

policy

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REPOSITIONING FAMILY PLANNING IN TOGO A Baseline



This publication was prepared by Elizabeth McDavid
and Sabine Attama of the Health Policy Project.



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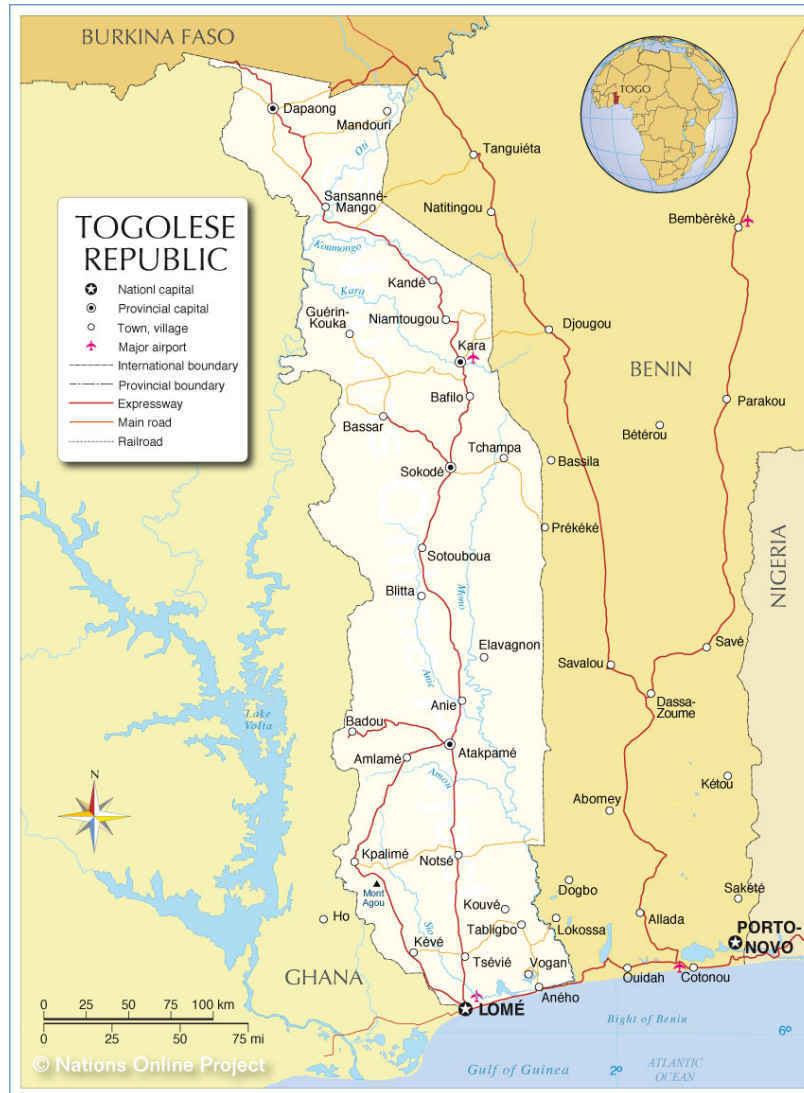


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Repositioning Family Planning in Togo: A Baseline



JULY 2012

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ABBREVIATIONS

ATBEF	<i>Association Togolaise pour le Bien Etre Familiale</i>
AWARE II	Action for West Africa Region II (Project)
CARMMA	Accelerated Campaign for the Reduction of Maternal Mortality
CBD	community-based distribution
CHW	community health worker
CMS	Socio-Medical Health Center
DHS	Demographic and Health Survey
DSF	Division of Family Health
DSRP-C	Complete Poverty Reduction Strategy
FHI	Family Health International
FP	family planning
FPE	Family Planning Program Effort (Score)
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HPP	Health Policy Project
IR	intermediate result
IUD	intrauterine device
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NGO	nongovernmental organization
PNDS	National Health Development Plan
PSI	Population Services International
RAPID	Resources for the Awareness of Population Impacts on Development
RH	reproductive health
SO	strategic objective
STI	sexually transmitted Infections
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

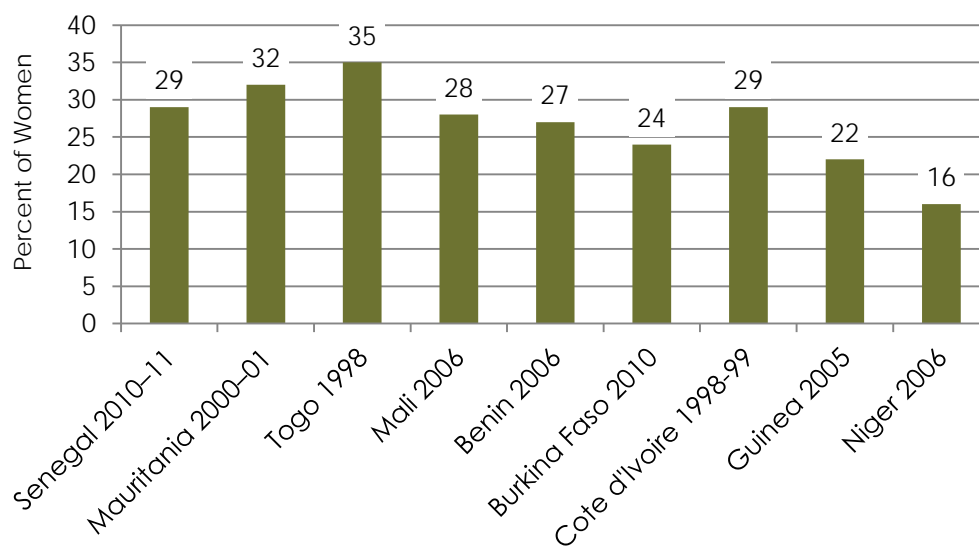
INTRODUCTION

Demographic pressures and lack of progress toward the Millennium Development Goals have encouraged countries and donors to “take a new look” at family planning (FP). Since 2001, the United States Agency for International Development (USAID), the World Health Organization (WHO), and other important partners have joined with national governments in sub-Saharan Africa in an initiative to raise the priority for family planning programs, known as repositioning family planning. The initiative was established to ensure that family planning remains a priority for donors, policymakers, and service providers in sub-Saharan Africa in an era when HIV, malaria, and tuberculosis programs dominate the global health agenda and receive a majority of the resources.

Although family planning is one of the most cost-effective, high-yield interventions to improve health and accelerate development, West Africa is lagging behind all other regions in FP use. With an average of 5.5 children per woman, the region has one of the highest fertility rates and fastest growing populations in the world. High fertility leads to many unplanned pregnancies that pose serious health risks for mothers and children. In Francophone West Africa, approximately three women die from maternal causes every hour (WHO, 2010) and one child under age five dies every minute (UNICEF, 2011).

There is substantial demand for family planning in Francophone West Africa. In six of the nine countries recently surveyed, an estimated one-third or more of currently married women have an unmet need for family planning (see Figure 1).

Figure 1: Unmet Need for Family Planning



Source: Demographic and Health Survey data (accessed at: <http://www.statcompiler.com/>)

Community-based programming is showing promise for expanding access to family planning. Many African countries have community-based programs to provide contraceptive methods and information to underserved groups, such as rural residents and the urban poor.

There are vast regional inequalities in access to and use of contraceptives between urban and rural populations, with rural populations almost always having fewer options. Bringing FP services into communities is an important strategy to improve access to family planning and satisfy unmet need. Several models for the provision of community-based services have been successfully tested in the region. In Francophone Africa, community-based distribution (CBD) for family planning is identified as an underutilized strategy to reach women in rural areas. Family planning is just one of the many health services that use CBD, and community health worker (CHW) training and supervision is usually integrated with these other services (child health services, malaria and diarrhea prevention and treatment, acute respiratory infections treatment, vaccinations, neonatal care, prenatal care, safe motherhood, as well as information on these and other health issues). Currently, in most Francophone West African countries, CHWs offer only condoms and refills on oral contraceptives and referrals.

The goal of USAID's Repositioning Family Planning initiative is to increase political and financial commitment to family planning in sub-Saharan Africa, which will lead to expanded access and help meet women's stated desires for safe, effective modern contraception (USAID, unpublished). The initiative has identified three key approaches or intervention areas for achieving this goal: (1) advocating for policy change; (2) strengthening leadership; and (3) improving capacity to deliver services. At the February 2011 Ouagadougou conference, "Population, Development, and Family Planning: The Urgency to Act" (<http://www.conferenceouagapf.org/>), the participating eight Francophone countries drafted action plans for repositioning family planning and appointed focal persons to spearhead implementation of these plans.¹ At a conference on civil society involvement in family planning in September 2011 in Mbour, Senegal, additional focal persons were named from civil society organizations and the action plans were further refined. CBD features prominently in the action plans.

While many activities are underway to reposition family planning, most countries lack a mechanism to assess the success of their efforts (Judice and Snyder, 2011). In response to this gap, in 2011, the MEASURE Evaluation Population and Reproductive Health project developed a results framework to assess efforts to reposition family planning. The Framework for Monitoring and Evaluating Efforts to Reposition Family Planning can be used by international donors, governments, and health programs to evaluate their efforts; identify gaps in strategies to reposition family planning in countries; and inform funding decisions, program design, policy and advocacy, and program planning and improvement (Judice and Snyder, 2011).

After an initial pilot test in Tanzania by MEASURE Evaluation, the Health Policy Project (HPP) adapted and pilot tested the framework in Togo and Niger. At the same time, the project conducted an in-depth assessment of the countries' policy and operational barriers to CBD, given its potential as a service delivery modality to increase access to and use of family planning in the region. This report presents the results of the pilot test and assessment in Togo.² The findings provide a strong baseline to assess progress in efforts to reposition family planning.

¹ The eight countries included Benin, Burkina Faso, Guinea, Mali, Mauritania, Niger, Senegal, and Togo.

² The results of the pilot test and assessment in Niger are also available (visit www.healthpolicyproject.com).

TOGO: BACKGROUND

Togo, a small country in the Gulf of Guinea, has experienced more than a four-fold population increase in 50 years—from an estimated 1.6 million people in 1960 to about 5.9 million in 2010³ (Guengant, 2010). While the rural population has almost tripled since 1960, the urban population is nearly 19 times larger than it was in 1960 (Guengant, 2010). Today, 37 percent of Togo's people live in urban areas (PRB, 2011). By 2020, more than half (56%) of Togo's people will be urban residents (UN, 2010). Togo has a young population, with two in five people (42%) younger than 15 years old (PRB, 2011).

With an economy based on agriculture and a per capita income estimated at US\$850 in 2009, Togo is one of the poorest countries in the world (PRB, 2011). In 2006, three in five Togolese (62%) lived under the national poverty level, according to World Bank estimates (Guengant, 2010).

Togo's total fertility rate is 4.7 children per woman (PRB, 2011). Women marry young; half of the women ages 25–29 surveyed in the 1998 Demographic and Health Survey (DHS) were married by age 19. Two in five (43%) women ages 15–49 are in a polygamous union; women living in rural areas and those with no education are more likely than other women to be in a polygamous union (Anipah et al., 1999).

The 1998 DHS reported that 7.9 percent of women of reproductive age were using modern contraceptives. Modern contraceptive use is higher among women with some education and among those living in urban areas (Anipah et al., 1999). The more recent 2006 Multiple Indicator Cluster Survey (MICS) showed an increase in the modern contraceptive prevalence rate to 13.2 percent. The MICS reported that condoms, injectables, and the pill were the most popular contraceptive methods (Ministry of Economy and Development, 2007).

Unmet need for family planning may be increasing. The 1998 DHS estimated the total unmet need for family planning to be 32 percent (21% for spacing, 11% for limiting) (Anipah et al., 1999). The 2006 MICS reported unmet need for family planning to be 41 percent (26% for spacing, 15% for limiting) (Ministry of Economy and Development, 2007).

