policy

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REPOSITIONING FAMILY PLANNING IN TOGO

Status of Family Planning Programs in Togo

Brief

Photo credit: Germain Passamang Tabati

Overview

Since 2001, the United States Agency for International Development (USAID), the World Health Organization (WHO), the William and Flora Hewlett Foundation, and other partners have collaborated with African governments on an initiative to raise the priority of family planning (FP) in their national programs by strengthening political commitment and increasing resources. This concept is known as "repositioning family planning" (RFP). In 2011, the RFP initiative gained momentum when national leaders from eight francophone West African countries approved the Ouagadougou Call to Action, a commitment to take concrete actions to increase FP use.

This brief summarizes the key findings and recommendations from a 2011 assessment of Togo's RFP initiative.

Togo is one of the poorest countries in the world, with a per capita income of about US$850. Togo's economy is largely based on agriculture, which supports nearly two in three Togolese workers.

In the past 50 years, Togo's population has quadrupled in size. It has a young population, with two in five people under age 15. As these young people become parents, Togo's population will continue to grow. Nevertheless, the potential to slow population growth exists because many couples are having more children than they would like. About one in three (32%) married women ages 15–49 want to space or limit future births but are not using any method of family planning.

Enabling Policies

The overall policy environment for family planning in Togo is favorable. The 1998 National Population Policy seeks to reduce the proportion of high-risk pregnancies. The 2007 Reproductive Health Law establishes the right of all citizens to access services and information about reproductive health (RH). Since 2009, the Ministry of Health (MOH) has been implementing the Policies and Norms for Family Planning, Reproductive Health, and Sexually Transmitted Infections. These

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A strong foundation for family planning programs exists, including

- The availability of a range of FP services in public and private facilities
- A cadre of community health workers who provide information, condoms, and pill refills to rural residents
- Mobile teams that provide IUDs and implants in district facilities

But, to meet women's desire to space or limit births, the government needs to

- Increase support for DSF to strengthen FP programs
- Invest more resources in FP services and information
- Address operational barriers to allow provision of injectables by trained community workers
- Give more attention to meeting the needs of the poor, youth, and other disadvantaged groups

norms include gender equity, male involvement, and men's reproductive health. Other policies related to family planning are the National Strategy for Securing RH Products (2008–2012), the 2009 National Policy on Community-Based Interventions, and the 2011 National Action Plan for Condom Use, which covers both male and female condoms.

Family planning services received a boost from the Accelerated Campaign for the Reduction of Maternal Mortality (CARMMA), launched by President Faure Gnassingbé in 2010 and subsequently expanded to all districts. When CARMMA began, the government announced that intrauterine devices (IUDs) and implants would be provided free-of-charge to clients at health facilities. Mobile teams had been providing these methods through health facilities, and following the announcement, they expanded their service coverage.

The assessment team recommended that several policies be updated to reflect new national goals and service delivery practices. For example, a revision to the National Population Policy drafted in 2004 has yet to be finalized. The draft was updated to incorporate a goal from the National Health Development Plan (2009–2013) to increase use of modern contraceptives among married women from 13 percent in 2006 to 50 percent by 2022. This goal will be difficult to achieve without additional funding for public education and expansion of FP services. The assessment team noted the lack of specific policies that promote access to FP services for the poor and other disadvantaged populations. Some key informants stated that people could not afford FP services, even at highly subsidized levels.

As a start toward raising awareness of policies supporting access to FP information and services, the team recommended that existing policies such as the RH Law be disseminated widely to health providers as well as the general public. Also, the team stated that more FP champions should be cultivated to raise awareness of family planning and advocate for increasing the national health budget.

Program Implementation

Togo's Family Planning Program Effort score, which rates 30 indicators reflecting policies, services, evaluation, and access to contraceptives in national FP programs, has improved slightly, rising from 53 in 1999 to 55 in 2004 out of a possible score of 100.[1] The 2009 Contraceptive Security Index for Togo was 49.5 on a scale of 100, indicating a relatively low level of contraceptive security.[2]

The Division of Family Health (DSF) within the MOH oversees and manages the FP program, as well as maternal and child health, youth, and nutrition services. With this large portfolio and overburdened staff, the DSF is finding it difficult to provide leadership to FP activities. Key informants recommended that the MOH designate DSF as a directorate; place it higher up in the MOH structure; and give it adequate human resources, equipment, office space, and funding to carry out its mandate. In addition, districts and communities need more qualified and better trained community health workers, as well as medical professionals such as nurses,

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midwives, and doctors. Togo has a critical shortage of health workers, with fewer than 0.33 health professionals per 1,000 people, much lower than the WHO's recommended minimum of 2.28 healthcare professionals per 1,000 people.[3]

The central level of Togo's health system comprises the MOH and all its departments, health training schools, special agencies, and university hospitals. Each of the six regions has a regional health directorate and regional services, including a hospital. At the base level, 35 health districts manage all healthcare service provision and facilities, including district hospitals, socio-medical health centers, and dispensaries. The districts also oversee facilities run by religious and private health providers.

The private sector flourishes in Togo, with FP services provided by nonprofit church- or community-based service providers, traditional medicine practitioners, and private for-profit service providers that are mainly concentrated in Lomé. The private sector purchases contraceptive commodities from government stores. The *Association Togolaise pour le Bien-Etre Familial* (ATBEF) is actively involved in repositioning FP activities and participated in the FP conference for civil society organizations, held in Senegal in 2011. Other groups supporting increased resources for FP programs are the Union of Religious Leaders of Togo for Health and the Network of Parliamentarians for Population and Development.

