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E2A EVIDENCE TO ACTION
for Strengthened Reproductive Health



STRENGTHENING POSTABORTION FAMILY PLANNING IN BURKINA FASO

Pre-Service and In-Service Training on Postabortion Care

BACKGROUND

Countries in Francophone West Africa have long worked to overcome the challenges related to implementing and scaling up reproductive health services, including providing the complete package of services included in postabortion care (PAC).¹ To help address these issues, an assessment² of the progress made by several West African countries, including Burkina Faso, was conducted and presented at a conference called *Best Practices to Scale up PAC for Lasting Impact* in Saly, Senegal, in 2008. At this meeting, participants, policymakers, and program managers drafted action plans detailing strategies for strengthening postabortion family planning (PAC-FP) services in their respective countries based on the evidence presented³ regarding each country's needs.

Prior to 2008, PAC services in Burkina Faso were available at the teaching hospital, 13 regional hospitals, and in some districts. PAC services were included in annual district planning, national PAC-specific registers were created, and PAC activities were integrated with other services and into the training curricula of the National School of Public Health (École Nationale de Santé Publique). The United Nations Population Fund (UNFPA), Jhpiego and Ipas, recognizing the need to improve PAC services, provided assistance by training health providers and providing manual vacuum aspiration (MVA) kits to address the situation.

After the 2008 meeting, the Virtual Fostering Change Program platform was adapted for PAC (VFCP for PAC) as a follow-up to countries participating in the 2008 conference in Saly, Senegal. The VFCP for PAC is an internet-based, interactive learning program that was used to teach teams about the application of the fostering change methodology as well as skills to help draft and refine action plans to strengthen PAC programs, namely emergency treatment of abortion complications, postabortion FP, and community empowerment via community mobilization. During the VFCP for PAC process, action plans initiated at the 2008 Saly meeting were revised, and participants were trained on leadership and management skills.

Throughout the VFCP for PAC implementation process, Burkina Faso's action plan, initiated at the 2008 meeting, was further refined. However, the action plan team lacked funding and associated resources to implement the range of activities. USAID/Washington responded to these challenges by providing \$40,000 for training and technical assistance to Burkina Faso, which was organized and implemented by EngenderHealth's Responding to the Need for Family Planning through Expand-

ed Contraceptive Choices and Program Services (RESPOND) Project from 2009 to 2010. Activities outlined in the action plan were originally planned for two facilities (CHU Yalgado Ouedraogo [CHU-YO] and CMA Sector 30), however, the activities were implemented in four facilities (CHU-YO, CMA Kossodo, CMA Pissy, and CMA Sector 30).

In 2009, a member from EngenderHealth's RESPOND technical support team visited Burkina Faso to hold preliminary meetings with Burkina Faso's country team, including supervision and site assessments of the facilities included in the action plan. During this visit, the team ascertained that service providers offering PAC services either had no training in using MVA, or in FP counseling and services and infection prevention. In 2010, RESPOND trained 20 participants, including doctors and midwives from the four selected facilities. The PAC trainings included the use of MVA for the treatment of abortion complications, FP counseling and service delivery, and infection prevention.⁴

In 2012, USAID/Washington provided funding to the Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) Project to conduct an assessment of the implementation of the action plans refined under the VFCP for PAC. The E2A Project, a USAID-funded project designed to support the strengthening of FP and reproductive health service delivery, conducted a four-country assessment of action plan implementation in Burkina Faso, Guinea, Senegal, and Togo. The goal of the assessment was to highlight successes achieved to date as well as to identify the processes needed to strengthen and scale up PAC-FP services. Burkina Faso's

About E2A

The Evidence to Action For Strengthened Reproductive Health Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services.

Awarded in September 2011, this five-year project is led by Pathfinder International, in partnership with the African Population and Health Research Center, ExpandNet, Intra-Health International, Management Sciences for Health and PATH.

action plan was created to address several key service delivery components:

- Reorganization of services
- Supply chain management to improve contraceptive security
- Training
- Community awareness

The assessment findings for Burkina Faso are presented in this brief.