Togo's health system is well integrated and forms three levels of a pyramid:

1. The base level comprises 35 health districts that manage all healthcare service provision and facilities in their districts. The facilities are grouped together under the name Peripheral Health Units and include all district hospitals, socio-medical health centers (CMS), and dispensaries. Health huts exist in some places but are not officially part of the health system, even if the CHWs are supervised by the district. The Peripheral Health Units include religious and private health providers and facilities. Auxiliary and permanent birth attendants are trained workers—usually but not always working in CMS—who provide specific methods of family planning, depending on their level of training.⁴
2. The middle level comprises six health regions, each with a regional health directorate and all the regional services, including a regional hospital.

³ The United Nations Population Division estimated Togo's population to be 6.8 million people in 2010 (Guengant, 2010).

⁴ Auxiliary attendants have more training and are allowed to perform more services than permanent attendants.

3. The top level (peak) comprises the Ministry of Health and all its departments, health training schools, special agencies, and university hospitals. This level is where all the central administrative work takes place.

Togo has a critical shortage of health workers, especially at the district and community levels. The World Health Organization recommends a ratio of 2.28 healthcare professionals per 1,000 people (WHO, 2006). However, as shown in Box 1, Togo has fewer than 0.33 health professionals per 1,000 people.

The Division of Family Health (DSF)—housed within the Directorate of Primary Health Care, which, in turn, is overseen by the General Directorate of Health under the Ministry of Health (MOH)—is responsible for the following services: Maternal and Child Health/Family Planning, the National Service for Youth and Adolescents, and the National Nutrition Service. The DSF has 13 staff members (including administrative staff). Three of those staff members are seconded by the United Nations Population Fund (UNFPA). The DSF is dispersed among three locations in Lomé and has not been on a supervisory visit to the country’s interior for two years due to lack of funds. However, the DSF makes substantial efforts with existing funds, offering three contraceptive methods (condom, pills, and injectables) in at least 70 percent of facilities nationwide. Key informant interviews indicated that few donors and external partner agencies are working in family planning in Togo.

Togo recently developed a National Policy on Community-Based Interventions to standardize the CHW job description, as well as norms for training, supervision, and pay, which ranges from 17,000 CFA to 34,000 CFA (US\$35–70)⁵ per month, depending on level of effort. The policy took effect in 2010, but the DSF was only able to provide a symbolic sum to the approximately 10,000 CHWs in the health system. Among many other health interventions, the policy includes the provision of resupplies of pills (but not the initial supply) and condoms by CHWs. Community-based implementation tends to be project- and donor-specific. About 8,500 of the CHWs were recruited for a malaria project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and provide no FP services. Several partners use a mobile FP strategy, which helps ensure access to long-term methods [Jadelle implants and intrauterine devices (IUDs)] in most of Togo’s socio-medical health centers. In some districts, CHWs play a role in identifying and bringing clients to the health centers if the workers have sufficient advance notice. In 2010, the DSF reported that one-third of couple years of protection resulted from mobile teams providing implants and IUDs.

Box 1. Ratio of Health Professionals to Population, 2010

Doctors 1:20,000

Nurses and midwives 1:3,703

Source: World Bank, 2012

⁵ US\$1= Approx. 500 CFA.

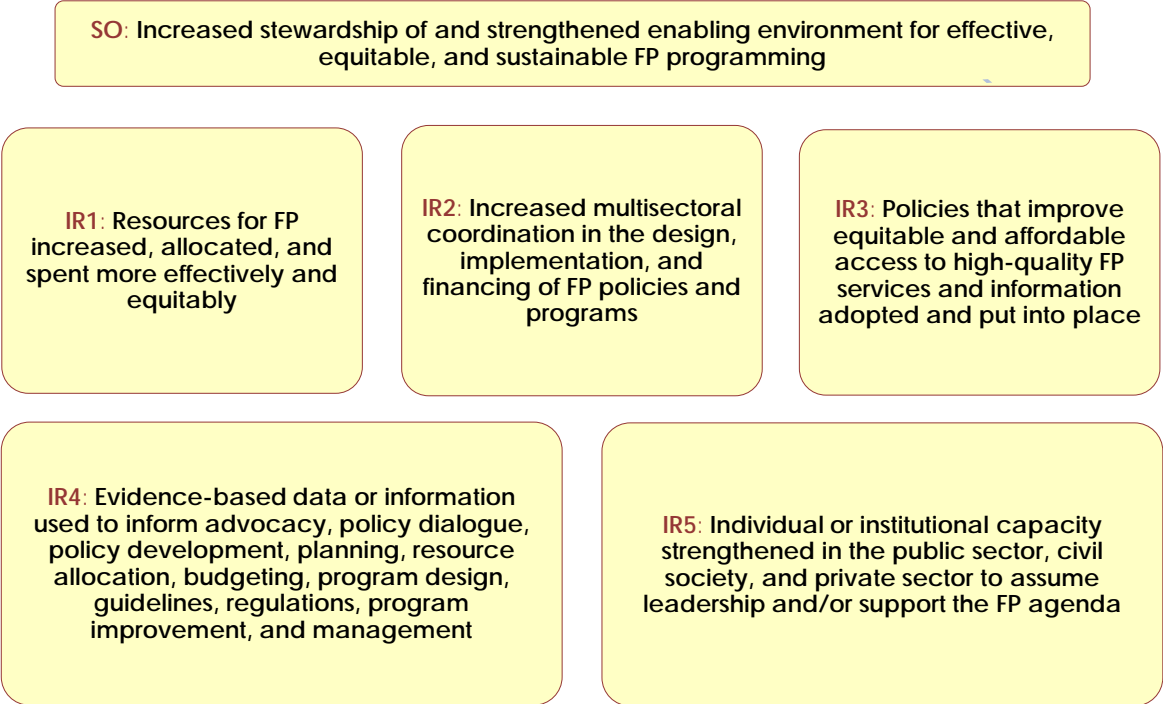
FRAMEWORK FOR ASSESSING THE REPOSITIONING FP INITIATIVE

The overall strategic objective (SO) of the Framework for Monitoring and Evaluating Efforts to Reposition Family Planning (hereafter referred to as the M&E Framework) is “Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable FP programming.” Under the SO, there are three illustrative indicators:

1. Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program
2. Instances of documented improvement in the enabling environment, using a validated instrument
3. Evidence of FP policies implemented and resources allocated and subsequently used in relation to the same FP policy

Each IR has specific indicators that contribute to overall achievement of the IR (see Figure 2).

Figure 2. Results Framework for Strengthening Commitment to and Increased Resources for Family Planning



Source: Judice and Snyder, 2011

Methodology

This study included two components:

1. Pilot testing of the M&E Framework
2. In-depth assessment of policy and operational barriers to community-based distribution

Document review and key stakeholder interviews

An HPP staff member and a local consultant conducted the study. Field work took place in Togo from September 13–29, 2011. The M&E Framework was pilot tested through conducting a document review and key stakeholder interviews. HPP used the M&E Framework first tested in Tanzania in 2011—adapting its components, indicator sheets, and interview guides for use in West Africa and translating them into French.

First, the HPP team reviewed policies, strategies, program materials, and other information related to the framework and policy barriers to CBD. Next, the team conducted key informant interviews based on the guides tailored to Togo (see Annexes 3 and 4). In collaboration with the Division of Family Health, the team selected two districts—Ave and Haho. The criteria were that one district be where an Action for West Africa Region II (AWARE II) pilot project was planned;⁶ the other district be where CHWs perform CBD activities, including family planning, but an AWARE II pilot project was not planned; and both districts be located within a short distance from the capital to conserve travel time and cost.

The key informants were identified through (1) contacts of the AWARE II project, (2) documents, and (3) subsequently, other informants. The HPP team conducted 43 interviews in total, including 16 women and 27 men (see Table 1). The team interviewed seven CHWs and five local leaders to assess the various policy barriers to CBD.

Table 1: Affiliation and Sex of Key Informants Interviewed in Togo

	Government Officials	Donors	Cooperating Agencies/Civil Society Orgs.	CHWs	Local Leaders	Total
Men	9	2	8	4	4	27
Women	5	4	3	3	1	16
Total	14	6	11	7	5	43

The team conducted individual interviews, but in many cases, the informant called in a colleague for additional information, which enriched the responses. Initially, the team collected information by taking notes and writing on the interview guides that were printed out in multiple copies. The team found this extremely cumbersome, needing to flip forward and backward through 19 pages during an interview. At

⁶ At the time the team was in Togo, AWARE II was planning a pilot activity for CBD in two districts, and CHW training was being conducted in Haho.

the end of each day or two, the team reviewed the information collected and determined whether there was sufficient information for specific indicators or whether additional information was required. As information collected met the needs of different indicators, the team focused on the indicators that required additional information. The interview findings were cross checked for consistency and entered into the records after each day's interviews. Overall, the interviews helped confirm the findings of the document review and provided some further insight on the implementation status of various plans. In addition, the interviews helped identify barriers not previously identified during the document review.

Ethical considerations

The protocol and data collection instruments for both study components were submitted to the Futures Group Research Ethics Committee and deemed exempt from review by an Institutional Review Board.

Study Limitations

The study group may not be representative of Togo as a whole. The two districts visited—Ave and Haho—are relatively close to the capital Lomé. As in many African countries, ethnicity, language, and geography in Togo create significant differences among regions within its borders. Anecdotal information collected suggests that circumstances in other districts may be different from those found in these two districts. For example, the ethnic groups in Ave and Haho differ from those in the north of the country. Time, distance, and cost prevented the team from visiting districts in the interior of the country.

Despite these limitations, this study provides an important baseline for repositioning family planning in the country and identifies key challenges to raising family planning on the agenda and expanding FP services through CBD.

ASSESSMENT FINDINGS

This section presents the findings from the pilot test of the M&E Framework. The findings are presented according to the SO indicators and intermediate results, as delineated in the framework. Annex 2 summarizes the findings in table format.

SO: Increased Stewardship of and Strengthened Enabling Environment for Effective, Equitable, and Sustainable FP Programming

Indicator 1: Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program

In Togo, the Division of Family Health oversees and actively manages the FP program, among other programs. The DSF is a unit under the Directorate of Primary Health Care, which, in turn, is overseen by the General Directorate of Health under the MOH. The DSF is responsible for three services: Maternal and Child Health/Family Planning, the National Service for Youth and Adolescents, and the National Nutrition Service.

According to many respondents, the DSF needs to be more strategically placed within the MOH. They noted that family planning is one of many programs in the division's large and varied portfolio. The respondents suggested that the DSF be placed higher up in the ministry structure as a directorate and be given adequate human resources and equipment, office space, and funding to carry out its mandate. Although the DSF manages the FP program, coordination among the various entities working in this area is insufficient; the division holds ad-hoc coordination meetings, but there is no established FP coordinating mechanism.

"The DSF is too low in the administration. It needs to be at a decision-making level. However, they do their best with what they have."

—Government official

Indicator 2: Evidence of documented improvement in the enabling environment for family planning using a validated instrument

Data from two validated instruments are available to assess the enabling environment for family planning in Togo: the Family Planning Program Effort (FPE) Score and Contraceptive Security Index.

The FPE Score was developed as an international measure to gauge key areas of each country's FP program. Togo's score has risen slightly between 1999 and 2004—from 52.7 to 54.7—indicating some progress in family planning, especially in the areas of policies and plans to strengthen the FP program (Ross and Smith, 2010). Since the score was not established in 2009, we cannot assess more recent progress. As the highest score is 100, the score also indicates considerable room for improvement in Togo.

Another index suggests some inadequacy in contraceptive supplies. The 2003 Contraceptive Security Index for Togo was 45.8, indicating a relatively low level of contraceptive security (USAID | DELIVER Project, 2009). Since 2003 was the only year the index was measured in Togo, it is difficult to draw many conclusions, but key informants confirmed that contraceptive security is a major issue in Togo.