Data on overall expenditures for family planning are not available. The total funds 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. These funds are provided mainly by donors, with Togo's government spending less than 2 percent of the total amount.

According to the DSF, condoms, pills, and injectables are offered in at least 70 percent of public and private health facilities. However, key informants pointed out that frequent stockouts may limit access to these methods and that poor road conditions make travel difficult. Provision of IUDs and implants by mobile teams visiting health facilities is helping to address unmet need for family planning and needs to be continued. The assessment team recommended that the government increase its national budget

for FP services and information and add a line item in the budget for FP/RH commodities, especially contraceptives. The team's overall impression was that the FP program lacked strong government commitment and was seriously under-funded to fulfill its mandate.

In addition to the service delivery component, the assessment team concluded that the national program needs to address the factors affecting demand for family planning, such as women's disadvantaged status, misconceptions about contraceptive methods, lack of male support for family planning, and health providers' bias against providing contraceptives to adolescents and unmarried women. Actions to reduce these barriers are greater outreach to communities, dissemination of accurate information about contraceptive methods, and reminders to service providers that the RH Law establishes the right of all citizens to RH services and information.

Currently, Togo does not have an established multisectoral group that meets regularly to plan and coordinate FP activities. Togo's participants at the 2011 Ougadougou conference on repositioning family planning could form the nucleus of a reinvigorated multisectoral working group. A Technical Advisory Committee responsible for contraceptive procurement exists, but it does not meet regularly. Since contraceptive stockouts are a chronic problem, this committee could play an important role in improving the contraceptive supply system.

Community-based Distribution

The 2009 National Policy on Community-Based Interventions sets standards for community health workers (CHWs), including their job description, training, supervision, and pay. CHWs are an important source of health services and information for rural residents—three in five of Togo's people live in rural areas. CHWs are authorized to provide condoms and resupplies of pills. However, they are not allowed to provide an initial supply of pills or give injectables. This limitation poses hardships for rural women, since they often must walk long distances to reach health facilities.

A demonstration project conducted in Togo in 2011–2012 showed that trained CHWs can effectively and safely provide hormonal contraceptives. Within eight months, 27 percent of women of reproductive age in the two study districts (Haho and Blitta) adopted modern contraceptive methods. More than two-thirds of the new contraceptive users chose injectables; other methods chosen were the pill, lactational amenorrhea, and the female condom. 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. If Togo were to change its policy regarding the provision of injectables and pills by CHWs, many women and their families would benefit and many high-risk births could be prevented, thereby reducing maternal and infant mortality.

Another policy that may limit access to FP services is the requirement that women undergo a gynecological examination by a doctor or nurse before they can receive a contraceptive method. While this policy does not seem to be widely enforced, many people might not be aware of this reality; thus, the assessment team recommended that the policy be revised to remove the requirement.

The assessment team also recommended that the MOH recruit more CHWs, especially women, and provide more training on family planning to CHWs and providers in district-level health facilities.

Recommendations

Based on its assessment, the assessment team made the following recommendations to the government of Togo and its partners:

- **Strengthen, support, and increase the DSF's capacity for leadership and coordination.** The government should place DSF at a higher level within the MOH and provide it with the human, material, and financial resources it needs to address the high unmet need for FP.
- **Revise the National Policy on Community-Based Interventions to ensure that CHWs are allowed to provide an initial supply of**

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oral contraceptives and give injectables. The MOH and its partners should continue to scale up provision of pills and injectables in more districts.

- **Provide additional training to nurses to enable them to provide quality long-term FP methods.**
- **Increase the government's funding for contraceptive commodities.**

The assessment team's recommendations for civil society organizations are to:

- **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.**
- **Urge decisionmakers to allocate more national resources to support FP services and information throughout the country.**
- **Intensify 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.**
- **Support the formation of the network of Muslim and Christian leaders involved in health.**

Assessment Report

During 2011–2012, the USAID-funded Health Policy Project (HPP) conducted assessments in two francophone West African countries to document the status of repositioning FP initiatives. Futures Group conducted six additional assessments with funding from the William and Flora Hewlett Foundation. These assessments can serve as a benchmark to highlight gaps in expanding access to FP and identify areas where challenges remain and more attention and resources are needed. The assessments used the Framework for Monitoring and Evaluating Efforts to Reposition Family Planning, developed by the MEASURE Evaluation project.[4]

In Togo, HPP conducted the assessment of the RFP initiative during September 13–29, 2011. The HPP team interviewed 43 key informants, including government

officials, civil society organizations, donors, local leaders, and community health workers, and visited the districts of Ave and Haho. The team also identified the policy and operational barriers to community-based distribution of contraceptives.

For the full report including the sources for cited data, see

McDavid, E. and A. Kodjo. 2012. *Repositioning Family Planning in Togo: A Baseline.* Washington, DC: Futures Group, Health Policy Project. Available at: www.healthpolicyproject.com.

Resources

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[2] The Contraceptive Security Index is based on ratings of 17 indicators related to the supply chain, finance, the health and social environment, access to FP, and use of FP. USAID | DELIVER Project, Task Order 1. 2009. *Contraceptive Security Index 2009: A Tool for Priority Setting and Planning.* Arlington, VA: USAID | DELIVER Project, Task Order 1.

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