

Breaking Down Barriers to Contraceptive Choice in the Public Health Sector in Burkina Faso and Togo

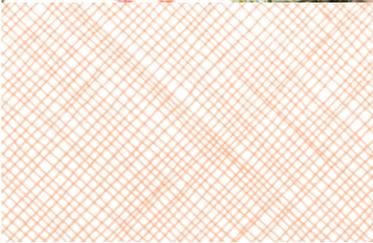
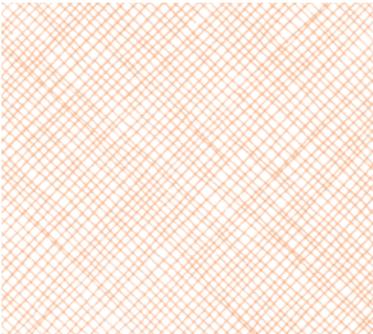
OVERVIEW

The lowest rates of contraceptive use in the world are found in West African countries, including Burkina Faso and Togo, where millions of women risk pregnancy against their wishes. Only 15% of married women in Burkina Faso and 13% in Togo use a modern method of family planning (FP), while 24% in Burkina Faso and 31% in Togo have an unmet need for FP (INSD & ICF International, 2012; DGSCN, 2011a). Only 3% of married women in Burkina Faso and 1% in Togo are able to access and use the hormonal implant or intrauterine device (IUD) (INSD & ICF International, 2012; DGSCN, 2007). These two long-acting reversible contraceptives (LARCs) are highly effective, convenient, and suitable for clients who wish to delay, space, or limit pregnancies. Expanding access to a wide range of method options is essential to ensuring contraceptive choice.

With funding from the U.S. Agency for International Development (USAID), from October 2010 to February 2013, the RESPOND Project built public-sector capacity in Burkina Faso and Togo to overcome barriers to contraceptive choice. The Ministry of Health (MOH) in each country received technical assistance addressing the three pillars of effective FP programs, as outlined in EngenderHealth's Supply-Enabling Environment-Demand (SEED) Programming Model™. This holistic framework is based on the principle that FP programs will be more successful if they include synergistic interventions that:

- Strengthen the **supply** of FP services, by extending their reach, improving their quality, and expanding the range of methods offered
- Break down barriers to foster an **enabling environment** for FP, including supportive policies and social norms
- Improve knowledge of contraceptive methods and cultivate **demand** for services

The project supported the improvement of the supply and demand for FP in three health districts in Burkina Faso (Koudougou, Kongoussi, and Diapaga) and two in Togo (Blitta and Haho). The combined population living in these districts is approximately 1.1 million in Burkina Faso (INSD, 2008) and 385,000 in Togo (DGSCN, 2011b). In Burkina Faso, RESPOND provided 123 health facilities with at least one type of support, which included provider training, supervision, FP equipment and sup-



plies, posters, and informational pamphlets for clients. The only three clinics in the districts in Burkina Faso that did not receive support were private Catholic facilities that do not offer FP services. In Togo, the project provided the full package of support to all 32 health facilities in the districts that had at least one provider from among the cadres authorized to offer LARCs.

RESPOND's enabling environment work focused on improving the quality and use of data for decision making, gaining acceptance of FP among men and religious leaders, and advocating for policy changes to improve FP access. In Burkina Faso, RESPOND successfully advocated for the MOH to reduce and standardize the prices of implants and IUDs across the country. In Togo, the government adopted the SEED model as the organizing framework for its national FP action plan for 2013–2017.

METHODS

In November–December 2012, a quasi-experimental mixed-methods design was used to evaluate the intervention in the five intervention districts and to examine two comparison districts (Zorgho in Burkina Faso and Wawa in Togo), which were selected on the basis of their geographic proximity and demographic similarity to the intervention districts.

Evaluators reviewed service statistics over a two-year period and analyzed supervision data for 141 facility-based providers (58 in Burkina Faso, 83 in Togo). In addition, 803 clients, 173 providers, 32 MOH managers, and 15 client champions participated in structured interviews (Table 1).

RESPOND also conducted facility audits at baseline (June–July 2011) and endline (November–December 2012). At baseline, RESPOND audited 126 health facilities in Burkina Faso and 30 in Togo. At endline, RESPOND audited 170 facilities in Burkina Faso and 49 in Togo, including the original facilities and comparison facilities. Evaluators used the data to map the availability of implant and IUD services over time, defining a method as “available” if a given facility had at least one trained, qualified provider, the requisite insertion and removal equipment and supplies, and the unexpired contraceptive product itself in stock.