Indicator 3: Evidence of FP policies implemented, resources allocated, and subsequently used in relation to the same FP policies

The document review showed that Togo has many key policies in place to implement a strong family planning program. In 2007, the Government of Togo passed the Reproductive Health Law, which establishes the right of all citizens to access services, information, and education about reproductive health—including the right to abortion in very limited circumstances.⁷ In 2010, Togo’s President Faure Gnassingbé launched the Accelerated Campaign for the Reduction of Maternal Mortality (CARMMA). At this time, the government issued a declaration that certain RH services (including cesarean sections, fistula repair and care, and some FP methods, including Jadelle implants and IUDs provided through pilot projects and mobile clinics, would be free-of-charge. The CARMMA campaign led to the sensitization of much of the population. The campaign used all nongovernmental organizations (NGOs) working in family planning and maternal health to transmit radio and TV spots and offer free antenatal care services and some FP methods for women. The DSF and its partners reinvigorated the mobile FP model by encouraging various groups to set up mobile teams to provide long-term methods (Jadelle and IUDs) free-of-charge at medical facilities.

In its review of annual reports and key informant interviews, the HPP team did not find that a national RH policy or plan had been prepared. Nevertheless, several activities have recently been implemented in Togo to support repositioning family planning based on existing policies. In 2009, the DSF and local NGOs began implementing the new Policies and Norms for Family Planning, Reproductive Health, and Sexually Transmitted Infections (STIs). However, implementation of the National Policy on Community-Based Interventions only began in 2010. Both of these key operational policy documents support the RH Law.

Inadequate staffing and other resources at the national, district, and community levels are a major factor limiting access to FP services. At the national level, DSF staff are highly overburdened; plans and activities cannot always be completed on time. The division’s work is also hampered by the dispersal of its staff among three locations in Lomé. Districts and communities need more qualified and better trained CHWs, as well as medical professionals such as nurses, midwives, and doctors.

In 2008, the MOH adopted the National Strategy for Securing RH Products (2008–2012), including antiretrovirals for HIV treatment. The strategy includes an assessment of the RH situation in Togo, a full projection for the time period, a strategic framework, objectives with results and process indicators, a budget, a capacity-building plan, and a monitoring and evaluation plan.

Intermediate Result 1: Resources for Family Planning Increased, Allocated, and Spent More Effectively and Equitably

The M&E Framework has four indicators related to resources for family planning:

- IR1.1: Total resources *spent* on family planning (by source and by activity/program area)
- IR1.2: Number of new financing mechanisms identified and tested
- IR1.3: Total resources *allocated* to family planning (by source and by activity)

⁷ Such as to save the life of the mother.

- IR1.4: New and/or increased resources are committed to family planning in the last two years

The HPP team was unable to identify the total resources spent or allocated for FP programs in Togo; such data appear to be unavailable. Data are, however, available for expenditures and budget allocations for contraceptive supplies. The team recommends that these data serve as proxy indicators for FP resources until more comprehensive data become available. As indicated below, existing data show important progress in the provision of contraceptives, suggesting increased contraceptive use.

The total financial resources spent on contraceptive commodities have nearly doubled in recent years, increasing from US\$1.2 million in 2008 to US\$2.1 million in 2010 (see Table 2). The UNFPA and the Global Fund were the main sources of the increased funding; their donations constituted 77 percent of total funds for contraceptive commodities during 2008–2010. Despite some fluctuations, their donations showed a marked increase, with UNFPA allocating a total of US\$1.5 million and the Global Fund providing US\$42.5 million during the three-year period.

The government budget does not have a line item for contraceptive commodities; the government's contribution for contraceptives goes through a line item for pharmaceutical products. So far, the contribution of funding for FP commodities to purchase contraceptives for health facilities has been small. The government's contribution rose from approximately US\$30,000 in 2008 to \$40,000 in 2009 but has remained stagnant since 2009.

Table 2. Total Resources Allocated and Disbursed for FP Commodities in Togo

Donors	Beneficiaries	Year (US\$)			
		2008	2009	2010	Total
Government (through the line item)	DSF	30,000	40,000	40,000	110,000
UNFPA	DSF	109,157	1,021,179	337,219	1,467,555
USAID	DSF	57,654	76,017	237,177	370,848
	PSI	43,484		261,582	305,066
IPPF	ATBEF	18,187	38,090	36,966	93,243
PSI	PSI		181,540	102,900	284,440
Global Fund	PSI	895,293	515,224	1,093,781	2,504,298
TOTAL		1,153,775	1,872,050	2,109,625	5,135,450

Source: MOH/DSF, 2011

The DSF is the main recipient of contraceptives provided by the government, USAID, and UNFPA. In the private sector, two agencies with funds for contraceptive commodities are the Togo Family Welfare Association (ATBEF) and Population Services International (PSI).

According to the “Summary of Product Shipments for the Period January 2008 to December 2012,” the DSF spent the allocated funds as planned. The key informants stated that no new financing or funding mechanisms exist for family planning. Government officials informed the HPP team that a new insurance scheme became effective in September 2011, but it is initially only for civil servants and retirees.

Intermediate Result 2: Increased Multisectoral Coordination in the Design, Implementation, and Financing of FP Policies and Programs

This IR assesses the extent to which various disciplines, such as health, education, agriculture, and the environment as well as the public and private sectors, are involved in FP policies and programs. The HPP team found numerous examples of multisectoral coordination, which will be reported under the following sub-IRs.

IR2.1: Evidence of family planning programs incorporated into national strategic and development plans

The Director of Population Planning at the Ministry of Economy, Finance, and Privatizations confirmed that neither the 2007 Poverty Reduction Strategy nor the new Complete Poverty Reduction Strategy (DSRP-C) (2009–2011) include any mention of family planning. Population issues are not included among the priorities outlined in the strategic plan, although there are vague allusions to demographic pressures. According to the director, there is a real risk that questions of population, reproductive health, and family planning will be forgotten in the implementation, monitoring, and evaluation of the DSRP-C. He also said he intends to highlight family planning in the next round of strategy documents.

IR2.2: Evidence of governments engaging multiple sectors in family planning activities

Family planning coordination appears to be done mostly ad hoc or by informal groups. The HPP team could not identify any established multisectoral group that meets regularly to plan and coordinate FP activities, which confirmed the reporting of only temporary committees by respondents.

Based on its review of documents and the key informant interviews, the team confirmed that family planning is integrated into the RH program in Togo. The team also found that the government engages multiple health sectors in FP activities. For example, family planning was an integral part of CARMMA in Togo. The campaign, launched in 2010, emphasized public information, advocacy, and service provision on maternal and child health and family planning. After the national launch in September 2010, a different cabinet minister and a different major partner visited each region to roll out the campaign at the regional level. The DSF established a committee to advocate for and mobilize resources for women’s and children’s health, as confirmed by CARMMA documents and key informants.

Multisectoral coordination related to contraceptive security takes place through the Technical Advisory Committee responsible for contraceptive procurement. The committee includes members from

“This rapid increase in the Togolese population, that is tied to a high birth rate and continuing decrease in death rates, is not without consequence for the economic development of the country... This situation can lead to an aggravation of poverty and vulnerability, especially among those already in a fragile situation.”

—Minister of Planning and Development, Mme. Dédé Ahoéfa Ekoué, 2011 International Population Day in Togo

Parliament, civil society (including the faith-based sector), the private sector, government, and partner agencies. According to several key informants, the committee does not regularly meet nor function well; it needs to be reinvigorated to become more proactive, meet regularly, and fill the coordinating role for contraceptive security.

The HPP team was informed that a National Gender Policy exists, but the team was unable to obtain a copy. In addition, the team read in the local newspaper that a National Youth Forum was created. Additional information on the Youth Forum is below.

IR2.3: Evidence of multisectoral structures that are established or strengthened to promote FP policy

Several structures and plans have been established or strengthened to promote FP policy, even if that is not their principal purpose.

In 2011, the government developed and launched a National Action Plan for Condom Use to combat sexually transmitted diseases and promote family planning. It covers both male and female condoms and contains a plan for the coordination and mobilization of resources (Togo-Presse newspaper, September 23, 2011).

Another high-profile multisectoral agency is the National Youth Forum, which the government set up to promote the development of youth. Launched by the Prime Minister in May 2011, the forum draws on education, health, employment, sports, and other areas to address one of the biggest social challenges facing Lomé in coming years—the entry of nearly half of its population into adulthood.

The Network of Parliamentarians for Population and Development is also multisectoral, as reported by a former member.

An example of multisectoral coordination is the process for preparing the Togo presentation on Resources for the Awareness of Population Impacts on Development (RAPID). Representatives of government ministries, partners, Parliament, the private sector, and religious groups came together to advise on the content of the presentation and review the data showing the effects of population growth on socio-economic development, education, health, agriculture, urbanization, and the environment. The RAPID presentation was finalized and presented in July 2011. However, one key informant involved in the RAPID process stated that it has not yet been widely disseminated.

Despite the existence of the committees and groups described in this section, the respondents conveyed a general sense that most of them are not active. One person said that they are “sleeping and need to be woken up.” Reinvigorated advocacy and leadership for family planning are lacking.

**“None of the coordination structures function anymore.”
—Government official**

IR2.4: Evidence of government support for private sector participation in family planning

According to government informants, the private sector flourishes in Togo and comprises (1) private non-profit service providers, essentially church or community-based; (2) private for-profit service providers, concentrated in Lomé and which generally escape oversight of the government; and (3) traditional medicine practitioners, who are omnipresent in the country’s interior.

Many respondents confirmed that the private sector's contraceptive needs are included in the government's procurement planning and that the private sector buys its contraceptives from government stores. However, government respondents seemed to believe that the private clinics are not interested in preventive services such as family planning, but rather curative care, since there is more profit in curing someone than in preventing a malady. The team was unable to meet with a private clinic operator.

Intermediate Result 3: Policies that Improve Equitable and Affordable Access to High-Quality FP Services and Information Adopted and Put into Place

IR3.1: Existence of national or subnational policies or strategic plans that promote access to family planning services and information

Togo has several policies that demonstrate the importance given to health in general and specifically to reproductive health and family planning. Two key policies include the National Population Policy and the National Health Development Plan.

The National Population Policy (1998) and the revised draft policy (2004) aim to help improve the living conditions of populations. The draft population policy has yet to be finalized, suggesting a lack of commitment to update the policy. However, it raises the issue of high fertility characterized by early, unintended, and too closely spaced pregnancies, leading to many problems for women and their families. The goals of the draft policy are to

- Reduce the proportion of high-risk pregnancies by 50 percent between 2005 and 2015;
- Increase access and use of reproductive health services; and
- Increase the contraceptive prevalence rate from 11.3 percent to 18 percent between 2003 and 2015 through the intensification of information, communication, and education campaigns for reproductive health. This goal has since been revised to a 50 percent increase by 2022 to align with the National Health Development Plan (PNDS).

The PNDS (2009–2013) is the country's national health development program and is based on the poverty reduction strategy. One of its goals is to increase the contraceptive prevalence rate from 13.2 percent for modern methods (as reported in the 2006 MICS) to 50 percent by 2022.

Other key health policies that promote access to FP services and information for all and lay out implementation directives are listed in Box 1. However, none of these policies specifically promote access to FP services for vulnerable populations.

Box 1. Togo's Major Health Policies

National Population Policy (1998)

Health Law, No. 2007-005

Reproductive Health Law (2009)

National Health Development Plan (2009–2013)

Road Map to Reduce Maternal and Infant and Child Mortality in Togo (2008–2012)

National Plan to Reduce Maternal and Neonatal Mortality (2004)

Operational Directives for the Law on RH (2010)

National Policy for Community-Based Interventions (2009)

National Strategy for Securing RH Products (2008–2012)

Policies and Norms for FP, RH, and STIs (2009)

IR3.2: Existence of national or subnational policies or strategic plans that promote access to family planning services and information for underserved populations

All of Togo's important policy documents aim to create an enabling environment for achieving the Millennium Development Goals, combating poverty, and promoting sustainable and sustained economic growth for the people of Togo. The Health Law and the RH Law lay out rights and responsibilities of the citizens and the government. Both the PNDS and the Road Map to Reduce Maternal and Infant and Child Mortality in Togo take into consideration the level of poverty of the majority of women who die in childbirth. During the launch of CARMMA in September 2010, the government declared that cesarean sections, fistula care and repairs, and some FP methods would be free to clients, thus giving vulnerable women access to RH care. Long-term FP methods provided through the mobile clinics are also free-of-charge to the clients.

