal to about $ 0.21 USD.

An additional cost barrier that service providers mentioned was the client cost for the MVA procedure, which was approximately 16,000 CFA. While the costs of short-acting methods were affordable in and of themselves, when all costs were combined, the total amount was prohibitive and hindered accessibility. As one midwife explained:

> *"We need to revisit the cost of the tickets, since we encounter special social cases. It is true that FP is more affordable; it costs 200 CFA or 300 CFA (for Depo Provera). The regular ticket costs 10,000 CFA, and the kit costs 6,000 CFA plus the cost of any prescriptions. All this needs to be reconsidered because it affects the accessibility of services."*
>
> FGD: Thiès, Midwife

Supervision

The MOH has integrated PAC in its RH and national health program roadmaps. The reviewed policy guidelines have been disseminated at both regional and district levels. As one policymaker explained, *"PAC has its place in the multi-sector road map of reproductive health. It has its place in the national program of health development and constitutes a component of low-risk maternity in general"* (Senior MOH Policymaker).

Policy recommendations specify regular supervisory visits: monthly (district), quarterly (regional), and biannually (national). Supervisory staff cadres are comprised of facility RH coordinators, staff of Regional Health Directorate, MOH, and trainers. The execution of regular supervisory visits per policy recommendations in the country was challenging due principally to logistics and transportation costs which were also experienced in other countries. One senior policymaker articulated the problem this way:

> "*The challenge is the regularity (… in the supervision…)……. since some sectors could be neglected without regular supervision such as in counseling, FP, or prevention of infection …..in some districts they tell you we have no logistics. If you go there, you will see some things that are not good for quality.*"
>
> Senior MOH Policymaker

Despite having these policies in place, overall lack of supervision has prevented their full realization and implementation at the service delivery level. Additionally, inadequate and irregular supervision has adversely affected staff morale. One country team member described how lack of supervision affected providers, "*because of a lack of supervision, service providers have become less motivated*" (Cooperating Agency, Country Team Member).

Training of Service Providers

Many service providers have received postabortion care training. The rationale for postabortion FP counseling and services (return to fertility, birth spacing, risk of closely spaced pregnancy and subsequent abortion) was frequently mentioned as a motivation to counsel women immediately post treatment. Providers interviewed in Senegal were well aware that "PAC" connotes a package of services. As one midwife stated during an FGD, *"…we are not in a position to have information about whether women receiving postabortion care have left the hospital with a method or not. This is a defect in PAC, since it is a package of services and if FP is missing, it is no longer PAC"* (FGD: Thiès, Midwife).

Respondents mentioned that one significant achievement in postabortion FP service delivery has been revisions in the training curricula to include FP counseling and services and community-based health care services. According to policymakers, another achievement has been the revisions to the basic training curricula of the health care training schools. Additionally, respondents reported that partners have facilitated in-service midwifery training on postabortion FP and post-training follow-up has been accomplished. Respondents also mentioned that challenges remained with regard to training the health

workforce; not all service providers have been trained (in FP and/or PAC) and there is high turnover of trained service providers. As one stakeholder described, the training curricula is one of the key components to overall PAC program success:

> "*A review of the training curriculum integrating counseling, the provision of FP methods and community-based health care services; the involvement of health care training schools for an effective review of the basic training curriculum of nurses and midwives in PAC/FP; the training of midwives providing PAC-FP services; and the post-training follow-up of service providers.*"
>
> Regional Research Organization, Country Team Member

Supply Chain Management

According to key policymakers, MVA kits and contraceptive products have become more available at health facilities, due in part to the involvement of senior MOH policymakers and the National Supplying Pharmacy (*Pharmacie Nationale d'Approvisionnement* – PNA).

Family Planning Commodities

Senegal has included all modern contraceptive methods in the essential drug list to improve availability at health facilities. Inclusion of FP methods and implementation of the Bamako Initiative resulted in improved availability of FP products through the PNA to the facility pharmacy, according to respondents. However, access to contraceptives after emergency treatment is limited due to inconsistent supply and contraceptives not being available at the point of treatment.

Service providers described FP commodity stock-outs, noting that they were generally caused by national shortages. Both policymakers and health providers acknowledged that with PNA instituting the push program,[g] such stock-outs are no longer a large problem and have recently declined. One senior obstetrician described the improvements this way: "*The facilities experience stock-out of contraceptives. This is better now because of the push program*" (Senior Obstetrician).

MVA Kits

MVA stock-outs were acknowledged by both service providers and policymakers in the MOH. While service providers were aware of the MVA quality assurance regulations,[h] they continued to use MVA kits due to high demand and stock-outs. As one service provider described, "*in the MVA kits pamphlet, there is a number of MVA procedures that should not be surpassed, but we are in a developing country, and to be honest, we do not comply with that number*" (FGD: Roi Baudouin, Midwife). Policymakers recognized limitations in the MVA supply chain management system as a remaining challenge. Cost of the MVA kits was identified as a barrier to procurement and this cost was passed along to clients, often to the providers' dismay. As one provider described, "*we need more support in MVA kits. If these could be subsidized, the cost would be less for women*" (FGD: Roi Baudouin, Midwife).

Community Mobilization for PAC

Respondents articulated the need for greater advocacy related to FP and community outreach to assist in overcoming socio-cultural barriers. This includes advocacy among specific target groups (religious leaders and community leaders) and the general public through mass media. As a senior policymaker described:

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[g] In a push system, the personnel who issue the supplies determine the quantities to be issued.

[h] Ipas MVA Plus can be used 25 – 50 times but must be inspected before next use. If the Ipas MVA Plus shows signs of damage or is not functioning properly, it should be discarded.

"*Contraceptive prevalence is very low, because of socio-cultural factors. The lesson learned from this is that the FP programs must involve all social and community leaders in FP promotion sessions and television, and radio IEC sessions should be multiplied.*"

Senior Policymaker

A successful pilot community mobilization program, implemented by an NGO, was expanded to 12 sites in the Thiès region. Community leaders were actively involved in the successful implementation of several programmatic activities including sensitization of religious leaders for FP. Other activities included provision of a meeting space for adolescents, creating an emergency solidarity fund, involvement of taxi drivers to transport emergency cases, and upgrading of four health posts to health care units. This effort resulted in community-based commitment for emergency abortion treatment and FP. A senior policymaker acknowledged the commitment of the NGO and the ultimate programmatic success, but nevertheless lamented that scale-up to all health units was not achieved – "*...but we have failed in expanding the community pilot project any further among all health units*" (Senior MOH Policymaker).

Country Feedback

Senegalese health providers and policymakers provided insights and suggestions to ensure continuation of positive trends and to address some of the barriers that stand in the way of even greater success. According to respondents, there has been notable achievement related to the reorganization of PAC services in Senegal. Although Senegal had already established separate PAC rooms for clients in a few facilities, respondents recognized the challenge faced by clients who received dilation and curettage, as opposed to MVA, and recommended a system be put in place to ensure all PAC clients receive FP counseling and services.

Challenges related to clients' cost of FP methods was another issue recognized by both providers and policymakers. In order to ensure a reduced cost to PAC clients for FP methods, one respondent suggested allocating specific financial resources for provision of supplies and commodities, for free or at subsidized rates.