THE INTERVENTION

Strengthening Supply

In June 2011, RESPOND led formative research on the factors underlying nonuse of LARCs in Burkina Faso and Togo. In-depth interviews with 32 providers and 28 clients, as well as 20 observations of counseling sessions, revealed a number of supply-side barriers to use:

- Providers were not up to date on the **medical eligibility criteria** for LARCs.
- **Insufficient information** on side effects was conveyed during counseling.
- **User fees** for LARCs were considered too high.

To address these findings, the two MOHs updated and standardized national curricula for in-service provider training in counseling and clinical FP, including LARCs, with technical assistance from RESPOND. Next, the project trained 20 MOH trainers per country using the updated curricula. Across the two countries, 104 providers from 82 public-sector health facilities

TABLE 1. KEY INFORMANT INTERVIEWS CONDUCTED AT ENDLINE

Type of key informant	Burkina Faso	Togo	Total
Provider	143	30	173
Birth attendant	68	6	74
Midwife	28	2	30
Nurse	46	20	66
Medical assistant	0	2	2
Doctor	1	0	1
Client	664	139	803
Champion	9	6	15
MOH manager	19	13	32
Total	835	336	1,171

TABLE 2. NUMBER OF PROVIDERS TRAINED, BY TYPE OF TRAINING, BURKINA FASO AND TOGO

Type of provider	Burkina Faso			Togo		
	Counseling	Infection prevention	Clinical FP	Counseling	Infection prevention	Clinical FP
Birth attendant	118	10	5	11	14	14
Midwife	42	22	20	6	17	8
Nurse	67	25	33	24	31	19
Medical assistant	1	0	0	4	11	4
Doctor	2	1	1	0	7	0
Mobile health worker	4	0	0	na	na	na
Total	234	58	59	45	80	45

Note: na=not applicable.

then received training in both counseling and clinical FP. The team in Burkina Faso also opened up FP counseling training to auxiliary birth attendants, who are authorized to provide short-acting methods only. For Burkina Faso and Togo, Table 2 breaks down the numbers of providers trained by cadre of provider and type of training.

RESPOND developed an FP counseling job aid and distributed 755 copies to the MOHs and to nongovernmental organizations (NGOs) across the two countries. Providers expressed great appreciation for the job aid, with 38% saying that they had no counseling job aid before. A nurse in Togo reported, “It’s a guide that has really helped us to follow the steps of counseling so that the client can make an informed choice.”

The MOH in each country stocked the health centers with contraceptive products, including LARCs. RESPOND provided LARC insertion and removal kits and infection prevention materials to all health centers that received training in clinical FP. These materials were distributed according to need, as identified by the baseline facility audits. In Burkina Faso, the percentage of facilities that had all three key supplies and equipment for waste management rose from 17% at baseline (21 of 126 facilities) to 50% at endline (60 of 120 facilities). In Togo, this figure rose from just 3% at baseline (one of 30) to 47% at endline (23 of 32).

EngenderHealth’s COPE® quality improvement process (which stands for client-oriented, provider-efficient services) engages service providers and other staff at a facility to assess the services they provide. Using various tools, they identify problems, find the

root causes, and develop effective solutions. The MOH and RESPOND led COPE® exercises at two health centers in Togo and at seven in Burkina Faso. Following these exercises, health centers improved confidentiality practices (such as by keeping doors closed during counseling sessions) and infection prevention



Victoire Aky chose the hormonal implant at a special FP day in Lomé, Togo.

practices (such as by washing hands with soap, wearing gloves, and using disposal boxes for sharps).

The two MOHs and RESPOND also organized 75 “special FP service days,” during which providers traveled to lower-level health care facilities to offer a wider range of methods than usual at no cost to clients. The intended beneficiaries of special service days were women who face particularly high geographic and financial barriers to accessing a range of FP methods in rural areas of the five districts and in the low-income outskirts of Lomé, Togo.

To ensure service quality, RESPOND trained nine MOH supervisors in Burkina Faso and 12 in Togo in facilitative supervision, an approach that emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and supervisee. Of the 82 health centers that received provider training in clinical FP, 80 (98%) also received at least one facilitative supervision visit from an MOH supervisor during the project. All 32 MOH managers interviewed said that supervision improved as a result of the project, with most adding that supervision is now supportive rather than punitive. Of the 141 providers supervised in counseling, 128 (91%) were deemed proficient by MOH supervisors based on national standards. All 79 providers supervised in implant provision were deemed proficient, and 47 of 48 (98%) supervised in IUD insertion demonstrated proficiency. The few providers who did not demonstrate proficiency were given on-the-job training to correct their approach.