Reorganization of services called for improvements such as creating a separate PAC room and ensuring FP counseling and methods were available at the point of treatment.

Activities related to **supply chain management to improve contraceptive security** included procurement of supplies and creating a stock management system to include supervision of stock reports.

Training activities included training on both MVA and FP counseling and services.

Raising **community awareness** called for community health workers to use behavior change communication and IEC materials to improve health promotion activities.

ASSESSMENT METHODOLOGY

In early 2013, E2A conducted interviews and focus group discussions with staff in Burkina Faso who had participated in the VFCP for PAC. For this assessment, data collection included a total of: (1) 12 key informant interviews with Saly meeting team members, senior health facility management champions, and policymakers; (2) four focus group discussions with service providers from the teaching hospital at CHU-YO and the CMAs of Sector 30, Pissy and Kossodo; and (3) a review of PAC patient registers from these four facilities.

RESULTS

Reorganization of PAC Services

Reorganization of PAC services to ensure curative services and preventative FP counseling and services at the point of treatment was operationalized in all facilities with some success, addressing two key components: (1) the creation of a separate room where clients could receive both emergency treatment for abortion complications and FP counseling; and (2) FP method provision at the point of treatment.

The creation of a separate PAC room was one of the greatest challenges faced by the health facilities in integrating these services. Challenges related to a complete reorganization of services have continued, specifically for a dedicated PAC room. Despite efforts by trained staff to establish a dedicated PAC room, respondents at some facilities mentioned that some senior management staff did not agree with having a dedicated room, and it was therefore impossible for the space to be created. Another significant challenge mentioned by respondents was the physical separation of PAC services, with the FP unit and the facility pharmacy in different locations within a facility.

“Making family planning service available for postabortion care would avoid loss of cases; when ladies that we send away following care are asked to come back the following morning, we are not sure if they do come back for family planning or to their office visit a week later. Making available an on-site planning service would fix this problem in a better way.”

**- Midwife
(focus group discussion)**

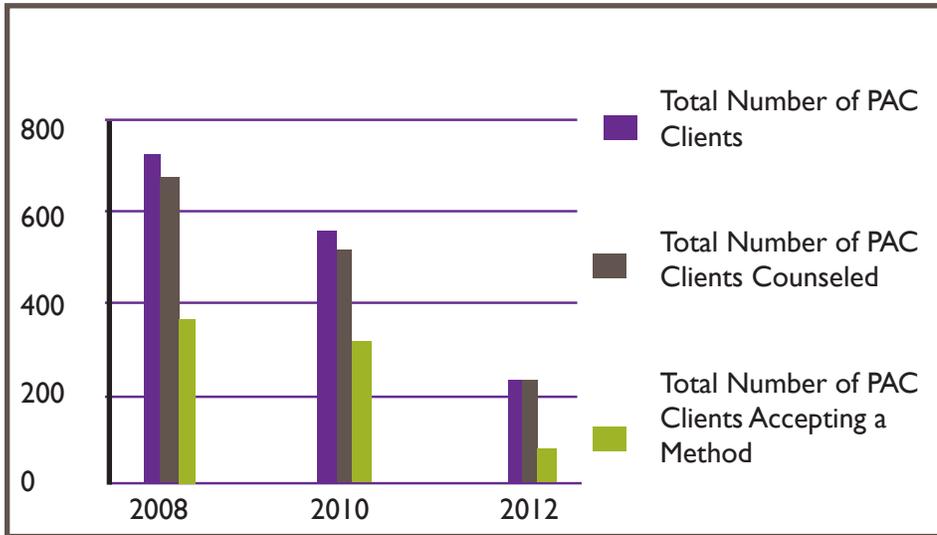
FP method provision at the point of treatment was another challenge faced in the strengthening of PAC-FP services, though according to the patient register data, all PAC clients were counseled in 2012. A FP unit offering counseling and services during normal working hours was functioning in all four facilities, although clients had to go to the facility pharmacy to receive their contraceptives. Providers mentioned that this created a barrier for clients, given that after receiving MVA treatment and FP counseling, clients would then be given a prescription for their chosen method and directed to the facility pharmacy to purchase it, before having to return to the provider to have the method administered.