While a great deal of progress has been made in training providers on PAC-FP services, providers and policymakers proposed strategies to maintain and

Box 10: Senegal Key Findings

Reorganization of PAC services:

- Separate PAC room created
- Separate location of PAC and FP units remain barrier to FP uptake
- Inadequate and irregular supervision remains barrier to quality PAC services

PAC client cost of FP methods:

- Costs for FP commodities have declined
- High costs for PAC services (MVA and FP commodities) remain a challenge

Training and supervision:

- Revised basic training curriculum includes FP counseling and services and community-based health care services
- All service providers not trained
- PAC guidelines in the PNP not implemented in all facilities offering PAC services

Supply chain management:

- FP modern methods included in essential drug list
- MVA kits available at health centers
- 'Push' program improved supply chain management
- Strengthen 'push' program to minimize stock-outs

PAC client registers:

- Few PAC clients (200/1,172) counseled
- Even fewer (46/1,172) accepted an FP method
- Record keeping has improved

Community mobilization for PAC:

- Community mobilization was successfully scaled to 12 additional sites
- Strengthen community mobilization and sensitization of community and religious leaders

enhance current success. These recommendations include continuing in-service trainings until all service providers have been trained; standardizing policy guidelines and norms for health facilities; and implementing the PAC-FP component of the PNP at all facilities where abortion services are provided.

Important progress has been made in the area of supply chain management, resulting in decreased stock-outs of MVAs and FP commodities. Despite this positive trend, stock-outs do still occur and need to be addressed. Key informants recognized the central pharmacy push program as a key component that needs continued support in order to ensure reduction of stock-outs.

Policymakers acknowledged the success of the PAC community mobilization program in selected sites in the Thiès region, but recommended greater investment to ensure scale-up in more communities where PAC services are available.

Although some progress has been made in maintaining PAC client registers, record keeping continues to be a challenge, specifically recording FP counseling and uptake. Both policymakers and health providers agreed this was a problem and suggested raising awareness amongst providers charged with maintaining the registers.

3.3.4 Conclusion

Senegal carried out some of the activities in the action plan including PAC community mobilization. However, barriers still remain to achieving full integration of PAC-FP services. Much work remains to be done to guarantee that all PAC clients are counseled and receive their chosen FP method at point of treatment, to limit stock-outs of needed equipment and supplies, and to improve record keeping of the PAC client register. Future progress depends on sustaining and improving these achievements to attain national coverage.

3.4 Togo

Togo currently has an estimated population of 6 million, with approximately 41% under the age of 15. While there has been some improvement in infant and maternal mortality rates, accessing quality RH services in Togo remains difficult, particularly outside of urban centers. Unmet need for contraception currently stands at 40.5%. The TFR has declined somewhat between 2005 and 2012 to 4.7 children per woman, but the CPR for modern methods remains quite low at 13%. Given the high unmet need for contraception and the continued low CPR in the country, it is not surprising that PAC services remain an important part of overall reproductive health care for women (Box 11).

Box 11: Selected Socio-demographic Indicators

Indicator	Value
Population size (in millions)[1]	6.0
Under 15 years of age[1]	41%
Infant Mortality Rate per 1,000 live births[1]	78
Maternal Mortality Ratio per 100,000 live births[2]	300
Total Fertility Rate[1]	4.7
Contraceptive Prevalence Rate, modern methods[1]	13%
Unmet need[1]	40.5%

Data Sources:
[1]Population Reference Bureau, "World Population Data Sheet 2012," accessed July 26, 2013, http://www.prb.org/pdf12/2012-population-data-sheet_eng.pdf.
[2] WHO, "Cause-specific mortality and morbidity: Maternal mortality ratio by country," accessed July 29, 2013, http://apps.who.int/gho/data/node.main.MATMORT?lang=en.

Abortion is illegal in Togo, except to save the life of a woman or in cases of fetal impairment, rape, or incest.[5] Estimates of the incidence of abortion-related complications and death are not available, as globally abortion-related complications and death are commonly misclassified in routine reporting. Although some progress has been made in the last few years to improve PAC, abortion-related deaths continue. A senior obstetrician noted that "*… death due to abortion still exists in this country, especially in cases where clandestine induced abortion is performed in unhygienic environments; we cannot perform miracles."* Postabortion services are provided at district, regional, and teaching hospitals, while FP is available at all levels of health care.

3.4.1 Background

Togo is divided from the south to the north into six health care regions, which are subdivided into 35 districts. Health care is structured on a pyramid system with three levels. Health huts/posts and *Centres pour la Protection des Mères et des Enfants* (Centers for the Protection of Mothers and Infants) serve as the primary health care units—*Unité de Soins Périphérique* (Peripheral Care Units - USP). Secondary facilities at sub-district and district levels have *Centres Médico-Social* (CMS), and tertiary facilities at regional [*Centre Hospitalier Regional* (CHR)] and national levels include university hospitals [*Centre Hospitalier Universitaire* (CHU)].[27] The Division of Family Health (DSF) within the MOH oversees and manages the FP program, as well as maternal and child health, youth, and nutrition services.

In 2006, Togo introduced PAC services at national and regional hospitals.[17] PAC services had previously consisted of digital or surgical curettage. The AWARE-RH project, funded by USAID and managed by EngenderHealth, supported the country during the introduction phase through training of trainers and service providers, MVA equipment and contraceptives. The roll-out of the training program gave some providers experience with using MVA kits.[17]

In 2008, findings from the Population Council's 2007 assessment study[17] were shared with six participating countries (Burkina Faso, Guinea, Niger, Rwanda, Senegal and Togo) at the Saly, Senegal workshop.[22] Since this assessment was conducted early in Togo's introduction phase, there was little information on the successes and challenges. However, the assessment identified some key concerns:

PAC was not present within district plans, and regional supervisors did not appear to have a clear vision of the PAC model, affecting the quality of supervision provided.[17] Additionally, there were challenges identified with training in paramedical schools due to the high volume of students needing training.[17]

Participants from each country team were oriented to the VFCP at the 2008 Saly, Senegal meeting and invited to participate in the year-long follow-up program as means of receiving technical assistance as they finalized and implemented the draft action plans. Several key people, including two senior policymakers from the DSF, one senior OB/GYN, and a representative from WHO, developed Togo's action plan. The overall goal of the action plan was to improve the availability and quality of PAC services by focusing on the following areas: reorganization of services, training, supplies and commodities, health information systems, financing, and leadership and management (Box 12).

During the VFCP for PAC implementation process, the Togo action plan 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 selected to implement the revised action plan activities (Annex –Virtual Fostering Change Program for Postabortion Care). However, the action plan team lacked funding and associated resources to implement the range of activities proposed. USAID Washington responded to these challenges by providing $40,000 for training and technical assistance, which was organized and implemented by EngenderHealth's RESPOND project; trainings were conducted in early 2010. Trainees were health providers from either the DSF or one of the four selected sites. The PAC service delivery workshop series trained 16 participants to update and/or develop their skills and competencies, including FP counseling, provision of specific FP methods, behavior change communication (BCC), and infection and HIV prevention. An additional 19 providers were trained on treatment of abortion complications, infection prevention, and FP during PAC. [23]

Box 12: Togo Action Plan

Reorganization of services:

- Create a separate PAC room
- Ensure FP counseling and methods available at the point of treatment

Training:

- Train all providers on PAC to maintain continuous service provision

Supply chain management:

- Ensure a constant supply of FP methods in the PAC unit
- Ensure night shift staff in the maternity ward have regular supply of contraceptives available

Health information systems:

- Review statistics within the PAC register

Financing:

- Advocate to the government, development partners and the community for resource mobilization
- Increase government contribution for the purchase of contraceptives

Leadership and management:

- Ensure regular supervision
- Ensure coordination activities at chosen health facilities
- Organize monthly meetings between the health facilities and the national PAC team

3.4.2 Data Collection

In early 2013, E2A conducted KIs and FGDs with Togolese staff who participated in the VFCP for PAC. Although ATBEF was identified as one of the four pilot sites by DSF, it was ultimately excluded from the assessment given the fact that it is an NGO-run facility, largely funded by IPPF, and although they do offer PAC services, their implementation of the action plan was somewhat limited. In addition, the challenges ATBEF faced were very different from the other three government-managed sites. The assessment team opted to collect data from a fifth site, CHU Kara, which was not an action plan facility. CHU Kara was included for its

role as a large referral center and teaching facility in northern Togo with PAC services. CHU Kara therefore provided useful insights for PAC services in Togo, and the chief obstetrician at CHU Kara had participated at the Saly meeting.