The 2009 Policy on Community-Based Interventions provides standards for community-based interventions, such as the CHW job description, training, supervision, and pay. It also addresses men and youth and seeks to increase access to services and information among rural residents whose closest health provider is a CHW.

IR3.3: Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy

Togo has issued several implementing or operational directives to accompany policies and laws. One year after the RH Law was passed, the government issued operational directives for the law. The Policies and Norms for FP, RH, and STIs is a document used to implement the PNDS. In addition, both the National Plan to Reduce Maternal and Neonatal Mortality and the Road Map to Reduce Maternal and Infant and Child Mortality were developed in response to the PNDS and to Togo's efforts to meet the Millennium Development Goals. However, some of these directives are not fully implemented.

IR3.4: Evidence that policy barriers to access to family planning services and information have been identified and/or removed

In May 2010, the USAID-funded AWARE II project conducted a study on policy barriers to family planning use. The main barriers to contraceptive use identified were geographic location, cost, and the need for clients to have access to a wider range of methods provided locally. In October 2011, AWARE II initiated a pilot project to determine whether CHWs can effectively and safely provide pills to new users and give injectables contraceptives. The project was implemented in Haho district for eight months and in Blitta for three months. Within this short period, 27 percent of women of reproductive age in the two study districts adopted modern contraceptive methods. (In contrast, there was no change in contraceptive prevalence in Wawa, a comparison district.) More than two-thirds of the new contraceptive users in the study districts chose injectables; other methods chosen were the pill, lactational amenorrhea, and the female condom. The FP services were provided free of charge. The CHWs provided contraceptive services to nearly six times more clients than the local health centers. The rapid adoption of family planning indicates that the CHWs filled an important need in the community and were readily accepted by FP clients. In addition, FP mobile teams provide long-term methods (Jadelle and IUDs) almost nationwide free-of-charge on about twice yearly visits to the Peripheral Health Units, thus addressing the barriers of cost and geographic accessibility for long-term methods. Several informants described this activity, although the team was unable to find full documentation on it.

Many policy barriers have been identified by the activity, but no policy reforms have yet occurred to remove the barriers.

IR 3.5: Evidence of the implementation of policies that promote family planning services and information

The annual report of the DSF (Rapport Annuel DSF, 2010) provides evidence of policy implementation.

Intermediate Result 4: Evidence-based Data or Information Used to Inform Policy Dialogue, Policy Development, Planning, Resource Allocation, Budgeting, Advocacy, Program Design, Guidelines, Regulations, and Program Improvement and Management

This IR assesses the extent to which policies and programs are grounded in data and information in order to ensure a sound rationale for selecting the program strategies, activities, and other elements.

IR4.1: Evidence of data or information used to support repositioning family planning efforts

Key informants asserted that CARMMA was developed because studies have shown that if family planning is implemented, maternal deaths can be reduced by 25 percent. This shows that Togo uses reducing maternal mortality as a major argument in favor of family planning.

The DHS and MICS studies contribute the majority of FP data used in Togo, such as for the Togo RAPID.

IR4.2: Evidence of international best practices incorporated into national health standards

Gender equity, male involvement, and men's reproductive health are all elements of Togo's 2010 Policies and Norms for FP, RH, and STIs and are also considered FP best practices. In addition, advocacy for family planning and CBD of family planning are also considered best practices. However, the HPP team was unable to determine whether these are indeed being implemented. In addition, CBD of family planning is not yet fully incorporated into the national health standards.

IR4.3: Evidence of a defined and funded research agenda in family planning

The HPP team was unable to determine whether a defined or funded FP research agenda exists in Togo.

IR4.4: Evidence of in-country organizational technical capacity for the collection, analysis, and communication of FP information

The MOH validated its policies and norms document in December 2009; it contains a strategy for developing operations research. However, the HPP team was unable to find any evidence of a research agenda in family planning. Key informants asserted that in-country technical capacity to collect and manage FP information is integrated in the DSF and includes all of primary health. Thus, there is no separate collection of FP information. In addition, many key informants said that capacity in the DSF is weak. The Division of Information, Statistics, Studies, and Research centralizes all the health information of the MOH, but there is no FP research agenda. The team met with several NGOs that have experience and capacity for this research, but their research is often closely related to their projects, plans, and activities—such as baseline/endline and impact assessments; knowledge, attitude, and practice studies; and project and program evaluations. These NGOs always involve the DSF as a partner of choice.

Intermediate Result 5: Individual or Institutional Capacity Strengthened in the Public Sector, Civil Society, and Private Sector to Assume Leadership and/or Support the FP Agenda

IR5.1: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement repositioning family planning activities

Interviews with partners, government, and donors, as well as a visit to ATBEF, confirmed that ATBEF can independently implement FP repositioning activities in Togo. The NGO has been actively involved in repositioning FP activities. One of its members is a civil society focal person named by the Togo delegation during the FP conference for civil society organizations in Mbour, Senegal, in September 2011. ATBEF has mobilized resources from a wide range of international and local donors.

IR5.2: Evidence of government departments or other entities established or strengthened to support the family planning agenda

The DSF, responsible for family planning, has 13 staff members at the central level, which includes 10 government staff and three staff seconded by UNFPA (two technicians and one administrator). The seconded personnel greatly increase the division's capacity. Nevertheless, there are clearly not enough staff to effectively support and manage the DSF mandate.

In addition, AWARE II helped create the *Union des Religieux de Togo pour la Santé* at the RAPID launch in July 2011. This group's mandate is to advocate for increased resources and better health for Togolese, including for family planning. Currently, the group is drafting its framing documents and applying for registration.

A group of focal persons (one each from the government and donors and two from Togolese civil society) was formed to follow up on the February 2011 Ouagadougou conference on repositioning family planning. However, it is not an official group or committee, although it could form the nucleus of a reinvigorated multisectoral working group.

IR5.3: Evidence of targeted public and private sector officials, faith-based organizations, or community leaders publicly demonstrating new or increased commitment to family planning

While there is a lack of high-level FP champions in Togo, there have been specific initiatives. For example, the President of Togo initiated CARMMA in September 2010 and is helping to launch it in all regions. At least five ministers have launched CARMMA in five regions. In addition, the Minister of Health launched the Togo RAPID in July 2011, but it has not yet been disseminated to the districts. Key informants in Togo could not name any committed, consistent FP champions, either in the government or in civil society.

IR5.4: Number of regional/national centers or collaboratives for shared education and research in family planning

No information was found to satisfy this indicator.

Overall, the document review and interviews found that while many policies exist, some need revision, which is an ongoing process. National development strategies and plans need to include family planning, since most do not now. Strategies and plans to implement the policies generally exist. However, these documents need to be updated and translated into concrete actions. Togo needs to improve multisectoral

coordination and management of the FP/RH program, including raising the level of the DSF within the ministry so that it has the authority, staff, and resources needed to carry out its huge mandate. In addition, a concerted effort to identify and support FP advocates and champions in all sectors could raise the profile of family planning in Togo.

BARRIERS TO COMMUNITY-BASED DISTRIBUTION OF FAMILY PLANNING IN TOGO

Community-Based Programs in West Africa

Many African countries have community-based programs to provide contraceptive methods and information to underserved groups, such as rural residents and the urban poor. These programs typically offer oral contraceptives and condoms and increasingly injectables. The programs either offer contraceptives free-of-charge or sell them at a subsidized price. Some countries have an existing cadre of CHWs, while others have set up a network of community distributors working under public or private programs to promote family planning and other health issues.

Several West African countries have implemented successful community-based FP programs. However, many programs were implemented as pilot studies and were not sustained or scaled up. For example, a pilot project in Mali to provide community-based programming increased contraceptive prevalence from 23 percent at baseline to 68 percent at the end of the project (Leonard, nd). Factors that contributed to the project's success include (1) recent adoption of national policies that facilitated women's access to family planning; (2) the integrated nature of the project; (3) the relative sophistication of the NGO sector in Mali; and (4) prior long and sustained efforts to raise awareness of family planning and increase access to CBD in some areas. Similarly, a pilot project in Senegal found that CBD was effective in quickly expanding access to FP/RH services in remote areas (Sanogo et al., 2004). While the pilot in Mali was not scaled up, another project is underway in the country. In Senegal, the NGO, Childcare, has recently designed another pilot project to test whether CHWs can provide injectables at the community level.

One aspect of CBD programs capturing the attention of health officials is the potential for providing injectable contraceptives in the community. Ten international organizations have endorsed the conclusions of a technical consultation held at the World Health Organization in 2009. Based on a review of scientific and programmatic experience, the experts concluded that trained CHWs can screen clients effectively and provide progestin-only injectables safely (WHO et al., 2010).

Injectables are the most popular contraceptive method in East and Southern Africa, accounting for 36 percent of all contraceptive use. In West and Central Africa, they are not as popular, making up about 13 percent. Nevertheless, injectable use has increased sharply in West and Central Africa in the past decade (Ross, unpublished).

Several countries in Francophone West Africa are conducting pilot studies on CHW provision of injectables. For example, in Burkina Faso, the Ministry of Health and Gesellschaft für Internationale Zusammenarbeit (GIZ) are currently conducting such a study (Douti, 2002). In Togo, AWARE II is also piloting the provision of injectables by CHWs. The lessons learned from these pilot studies can be used to scale up CBD programs and develop appropriate national policies and operational guidelines.

In Togo, there is a lot of FP activity at the community level. The DSF, ATBEF, and PSI have begun an initiative to take long-term methods (Jadelle and IUDs) to the communities, and it seems to be working quite well. Twice a year, an outreach team from the Peripheral Health Units visits dispensaries. CHWs from the catchment area sensitize the communities and register women for the day of the visit. CHWs

report registering about 15–20 women (sometimes as many as 50 women) for long-term methods. Without exception, the CHWs told the HPP team that women in their villages prefer long-term methods. CHWs and midwives who provide services via the “mobile FP” teams report that rural women are enthusiastic about long-term methods—and not just because they are free-of-charge. The mobile teams have been so successful that the DSF wants to start taking them to the health huts closer to where the people are. If this happens, it will mean that long-term methods will be available in villages. Indeed, the DSF annual report for 2010 shows that one-third of the couple years of protection achieved during the year comes from the mobile FP teams.

“If we don’t move, and just leave FP where it is, in the facilities and clinics, nothing will happen. We need to go to the communities with FP.”

—NGO staff member

The HPP team found that injectables are also popular in districts and rural areas. According to CHWs and midwives, in many places, CHWs already provide injectables and, in at least one case of the CHWs interviewed, Jadelle. These CHWs were trained on the job by colleagues or by a supervisor.

Togo is the site of AWARE II’s pilot program for CBD where, among other community-based interventions, two districts are testing the feasibility of CHWs providing injectables. The training of CHWs took place while the HPP team was in the field.

Barriers

Informants reported numerous barriers to FP provision in the community, especially in rural areas; and the document review done for the M&E Framework assessment confirmed these barriers. Since family planning in the community is not widely available, many respondents could only inform the HPP team about access to family planning in more general terms. This section summarizes both supply- and demand-side barriers that hamper improvement in community-based family planning.

“Community barriers are so many, we have not finished identifying them and they can differ among differing villages.”

—Civil society respondent

Supply-side Issues

Policy limitations. Respondents at the DSF and Ministry of Plan told the team that the Policies and Norms for Reproductive Health, Family Planning, and STIs and the National Policy on Community-Based Interventions (2009) do not allow CHWs to provide injectables or initially prescribe pills. Although the RH Law, which established women’s right to RH services including contraception, was passed in 2009, it has not been disseminated—

meaning that providers, CHWs, local leaders, and the general population are unaware of the rights of women to RH services. The National Population Policy of 1998 is still in effect, even though a new population policy was drafted in 2004. According to the Ministry of Plan, the new policy has been on hold, pending the results of the National Census. Resources for FP/RH are so tight in Togo that it is not possible to widely disseminate laws, policies, and texts to service providers; most of the dissemination that does occur is provided by partners.