“Supervision is no longer stressful, commando, police-like, but reassuring, participatory, and cooperative in the resolution of challenges faced.”

—Supervisor, Burkina Faso

In client exit interviews, data collectors asked 803 clients which methods the provider had told them about during FP counseling. Their responses showed that providers in the intervention districts counseled clients on a wider range of methods than did providers in comparison districts. Clients in intervention districts were more than twice as likely to say the provider told them about the IUD. When providers counsel clients on the full range of methods, clients are able to make a more informed choice.

Fostering an Enabling Environment

RESPOND participated in National Working Groups for Repositioning FP in both countries, using these meetings as a platform for advocacy as well as coordination. In Burkina Faso, RESPOND advocated for the MOH to authorize auxiliary birth attendants to offer LARCs. The MOH expressed an interest in doing so in its next revision of its Policies, Norms, and Procedures (PNP) in 2015. In both countries, RESPOND promoted holistic FP programming. All of the MOH managers interviewed said they found the SEED model useful. Following advocacy by RESPOND, the government of Togo based its national FP action plan for 2013–2017 on SEED.

In Burkina Faso, RESPOND met with the MOH in March 2011 to discuss how to address barriers to FP access. RESPOND raised concerns about the inconsistent prices of LARCs and about high user fees for service provision and supplies in government clinics, explaining that these factors contribute to inequity in access to LARC services. FP services are offered free in many other countries in Africa, including nearby Niger. In response, Burkina Faso’s MOH issued a national directive in April 2011 reducing and standardizing the prices of LARCs. The directive mandates that clients pay no more than 1000 CFA francs (\$2.07) for an implant and 800 CFA francs (\$1.65) for an IUD, with no charges for service provision or supplies. Fifteen of the 143 providers interviewed in Burkina Faso (11%) named this cost reduction as one of the major successes of the project.

To improve data for decision making, both MOHs held workshops to standardize forms used for collecting and reporting FP data. Many providers had previously made registers out of blank notebooks and omitted important data. RESPOND distributed newly revised FP registers to 123 health care facilities in Burkina Faso, and the MOH did the same in other districts. The project assisted the MOHs to orient 61 providers in Burkina Faso and 45 in Togo on how to fill out FP reporting forms correctly.

In Togo, RESPOND also assisted the MOH by printing and distributing 400 copies of the national PNP for FP and orienting 80 providers to them.

Across the two countries, 29 MOH managers and partners received training in Reality \sqrt , a tool for set-

ting FP goals and projecting FP commodity needs. The Burkina Faso MOH used Reality √ to set goals, estimate product needs, and project health impacts in their national FP action plan for 2013–2015.

At the district level in Burkina Faso, 338 religious and traditional leaders attended nine meetings to discuss FP. An MOH manager applauded the project for making “direct appeals to religious, traditional, and administrative leaders to influence their perceptions of FP.” In some places, no project had attempted to discuss the benefits of FP with religious leaders before.

“Now we preach in the mosques and explain FP. Before, FP was a game of hide-and-seek. Now in our homes, it's official, and it doesn't create infidelity.”

—Muslim leader, Burkina Faso

Cultivating Demand

The formative research conducted in June 2011 identified several issues affecting demand for LARCs:

- Client **attitudes** were more favorable toward the implant than the IUD
- **Rumors** about the health effects of IUDs were widespread
- Opposition to FP by **husbands** was common

To address these demand-side barriers, the two MOHs and RESPOND carried out a variety of facility- and community-based strategies. Following message development workshops, the project developed and pre-tested posters promoting acceptance of FP by men and religious leaders and pamphlets explaining the full range of methods to clients. Across the two countries, the project distributed more than 80,000 of these posters and pamphlets to the MOHs, NGOs, and health facilities. An auxiliary nurse in Togo reported that the pamphlets are useful because they “show the community that we offer these services and guide clients toward the center.”