For this assessment, data collection included: (1) 12 KIs with the 2008 Saly meeting team members, senior health facility management champions, and policymakers; (2) 4 FGDs with service providers from the regional teaching hospital (CHU Kara) and three facilities (CHR Tsévié, CMS Kévé, CMS Adidogomé); and (3) a review of PAC client registers in three of the facilities (CHU Kara, CHR Tsévié, and CMS Kévé). A specific PAC client register was not available at CMS Adidogomé; instead PAC clients were recorded in the maternity register. The 2008–2012 maternity registers were reviewed, but only one PAC client was recorded. Data from CMS Adidogomé was therefore excluded from the assessment.

3.4.3 Findings

The findings describe the achievements, challenges, and barriers for the effective implementation of the action plan activities to strengthen FP counseling and services for abortion clients. The results are organized around the key themes of reorganization of services, trainings, supply chain management, PNP, community awareness, male involvement, and youth. With country feedback, these findings provide a holistic assessment of the current status of PAC services in the respective facilities.

Reorganization of PAC Services

An essential part of providing integrated PAC services at point of treatment is establishing a separate PAC room where clients also receive FP counseling and methods as a one-stop shop. Challenges to maintaining well-integrated PAC and FP services arose primarily due to space issues. Of all the health facilities included in the assessment, CHU Kara was the only one able to establish a separate PAC room apart from the delivery unit. Problems began occurring when competition for the space arose. The senior management champion at CHU Kara described that:

> *"At the beginning we had an MVA room and another for recovery, but since we had to readjust our space in order to include a surgical unit, we lost our recovery room. Only that of the MVA procedure is still in place, but this is where we also perform simple and postsurgical dressings; this is becoming really frustrating."*
>
> CHU Kara, Senior Management Champion

The issue of competing priorities for space also affected the Kévé facility. When one senior management champion was asked how staff managed having both a PAC and delivery case at the same time, the champion explained, "*this is the problem! In this case, we have to do both in that delivery room, since we have two delivery tables. We can't perform PAC elsewhere."*

The Adidogomé health facility experienced pronounced challenges regarding a separate PAC room. Despite having trained personnel and a functioning MVA kit, due to lack of a dedicated space for providing MVA, health providers were only able to provide basic digital curettage. Health providers cited the lack of a separate space for MVA and FP as one of the main reasons for their inability to offer PAC services despite concerted attempts to adapt a small room in their facility. *"Then we found a space, but it was very tiny. We asked if we could have a fan installed there, but it was not done. Conditions were not suitable for us to properly perform postabortion care*" (FGD: CMS Adidogomé, Midwife). *"We have raised this issue (separate PAC room) many times to the DSF, but there was no reaction on their part. We then wished that they would ventilate the tiny room that we have mentioned, but nothing happened" (*FGD: CMS Adidogomé, Midwife). Consequently, PAC clients were routinely referred to the CHU – "*…it is when the cervix is not*

soft and open that our hands become tied; the patient needs MVA at this point and we evacuate her to CHU Sylvanus Olympio" (FGD: CMS Adidogomé, Midwife).

Providers were very aware of the importance of offering curative and preventative PAC services at the same location. When describing how services had been offered in the past, the senior facility champion at CHR Tsévié commented, "*before 2010, we evacuated uterine contents using curettes. FP was not systematic. The woman was discharged without referral to the FP unit.*"

Although the Kara facility was able to temporarily offer a variety of FP methods in the MVA room, the facility soon began to experience problems and the services were once again separated, as explained by the facility's senior management champion. "*Previously, we put contraceptive methods in the MVA room, but since some of them expired there, we started prescribing them only as needed."* CMS Kévé's FP unit also operated apart from the PAC services due to space limitations.

By separating services, access to a variety of FP methods by PAC clients was difficult. FP units are 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. At CHR Tsévié, one midwife explained that when given the FP counseling choice to return later to the facility, "*most of them come back on the eighth day"* (FGD: CHR Tsévié, Midwife). Unfortunately 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).

Despite the separation of the PAC and FP units, all of the facilities seemed able to maintain a good method mix with few stock-outs. One health provider noted that "*we have everything available: pills, Jadelle, IUDs, and spermicide*" (FGD: CHU Kara, Midwife). When viewing the PAC client register (Table 7), oral pills seem to be the favorite choice of clients, and this can be explained for a few key reasons. One facility overwhelmingly offered oral pills to PAC clients, with a very clear explanation as to why this was the case. As previously discussed, CHU Kara struggled with strengthening FP for PAC clients due largely to the expiry of some FP commodities available in the PAC room. To address the problem of expired methods, health providers chose to offer oral pills in the PAC room and send clients to the FP unit for others.

> "*If you look at our records, you will notice that in 99% of cases we offer the oral method after treatment. Why? Because most situations (abortions) take place over weekends and the FP unit is not associated with the facility…The FP service operates apart from us during business days. There is no family planning service at night or on weekends, just Monday through Friday."*
>
> FGD: CHU Kara, OB/GYN

Having a variety of methods available to clients did not guarantee they would choose them; for example, although several of the facilities offered IUDs, it was one of the methods least likely to be chosen by clients (Table 7). As one midwife noted, "*even when one takes care to explain that the IUD is one of the best methods, they continue being prejudiced by this method" (*FGD: CHR Tsévié, Midwife). Another added, "*…the IUD, they fear that it creates problems for them in the womb*" (FGD: CHR Tsévié, Midwife). This prejudice against IUDs did not hold up against all long-acting methods though; Jadelle was a method slightly more popular than IUDs, as one midwife observed, "… *following suction I frequently (*…am requested to…*) order Jadelle"* (FGD: CHU Kara, Midwife).

PAC Client Register Maintenance

The importance of maintaining and regularly monitoring the PAC client register were elements identified in the action plans and reiterated by health providers and policymakers alike. Creating and maintaining a PAC register was a process that each of the four health facilities discussed in relation to trainings and viewing the register at the university teaching hospital in Lomé. As remarked by a senior management champion: "*We use a model for our registers that we received during training. We have also updated this model according to that used in CHU Sylvanus Olympio.*" At CHU Kara, as well, a provider took the initiative to update the facility PAC register based upon the one established at CHU Sylvanus Olympio.