Stockouts. The respondents often mentioned challenges such as an insufficient government commitment to contraceptive procurement, as well as an inefficient distribution system and a lack of funding. As a result, commodities often take a long time to reach facilities and CHWs. Several informants emphasized that frequent stockouts are a problem. Indeed, while in Togo, the HPP team became aware of a condom stockout and some depleted stocks of pills. According to district-level informants, supplies of injectables typically only last a day or so. Informants generally attributed stockouts to poor operational policies around the supply system—from poor planning, training, supervision, and distribution to a lack of funds to procure commodities.

“The community is the first place to feel the stockout,” since they are at the end of a long chain of supply.”

—Local informant

Medicalization of family planning. “Those are hormones!” exclaimed one physician working in an international NGO, when asked if he thought CHWs should provide injectables. The view that they should be provided only by physicians and nurses is common in Togo. Hence, medicalization of family planning is still an issue, although practices in the field may sometimes differ from Lomé. For example, the HPP team met CHWs who provided injectables even if they had received no formal training. Their supervisors had trained them on the job, but they had not yet received the full formal training. Many of these service providers requested training in injectables and Jadelle during the team’s visit.

Current policies require that women undergo a gynecological examination before they can receive a contraceptive method. This requirement seems to be ignored in the districts the team visited; no one mentioned this during the interviews in the districts and only one person did in Lomé. Still, it is an example of the need to revise the norms and standards to reflect updated practices.

The team found that some providers create their own policies and practices for FP service provision, with the result that women are sometimes denied their method of choice or any family planning at all because of provider bias or ignorance. For example, one CHW who provides injectables stated that she would not provide family planning to girls who came to her, but would rather refer them to the health center at the next level, several kilometers away. Other providers reported that they did not generally insert IUDs in nulliparous or single women because of fears of infection.

“It’s a question of human resources, training. Our policies need to be revised so that all the medical personnel are trained on Jadelle.”

—District-level manager

Some providers try to meet FP needs and remove barriers even when this means not following existing policies. When asked why a permanent attendant would provide a method she is not formally trained to provide (only trained on the job), one CHW answered, “The reality of the field requires that a women be allowed to have her method of choice. We should not make her wait or force her to walk 10–15 kilometers when we can do it here.” In addition, injectables are usually given in the hip of the client at the facilities. Under the AWARE II pilot project, however, CHWs were trained to inject in the upper arm, thus removing another possible barrier

for women who select this method. They no longer need to show their body, which is often important when the provider is male.

Access to educated CHWs. The Policy on Community-Based Interventions has established the educational level for a CHW as equivalent to ninth grade in the U.S. system. According to MOH informants, many CHWs have reached this level of education (and even some high school level equivalent) in Togo. However, other informants reported that hiring a CHW with adequate education is a challenge, largely because those who have been educated often leave their home village for Lomé or other large cities to find work.

Training of CHWs and other FP providers. According to the MOH, there are approximately 10,000 CHWs in Togo; 8,500 of them were recruited for a Global Fund malaria project, although they are trained in community health and usually work on several health programs. Other projects recruit and train other CHWs, according to local NGO informants. In addition, many providers in the Peripheral Health Units require training in specific methods and refresher training in others, even if, in some cases, they receive on-the-job training in injectables or Jadelle from their supervisors.

Supervision. According to District Medical Officers, supervision of CHWs is supposed to take place once a month, but given their many responsibilities this would be an excessive work load. Where implementing partners have presence, they usually conduct supervision jointly with the DSF partner, alleviating some of the burden on the Peripheral Health Unit. Even at the central level, supervision is a barrier: the DSF staff reported having only gone to the field once in the previous two years.

Gender. According to the MOH, most CHWs are male, since they were recruited for a malaria Global Fund project. With the new National Policy on Community-Based Interventions, the MOH wants to recruit more women to ensure parity. When asked if they feel there is anything they can or cannot do because of their sex, both male and female CHWs responded no.

Motivation and incentives of CHWs. CHWs are technically volunteers working for different projects, such as PSI, ATBEF, and the Global Fund. According to the MOH, they receive a monthly stipend; the amount varies greatly depending on the project. The National Policy on Community-Based Interventions establishes payment for CHWs and was developed to recognize their work; provide funds for recruitment, training, and compensation; and ensure appropriate workload. The policy calls for the government to provide a monthly stipend of between 17,000 CFA and 34,000 CFA,⁸ depending on workload. It calls for all partners to follow suit to ensure a uniform standard for compensation. An MOH informant stated that for the policy to be respected and implemented, advocacy is needed to increase the health budget to support remuneration for CHWs. Besides this MOH official, CHWs were the only other respondents to mention motivation.

Almost without exception, the CHWs mentioned low motivation as a barrier to their work; they need adequate compensation to remain interested and involved. They emphasized their multiple responsibilities in the community management of integrated maternal and child health, malaria, and HIV activities, in addition to FP/RH. They also expressed interest in growing professionally and advancing in their field of work, but they do not see any possibilities for career growth.

⁸ US\$1= Approx. 500 CFA.

Geographic location. Distance traveled to obtain an FP method of choice has long been a barrier, say CHW informants. Also, sometimes, even if a woman lives close to a facility, the state of the roads and the (rainy) season impede access, since most Togolese in rural areas rely on “bush taxis,” walking, or riding animals to get where they need to go. The time it takes to travel can sometimes mean the loss of a whole day of work.

Cost. According to the DSF, the government subsidizes 80 percent of the cost of contraceptives provided to clients. The 20 percent paid by clients covers the consultation, registration card, and product. Clients pay 3,500 CFA (approximately US\$8) for Jadelle, 1,500 CFA (US\$3.50) for IUDs, and 1,200 CFA (US\$3) for injectables. Injections after the first one cost slightly less, since clients only buy the card once. Many informants, including all the CHWs, said the cost is prohibitive and family planning should be provided without any cost to the client. According to informants, the AWARE II pilot project offers free of charge all methods provided by CHWs. The mobile FP teams already offer Jadelle and IUDs free-of-charge.

Demand-side Issues

Gender. According to informants, much remains to be done to sensitize leaders and men to the benefits of family planning. While some men are already convinced of the benefits and are supportive, some providers noted that women often need the approval of their husbands or partners to obtain a method—for “peace in the family.” In addition, some providers require the husband’s or partner’s consent either because they are not familiar with the RH Law, which clearly states that no approval is needed, or because they recognize the local social dynamics that require approval for such a decision. However, in other cases, sometimes in the same community, CHWs report that men are eager for family planning and bring their spouses in for a method. They clearly see the advantages and are thrilled that family planning is available. CHWs in one village the team visited confirmed that the whole village is in favor of family planning and many, many women are already using it. During one interview, a male president of the village health management committee openly discussed which method his wife preferred and why.

“Now women [in my village] really like FP, especially the long-acting methods.”

—CHW working in a village

CHWs report that often husbands are against family planning because of the cost. One local leader stated, “Men are irresponsible and do not look out for the long term but are only concerned with what it costs them immediately.” In other situations, men do not know about the advantages of family planning and are open to an orientation and sensitization by the CHW or Peripheral Health Unit staff; after talking with these providers, they often end up in favor of planning their families.

Status of women. While the RH Law is clear that women can obtain family planning without family approvals, NGO informants confirmed that the lower status of women continues to play a role in society. Some women may not think they can obtain family planning without their husband’s consent or approval. Nevertheless, all providers said that some women use family planning without their husband’s knowledge. This situation might improve if men receive more detailed information about its benefits for the family and community.

Lack of information; rumors, and side effects. In one area where the team interviewed CHWs, it was found that, even though family planning is well accepted, many rumors still exist. Some people think that the IUD can move up in the woman's body; or that if a woman uses a method for a long time, she will never be able to get pregnant after she stops; or that the method will make her sick or even kill her. Providers stated that if a woman experiences a side effect from a certain method, she can quickly influence other women's attitudes toward and choice of that method; and for that reason, the providers need to have the right information to dispel rumors.

Stigma. Stigma on the part of CHWs can negatively affect demand. The team found that some CHWs were open to providing the client's method of choice to unmarried girls and girls in school. One CHW said, "If we do not provide her with a method, she may get pregnant and drop out of school. We don't want that." Other CHWs were not as willing to give methods to girls. Providers and NGOs generally agree that once a girl is turned away, whether it is by a CHW or a provider at the Peripheral Health Unit, she will not go back, and word will spread to the other girls that they cannot get family planning at those places. When other girls hear of this, they opt not to go and ask for a method.

RECOMMENDATIONS FOR REPOSITIONING FP IN TOGO

Togo has made considerable progress in creating a more enabling environment for family planning. Nevertheless, much remains to be done to strengthen ongoing activities to reposition family planning. According to respondents, communities are increasingly interested in family planning, and the government is struggling to keep up with demand. Several recommendations for the government and its technical and financial partners emerged from this assessment.

- 1. Support the translation and dissemination of the 2009 RH Law to all levels.** The Togo RH Law has been not been printed or disseminated. It is important that providers, civil society, and leaders at all levels are aware of this law. Dissemination in French and, if funds are available, in local languages will reach most of the population and help them learn about their RH rights.
- 2. Strengthen, support, and increase the DSF's capacity for leadership and coordination.** The government should provide the DSF with the human, material, and financial resources it needs to address the high unmet need for family planning in the country. It should also support any plans to place the DSF at a higher level within the ministry.
- 3. Identify, develop, and support FP champions at all levels.** Champions are needed in Parliament, government agencies, and the civil society and religious sectors, as well as in communities, including among men, mothers' clubs, and youth organizations. The effort to cultivate champions could begin with dissemination of the RH Law and the RAPID presentation to the regions and districts. Champions can be used to help create community networks to raise awareness about family planning and dispel myths and rumors around certain contraceptive methods.
- 4. Advocate for increasing the national health budget to 15 percent of the total budget.** Togo should increase the proportion of its national budget allocated to health to 15 percent, as countries have pledged in the Abuja Declaration. Within the increased health budget, the government should increase funding for FP services and information and add a line item in the budget for FP/RH commodities, especially contraceptives. Such budget increases will entail developing and strengthening partnerships and networks in Parliament, government, and civil society. Such a budget increase would signify true government commitment to family planning.
- 5. Revise the National Policy on Community-Based Interventions to ensure that CHWs are allowed to provide an initial supply of oral contraceptives and give injectables.** The MOH and its partners should continue to scale up provision of pills and injectables in more districts. Making injectables and other contraceptives available at the community level would help poor women, youth, and disadvantaged groups to obtain contraceptive supplies and information.
- 6. Continue recruiting CHWs, making sure to target gender parity.** CHWs are an important source of healthcare and information for many people. The MOH should continue to recruit them, especially women. The MOH should also orient CHWs and providers in Peripheral Health Units on the RH Law and train them in family planning.
- 7. Provide additional training to nurses to enable them to provide quality long-term FP methods.**

8. Increase the government's funding for contraceptive commodities.

It is recommended that civil society organizations

- 1. Form a strong network to advocate for improved RH/FP policies and for CSO participation in the design, implementation, and monitoring of RH/FP policies.**
- 2. Urge decisionmakers to allocate more national resources to support FP services and information throughout the country.**
- 3. Intensify their efforts to monitor the government's national and international commitments to FP programs and provide regular updates on progress toward greater support for FP programs.**

ANNEX 1: PERSONS INTERVIEWED

- Dr. Eloi Amegan, Program Manager, EngenderHealth
- Dr. Solange Toussa, Executive Director, ATBEF
- Cecile Mukurubuga, Representative, UNFPA
- Dr. N'Tapi, Director, DSF
- Jennifer Welsh, USAID Liaison Officer, U.S. Embassy
- Lanny Spencer, Political Officer, U.S. Embassy
- Chantal Afoutou, U.S. Embassy
- Leandre Ayawogan Koudan, Technical Assistant Franchising, PSI
- Dr. Moukaila Tchagafou, Local Consultant, AWARE II
- Modibo Maiga, Sr. Technical Advisor/Policy, AWARE II
- Dr. Fanta Diabate, Sr. Technical Advisor/FP, AWARE II
- Dodgi Doevi, Coordinator, Management and Coordination Unit, Ministry of Planning and Development
- Mr. Sodgi, President, *Forces en Action pour le Mieux Etre de la Mere et de l'Enfant*
- Dr. Calixta Aquereburu, Policy Advisor, AWARE II
- Agarem Ngamine, Policy Advisor, AWARE II
- Prof. Bouraima Sopho Boukari, Vice-President, *Union des Religieux de Togo pour la Promotion de la Sante*
- Dr. Elise Agbobli, In Charge of FP, WHO
- Dr. Kpensaga, Program Officer, WHO
- Dr. Sognikin, Division of Community Health, MOH
- Dr. Adolphe Sodji, Chief Medical Officer, Haho
- Col. Makara, Chief Medical Officer, Ave
- Mr. Damessi, Program Officer, DSF

In addition, the HPP team interviewed 3 CHWs in Haho, 4 in Ave, 6 local leaders, 8 district health staff (4 each in Haho and Ave), two governmental partner informants, and one informant from a donor agency.

