Agir pour la Planification Familiale

PROJECT BRIEF NO. 7 · APRIL 2017

Using Baseline Data to Develop an In-Country Strategy for Improving Family Planning Use and Service Delivery in Togo

BACKGROUND

Ensuring access to quality family planning (FP) services is a key aspect of national efforts in Togo to reduce maternal mortality rates, which are among the highest in the West African subregion, with 401 maternal deaths per 100,000 live births (MPDAT, MS, & ICF International, 2015). The World Health Organization (WHO) states that globally, satisfying the unmet need for FP alone could reduce the number of maternal deaths by almost one-third (WHO, 2015). Unmet need for FP in Togo is 34% (MPDAT, MS, & ICF International, 2015). In addition, the Togolese Government's Act No. 2007-005 of January 10, 2007, on Reproductive Health in Togo entitles all women and girls of reproductive age to have access to information, education, and family health services.

In 2013, to support advancement toward this critical development goal, the United States Agency for International Development (USAID) West Africa Regional Health Office awarded a five-year, $29 million project, Agir pour la Planification Familiale (AgirPF), to EngenderHealth, with its core partner, Avenir Health (formerly the Futures Institute). The goal of AgirPF is to enable individuals and couples living in selected urban and peri-urban areas of Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo to make, and voluntarily act on, informed decisions about FP. To create precise, realistic, and attainable goals and successfully implement sexual and reproductive health (SRH) activities in Togo, AgirPF carried out a baseline assessment study from March to June 2014.

METHODS

Aim and Objectives

Between March and June 2014, AgirPF conducted a baseline assessment study in Togo to help inform future project programming, provide a benchmark for comparisons over time, and identify priority areas and existing strengths and best practices on which to build.

Design, Methods, and Sample

The study incorporated a quasi-experimental design, including a nonequivalent nonintervention group. Study groups ("zones") included facilities and their catchment populations. The study consisted of five data collection elements: a randomized household survey of men aged 15–59 and women aged 15–49; a facility survey of all intervention facilities and a matched sample of control facilities; a survey of all providers present at the facility

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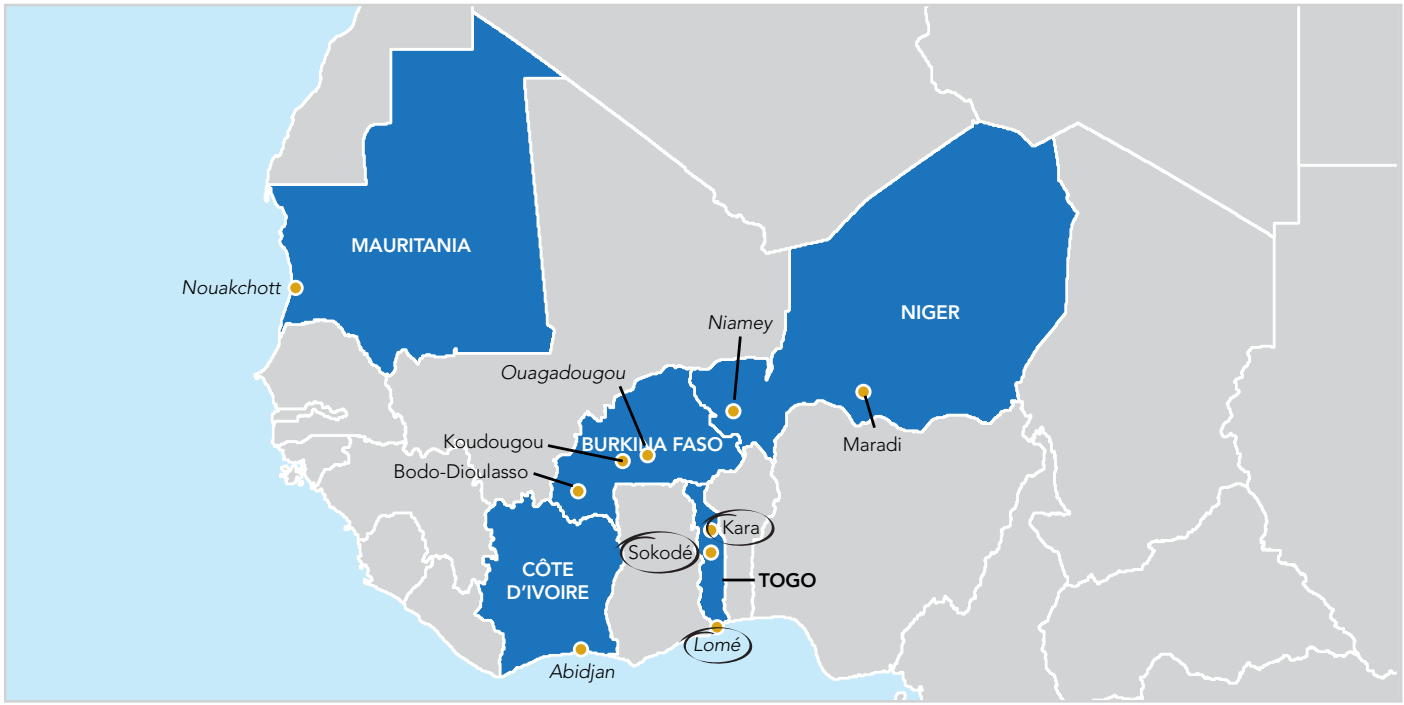
Figure 1: Among AgirPF focus countries and cities, intervention cities in Togo