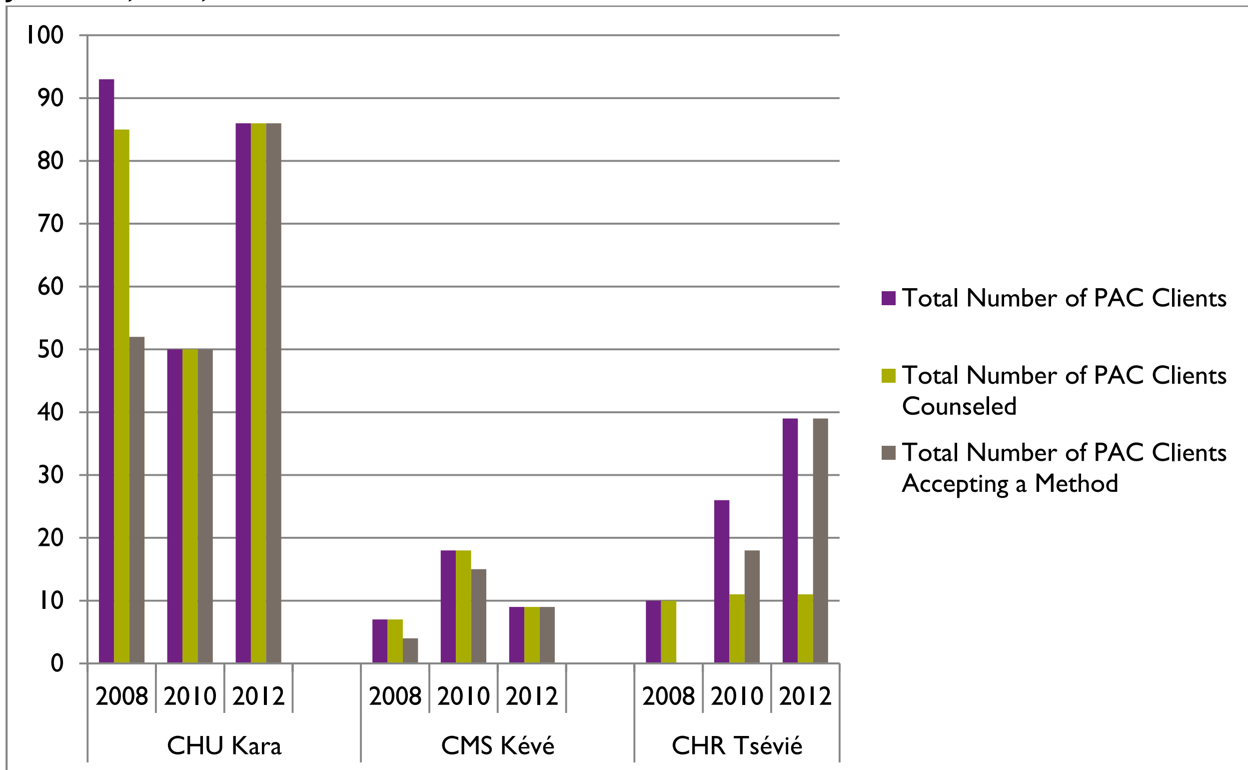
> "*My supervisor proposed a model at the beginning, but when I went to Lomé I wanted to know what the CHU-Sylvanus Olympio register looked like. I was inspired by that model and adopted it following the consent of my supervisor.*"
>
> FGD: CHU Kara, OB/GYN

Three of the four health facilities were able to successfully create and maintain PAC client registers. Of the four health facilities, only CMS Adidogomé (which experienced acute challenges providing PAC services) was unable to create and maintain a PAC client register. Of the other three facilities, PAC clients were recorded along with whether they received FP counseling and if/which method they chose to accept. Since no national PAC register exists, all entries were hand-written and this caused challenges in terms of consistent data recording.

PAC Client Register Data

In order to gauge progress in this area, E2A's assessment team gathered PAC statistics at three facilities (CHU Kara, CHR Tsévié, and CMS Kévé) offering PAC services. Prior to the conference in Saly, Senegal, over a six-month period of time from January to June 2008, 110 PAC clients were seen at the three selected facilities, though only 56 of these PAC clients had accepted a method. The implementation of the action plans, following the completion of the VFCP 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). Although the number of PAC clients who had received FP counseling remained flat, at 102 in 2008 and106 in 2012, the number of the PAC clients who had accepted a method increased by 139% from 56 (2008) to 134 (2012) (Graph 4).

Graph 4: PAC-FP Client Register Statistics from CHU Kara, CHR Tsévié and CMS Kévé, January – June 2008, 2010, and 2012



Contraceptive Methods: Availability and Uptake

Service statistics from the PAC registers illustrate that although oral pills was the most preferred method in the three facilities, the other methods accepted were injectables, implants, and IUDs. CHU Kara PAC statistics revealed a good method mix available at point of treatment, as illustrated by the 2008 data (Table 7); however, in subsequent years, the preferred, and albeit only, method chosen at point of treatment was oral pills. This could be due to the availability of FP supplies at point of treatment 24/7, financial constraints, or referrals to the FP unit during normal business hours. Meeting the needs of PAC clients outside of normal business, acknowledged as a predicament, was addressed through 24/7 availability of temporary methods at point of treatment.

> *It (…FP services…) is not an emergency service, and the service providers assigned for FP cannot be here on Saturday or Sunday. So once we are done with our part, we can only offer a temporary method."*
>
> FGD: CHU Kara, Obstetrician

Interestingly, the CHU Kara data, during the January to June 2010 and 2012 periods, illustrate that the only method accepted was oral pills. The situation was different in CHR Tsévié and CMS Kévé, where despite concerns for confidentiality among youth that constrained method acceptance, data from the client registers depicted a good method mix (Table 7).

> "*Since most of the girls coming for PAC are students, for confidentiality reasons they don't like methods like Jadelle; they prefer IUDs and pills so that no one finds out."*
>
> FGD: CMS Kévé, Midwife

Table 7: Frequency Distribution of Contraceptive Method Uptake by PAC Clients from CHU Kara, CHR Tsévié, and CMS Kévé (2008, 2010, and 2012 [January – June])

Method type %	CHU Kara			CMS Kévé			CHR Tsévié		
	2008	2010	2012	2008	2010	2012	2008[1]	2010	2012
Abstinence	4	-	-	-	-	22.2	-	5.6	10.3
Condoms	2	-	-	25	6.7	-	-	50	46.1
Oral Pills	90	100	100	-	40	22.2	-	38.9	12.9
Injectables	2	-	-	25	6.7	22.2	-	5.6	23.1
Implants	-	-	-	-	40	22.2	-	-	7.7
IUDs	2	-	-	50	6.7	11.1	-	-	-
Tubal Ligation	-	-	-	-	-	-	-	-	-
TOTAL (n)	52	50	86	4	15	9	0	18	39

1: Register began in May 2008

Cost of Postabortion Care

Women's inability to pay for treatment and FP methods was cited as a major barrier for PAC clients seeking help. The senior management champion at the CMS Kévé facility explained all the costs incurred for a PAC client before opting for a FP method:

> "*She needs to pay first the admission fees and the card, all costing 400 CFA. After she is examined, we order suction materials for her and it costs money. Simple cases pay between 10,000 and 15,000 CFA. This represents a limitation to many of our patients.*"[i]
>
> CMS Kévé, Senior Management Champion

Facilities practiced different approaches to make services more financially accessible to their clients, as in the case of CHU Kara:

> "*Since 2010, we have eliminated curettage and we practiced only MVA. The problem that we encountered then was the cost. We had a meeting with the administration and we decided to lower the price to 10,000 CFA, including all PAC components.*"
>
> CHU Kara, Senior Management Champion

Despite lowering the cost of PAC services for clients, the price still remained high for the most vulnerable women. When all else has been exhausted, some providers even pay out of their own pockets to help provide services to clients, as one midwife at CHU Kara explained, "*the gynecologist is trying to find us a budget for the material, just a small amount for some materials. We donate from our own money to get the work done out of obligation to our needy sisters*" (FGD: CHU Kara, Midwife).