Method mix: Service providers reported that facilities struggled to provide a range of methods at the point of treatment and were only partially successful, with oral pills remaining the most common method of choice. Information from one facility shows that, at first, both short-acting and long-acting methods were offered, though more recently, only oral pills were accepted. This occurred following the implementation of the Bamako Initiative, which required that most FP methods be purchased at the facility pharmacy.

In order to gauge progress in this area, E2A gathered PAC statistics at four facilities (CHU-YO, CMA Kossodo, CMA Pissy, and CMA Sector 30) offering PAC services.³ At three facilities, the total number of PAC clients decreased by 71% (from 735 in 2008 to 212 in 2012). During the same period, 99% of PAC clients were counseled on a FP method in 2008; increasing to 100% in 2012. A little over 51% accepted a contraceptive method (377/735) in 2008; declining to 47% (100/212) in 2012 (see graph on next page).

³Data presented for CHU-YO, CMA Sector 30, and CMA Kossodo. CMA Pissy PAC statistics excluded: PAC statistics not recorded for the 2012 January – June period.

PAC-FP Client Register Statistics from CHU-YO, CMA Kossodo, and CMA Sector 30, January - June 2008, 2010, and 2012



Data Sources: PAC statistics from CHU-YO, CMA Sector 30, and CMA Kossodo: January - June 2008, 2010, and 2012

Cost of FP Methods

Respondents mentioned that the cost of FP methods was another barrier to PAC clients obtaining them. One respondent described how donor agencies provide contraceptives for free to the government, but the actual cost to the client is high since the government has a cost-recovery system. The respondent added that while recognizing that the high cost of methods has remained a barrier for clients, the Ministry of Health (MoH) seems open to working towards a solution.

Supply Chain Management

A notable achievement of the action plan was the recognition that concerted efforts have been made to improve supply chain management for PAC supplies, including contraceptives. Service providers from one facility mentioned that they had received MVA kits on a regular basis, but other facilities didn't fare as well. As reported by a senior obstetrician and midwives at one facility, stock-outs of MVA kit items, particularly cannulas as well as contraceptives and consumables continue, significantly limiting providers' ability to offer quality care to their PAC clients. Some of these stock-outs can be traced to the logistics of the supply chain management system. This has received considerable attention from the MoH with technical support from UNFPA resulting in improved supply chain logistics

at the central level, though stock-outs at the peripheral levels continue, especially for implants due to high demand.

Training of Service Providers

The providers at the four health facilities benefited from PAC service provision trainings. UNFPA collaborated with the MoH and implemented a program for strengthening pre-service training that included technical support and equipment for the skills laboratory in order to bring them up to the International Confederation of Midwives standards. Respondents mentioned that a critical operational success during the past few years has been the strengthening of the pre-service and in-service training for midwives. PAC-FP training modules have been included in both the pre-service and in-service training manuals. While training on the provision of PAC had been strengthened, providers expressed the need for further trainings to ensure adequate numbers of trained staff to manage PAC cases and provide FP counseling and services, particularly after hours.

"The achievements, I would say, are the critical mass of competent people on the ground who can handle postabortion complications. This has accrued to the point that I believe that at all levels we have the trained personnel to do the work."