on the day of the facility assessment; key informant interviews with members of the district management team and with staff of civil society groups and nongovernmental organizations (NGOs); and a survey of every other community health worker associated with a study facility. More complete information about the methods, key variables, and study samples can be found in the full baseline report (AgirPF, 2015).

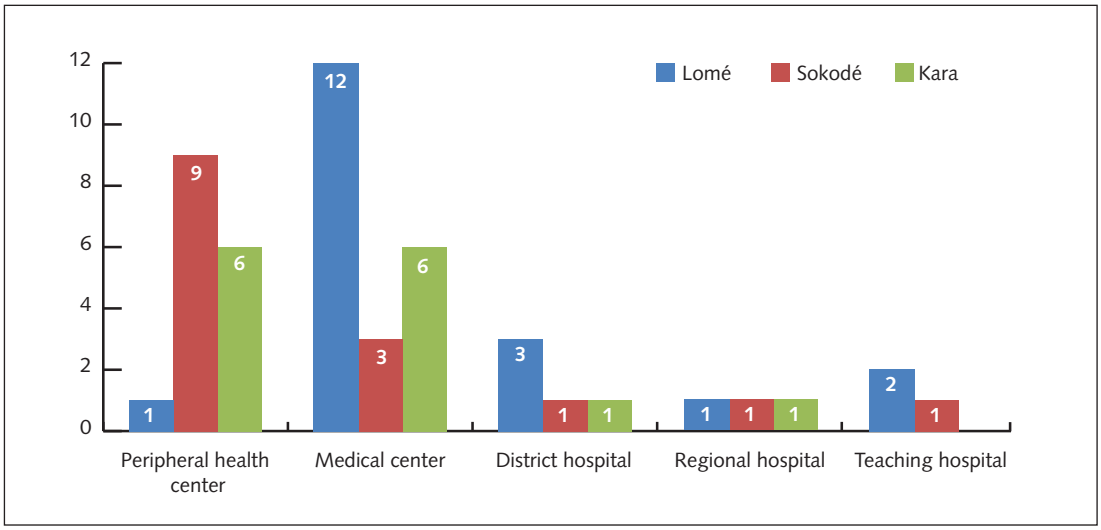
The study was reviewed by the Western Institutional Review Board and the national ethics committee, the Comité de Bioéthique pour la Recherche en Santé (CBRS). Each study participant provided written informed consent before any interview was conducted. Participants' names and other identifying information were not collected. Data collection, data management, and preliminary analysis were conducted by Unité de Recherche Démographique of Université de Lomé. During data collection, AgirPF staff conducted regular monitoring with field visits.

The baseline research was carried out in three cities in Togo: Lomé, the nation's capital; Sokodé, the capital of the Centrale Region; and Kara, the capital of Kara Region (Figure 1). Out of 117 public health facilities in these three cities, there are 48 intervention sites—19 in Lomé, 14 in Sokodé, and 15 in Kara (Table 1). The proportion of the total local population served by AgirPF intervention sites ranges from 71% in Lomé to 45% in Sokodé.