In the community, the project trained 24 satisfied FP clients in Burkina Faso and 16 in Togo—half of them male, half female—to volunteer as FP champions. The team in Burkina Faso trained 24 community health workers (CHWs) to raise awareness as well. In Burkina Faso, the champions and CHWs teamed up with providers to lead 688 health talks in pub-



Example of a poster developed by RESPOND/Togo. It reads, “I'm supporting my wife in the choice of a contraceptive method to ensure the future of our family. Go to a health center!”

lic spaces such as marketplaces. At these talks, they reached more than 24,000 women and 7,500 men with messages about FP. At 75 community theater performances, more than 14,500 women and 34,000 men in Burkina Faso watched plays about couple communication on FP. While the project did not track champions' activities as closely in Togo, 27% of providers in Togo and 32% in Burkina Faso said they “sometimes” or “often” received clients referred by RESPOND champions. Clients in both countries overwhelmingly reported that men's views of FP had improved over the course of the project.

“Husbands who were reticent now come to us for information on methods.”

—Male FP champion, Togo

The project also involved real service providers, clients, community health agents, and religious leaders in radio shows and spots targeting men and religious leaders with messages about modern FP. On community radio stations in Burkina Faso and Togo, RESPOND aired spots 3,290 times in five languages, as well as 90 radio shows and more than 400 radio advertisements for special service days. In exit interviews with 572 clients, 46% said they had heard recent messages about FP on the radio.

In addition, the project aired short documentary films to encourage couple communication about FP. The films, produced by RESPOND, profile real couples in Burkina Faso who use LARCs and permanent methods. The videos depict the issues each couple

TABLE 3. NO. OF FACILITIES OFFERING LARC SERVICES (PROVIDER, EQUIPMENT, AND PRODUCT) AT BASELINE AND ENDLINE, AND PERCENTAGE INCREASE

Country	Method	Baseline (June–July 2011)	Endline (Nov.–Dec. 2012)	% increase
Burkina Faso (3 intervention districts)	Implant	8	25	213%
	IUD	2	26	1,200%
Togo (2 intervention districts)	Implant	5	32	540%
	IUD	3	31	933%

struggled with as they considered their choices. In Burkina Faso, RESPOND organized 16 public showings, reaching more than 2,000 people, as well as 16 showings on national television. In Togo, two hospitals showed the films twice a month in waiting rooms.

RESULTS

Access to a wide range of methods increased dramatically in the intervention zones. At baseline, 13 public-sector health facilities across the five intervention districts in Burkina Faso and Togo could offer the implant and only five could offer the IUD. At endline, both LARCs were available at 57 facilities, representing a fourfold increase in implant access and an 11-fold increase in IUD access (Table 3). The remaining facilities were missing one or more elements of contraceptive security—the provider, equipment, supplies, or product.

As the range of available methods expanded, clients responded positively, coming in large numbers for LARCs. At endline, intervention facilities in the two countries provided 2.6 times more implants per month (1,409 insertions) than they had in the same month of the prior year (538 insertions). The comparison districts in both countries saw a smaller rise: Their monthly implant insertions doubled, from 66 to 134. In the five intervention districts, IUD insertions increased from eight to 67 per month—an eightfold increase—while the comparison districts saw no increase in IUD use.

When trends in LARC use in the intervention and comparison districts in Burkina Faso and Togo are examined, it becomes clear that demand for LARCs was particularly high during months with at least one special service day (Figures 1 and 2), when all methods were offered for free.