[i] At the time of the assessment, 100 CFA was equal to about $ 0.21 USD.

As previously discussed, women are frequently asked to come back to facilities for an FP method during their follow-up visit to check for complications, but monetary concerns also play a role sometimes. "*We do the counseling (FP) after the MVA. If they have the means (money), they receive FP on the same day; otherwise, they come back later. Generally speaking, we ask her to come back on the eighth day"* (FGD: CHR Tsévié, Midwife). However, concerns were expressed that women not experiencing a complication tend not to come for the follow-up visit simply to accept an FP method due primarily to additional transportation costs incurred. *"Most of our women come from afar and they will not travel 90 km for a service that costs 1,500 CFA"* (CHU Kara, Senior Management Champion).

The cost of FP methods also influenced women's method choice, particularly regarding long-acting methods. As one provider explained, "*women prefer injections over implants because of the cost, because the injections cost 1,000 CFA while Norplant costs 3,000 CFA*" (FGD: CHR Tsévié, Midwife).

Supervision

Both external supervision of the health facilities by DSF and internal supervision within the facilities were identified as important aspects for successful PAC-FP implementation. From the perspective of senior policymakers, supervision was vital to ensuring PAC services were being carried out appropriately. *"We had to do supervision… it was from supervision centers that had been able to identify problems and needs with PAC…*" (Senior Policymaker). Supervision was also seen as important for identifying and solving specific issues with implementation, such as the need for retraining personnel. Although initially DSF was able to conduct regular supervisory visits, eventually resource restrictions began to impede these trips. Inside the health facilities, internal supervision, while articulated in the action plan, was not implemented effectively. "*There is a lack of follow-up/supervision,*" remarked the CHR Tsévié senior management champion.

Training of Service Providers

The trainings conducted in early 2010 by RESPOND reinforced PAC skills and expanded the pool of personnel able to provide PAC treatment, as one management champion explained:

> *"I can say that there is net improvement in PAC service offering since our training in 2010. Previously, there was no one but the midwife who offered the service, but now there are three of us doing it."*
>
> CMS Kévé, Senior Management Champion

Unfortunately, not all providers at the health facilities were able to attend the training, and staff turnover meant that sometimes it was not possible to provide the full package of PAC services. This lack of sufficient trained personnel hampered the ability of the health facilities to provide consistent PAC services, 24 hours per day, 7 days per week. One midwife explained the need for more trained personnel to keep up with demand, saying "*the number of patients has been increasing and they are not feeling at ease in these crammed rooms. Work is non-stop and we need more personnel…" (*CHU Kara, Midwife). Even when adequate personnel had been trained, the lack of appropriate space, MVA kits, and FP commodities was very discouraging to some health providers, as one senior management champion explained:

> *"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."*
>
> CMS Adidogomé, Senior Management Champion

Supply Chain Management

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 replenish worn out kits. As one senior OB/GYN explained:

> "*…at the end of training, we offered them an intrauterine manual suction kit…We told them that the purpose of these kits is to get them started in practice in order not to lose what they have learned. Each facility needed to secure the continuity of service providing depending on their own means."*
>
> Senior OB/GYN

MVA Kits

In order to secure an adequate supply of MVA kits to meet the demand for PAC services and replace suction kits as they broke/wore out, health facilities turned to alternative sources (ATBEF and UNFPA). "*We have two manual vacuum aspiration kits offered by the United Nations Population Fund…"* (Senior Management Champion, CHR Tsévié). 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. As a facility receiving a high number of PAC clients a year, CHU Kara experienced particular difficulties resulting from an inadequate supply of MVA kits:

> "*We have a total of two kits which we have been using for six months. Not only do these two kits not meet the 25-50 cases standard, but sometimes we have such an abundance of cases that they barely meet the demand.*"
>
> FGD: CHU Kara, Medical Assistant

The senior management champion at CHU Kara echoed this concern regarding MVA kit shortages saying, "*we have turned away complicated cases due to the simple fact that equipment (MVA) was not functional. When a kit is out of service and we are forced to use it, it takes more time and creates risks for the patient."*

Family Planning Commodities

Equally important to the provision of integrated PAC-FP services was the continuous availability of contraceptives at point of treatment. Maintaining adequate supply of FP methods, however, presented somewhat less of a challenge than that of the MVA kits. At CHU Kara, one midwife stated:

> "*I can say that down here we manage so as not to have any shortage of supplies. If there is any, it has happened mostly at a higher level (central pharmacy). Last year, we had a shortage of Jadelle because we overused it a little. When we ordered it, we found that the shortage was at the next level, but it didn't take longer than a week for us to receive our needs."*
>
> FGD: CHU Kara, Midwife

Other facilities were not as fortunate in maintaining a continuous contraceptive supply, particularly of the more popular methods. The senior management champion at CMS Kévé explained that "…*we have had shortages of pills and implants."*

National Policies, Norms and Protocols

Aside from demonstrable results, one critical operational success of implementing the action plan was the inclusion of PAC into the national RH PNP by senior policymakers at the DSF. Despite this achievement, policymakers recognized that simply including PAC as a component in the PNP for RH was

insufficient and more needed to be done to strengthen PAC services within Togo. A 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.

Community Awareness

The need for raising community awareness around PAC and FP services was well articulated in the 2008 Saly and VFCP action plans and reiterated during KIs and FGDs conducted at the four health facilities. This desire for a community approach was meant to be two-fold, focusing on informing the public at the community level about PAC and FP services available at the health facilities, and creating a link between the health facilities and community health workers (CHWs).

Attracting media attention and involvement was identified as one way to inform the public about PAC-FP, "*… we need the involvement of the media to raise awareness about postabortion care*" (FGD: CMS Adidogomé, Midwife). As in many other West African nations, radio is a popular and effective way to reach the population with information, but barriers were encountered when attempting to implement this component of the action plan. Although CMS Kévé was initially able to do a few radio shows, all facilities experienced problems with financing and eventually the broadcasts ended. "*We do not have the resources to conduct mass awareness campaigns to the population on PAC…*" (FGD: CHR Tsévié, Midwife).

Although not specifically identified in the action plans, the importance of involving CHWs in linking women in the community with PAC services was a frequently recurring topic among KI and FGD participants. "*Previously, postabortion care did not take place in health facilities, so the current role of CHWS is to inform populations that the PAC services are now available in the health centers*" (FGD: CMS Adidogomé, Midwife). Unfortunately, CHWs were not significantly involved in efforts to strengthen PAC services due to lack of financing and supervision.

Other challenges to advancing the role of the community in PAC-FP services included sensitivity around discussing the issue. As one key informant warned, "*…we should not do much publicity about PAC; otherwise, we will have problems with the church. We should implement PAC very naturally without too much publicity*" (Senior Policymaker).