Table 1: Background information on Togo health facilities covered by AgirPF, by city

	Lomé	Sokodé	Kara
No. of AgirPF intervention sites	19	14	15
Total no. of public health facilities	34	30	53
% of all sites covered by AgirPF	55.9	46.7	28.3
Population served by AgirPF sites (no.)	1,256,664	97,329	173,469
Total population	1,770,273	214,160	273,035
% of total population served by AgirPF sites	71.0%	45.4%	63.5%

Figure 2: Distribution of AgirPF intervention sites, by type and city



A total of 43% of intervention facilities are medical centers, and 33% are peripheral medical centers (Figure 2). Intervention sites also included a small number of teaching hospitals (6%), regional hospitals (6%), and district hospitals (10%). Nonintervention sites were either peripheral health centers (63%) or medical centers (38%) (not shown).

RESULTS

Supply

Family Planning and Postabortion Care Services

Intervention sites were more likely to offer contraceptive services and postabortion care (PAC) services overall than were nonintervention sites (Table 2, page 4). The methods offered at 100% of intervention sites were the hormonal implant (Jadelle®) and injectable (Depo-provera). The intrauterine device (IUD) showed the biggest variance between cities, with 95% of intervention sites offering the method in Lomé, 80% in Kara, and 43% in Sokodé.

With the exception of the injectable, which was available at all sites, intervention sites in Lomé and Sokodé were more likely to have FP commodities available than were nonintervention sites. Emergency contraception and the standard days method were available at 36% and 68% of intervention sites, respectively. Female condoms were available at slightly fewer than half of intervention sites in Lomé and Sokodé and at only 13% of intervention sites in Kara. Female and male sterilization were the least-offered methods at both intervention and nonintervention sites (0–11%). Overall, sites in Sokodé generally offered fewer contraceptive services than those in Lomé and Kara.

A lack of supplies was one of the major reasons for not providing oral contraceptives, implants, and male and female condoms in Togo. Lack of staff training, as well as a lack of supplies, was noted as a reason for not providing IUDs and female and male sterilization.

Kara had the highest number of intervention sites offering PAC services, at 73%, followed by Sokodé and Lomé, at 64% and 16%, respectively.

Youth-Friendly Services

Results show that there is a lot of work to be done in terms of improving the youth-friendly characteristics of health facilities. A series of eight characteristics were considered to evaluate how youth-friendly a facility is: having separate operating hours for youth; having a separate space in which to offer youth services; having a separate waiting room for youth; having at least one provider trained in youth-friendly services (YFS); having at least one provider oriented on YFS; having counseling on SRH available for youth; providing services regardless of whether a youth has parental/spousal consent; and providing services regardless of youth's marital status.

Only 0–11% of sites in both intervention and nonintervention areas had a separate space or waiting area for youth (Table 3, page 5). A similar deficiency was the lack of separate hours for youth, seen at only 0–13% of sites. The percentage of staff who received training or an orientation on YFS ranged between 7% and 47% at intervention sites and was lower overall

Table 2: Percentage of facilities offering selected FP and PAC services

Contraceptive method	Lomé		Sokodé		Kara	
	Intervention (n=19)	Non-intervention (N=9)	Intervention (n=14)	Non-intervention (N=7)	Intervention (N=15)	Non-intervention (N=8)
Short-acting methods						
Combined pill	100	89	93	57	100	100
Injectable (Depo-Provera)	100	100	100	100	100	100
Male condom	74	67	79	43	87	88
Female condom	47	22	43	0	13	25
Emergency contraception	68	56	36	14	67	50
Standard days method (SDM)	84	56	36	14	47	13
Long-acting/permanent methods						
Female sterilization	0	0	7	0	7	0
Male sterilization	11	0	0	0	7	0
Implant (Jadelle®)	100	50	100	43	100	63
IUD	95	89	43	43	80	50
PAC services	16	0	64	43	73	50

among nonintervention sites. Counseling for youth was available in 71–89% of intervention and nonintervention sites in all cities. Between 57% and 100% of intervention and nonintervention sites in all cities offered services to youth regardless of marital status and parental/spousal consent.

Enabling Environment

Community Engagement

In Togo, most of the intervention (81%) and nonintervention (67%) facilities held formal meetings on quality of care, while only 42% of the intervention facilities and 50% of the nonintervention facilities had community members routinely take part in these formal meetings. On average, 50% of intervention facilities and 42% of nonintervention facilities had any type of client feedback system. The availability of a client feedback system was similar throughout Togo (see Figure 3).

Availability of Guidelines at Health Facilities

The baseline evaluation also noted the availability of four important reproductive health service protocols: a WHO reference book on family planning; the national reproductive health service protocol; an FP counseling guide; and a sexual violence protocol.

