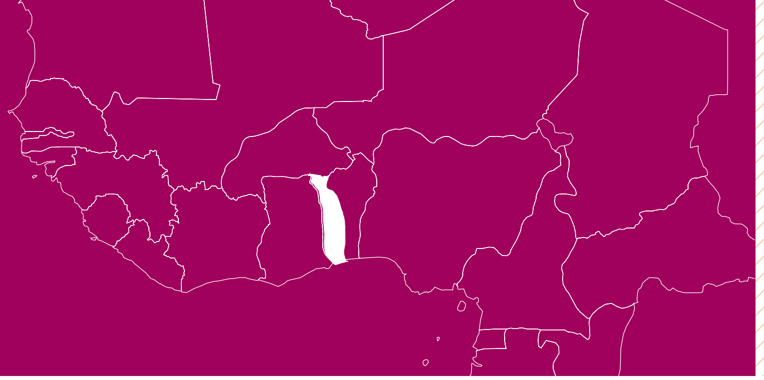
TOGO

PAC-FP COUNTRY BRIEF



Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights te Togolese Republic's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Togolese Republic's national family planning (FP) and reproductive health (RH) policy is included in a number of documents, including: the Law on Reproductive Health (2006); the Policy and Standards in Reproductive Health, Family Planning, and Sexually Transmitted Infections (2009); the National Health Development Plan 2012–2015 (2012); and the Action Plan for Repositioning Family Planning in Togo 2013–2017 (2013). The latter document aims to increase FP demand, improve the quantity and the quality of FP commodities; improve the enabling environment for FP, including through increasing political commitment and funding; and ensure efficient coordination, management, and monitoring of all FP interventions. The primary objectives of the country's FP political strategy are to improve the availability, accessibility, and quality of RH services and to create a social, economic, and legal environment favorable to the RH of target groups.

In Togo, the Ministry of Health's Division of Family Health works to increase access to FP counseling and voluntary methods as part of postabortion care (PAC); it also coordinates all maternal and child health, youth, and nutrition services (Health Policy Project, 2013). While PAC, introduced in Togo in 2006, is included in the country's National Roadmap, strategic documents guiding national scale-up have yet to be developed (Turner, Senderowicz, and Marlow, 2016).

Legal status of abortion

Abortion is illegal in Togo except to save the life of a woman or in cases of rape, incest, or fetal impairment (Singh et al., 2009).

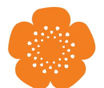
PAC TRAINING AND STANDARDS

Prior to 2010, PAC trainings were available for healthcare professionals in Togo, but they focused primarily of digital or surgical curettage. In 2010, EngenderHealth's USAID-funded Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) project conducted a series of trainings and workshops on PAC service delivery. These workshops—which targeted midwives, doctors, and medical assistants—trained participants to perform manual vacuum aspiration (MVA) to treat incomplete abortions and to counsel clients on FP methods (Fikree, Mugore, and Forrester, 2014a). Additionally, the midwifery school in Togo started providing preservice training on MVA in 2016.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT

Expanding contraceptive methods and informed choice to PAC clients

USAID FROM THE AMERICAN PEOPLE



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Nevertheless, the number of personnel trained to provide PAC is not sufficient to respond to demand. And, when qualified personnel are available, they are poorly distributed across the different levels of the health sector (Turner, Senderowicz, and Marlow, 2016).

STRENGTHENING SERVICE DELIVERY

In 2006, Togo introduced PAC at national and regional hospitals (Dieng et al., 2008). EngenderHealth's USAID-funded Action for West Africa Region Reproductive Health and Child Survival Project (AWARE-RH) project facilitated training for trainers and service providers and provided MVA equipment and contraceptives (Fikree, Mugore, and Forrester, 2014b). The government has also strengthened recruitment and placement of trained midwives in health facilities and ensured voluntary contraceptive methods are available for clients before leaving the health facility following treatment for abortion-related complications. In 2015, Togo began to scale up PAC and expand community-based distribution of voluntary contraceptives and emergency obstetric care activities throughout the country (FP2020, 2016). Nevertheless, Togo does not currently have a multi-sectoral group to coordinate FP activities. A Technical Advisory Committee responsible for contraceptive procurement exists but does not meet regularly (Health Policy Project, 2013).

BARRIERS TO PAC

Women in Togo face multiple barriers in accessing PAC and FP services. The cost of contraceptive services is a major barrier for PAC clients, as many women are unable to pay for FP methods (Fikree, Mugore, and Forrester, 2014b). While some facilities have tried to lower the cost of PAC, the price remains too high for many women, affecting their subsequent FP decision making (Fikree, Mugore, and Forrester, 2014b).

Compounding these cost challenges, Togo faces frequent stock-outs of RH and PAC commodities. An Ipas-led situational analysis found that misoprostol was out-of-stock in all of the pharmacies visited, including the main teaching hospital in Lomé (Turner, Senderowicz, and Marlow, 2016). Further, among five facilities reviewed for quality improvement by USAID's Evidence to Action project and the Division of Family Health, only two facilities had MVA kits, and four had limited capacity to offer full contraceptive method choice (Mugore et al., 2016).

FINANCING MECHANISMS

While Togo does not have a national health insurance plan that covers PAC or FP products, in 2011, Togo met its Abuja+12 pledge to devote 15% of public expenditures to health and is spending 6% of the total health budget on maternal and neonatal health (UNAIDS, 2013; and Republic of Togo, 2012).

Furthermore, total funds spent on contraceptive commodities have nearly doubled in recent years, increasing from $1.2 million in 2008 to $2.1 million in 2010 (Health Policy Project, 2013). Yet Togo's government spends less than 2% of this total amount; the majority of the funds are provided by international organizations and donors (Health Policy Project, 2013).

Despite increased FP financing, women often lack the funds to pay for their preferred FP method before being discharged from a facility. As a result, the full spectrum of PAC is not available to most women (Fikree, Mugore, and Forrester, 2014b).

TOGO		Year	Source
Demographic/background indicators			
Country population	8,074,867	2018	United Nations
Total fertility rate	4.8	2013	Demographic and Health Survey, 2013–14
Age at first birth	18		
Maternal mortality per 100,000 live births	401		
Newborn mortality per 1,000 live births	27		
Infant mortality per 1,000 live births	49		
Under-five child mortality per 1,000 live births	88		
Facility-based delivery	73%		
At least one antenatal visit during previous pregnancy	73%		
At least one postnatal visit during previous pregnancy	71%		
Abortion and FP-related indicators			
Number of unintended pregnancies	164,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unintended pregnancies averted due to use of modern contraceptive methods	163,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	58,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of maternal deaths averted due to use of modern contraceptive methods	400	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	23.3 %	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Knowledge of FP, all WRA	97.6%	2010	Demographic and Health Survey, 2013–14
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	1.2%		
Sterilization (male)	0.0%		
Intrauterine device	3.6%		
Implant	20.4%		
Short-acting methods		2017–2018	
Injection (intramuscular and subcutaneous)	30.5%		
Pill	11.4%		
Condom (male)	32.3%		
Condom (female)	0.0%		
Other modern methods (e.g., female condom, cycle beads, and lactational amenorrhea method)	0.6%		
Unmet need for FP[1] (2018)	34.4%	2017–2018	
Unmet need for spacing	22.2%		
Unmet need for limiting	12.2%		
Percentage of all women who received FP information during their last visit with a health service provider (2016)	38.0%	2017–2018	

[1] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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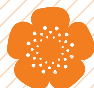

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