Male Involvement and Youth

While there were no activities listed in the action plan related to increasing male involvement, health providers talked about male involvement as important for successful service delivery. When asked about the general habits of men accompanying their wives to the health facility to access services, one midwife at CHR Tsévié explained, "*it is mostly urban women who are accompanied by their husbands. In rural areas, few men accompany their wives to the hospital.*" As it is often the husbands that control household finances, their presence can determine whether a woman ultimately obtains postabortion services or an FP method. At the CMS Kévé facility, one delivery attendant described how health providers had tried to get men more involved. *"Sometimes we go to the men to encourage them to come to the facility, but they don't come."* Another explained, *"they say that when they come, we ask them for a lot of money."* Despite these challenges, things may be improving with regards to male involvement; one midwife at CHR Tsévié was happy to share:

> *"I would like to emphasize that support for women by their husbands in health facilities is increasing more and more, even to the ANC (unit), they come."*
>
> FGD: CHR Tsévié, Midwife

Providers also brought up young people and postabortion care. Although clinic registers did not necessarily indicate an overwhelmingly young population accessing PAC treatment and counseling (highest recorded in clinic registers was 22% at CHU Kara in 2008), youth concerns drew the attention of policymakers and health providers—the need to educate them about FP to avoid unintended pregnancy. The senior management champion at CMS Kévé commented that:

> *"We are suggesting that action should be taken in terms of FP at the youth level, since they form the larger portion of PAC cases. Rarely do we see housewives (older/married women) among these cases."*
>
> CMS Kévé, Senior Management Champion

CMS Kévé was one of the facilities that described their involvement with youth education, although they had experienced some challenges with implementation:

> *"…we are doing dialogues/debates in certain schools to spread information about FP and other things; we sometimes distributed condoms during these activities. As time passed, we had to negotiate with the managers of these institutions (directors and principals) because they told us we needed to change the way we do things. This has blocked our efforts …"*
>
> CMS Kévé, Senior Management Champion

The challenges faced by CMS Kévé involving youth and FP discussions were not unique; the issue of stigma around young people, PAC, and FP was evident in other facilities as well. One senior OB/GYN explained the stigma that exists this way:

> *"… whenever there is a case of abortion, people in rural areas mostly think of it as induced; the involved woman is badly looked at, especially if she is a young girl. Her intentions are questioned, since she aborted herself. She is ill-treated in her community, subjected to moral and psychological violence, rejected, and deprived."*
>
> Senior OB/GYN

Health providers were concerned about stigma around young girls accessing PAC. A senior management champion at CHR Tsévié commented, *"in general, when a young girl undergoes an abortion, people tend to think it is an induced abortion. Even service providers used to think so before their training, but now they better understand and they assist them."* Although this stigma persists, providers and policymakers continue to fight it. One success has been the passing of legislation that protects young people's rights to contraception as one senior policymaker described:

> *"…at the community level CHWs offer contraception to everyone, including young people. To do this, all providers are protected by the Law on Reproductive Health that was passed and signed by the Head of the State."*
>
> Senior Policymaker

Country Feedback

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 be mobilized to ensure the creation of a PAC room, or alternatively, a private space 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. This would likely improve client uptake, as one senior policymaker explained, "*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."*

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. As one senior management champion at CMS Kévé said, "*we need to be able to provide free FP to PAC clients.*"

Box 13: Togo Key Findings

Reorganization of services:

- Created separate PAC room in a facility; other facilities faced space constraints
- Achieved some progress in offering FP counseling and methods at the point of treatment

Training:

- Trained in-service providers for MVA, infection control, and FP counseling and services
- PAC component included in the national RH policy

Supply chain management:

- Selected FP commodities available at point of treatment
- Functioning MVA kit stock-outs at facilities providing PAC services

Health information systems:

- Informal PAC client registers; inadequate record keeping
- Strengthen data utilization at facility and national level
- Introduce standardized national PAC register

Financing:

- Cost of FP methods, especially LARCs, high
- Reduce or eliminate costs for FP methods

PAC client register:

- Most PAC clients (79%) received counseling
- All counseled PAC clients accepted an FP method, principally oral pills

Leadership and management:

- Strengthen internal and external supervision
- Continue and strengthen community awareness programs
- Introduce youth-friendly PAC programs
- Create a national PAC plan

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. One senior policymaker explained the need this way: "*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.*"

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.

3.4.4 Conclusion

Togo achieved considerable success in improving PAC services in the target facilities by training and reorganizing PAC services as well as including PAC in national RH PNP. Sustaining these achievements and scaling up PAC services should be pursued within existing DSF strategies or in cooperation with national RH 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.

4. Conclusions

The assessment findings from the four countries reflect different stages of PAC service program maturity. Senegal, the most mature program, implemented its PAC strategy in the mid-1990s, whereas Togo, the least mature program, rolled out its PAC strategy in the mid-2000s. Each of these four countries drafted action plans based on their respective country evidence that was presented at the 2008 Saly, Senegal workshop.[22] Burkina Faso, Guinea, and Togo were led through the process of action plan revisions via the VFCP for PAC (Senegal's country team did not complete the VFCP for PAC). By and large, the 'virtual' component of the Fostering Change scale-up approach was challenging due to Internet connectivity, computer availability, and participant workload that prevented hosting meetings and completing homework assignments in a timely fashion. Nevertheless, all countries implemented PAC programs with varying degrees of success. This section synthesizes the assessment results across the four countries to distill the achievements, challenges, and barriers to the effective implementation of the action plan activities to strengthen FP counseling and services for postabortion clients.

Reorganization of PAC services to ensure curative services and preventative FP counseling and services at the point of treatment was operationalized by addressing 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. Regional, national, and teaching hospitals were able to designate a room for the provision of PAC services in all four countries, indicating that assigned room/space was made available at larger facilities. The lower level facilities, at district and sub-district level, were particularly challenged to designate a separate PAC room, despite concerted efforts by Togo and Burkina Faso maternity staff as described earlier. The findings also depict that these challenges were overcome in Guinea where the PAC senior management champion and Jhpiego were successful in designating separate PAC rooms in each of the target facilities. These findings demonstrate that while space is very limited at lower level facilities, adjustments can be made to accommodate either a separate room or at minimum, ensure privacy for the PAC client. Across the four countries, PAC clients received FP counseling at the point of treatment, though universal counseling to PAC clients in the target facilities was only recorded in Guinea. This indicates that concerted efforts need to be made to reorient maternity staff to offer FP counseling as part of a standard package of services for PAC clients.

Provision of FP methods at point of treatment was perhaps the most significant barrier encountered in attaining comprehensive reorganization of PAC services in all countries except Guinea. The other countries faced barriers that were largely reflective of implementation of the policy emanating from the Bamako initiative—after receiving MVA treatment and FP counseling, clients were given a prescription for their chosen method and directed to the facility pharmacy to purchase it, before having to return to the provider to have the method administered. This policy; the physical separation of the PAC, FP, and pharmacy units; as well as the availability of FP services only during normal business hours were three challenges that Burkina Faso, Senegal, and Togo consistently faced. Guinea, also a Bamako initiative country, overcame these challenges by successfully negotiating with the facility and pharmacy management team in each facility to agree to keep FP methods in the assigned PAC room. Oral pills, the least expensive contraceptive method, were available at the point of treatment in all countries. The service delivery improvements demonstrated by Guinea are a significant achievement that can serve as a learning experience for other countries.