ANNEX 2: REPOSITIONING FAMILY PLANNING RESULTS AND INDICATORS FOR TOGO

Repositioning Family Planning Results and Indicators for Togo			
Results	Indicators	Information	Indicator Source
Strategic Objective: Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable family planning programming	1. Instances of a government-led council, coalition, or entity that oversees and actively manages the family planning program	The DSF manages and carries out all FP work. However, partners do not think it is adequately supporting FP programs because of its low placement in the MOH structure and its lack of adequate resources.	DSF annual report, 2010; Key informants
	2. Evidence of documented improvement in the enabling environment for family planning, using a validated instrument	The FPE score increased from 52.7 in 1999 to 54.7 in 2004. The Contraceptive Security Index score was 45.8 in 2003.	FPE Score (Ross and Smith, 2010); Contraceptive Security Index (PRB, 2009)
	3. Evidence of FP policies implemented, resources allocated, and subsequently used in relation to the same FP policies.	The DSF implements all FP and family health policies and programs.	DSF annual report 2010; Key informants
IR1: Resources for family planning increased, allocated, and spent more effectively and equitably	IR1.1: Total resources <u>spent</u> on FP (by source and by activity/program area)	This indicator is the same as 1.3 (below). Total funds spent on FP commodities in 2010 were US\$2,109,624.	Summary of Products Provided by Donors between January 2008 and December 2010. Togo (DSF, 2011)
	IR1.2: Number of new financing mechanisms for family planning identified and tested	No new financing mechanisms were identified.	

Repositioning Family Planning in Togo: A Baseline

Repositioning Family Planning Results and Indicators for Togo			
Results	Indicators	Information	Indicator Source
	IR1.3: Total resources <u>allocated</u> to FP (by source and by activity)	See IR1.1 above.	Summary of Products Provided by Donors between January 2008 and December 2010. Togo (DSF, 2011)
	IR1.4: New and/or increased resources are committed to FP in the last two years	In 2008, donors committed US\$1.2 million to FP commodities; this amount increased to US\$1.9 million in 2009 and US\$2.1 million in 2011. The government of Togo allocated US\$30,000 for contraceptive commodities in 2008 and \$40, 000 in 2009 and 2010.	Summary of Products Provided by Donors between January 2008 and December 2010. Togo (DSF, 2011)
IR 2: Increased multisectoral coordination in the design, implementation, and financing of family planning policies and programs	IR2.1: Evidence of family planning programs incorporated into national strategic and development plans	There is no evidence of FP being incorporated into national strategic documents.	Key informant interviews; Review of the DSRP (2007) and new DSRP-C (2009)
	IR2.2: Evidence of governments engaging multiple sectors in family planning activities	The government engaged CARMMA in FP activities. The Technical Advisory Committee for RH products involves various public and private sector groups.	DSF annual report 2010; Key informants
	IR2.3: Evidence of multisectoral structures that are established or strengthened to promote FP policy	Multisectoral structures and plans include the National Action Plan for Condom Use, the Technical Advisory Committee for RH products, the National Youth Forum, and the Network of Parliamentarians for Population and Development. Most of these groups are inactive, although the advisory committee does meet sporadically.	Key informants
	IR2.4: Evidence of government support for private sector participation in FP	The team was unable to find any evidence of this.	

Annex 2: Repositioning Family Planning Results and Indicators for Togo

<p>IR 3: Policies that improve equitable and affordable access to high-quality family planning services and information, adopted and put into place</p>	<p>IR3.1: Existence of national or subnational policies or strategic plans that promote access to family planning services and information</p>	<p>The RH Law of 2007 clearly lays out a woman's right to FP. The draft 2004 National Population Policy and the PNDS call for an increase in the contraceptive prevalence rate to 50 percent by 2022. The draft 2004 population policy also aims to improve access and use of RH services and reduce at-risk births by 50 percent between 2005 and 2015.</p>	<p>PNDS (2009–2013), National Population Policy (1998), Road Map for Reducing Maternal Mortality (2008–2012), Reproductive Health Law (2007), National Plan for Securing RH Products (2008–2012)</p>
	<p>IR3.2: Existence of national or subnational policies or strategic plans that promote access to family planning services and information for underserved populations</p>	<p>The Health Law and the RH Law recognize reproductive rights. CARMMA provides many RH services for free. Mobile clinics provide long-term FP methods for free.</p>	<p>Reproductive Health Law (2007)</p>
	<p>IR3.3: Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy</p>	<p>There are many texts that interpret and guide implementation of the laws and policies around FP. However, some are not fully implemented.</p>	<p>Implementing guide for the RH Law (2010), National Policy on Community-Based Interventions (2009), National Plan to Reduce Maternal Mortality (2010)</p>
	<p>IR3.4: Evidence that policy barriers to access to family planning services and information have been identified and/or removed</p>	<p>The 2011 AWARE II study on identified geographic and cost barriers and the need for clients to have access to FP methods locally. The pilot study on CHW provision of injectables and the FP mobile teams are initiatives to address policy barriers.</p>	<p>RH Law (1998), National Population Policy (1998 and 2004, still in draft); Key informants</p>
	<p>IR3.5: Evidence of the implementation of policies that promote family planning services and information</p>	<p>DSF annual reports provide an overview of FP activities that the government has implemented, as do ATBEF and PSI reports.</p>	<p>DSF annual report, 2010; Key informants</p>

Repositioning Family Planning in Togo: A Baseline

<p>IR 4: Evidence-based data or information used to inform advocacy, policy dialogue, policy development, planning, resource allocation, budgeting, program design, guidelines, regulations, program improvement, and management</p>	<p>IR4.1: Evidence of data or information used to support repositioning family planning efforts</p>	<p>The DHS and MICS are the two major data sources the government uses to support CARMMA and the RAPID analysis. CARMMA declared that if FP is implemented, maternal deaths can be reduced by 25%.</p>	<p>Key informants; RAPID; CARMMA documents</p>
	<p>IR4.2: Evidence of international family planning best practices incorporated into national health standards</p>	<p>Gender equity, male involvement, men's reproductive health, and advocacy for FP are integrated into Togo's 2010 Policies and Norms for FP, RH, and STIs. CBD of FP is not yet fully incorporated into national health standards.</p>	<p>Policies and Norms for FP, RH, and STIs, 2010</p>
	<p>IR4.3: Evidence of a defined and funded research agenda in family planning</p>	<p>No evidence of a research agenda could be found.</p>	
	<p>IR4.4: Evidence of in-country organizational technical capacity for the collection, analysis and communication of FP information</p>	<p>In-country capacity for FP information collection, analysis, and communication is weak.</p>	<p>Key informants; RAPID; CARMMA documents</p>
<p>IR 5: Individual or institutional capacity strengthened in the public sector, civil society, and private sector to assume leadership and/or support the family planning agenda</p>	<p>IR5.1: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement repositioning family planning activities</p>	<p>ATBEF is the only national organization that can implement repositioning activities on its own.</p>	<p>Key informants</p>
	<p>IR5.2: Evidence of government departments or other entities established or strengthened to support the family planning agenda</p>	<p>DSF is small, underfunded, and not in a decision-making position within the MOH. The launch of RAPID Togo coincided with the creation of the <i>Union des Religieux de Togo pour la Santé</i>.</p>	<p>DSF annual report, 2010; Key informants</p>

Annex 2: Repositioning Family Planning Results and Indicators for Togo

	<p>IR5.3: Evidence of targeted public and private sector officials, faith-based organizations, or community leaders publicly demonstrating new or increased commitment to FP</p>	<p>The President of Togo launched CARMMA in 2010, and at least five ministers have launched it in five regions. The Minister of Health launched the Togo RAPID in July 2011. However, there are no committed, consistent FP champions in the government or in civil society.</p>	<p>Key informants</p>
	<p>IR5.4: Number of regional/national centers or collaboratives for shared education and research in family planning</p>	<p>No regional/national centers for sharing information, or collaboratives for FP were found.</p>	

ANNEX 3: SEMI-STRUCTURED INTERVIEW GUIDE FOR NATIONAL LEADERS

Introductory Questions for Key Informants

Verbal Informed Consent Language

Hello, my name is [_____] and I am working with the USAID-funded Health Policy Project (HPP) to study efforts to strengthen family planning in [country name]. Thank you for meeting with me to discuss the work that you and your organization are doing to related to family planning. This interview will take up to 60 minutes, and you are welcome to stop at any time and to answer the questions you wish to answer. The report will not include quotes that are attributed to your name or your organization. You may choose to allow me to include your name and your organization's name in the list of organizations consulted during the study.

Do you agree to be interviewed for this study?

- YES, verbal consent was received
- NO, consent was not received. End the interview.

Do you authorize HPP to use your organization's name in a list of all key informants that we interviewed in Togo? This list may be used in a report or other publicly available documents.

- YES, verbal consent was received
- NO, consent was not received. Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.

Signature of interviewer: _____

If you have any questions about this interview, please contact Elizabeth McDavid at 241-0798-9897 (or TBD).

Date of interview: _____

Time started: _____ **Time ended:** _____

Background Information

Check to indicate whether respondent is male or female.

- Male
- Female

Age of respondent: _____

1. Name of key informant: _____
2. Name of organization: _____
Position in organization _____
How long in position _____
3. Name of donor funding FP-related portfolio in your organization (if relevant):

4. Please tell me about your organization's work related to family planning.

5. Did you ever provide FP services?

- Yes
- No

6. Do you ever, or do you currently, supervise FP providers?

- Yes
- No

(Note: Interviewer should consider the organization's work and check off those areas of the framework that the respondent may be able to inform.)

- IR1—Resources
- IR2—Multisectoral
- IR3—Policy
- IR4—Information
- IR5—Capacity
- Community FP

Questions related to IR4.1 (for all organizations)

1. Does your program do any work to promote evidence-informed decision making in family planning?

Yes

No

If yes, please describe your work.

Questions Related to SO

The discussion guides for each result area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

For all respondents

SO.1

1. Is there a government established body that oversees family planning?
 - a. Please tell me about the body's roles and responsibilities.
2. Does the organization have power, influence, funding? Does it actively coordinate and manage the FP program?
3. What are the organization's limitations?
4. In your opinion, does the government play a leadership role in family planning?

Questions Related to IR1

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

USAID Mission

IR1.1/1.3

1. Are any USG agencies other than USAID funding FP information, services, or projects? If so, do you know how much these agencies allocate to FP-related work?
2. How much funding does USAID allocate to family planning annually? Can you, please, provide documentation of the amount allocated and/or disbursed?
3. Do you track the amount of funds allocated and spent by USAID on different types of FP interventions (i.e., commodities, BCC, enabling environment, etc.)? If so, can you share that information with me?
4. How is money budgeted, allocated, and disbursed for family planning? (What is the process?)
5. When was the most recent budget/allocation doc/disbursement record released?
6. Can we get a copy of the budget/allocation doc/disbursement record?
7. If not, is money budgeted/allocated doc/disbursed by donor? How would we figure out the percent of money budgeted/allocated/spent on family planning from USAID and from other sources?