The availability of the four examined national reproductive health service protocols was the poorest-ranking indicator in Togo's baseline study. Of nonintervention clinics, two had the WHO reference book and one had the sexual violence protocol; all three of these were in Lomé. This was the only city

Figure 3. Percentage of facilities with and without a client feedback system

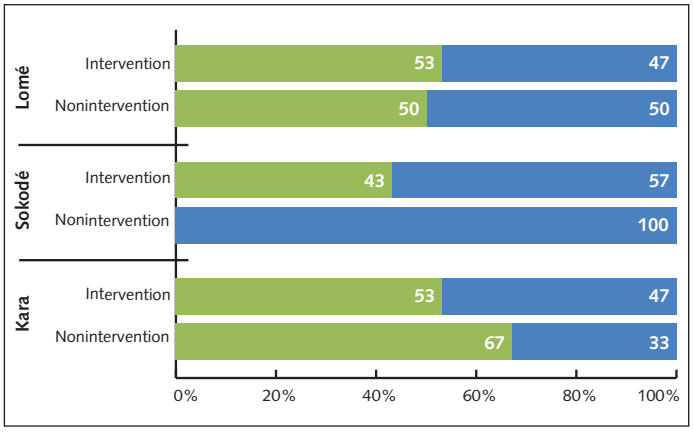
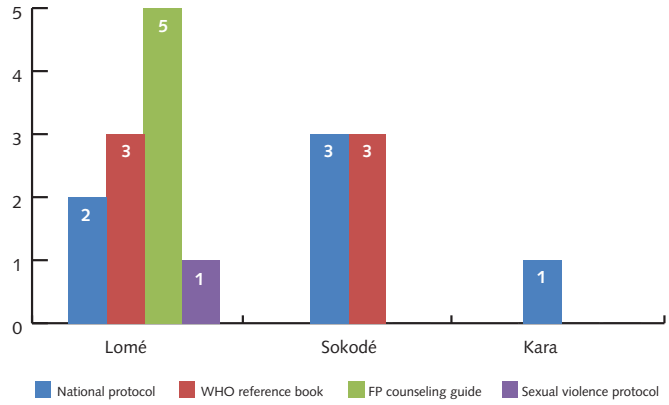


Figure 4. Number of facilities with observed protocols (intervention sites only*)



*Of nonintervention clinics, two had the WHO reference book and one had the sexual violence protocol.

in Togo where each protocol was observed in at least one site. The national reproductive health service protocol was observed in all three cities, at eight out of 48 sites. The resource most lacking was the sexual violence protocol, which was seen at only one site nationwide. No facilities in Togo had all four protocols available. EngenderHealth, through the USAID-funded RESPOND Project, had disseminated national protocols in Haho and Blitta districts, but due to a lack of funding by the Ministry of Health, the produced documents were not disseminated in the other districts of the country.

Demand

Exposure to FP Messages

The questionnaire in the household survey collecting data on exposure to media and FP messages for both males and females included the following sources: radio, television, newspapers, magazines, posters, billboards, leaflets, and community events. The rate of exposure to FP in different types of media was consistent throughout intervention and nonintervention sites, cities, and sexes. The medium with the highest exposure in both intervention and nonintervention sites, for both males and females, and in every city was radio (Figure 5, page 6). Television had the second highest level of exposure. Exposure to FP messages through newspapers was consistently second-to-last, except in Sokodé, where exposure to FP at community events scored higher than newspapers at both intervention and nonintervention sites and among both sexes.