Across the four countries, FP methods were not free. Clients, including PAC clients, had to purchase their selected methods, in addition to paying for emergency obstetric and other services. Costs ranged from 200 – 300 CFA for injectables to 3,000 CFA for implants.[j] The additional costs for any of these

[j] At the time of the assessment, 100 CFA was equal to about $0.21 USD.

methods were an added financial burden for many PAC clients who had to pay nearly 10,000 CFA for the MVA procedure alone. Maternity staff recommended that costs for FP methods be reduced or eliminated, especially for PAC clients.

Supervision, by facility and MOH supervisors, was acknowledged as important for improving quality of services in all four countries. Senegal's policy for supervisory visits—monthly (district), quarterly (regional), and semi-annually (national) —was problematic in its implementation, largely due to logistics and transportation issues. MOH staff from Burkina Faso and Togo conducted supervisory visits in their respective countries during the earlier phases of program implementation but failed to maintain those visits due to personnel and cost implications. Guinea, on the other hand, through the SBM-R approach, was the most successful among the four countries in instituting supportive supervision in the target facilities.

Countries also moved forward with policy revisions to address PAC as part of pre-service curricula for midwives and doctors. Maternity and MOH staff had received PAC trainings as part of their in-service programs. However, as all maternity staff had not received PAC trainings, PAC was unavailable 24 hours a day, 7 days a week in all facilities. Maternity staff and senior policymakers advocated continued support for in-service trainings to close this gap.

Maintaining a continuous supply chain for essential commodities including contraceptives, MVA kits, and consumables was a challenge in all countries. While progress in all countries was made in forecasting, including the successful pilot application of a "push" commodities system in Senegal, stock-outs of PAC services, especially at the peripheral health facilities, continue. Designing and implementing a facility- or PAC unit-based stock management system was advocated.

Senegal's, Burkina Faso's, and Togo's action plan activities included community empowerment through community mobilization and awareness-raising strategies regarding maternal mortality, abortion complications, emergency referrals, consequences of unintended/unwanted pregnancy, and FP. Senegal's pilot program was successfully scaled up to additional sites. Burkina Faso and Togo invested in mass media and community-based IEC, though these programs were short lived due to funding limitations.

PAC is included in the PNP in all countries, with Togo achieving this milestone since the 2008 Saly meeting. However, implementation barriers were recognized, due primarily to low provider knowledge about protocols and guidelines. This suggests that implementing ongoing trainings (pre-service and in-service) and supportive supervision could ensure more effective implementation.

Standardized PAC client registers distributed by the MOH were available in Burkina Faso, Guinea, and Senegal. While Togo did not have a formal PAC client register, each facility had created a client register modeled on the university hospital register. Guinea made clear efforts to improve completion of registries. While staff from Burkina Faso, Senegal, and Togo recognized the value of good record keeping and data utilization, few concerted efforts were made to improve record keeping in facilities in these countries.

The review of data from PAC registers in the four countries depicted a mixed trend in three key PAC-FP indicators: (1) number of PAC clients who received emergency treatment; (2) number of PAC clients who received FP counseling; and (3) number of PAC clients who accepted an FP method. Registers were reviewed to assess progress before implementation of action plans and during two time periods afterwards (January – June 2008, 2010, and 2012). Statistics from facilities in Guinea demonstrated the most significant improvement. Togo's statistics also illustrated progress: the number of PAC clients increased by 22%, and number of FP acceptors increased by 139%. However, the number of PAC

clients declined in Burkina Faso and Senegal over the study period. Jhpiego's sustained technical assistance likely contributed to Guinea's significant progress, and some technical assistance in Togo perhaps contributed to improving its nascent PAC program. The declining trend observed in Burkina Faso and Senegal might indicate that in countries where the PAC program is more mature, initiatives at lower level facilities and a community component should be emphasized to generate demand for PAC-FP.

The assessment results highlight the achievements and challenges countries have faced in implementing PAC services, irrespective of program maturity. A well-functioning PAC program ensures that PAC clients leaving a facility are counseled and are offered an FP method of their choice, as applicable. Consequently, all contraceptive methods must be available at point of treatment and all maternity service providers must be trained to counsel and administer the client's chosen method. Strengthening service delivery and national health systems to ensure the availability of trained personnel and commodities at point treatment is paramount to reducing maternal mortality and severe morbidity, improving maternal health and achieving Millennium Development Goal 5.

5. Recommendations

The recommendations, grouped according to the major themes addressed in this report, are based on an analysis of the four country assessment findings. The ultimate goal of these recommendations is to provide guidance to policymakers, PAC program managers, stakeholders, and development partners for improving the functional effectiveness of their national PAC programs.

National policies, norms and protocols: Service delivery protocols for comprehensive PAC services should be disseminated to all service providers, and supervisors should ensure that all providers have access to and are using the protocols. The PNP need to be reviewed and updated periodically to ensure application of emerging evidence-based practices and/or new technology.

Reorganization of PAC services: It is important for all health facilities that provide PAC services to have a separate room or service area where clients can receive emergency treatment for abortion complications, FP counseling, and services in an environment that respects their right to privacy and confidentiality.

FP counseling and services: Countries should make available a broad range of contraceptives, including LARCs. These should be made available at the same location where emergency treatment for abortion complications is offered, regardless of method of treatment. This will meet the variety of reproductive needs of clients, foster voluntary informed choice, and ensure that an appropriate contraceptive method can be initiated immediately before discharge if the woman chooses to use one.

Additionally, mechanisms to ensure continuity of care should be developed or strengthened, implemented, and monitored to ensure that clients receive follow-up after PAC and are supported to continue with FP services. Referral mechanisms should be encouraged for clients to access follow-up for PAC and continuity of FP services to health facilities nearest to the client's home.

Male involvement and youth: As much as possible, service providers should, with the client's consent, involve a woman's partner during counseling for FP to help increase uptake of FP methods. In countries that have a high demand for PAC among youth clients, there is need to design youth-friendly PAC services and train providers in these services in order to meet the special needs of young people.

PAC client registers: Supervision should include ensuring quality in the maintenance of PAC registers and monthly returns that are submitted to the national PAC program. Service providers and national program managers should be oriented on use of data for decision-making to improve the PAC program and service delivery.

Training: In order to improve access to comprehensive postabortion services on a 24 hour per day, 7 day per week basis, all service providers that work in PAC service delivery must be trained on PAC and FP service delivery. Protocols and other materials to support providers' skills should also be provided. Trained providers and supervisors could conduct on-the-job training for colleagues as one approach to low-cost scale-up of training. Pre-service education of midwives and doctors should also be strengthened to ensure acquisition of skills in treatment and FP counseling and service provision. Supervisors should assess and document providers' skills while offering treatment, counseling, and providing FP methods at least once a year. This will help identify training needs and additional supportive supervision.

Supervision: Training alone is not enough; trained service providers should receive routine monitoring, supportive supervision, and refresher training to continuously improve performance and quality of services. On-site facility supervisors should be oriented to PAC service delivery protocols, record keeping, logistics, treatment procedures, FP counseling, and method provision to enable them to implement quality and performance improvement activities as necessary. External district, provincial/regional, and national supportive supervisors should monitor and reinforce use of service delivery protocols.

Supply chain management: MVA kits should be included in national procurement plans as part of the logistics system of RH/FP supplies and commodities. There needs to be advocacy for resources to procure MVA kits. Sufficient quantities of MVA syringes and cannulas must be made available at each service delivery point. The actual number of kits needed at any one health facility will depend on the estimated client load of the health facility.