FIGURE 1. LARC USE IN BURKINA FASO DISTRICTS, JANUARY 2011–NOVEMBER 2012

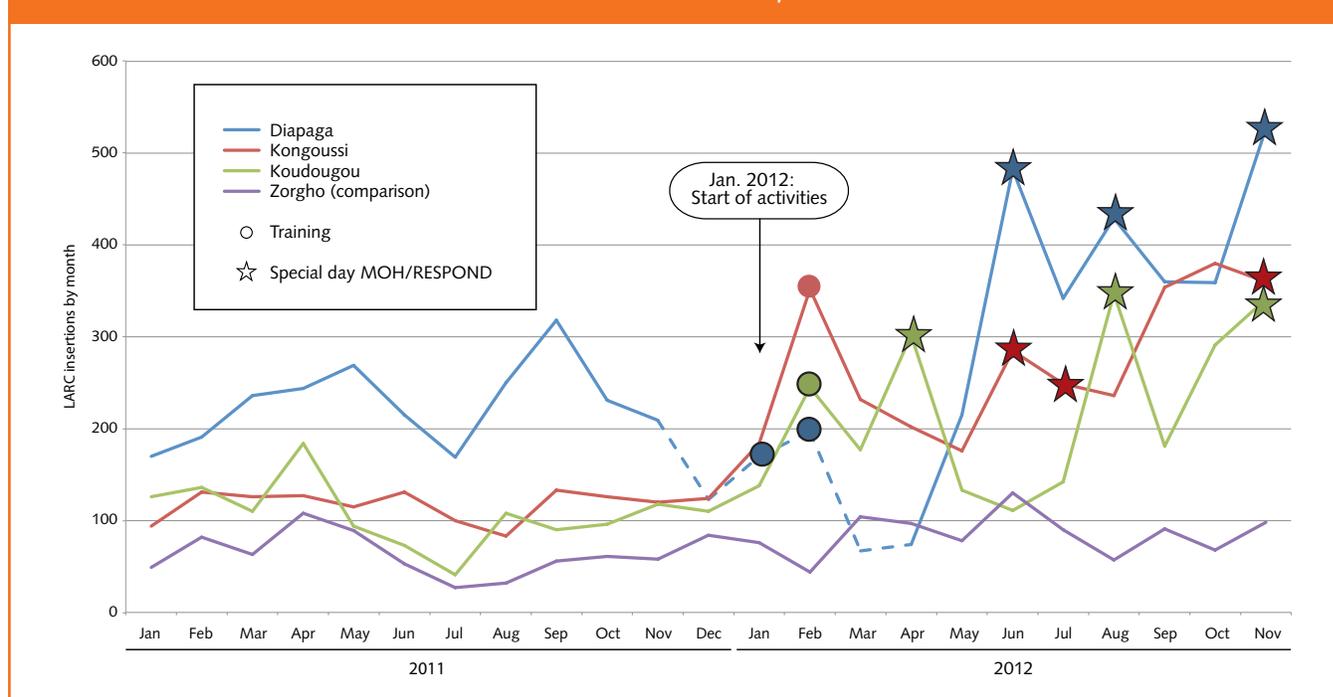
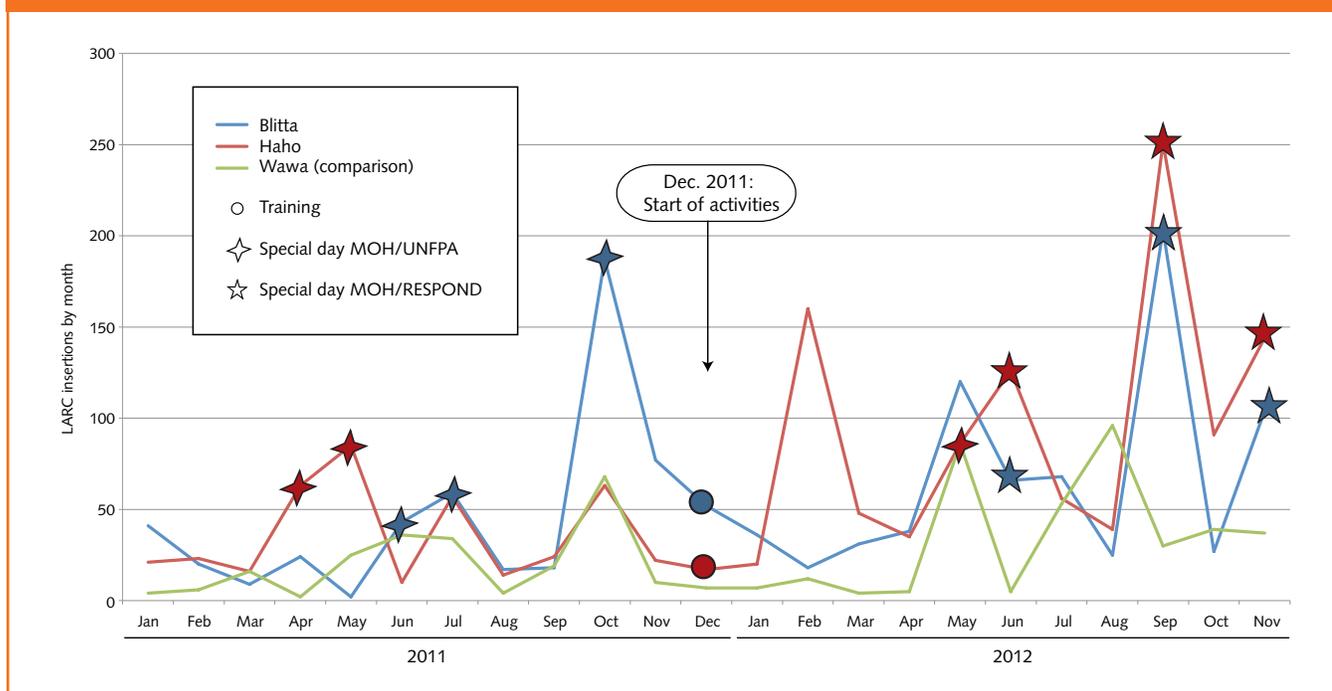