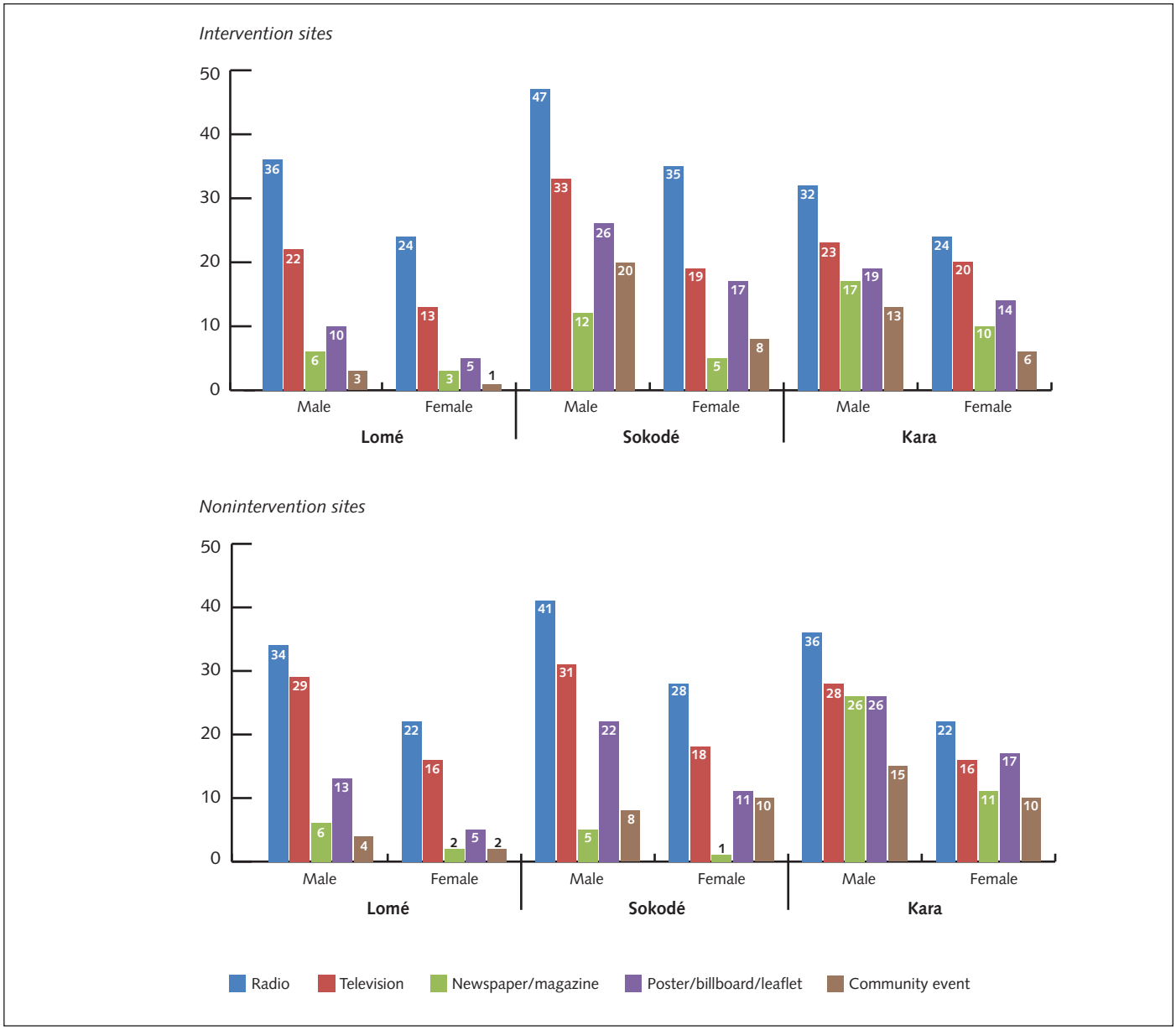
INTERVENTION

Taking into consideration the findings in the baseline study, the AgirPF team in Togo will work to improve FP and PAC services; YFS; community engagement; the availability of guidelines at health facilities; and exposure to FP messages, by conducting the following interventions.

Table 3: Percentage of facilities with youth-friendly characteristics

Youth-friendly intervention	Lomé		Sokodé		Kara	
	Intervention (n=19)	Non-intervention (N=9)	Intervention (n=14)	Non-intervention (N=7)	Intervention (N=15)	Non-intervention (N=8)
Separate hours	11	0	7	0	7	13
Separate space	5	11	0	0	0	0
Separate waiting room	11	0	7	0	0	0
At least one provider trained in YFS	32	56	21	14	47	25
At least one staff member oriented on YFS	21	0	7	0	40	0
Counseling on SRH for youth	89	78	79	71	87	75
Services provided regardless of parental/spousal consent	89	100	71	86	87	100
Services provided regardless of marital status	79	67	100	57	67	88

Figure 5. Percentage of respondents reporting exposure to FP messages, by type of medium, according to type of site



Emphasis on High-Impact Practices

High-impact practices (HIPs) are a small selection of practices in FP that have been identified by a technical advisory group of international experts as practices which, when implemented, scaled up, and institutionalized, will likely maximize investments in comprehensive FP strategy (HIP, 2012; USAID, 2011). Key to AgirPF's success will be to test, scale up, and replicate HIPs in a holistic manner (USAID & K4Health, 2015). Many FP programs focus on increasing the supply of services, in part to meet high unmet demand. However, that is rarely sufficient to sustain long-term use and quality services that meet the needs and respect the rights of individuals. It is also critical to address the resource and policy context within which FP programs operate, as well as the sociocultural environment (RESPOND Project, 2014).