User fees for postabortion care: The MOH should review charged fees for postabortion services and contraceptives to ensure that they are more affordable for all women (and possibly free for the poor), in order to increase access to PAC-FP services, including more expensive methods such as implants. This will help ensure that clients obtain a method of their choice and reduce the risk of repeat unwanted pregnancy and abortions.

Community mobilization for PAC: Countries should develop strategies to reach communities with messages that create awareness of abortion complications as a major cause of maternal mortality, importance of seeking health care early, and use of FP for healthy timing and spacing of pregnancy to prevent unplanned pregnancies.

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Annex: Virtual Fostering Change Program for Postabortion Care

A Virtual Fostering Change Program (VFCP) platform was adapted for PAC as a follow-up to countries participating in the 2008 workshop 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 programs, namely emergency treatment of abortion complications, postabortion FP, and community empowerment. During the VFCP for PAC process, action plans were revised and participants were trained on leadership and management skills. Two reproductive health experts, from MSH and Jhpiego, facilitated the program, with the USAID PAC Team Leader serving as the program champion.[i] The facilitators led participants through several fostering change modules in addition to other co-operating agency staff that provided technical guidance.

The VFCP for PAC was concurrently implemented in four countries. The VFCP program encouraged team work, regular meetings, program implementation, management skills, and problem-solving. For example, the VFCP participants were encouraged to constitute a country team from a broad group of relevant stakeholders who would oversee the process of the Action Plan acceptance by the MOH. As one of the facilitators explained:

> "*…they were advised to identify people from all stakeholders, for example ministry of health, service providers, program managers, USAID, WHO, UNFPA, all those organizations. They have to have a team, a team to work on this VFC program*"
>
> VFCP Facilitator

This process resulted in the drafting or refining of Action Plans targeted at improving PAC services within certain pilot facilities. Although each of the four countries participated in the process and were able to take away some learning from their involvement, all of the countries experienced a variety of challenges that ultimately prohibited full participation and success. As a result of these challenges, USAID made the decision to end the program following the introductory period. USAID partner organizations gave continued technical assistance through additional funding to teams from Togo, Burkina Faso and Guinea.[ii] In addition, remaining funds from the VFCP for PAC were utilized to conduct a 'face-to-face' training in Togo on change management and leadership development. Below is a description of the VFCP for PAC implementation process, successes and challenges faced in each of the four countries.

Senegal: During the initial VFCP for PAC implementation process, the country team was composed of representatives from the MOH as well as CEFOREP and other nongovernmental organizations. Due to a range of inherent barriers that prevented continued participation in the VFCP for PAC program, in May 2009, the Senegal country team opted out of the VFCP. Competing job responsibilities were one of the hindrances identified to organizing meetings, low meeting attendance and completing homework exercises. As one of the country team members explained:

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[i] Nilon E. *Final Report: Virtual Fostering Change Program for Postabortion Care Teams in Francophone Africa January 26, 2009 - March 19, 2010* (Leadership, Management and Sustainability Project; Management Sciences for Health, June 2010).

[ii] Ibid.

> "…..*on the outset, all members did participate. And the Institute for Social Hygiene was taken as headquarters. But then, the Ministry of Health faced some difficulties in ensuring the coordination process…. at times they invited the team late or never managed to invite the team. The coordination was not very good maybe because it PAC-FP at the time was not a priority of the ministry and everyone was too busy to attend the meetings and do the exercises. We met a few times though but if failed*"
>
> Cooperating Agency, Country Team Member

A further contributing factor was a VFCP principle - each country team member completes all assignments - in order to graduate. As all team members either did not participate or complete their homework, the inability to graduate and receive certificates contributed to low morale. One country team member described that since some team members had no time to complete the homework or participate fully in the exercises, the ones who were working lost motivation. Other challenges articulated by country team members included designating a focal person in the MOH to coordinate the action plan activities, elaborating the team members' terms of reference in addition to their specific roles and responsibilities. Overall, the VFCP program was deemed a '*good program*' though addressing barriers to successful implementation mentioned earlier and including face-to-face meetings were recommendations expressed by key informants.

Guinea: The country team members that participated in the Saly 2008 continued with the VFCP roll-out with the exception of one member. The team received sustained technical support from Jhpiego, but despite this assistance, challenges remained. Many of the team members were relocated and/or transferred to other positions, so they had to reform the team. This ultimately delayed finalization and implementation of action plan activities as it took time to find new members and then revitalize regular meeting. Other challenges included the lack of dedicated computers, periodic electricity outages, team member availability and completion of the homework assignments. Scheduling challenges and workload were repeatedly cited as barriers to full participation in the VFCP for PAC. As the senior management champion at CMC Miniére described, "*I preferred being at the clinic and taking care of my patients*" (CMC Miniére, Senior Management Champion). Despite these challenges, a Senior Ministry of Health policy maker was appreciative of the learning and commented that the "*VFCP was worthwhile, and it has greatly helped me bolster my own credentials*"

Togo: The Togolese country team was comprised of several key members, including two senior policymakers from the DSF, one senior OB/GYN, and a representative from the WHO. Working together through the VFCP for PAC platform, they further refined the Action Plan which had initially been drafted at the 2008 Saly meeting. Like the other countries, Togo also experienced similar challenges. The VFCP required participants to communicate via Internet which proved challenging, particularly for the two team members who were outside of the capital. As one participant explained:

> *"….but at one point I could no longer have access to this site (VFCP). I do not know if this is the code that has been changed or what, but it really bothered me. Yet everything about PAC, the management and leadership, it was on the site."*
>
> CHU Kara, Senior Management Champion

Ultimately, the internet access barrier prevented full collaboration between the VFCP team members, although two country team members were able to rally and complete the modules. The Togo team benefited from a 'face-to-face' leadership and management workshop facilitated by MSH.

Burkina Faso: Active participation of the country team members proved to be a significant challenge. Only two of the five country team members that participated in Saly, 2008 continued with the VFCP roll-out and an additional three members were recruited including one doctor from each of the two

target facilities (CHU- YO and CMA Sector 30) and a MOH policy champion for Safe Motherhood. Technical assistance to the country team was provided by EngenderHealth.

Participation in the VFCP program was fragmented - country team members recollected their participation in sessions sporadically. Unavailability of team members due to work pressures, travel and dedicated time, were expressed as the major reasons for poor participation. As one VFCP participant explained:

> "*There were many limitations related to availability of the members. How to find time to get together? Since we do not work at the same place, when one is available, the other is not, and another is travelling, so we were not able to maintain the dynamics to convene together*"
>
> WHO, Maternal Health Officer

Internet connectivity and access to computers were also raised as other challenges for the VFCP for PAC implementation. Participants explained that the Internet is slow most of the time; furthermore some people weren't able to have access to a functional computer to access the VFCP. Another significant limitation expressed by the country team was the VFCP heavy work load that made meeting the demands of the program and maintaining their busy professional jobs difficult.

Despite these challenges, policy makers, senior obstetrician and facility champions expressed some satisfaction with the program. Specific learning opportunities expressed included being part of a global community, accessibility to technical experts, and leadership and management tools.

In summary, all of the countries that participated in the VFCP process offered some positive feedback on the experience, but despite these aspects, the challenges teams faced ultimately prevented full participation. Difficulties with internet connectivity, geographic distance between team members, and other competing tasks hampered the successful execution of the VFCP process for PAC.

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