FIGURE 2. LARC USE IN TOGO DISTRICTS, JANUARY 2011–NOVEMBER 2012



By broadening contraceptive choice to include LARCs, the intervention districts provided many more couple-years of protection (CYPs)¹ than they had in the prior year. For the three intervention districts in Burkina Faso, CYPs from four major FP methods—the pill, injectables, implants, and IUDs—rose by 39%, from 31,592 in 2011 to 43,984 in 2012. This increase came even in the face of a prolonged stockout of implants in Diapaga District in 2012. In contrast, the comparison district in Burkina Faso saw an increase of only 9% (from 7,754 CYPs in 2011 to 8,421 in 2012). In Togo, the two intervention districts provided 9,166 CYPs in 2012—54% more than the 5,934 they provided in 2011. The comparison district in Togo saw a smaller but also impressive increase of 32% (from 1,502 CYPs in 2011 to 1,987 in 2012).

In Burkina Faso, 1,817 clients received FP during the 57 special FP service days. During 18 special days in Togo, 1,406 clients received FP services. Across the two countries, 86% of special day clients chose the implant, 11% chose the IUD, and 3% chose injectables. Special days were very popular and contributed 12,188 CYPs across the two countries.

LESSONS LEARNED

With holistic planning and the right inputs, the public health sector expanded contraceptive choice in two West African countries. The enthusiastic response of clients indicates that the project tapped into a strongly felt need for wider contraceptive choice. A number of lessons emerged:

- **Training and equipment for infection prevention are critical and neglected.** It is essential to refresh providers' counseling and infection prevention skills, as the project did, before training them to offer additional methods. In Togo, eight of the 13 MOH managers who were interviewed named "infection prevention" as a best practice introduced by RESPOND, indicating that it had been neglected prior to the project.
- **Special service days run by health districts were highly effective in expanding access.** Demand for LARCs was high when geographic and financial barriers were reduced through special FP days. Special days also offered providers an important opportunity for supervised practice; 23% of providers interviewed in Togo mentioned that special days strengthened their skills in providing LARCs.

¹ As an outcome measure for FP services, CYPs refer to the total number of years during which couples will be protected against unintended pregnancy, based on the volume of contraceptive services delivered in a given period of time and the average duration of use of each contraceptive product.

It was cost-effective to involve providers from the district rather than bringing in providers from the capital.

- **Standardization of LARC costs is not enforced in all facilities.** At endline, RESPOND found that 81% of facilities in the intervention districts in Burkina Faso followed the directive on LARC user fees. The other facilities continued to charge prices above the rates outlined in the directive. Standardizing prices was an important step, but the policy will only have an impact if it is enforced.
- **Transfers of providers disrupted LARC access.** Even in the brief timeframe of the project, a number of providers who were trained were reassigned to other districts. In one district in Burkina Faso, more than one-quarter of the facilities RESPOND supported were not able to offer LARCs at endline because the provider who received training had been reassigned to another district. An MOH manager from the district questioned whether increased access to LARCs will last because of the movement of health care personnel from sites with LARC commodities and equipment to sites that lack them.
- **Involving providers in health talks was helpful.** When FP champions in Burkina Faso were asked what factors contributed to their success, four of nine named the accompaniment of providers. At health talks, providers were able to offer accurate information about side effects, reassure potential clients, and demonstrate that they were welcoming and approachable.

- **Women recommend continuing to target men with FP messages.** When asked for their recommendations, 145 of 664 clients in Burkina Faso (22%) suggested, without prompting, targeting men with messages to encourage their acceptance of FP. A client in Togo explained, “Before, men refused FP services. With the awareness-raising of RESPOND, they accept and support their wives.”
- **Holistic programming is key.** Contraceptive method choice requires access to quality services, supportive policies and social norms, and accurate information about FP options from a trusted source. By addressing all of these elements, the project and the governments of Burkina Faso and Togo succeeded in expanding choice.

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