FP and PAC Services

AgirPF will train providers and health center managers in logistics, contraceptive product needs assessment, contraceptive technologies, and procurement of and collection of data about contraceptive stocks (at least one provider and one manager per site). AgirPF will orient 96 providers on USAID FP and abortion requirements about PAC services, as well as build the

capacity of 50 providers to provide FP counseling and services at the same time and same location as women receive PAC services. The execution of the informed push model (IPM) will improve the availability and access of the population to SRH products. The IPM is a distribution model that adapts principles used in commercial distribution to the public health sector. The IPM addresses common supply chain obstacles of transportation, quantification, data availability, and financial flows.

AgirPF will also invest in building the capacity of civil society, private-sector actors, and community health workers to provide FP services. Sexual and reproductive rights and gender will be integrated into technical and counseling curricula for providers. To address issues regarding accessibility, AgirPF will provide a wide range of free FP services and commodities through 180 mobile outreach services and 320 special FP days. AgirPF will build the capacity of 103 providers to integrate FP into postpartum care and routine health services (e.g., immunization contacts). Training systems will be built around the center of excellence model, to have a sustainable local model for capacity building in best practices.

These actions will eradicate stock-outs of FP products financially and sustainably. AgirPF will identify the conditions for extension of other essential products and deploy the IPM to reduce stock-outs of certain identified medications. The tools and competences developed will be used as a best practices model to be replicated in other AgirPF countries.

Youth-Friendly Services

AgirPF will train health care providers and managers on YFS provision in Sokodé, Kara, and Lomé. Youth SRH services will be integrated into universities in Kara and Lomé. After training, AgirPF will help site managers to better organize services for youth (by determining appropriate hours and spaces for serving youth).

By the end of the AgirPF project, at least 20% of intervention sites will offer YFS according to international criteria. In collaboration with the Association Togolaise pour le Bien-Etre Familial (ATBEF), an affiliate of International Planned Parenthood Federation, and ATBEF's youth group, the Mouvement d'Action des Jeunes (MAJ), AgirPF will support the development of a document to integrate SRH services and advocate its incorporation into secondary schools and universities in Togo. Due to the findings of the baseline survey about youth-friendly characteristics, AgirPF will undertake a study to gather more comprehensive data from sites and identify barriers for youth to access health centers. This study will provide data beyond the scope of the baseline and will provide clear targets with which to develop an action plan.

Community Engagement

Site walk-throughs will be undertaken to monitor quality of services and to provide assistance to health center providers and managers to improve service provision. Site walk-throughs allow for:

- Information sharing between community members and health providers
- Monitoring of data quality
- Assurance of transparency of services offered to community partners
- Resolution of problems together with the community
- Engagement with community members to remove obstacles

Availability of Guidelines at Health Facilities

AgirPF will disseminate all four guidelines (the WHO reference book, the national document of policies, norms, and protocols (PNPs), the sexual violence protocol, and the FP counseling guide) at all 48 intervention sites. AgirPF will ensure during supervision visits to the intervention sites that these documents are being used.

Exposure to FP Messages

In collaboration with Camber Collective, social and behavior change FP messages, as well as information on special days and mobile services, will be disseminated to target women, men, and other influencers through various media:

- Posters, flipcharts, and brochures
- A comic book developed for and by youth
- Radio shows discussing FP messages
- mHealth interventions

CONCLUSION

To implement an FP program efficiently, it is important to have detailed data that provide the current level of knowledge about and use of FP services and that also allow adoption of strategies that take into account the strengths and weaknesses of the supply of these services. These data are the foundation of AgirPF and are essential for implementing, monitoring, and evaluating interventions. The data will enable the project to better address weaknesses in the areas of supply of services, demand generation, and the enabling environment. They also will assist decision makers to ensure that planning and implementation match need in the Togo context.

The following are key recommendations arising from the baseline analyses:

- Demand-side barriers to hormonal methods should be investigated, and findings should be incorporate into social and behavior change communication strategies.
- FP providers would benefit from training/ retraining in the provision of implants, the IUD, and PAC. Midwives can be trained to provide manual vacuum aspiration. The majority of facilities also need equipment for PAC services.
- Providers may also benefit from sensitization/ orientation to serving youth.
- Equipment is needed for implant service provision, and supplies of implants need to be improved at the facilities.

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