IR1.2

1. Have you funded organizations to test alternative financing mechanisms for family planning? Please describe.
2. If not, are there any other donors or organizations working on those issues? Which one?
3. What types of financing mechanisms are being explored by the government?
4. How are these mechanisms reviewed?
5. Who suggests new ideas for health financing?
6. What barriers, if any, have prevented the implementation of alternative financing for family planning?

IR1.4

1. How does your program work to strengthen funding for family planning?
2. Can you think of any achievements resulting from your strengthening efforts? New commitments for FP funding?

IR1.4.1

1. How is money budgeted, allocated, and disbursed for family planning at the district level? Please describe.
2. Are you familiar with instances of increased FP funding at that level? Please tell me about this.

Donor-Funded Projects

IR1.1/1.3

1. Do you track budget information as part of your project work?
2. How is money budgeted, allocated, and disbursed for family planning? (What is the process?)
3. When was the most recent budget/allocation doc/disbursement record released?
4. Can we get a copy of the budget/allocation doc/disbursement record?
5. If not, is money budgeted/allocated doc/disbursed by donor? How would we figure out the percent of money budgeted/allocated/spent on family planning that is coming from USAID? From other donors? From the government? From private sources?

IR1.2

1. Does your organization work on alternative financing mechanisms for family planning?
2. If not, is there an organization working on those issues? Who?
3. What other financing mechanisms are being explored by the government?
4. How are these mechanisms reviewed?
5. Who suggests new ideas for health financing?
6. What barriers, if any, have prevented the implementation of alternative financing for family planning?

IR1.4

1. How does your program work to strengthen funding for family planning?
2. Can you think of any achievements resulting from your strengthening efforts? New commitments for FP funding?
3. How do you document successes in this area?

IR1.4.1

1. How is money budgeted, allocated, and disbursed for family planning at the district level? (What is the process?)
2. How would we learn about increases for FP funding at that level?

Government or Local NGOs

IR1.1/1.3

1. How is money budgeted, allocated, and disbursed for family planning? (What is the process?)

2. When was the most recent budget/allocation doc/disbursement record released?
3. What is the total annual amount from the national budget destined for the purchase of contraceptives during the last three years? (2009_____ 2010_____ 2011_____)
4. Is money budgeted/allocated doc/disbursed by donor? How would we figure out the percent of money budgeted/allocated/spent on family planning that is coming from USAID? From other donors? From the government? From private sources?
5. Are contraceptive methods easily available at all levels of the health system, including the community level?
 Yes
 No
(If no, explore what makes them unavailable at different levels; frequency of stockouts)
6. Does the Contraceptive Security Plan take into account the supply needs of NGOs and private providers?
 Yes
 No
(Explore how supply needs are/are not taken into account)

IR1.2

1. What other financing mechanisms are being explored by the government?
2. How are these mechanisms reviewed?
3. Who suggests new ideas for health financing?
4. What barriers, if any, have prevented the implementation of alternative financing for family planning?

IR1.4

1. Have there been any new commitments for FP funding by the government or other non-USAID sources recently?

IR1.41

1. How is money budgeted, allocated, and disbursed for FP at the district level? (What is the process?)
2. How would we learn about increases for FP funding at that level?

Questions Related to IR2

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

For USAID and Implementing Partners

IR2.1

1. Is family planning included in the poverty reduction strategy? What was the process for including family planning into this strategy document?
2. Has family planning been included in other key strategy documents?
3. What is positive about the way family planning has been included in these documents?
4. What is missing in terms of how family planning has been incorporated?

IR2.2

1. Is there a national population steering committee or commission?
2. If not, what is the primary government organization responsible for family planning?
3. Does this body involve groups from outside the health sector? From outside government sector?
4. How does this governmental organization involve groups from other sectors? (Examples could include in the design, implementation, financing, and/or monitoring and evaluation of FP policies and programs.)

IR2.3

1. Is there a multisectoral group that focuses on family planning? Who helped to form this group? What is the purpose of this group?
2. What has the group done in terms of advising on or setting FP policies; ensuring compliance to FP policies or norms; and developing plans to implement FP policies?
3. Does the group have power, influence, or support from the government?
4. Does your project work to strengthen this multisectoral group?
5. Can you think of any achievements resulting from your strengthening efforts?

IR2.4

1. Are there barriers to private sector participation in FP policy development or service delivery?
2. Historically, what has been the greatest barrier to private sector involvement in FP policy development and/or service delivery?
3. Has your organization worked to remove these types of barriers?
 - a. If not, which organizations do?
 - b. If yes, when and how were these barriers overcome? What was your organization's role in the process? Do you have any documentation of that success?

Government or Local NGOs

IR2.1

1. Is family planning included in the poverty reduction strategy?
 - a. What was the process for including FP into this strategy document?
2. Has family planning been included in other key strategy documents?
3. What is positive about the way family planning has been included in these documents?
4. What is missing in terms of how family planning has been incorporated?

IR2.2

1. Is there a national population steering committee or commission?
2. What is the primary government organization responsible for family planning?
3. Does this body involve groups from outside the health sector? From outside government sector?
4. How does this governmental organization involve groups from other sectors? (Examples could include in the design, implementation, financing, and/or monitoring and evaluation of FP policies and programs.)

IR2.3

1. Is there a multisectoral group that focuses on family planning? Who helped to form this group?
2. What is the purpose of this group?
3. What has the group done in terms of advising on or setting FP policies; ensuring compliance to FP policies or norms; and developing plans to implement FP policies?
4. Does the group have power, influence, or support from the government?

5. Is there a multisectoral committee for contraceptive security? Is the private sector a member? Is the committee functional? What is the frequency of meetings and when was the last one held?

IR2.4

1. Are there currently any barriers to private sector participation in FP policy development and/or service delivery?
 - a. If so, what are they?
2. Historically, what has been the greatest barrier(s) to private sector participation in FP policy development and/or service delivery?
3. When and how were these barriers overcome? What was your organization's role in the process?
4. How could we document that success?

Questions Related to IR3

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

(Note to interviewer: For each of these questions, if the informant responds that there is such a policy or plan, ask how you could get access to the policy document.)

USAID or Donor-Funded Organizations

IR 3.1

1. Are you familiar with a national FP policy or a national policy that includes family planning (e.g., RH policy, health policy, population policy)?
2. Is there a national policy to ensure contraceptive security?
3. Are there any national guidelines that have been developed to guide the provision of FP services?
4. Were stakeholders working at the subnational level involved in policy development?
5. Are there any specific subnational policies related to family planning?

IR 3.2

1. Are you familiar with national policies or guidelines that promote access to FP services for underserved populations? (*Note: "Underserved populations" may be defined by the country context. This could include youth, men, people living with HIV, the poor, the rural, postpartum women, and others.*)

IR 3.3

1. Is there a national plan related to family planning? An FP implementation or operational plan?
2. Are there subnational plans for providing FP services? Are these plans developed at the subnational level?

IR 3.4

1. Are there any policy barriers to providing FP services and information in this country? (*Example probes: Policy barriers may include taxation on contraceptive commodities, lack of guidelines on providing FP methods and information, limitations on medical personnel providing FP services*)
2. Are you familiar with initiatives to identify or remove policy barriers to family planning?
 - a. Please describe these barriers and how they were identified and removed.

IR 3.5

1. Is family planning a priority in this country for the government, donors, and/or the population?
2. Is there broad support for family planning in this country? Please describe any support or opposition for family planning.
3. Is the MOH or another organization monitoring the implementation of FP policies and plans?
 - a. Who is responsible? Do they produce reports about the implementation of FP policy?
4. Are there barriers in the release of funding for family planning (*refer to IRI indicators*)?
5. Are you or your organization working at the subnational level?
 - a. Do you have any documentation of the planning and implementation of family planning subnationally?

Questions Related to IR4

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

All Respondents

IR4.1

1. In terms of moving the FP agenda forward in this country, what was the last important decision made by the government or your organization related to family planning?
2. Who made the decision?
3. Was there a data review process to inform the decision? If so, what data were reviewed?
4. In your opinion, was it an evidence-informed decision?
5. Is there any documentation of using evidence to inform the decision?

IR4.2

1. Does Togo have standards of care or protocols related to providing RH services? Do these standards include family planning?
2. In your opinion, do these standards of care/protocols include current best practices in family planning?
3. What aspects have been overlooked or need to be updated?

IR4.3

1. Is there a defined research agenda related to family planning in this country?
2. How was it developed?
3. Has the research agenda been funded? By whom?
4. Who implements and monitors the research agenda?
5. How do you get data about family planning in this country?

IR4.4

1. If an international NGO is conducting most of the research and data generation, is there a local organization that is receiving capacity-building support in data collection, analysis, and dissemination?
2. Did anyone conduct an assessment of this organization's capacity before providing capacity-building assistance?
3. What are the strengths of this organization?
4. What are the limitations?
5. Has anyone conducted training events focused on data collection, analysis, and communication of information related to family planning? Can you please provide more information about this?
6. Do you have indicators and tools to measure the implementation of policies, especially RH policies ?

Questions Related to IR5

The discussion guides for each IR area are loosely organized by type of respondent: USAID Mission, donor-funded projects, and local NGOs or country government staff. It is not necessary, nor will there be sufficient time with a respondent, to ask all the questions below for each and every IR. Prior to beginning the discussion, interviewers should consider the type of respondent, the roles and responsibilities of the respondent, as well as the information already collected to select a limited number of specific questions to guide the discussion. For example, if the interviewer has already received adequate data on the resources mobilized for family planning, s/he could focus questions on another topic.

Donor-Funded Organizations or Donor Missions

IR5.1

1. Has your organization trained or assisted champions/networks/organizations/institutions to independently implement activities in one or more of the following areas: policy dialogue, planning, priority setting, resource allocation, program improvement, and/or advocacy for family planning?
2. Did you collect baseline information about the individuals'/organizations' capacity?
3. Can you think of an example of a capacity-building success story based on your work?
4. *Possibly question the M&E person at the organization:* Do you have a program indicator that measures increases in knowledge and/or capacity following a training event or technical assistance? If so, can you share results that you have reported to the indicator?

IR5.2

1. What is the primary government body responsible for overseeing family planning? Are there other departments or governmental entities that work on FP issues? When were they established?
2. Are there any newly formed local civil society groups/associations/networks/coalitions that support the FP agenda?
 - a. If so, when was it (or were they) formed?
3. What role does the organization play in promoting the FP agenda? Is this a greater or lesser role than the organization has held in the past?

IR5.3

1. If your program works with public or private sector leaders, do you track increases in demonstrated commitment for family planning?
2. Can you share successes in strengthening leadership commitment to family planning?
3. How do you document your successes?

Government or Local NGOs

IR5.2

1. What is the primary government body responsible for overseeing family planning? Are there other departments or governmental entities that work on FP issues? When were they established?
2. Are there any newly formed local civil society groups/associations/networks/coalitions that support the FP agenda?
3. If so, when was it (or were they) formed?
4. What role does the organization play in promoting the FP agenda? Is this a greater or lesser role than the organization has held in the past?

IR5.3

1. Does your organization track statements of support and demonstrated commitment for family planning by public and private sector leaders?
 - a. Please provide some examples.

Barriers to Family Planning at the Community Level

If respondents have said or demonstrated that they or their organization work or are knowledgeable of family planning at the community level, please use these questions to explore about operational or policy barriers to community-based distribution of family planning at the community level.

1. Are you aware of any ongoing or past pilot projects in Togo that give communities better access to contraceptives?

- Yes
 No

If yes, which products/methods were/are available?

(Collect information on who the contact person is so we can interview this person.)

2. What do you think are the barriers women encounter when they seek an FP method at the community level?

If not brought up, ask about the following (check):

Are methods easily available at the community level?

- Yes
 No

Is it easy for CHWs to get resupplied at the health posts or health centers?

- Yes
 No

Do women need the permission of their husband/partner to receive FP methods?

- Yes
 No

Can unmarried women receive a method?