- Country Team Member

Community Awareness

A key part of the action plan was the recognition of the need to raise community awareness about obstetric danger signs and enable timely referral to appropriate facilities when pregnancy complications arise. One respondent pointed out that in order to address these concerns, a community awareness program for obstetric emergencies (that included PAC) was implemented, which established management cells for obstetric emergencies at the village level. These village-based committees used IEC materials and mass media, especially radio, to raise community awareness about maternal mortality and abortion, and encouraged community leaders to recognize the contribution of abortion to maternal mortality.

National Policies, Norms, and Protocols

Given that PAC clients are at high risk of unintended pregnancy, FP counseling and services at point of treatment have been included in national standards and protocols, though these have faced implementation challenges—for example, low provider knowledge about protocols and guidelines.

Country Feedback on Implementation of Action Plan

Health providers and policymakers in Burkina Faso offered valuable suggestions for strengthening PAC-FP services and addressing the remaining barriers and challenges. Respondents proposed continuing the training programs to attain national coverage. Given the growing demand for long-acting reversible contraceptives (LARCs), particularly implants, respondents suggested conducting LARCs skills training, especially for implants.



EXPANDNET



Respondents were well aware of the challenges PAC clients have faced when trying to acquire a method after regular working hours due to the national cost-recovery policy for drugs. They recommended offering contraceptives free of cost to all clients and making contraceptives available at the PAC unit. They also proposed further investments in raising community awareness about maternal mortality and its associated causes by mobilizing community leaders through advocacy campaigns on the link between maternal mortality and abortion.

Senior policymakers raised concerns about the action plan created in Saly, citing uncertain funding sources, and its apparent lack of alignment with national plans and budget. They proposed better alignment with national plans, rather than the creation of parallel plans that they said were unlikely to progress.

“The people who have asked you to prepare the plan of action, have they given you the money for its execution? You can’t just come and say insert this plan in your programs. You really can’t do it this way; it is not the right process.”

- Senior Policymaker

CONCLUSION

Burkina Faso has made progress in the quality of PAC-FP service provision by strengthening its pre-service and in-service training programs for PAC and including PAC in its national standards and protocols. Respondents suggested that investments need to be made that will allow contraceptives to be offered for free to all clients and ensure they are available to all PAC clients at the PAC unit so that they can receive their chosen FP method at point of treatment. Particular attention needs to be paid to the logistics of

the supply management chain, and efforts need to be undertaken to work within existing national plans.

These results were presented at the *Inter-country Workshop to Disseminate the Results of the Postabortion Care Evaluation and the Introduction of Best Practices for the Development and Sustainability of PAC*, held in Saly, Senegal, October 7 -11, 2013. At this meeting, the Burkina Faso country team proposed strengthening PAC services by advocating to the MoH and partners for the inclusion of FP commodities in the PAC unit and integrating PAC indicators in the routine health information system. Ensuring availability of MVA kits and FP commodities for PAC services and strengthening maternal health care providers’ skills, as well as data collection and monitoring and evaluation, were other proposed activities for the subsequent 18 months.

Endnotes

¹ For the purposes of this report, the definition of postabortion care (PAC) is based on the USAID PAC service delivery model, which includes three components:

1. Emergency treatment for complications of spontaneous or induced abortion.
2. Family planning counseling and service provision; sexually transmitted infection evaluation and treatment; and HIV counseling and/or referral for HIV testing.
3. Community empowerment through community awareness and mobilization.

² Dieng T, Diadhio M, Diop NJ, Faye Y. Assessment of Progress of the Postabortion Care Initiative in Francophone Africa. Centre de Formation et de la Recherche en Santé de la Reproductions (CEFOREP), Frontiers in Reproductive Health (FRONTIERS), The Population Council, April 2008.

³ Dissemination of Workshop Report: PAC (Postabortion Care) Assessment Results from Six West African Countries and Introduction of High Impact Best Practices for Scale-up in these Countries, October 20-23, 2008, Palm Beach, Saly Portudal, Senegal.

⁴ RESPOND Project Annual Report to USAID (July 1, 2009 - June 30, 2010).

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