- Yes
 No

Can unmarried men get condoms?

- Yes
 No

Are there some methods women cannot get unless they already have children?

- Yes
 No

Do people have to pay for FP methods?

- Yes
 No

Is there an age requirement for people to receive FP methods?

- Yes
 No

(Explore “no” responses and ask interviewee how laws/ policies/ standards/guidelines or operational policies could be underlying causes of the barriers identified.)

3. What do you think are the major barriers CHWs face in the delivery of family planning?

If not brought up, ask about the following (check):

Do CHWs have adequate skills and knowledge to provide FP?

- Yes
 No

Do CHWs have contraceptive supplies?

- Yes
 No

Are CHWs allowed to provide pills and injectables?

- Yes
 No

Do laws/policies/guidelines/norms allow CHWs to provide family planning?

- Yes
 No

Do CHWs prioritize family planning?

- Yes
 No

Do CHWs receive supervision and support to provide family planning?

- Yes
 No

(Explore “no” responses and ask interviewee how laws/ policies/ standards/guidelines or operational policies could be underlying causes of the barriers identified.)

4. Has your organization trained enough CHWs in family planning (first provision of pills, injectables). How long was the training? What is the frequency of refresher training? What is the profile of the CHW and what is the gender breakdown?

ANNEX 4: INTERVIEW GUIDE FOR CHWS, LOCAL LEADERS

Evaluating Repositioning Family Planning Efforts and Assessing Barriers to Community-Based Distribution

Country: _____

Date: _____

Interview Guide for Community Health Workers

Verbal Informed Consent Language

Hello, my name is [_____] and I am working with the USAID-funded Health Policy Project (HPP) to study efforts to strengthen family planning in [country name]. Thank you for meeting with me to discuss the work that you and your organization are doing to related to family planning. This interview will take up to 60 minutes, and you are welcome to stop at any time and to answer the questions you wish to answer. The report will not include quotes that are attributed to your name or your organization. You may choose to allow me to include your name and your organization's name in the list of organizations consulted during the study.

Do you agree to be interviewed for this study?

- YES, verbal consent was received
- NO, consent was not received. End the interview.

Do you authorize HPP to use your organization's name in a list of all key informants that we interviewed in Togo? This list may be used in a report or other publicly available documents.

- YES, verbal consent was received
- NO, consent was not received. Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.

Signature of interviewer: _____

If you have any questions about this interview, please contact Elizabeth McDavid at 241-0798-9897 (or TBD).

Date of interview: _____

Time started: _____ **Time ended:** _____

Background Information

Check to indicate whether respondent is male or female.

- Male
- Female

Age of respondent: _____

1. Name of respondent: _____

2. District/subdistrict/village: _____

Type of CHW (if applicable): _____

How long in position _____

3. Do you provide FP services?

Yes

No

Educational background—circle what applies (revise as appropriate for Togo):

Years of primary: _____

Years of secondary: _____

CBD training: _____ months

Other: _____

Interest in/Opposition to Family Planning in the Community

1. As far as you know, are women who live in this community generally interested in using family planning?

Yes

No

(Explore reasons why and why not.)

2. As far as you know, is there any opposition to women using family planning in this community?

Yes

No

(Explore opposition from husband, family, religious leaders, community leaders, etc., and the reasons for the opposition.)

Availability of Family Planning

3. What contraceptive methods are available in your community? (Probe for each and check.)

Condoms:

- Yes
- No

If yes, who provides: _____

Pills:

- Yes
- No

If yes, who provides: _____

Injectables:

- Yes
- No

If yes, who provides: _____

Other: _____

- Yes
- No

If yes, who provides: _____

Other: _____

- Yes
- No

If yes, who provides: _____

Other: _____

- Yes
- No

If yes, who provides: _____

4. If no, ask: What are the reasons the method(s) is (are) not available at the community level?

Condoms:

Pills:

Injectables:

Other (specify):

Other (specify):

Other (specify):

5. Do you think that the methods should be available at the community level?

Condoms:

- Yes
- No

Please explain: _____

Pills:

- Yes
- No

Please explain: _____

Injectables:

- Yes
- No

Please explain: _____

Other: _____

- Yes
- No

Please explain: _____

Other: _____

- Yes
- No

Please explain: _____

Other: _____

- Yes
- No

Please explain: _____

6. Have you been trained to provide:

Condoms:

- Yes
- No

Other: _____

- Yes
- No

Pills:

- Yes
- No

Other: _____

- Yes
- No

Injectables:

- Yes
- No

Other: _____

- Yes
- No

If “no”: What were the reasons that you were not trained in FP? (*Explore: Is family planning not part of basic training, or other?*)

If “yes”: Do you think that you can safely provide these methods?

- Yes
- No

(*If response is no, probe the reasons: insufficient training; lack of experience; lack of demand for method, etc.*)

7. According to policies/standards, are you (CHWs) allowed to provide:

Condoms:

- Yes
- No

Other: _____

- Yes
- No

Pills:

- Yes
- No

Other: _____

- Yes
- No

Injectables:

- Yes
- No

Other: _____

- Yes
- No

(Probe which methods CHW is not allowed to provide and how he/she knows.)

8. Do you have the supplies you need to provide:

Condoms:

- Yes
- No

Pills:

- Yes
- No

Injectables:

- Yes
- No

Other: _____

- Yes
- No

Other: _____

- Yes
- No

Other: _____

- Yes
- No

(If no, probe what is missing: contraceptive method or other supplies, and whether he/she knows the reasons there are stockouts or lack of supplies.)

9. In your work to provide family planning, do you receive regular supervision?

- Yes
- No

If yes, by whom: _____ How often: _____

Other encouragement: Explain:

Knowledge of Laws/Policies and Policy Barriers

10. What do you know about (explore):

Togo's RH Policy

- Never heard about it
- Received orientation

Togo's SRH Law

- Never heard about it
- Received orientation

Policy guiding the work of CHWs?

Anything else?

Describe what CHW knows about policies/laws:

11. How well do you think the policies/laws are actually implemented at the community level?

12. Can you think of any other policy that would help you better provide family planning?

13. Can you think of any other policies that would make it easier for people to use family planning?

Barriers to Family Planning Provision and Use

1. What do you think are the barriers women encounter when they seek an FP method at the community level:

Explain:

(If not brought up, ask about and explore the following.)

- Do women need the permission of their husband/partner to receive an FP method? (Explain.)
- Can unmarried women receive a method?
- Can unmarried men get condoms?
- Are there some methods women cannot get unless they already have children?
- Cost? Do people have to pay for FP methods? (Togo) Do you know that Togo's government has declared family planning to be free of charge?
- Lack of female providers
- Stockouts of methods

2. How do you think contraceptives could be made more easily available at the community level?

3. What particular barriers, if any, do you face as a man (or woman) in providing family planning?

Improvements in Government Support and Services

1. Have you noticed any improvements in terms of government support of family planning recently? If yes, please explain and tell me when this improvement began. If no, do you have any suggestions for how the government could improve its support for family planning?

2. Have you noticed any improvements in terms of availability of contraception at the community level recently? If yes, please explain and tell me when this improvement began. If no, do you have any suggestions for how availability of family planning could be improved at the community level?

(Thank you very much for your time. This information will assist us in providing information on family planning at the community level to the government.)

Evaluating Repositioning Family Planning Efforts and Assessing Barriers to Community-Based Distribution

Country: _____

Date: _____

Interview Guide for Community Leaders

Verbal Informed Consent Language

Hello, my name is [_____] and I am working with the USAID-funded Health Policy Project (HPP) to study efforts to strengthen family planning in [country name]. Thank you for meeting with me to discuss the work that you and your organization are doing to related to family planning. This interview will take up to 60 minutes, and you are welcome to stop at any time and to answer the questions you wish to answer. The report will not include quotes that are attributed to your name or your organization. You may choose to allow me to include your name and your organization's name in the list of organizations consulted during the study.

Do you agree to be interviewed for this study?

- YES, verbal consent was received
- NO, consent was not received. End the interview.

Do you authorize HPP to use your organization's name in a list of all key informants that we interviewed in Togo? This list may be used in a report or other publicly available documents.

- YES, verbal consent was received
- NO, consent was not received. Informant's organization name must not be used in list of key informants in any published documents or reports prepared by HPP.

Signature of interviewer: _____

If you have any questions about this interview, please contact Elizabeth McDavid at 241-0798-9897 (or TBD).

Date of interview: _____

Time started: _____ Time ended: _____

Background Information

Check to indicate whether respondent is male or female.

- Male
- Female

Age of respondent: _____

Repositioning Family Planning in Togo: A Baseline

District/subdistrict/village: _____

Type of leader: _____

How long in leadership position: _____

Age of respondent: _____

Educational background—circle what applies (revise as appropriate for Togo):

Literate:

Yes

No

Years of primary: _____ Years of secondary: _____ Other: _____

Interest in/Opposition to Family Planning in the Community

1. As far as you know, are women who live in this community generally interested in using family planning?

Yes

No

(Explore reasons why and why not.)

2. As far as you know, is there any opposition to women using family planning in this community?

Yes

No

(Explore opposition from husband, family, religious leaders, community leaders, etc., and the reasons for the opposition.)

Availability of Family Planning in the Community

3. What contraceptive methods are available in your community? *(Probe for each and check).*

Condoms:

- Yes
- No

If yes, who provides: _____

Pills:

- Yes
- No

If yes, who provides: _____

Injectables:

- Yes
- No

If yes, who provides: _____

Other: _____

- Yes
- No

If yes, who provides: _____

Other: _____

- Yes
- No

If yes, who provides: _____

Other: _____

- Yes
- No

If yes, who provides: _____

4. Do you think that the methods should be available at the community level?

Condoms:

- Yes
- No

Please explain: _____

Pills:

- Yes
- No

Please explain: _____

Injectables:

- Yes
- No

Please explain: _____

Other: _____

- Yes
- No

Please explain: _____

Other: _____

- Yes
- No

Please explain: _____

Other: _____

- Yes
- No

Please explain: _____

5. As far as you know, are community health workers allowed to provide:

Condoms:

- Yes
- No

Pills:

- Yes
- No

Injectables:

- Yes
- No

Other: _____

- Yes
 No

Other: _____

- Yes
 No

Other: _____

- Yes
 No

(Probe which methods CHW is not allowed to provide and why.)

Knowledge of Laws/Policies and Policy Barriers

6. Are you aware of Togo's policies and laws related to family planning?

- Yes
 No

(Probe the names of the policies and laws and what the respondent knows about them.)

7. *If aware of policies:* How well do you think Togo's policies related to family planning are actually implemented at the community level?

8. Do you think that Togo's policies related to family planning are sufficient to ensure access to family planning at the community level?

- Yes
 No

(If no, probe for policy barriers.)

Barriers to Family Planning Provision and Use

1. What do you think are the barriers women encounter when they seek an FP method at the community level?

Explain:

If not brought up, ask about and explore following and have informant explain/describe:

- Do women need the permission of their husband/partner to receive FP methods?

- Do women fear that husbands/partners do not approve of family planning? If yes, is this actually the case?
- Can unmarried women receive a method?
- Can unmarried men get condoms?
- Are there some methods women cannot get unless they already have children?
- Cost? Do people have to pay for FP methods?
- Is there a lack of female providers? Are there mostly male providers?
- Do people fear side effects?
- Are there stockouts of contraceptive methods? If so, which methods?

2. How do you think contraceptives could be made more easily available at the community level?

3. Are there any barriers to community-based workers providing contraceptives?

Yes

No

4. If yes, please explain.

Improvements in Government Support and Services

5. Have you noticed any improvements in terms of government support of family planning in Togo recently? If yes, please explain and tell me when this improvement began and how the renewed support has been shown. (*Probe: speeches, increased funding, new policies.*)

6. Have you noticed any improvements in terms of availability of contraception at the community level recently? If yes, please explain and tell me when this improvement began and what the reasons are for the improvement

- 7. Is there anything else you would like to say about what could be done to increase access to family planning at the community level?**

(Thank you very much for your time. This information will assist us in providing information on family planning at the community level to the government.)

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