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Assessing the Feasibility of Integrating Family Planning Services into Postpartum and Post Abortion Care in Togo, West Africa

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An abstract of
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Abstract

Assessing the Feasibility of Integrating Family Planning Services into Postpartum and Post Abortion Care in Togo, West Africa

By Katherine Maher

Background: Western Africa has one of the highest rates of maternal mortality in the world. One initiative to decrease this high rate of maternal mortality, is the integration of family planning (FP) into postpartum and post abortion care. In 2014, Togo made a commitment to establish family planning integration as an essential element of their health care plans. However, there is a need to understand the barriers within the healthcare system that may impede effective integration of family planning into postpartum and abortion care.

Objective: This study explores key stakeholders' perspectives on the feasibility of integrating family planning into Togo's postpartum and post abortion care and to identify if there are areas that require capacity building for successful FP integration.

Methods: To gain diversity of perspectives from Togo's health care system, 41 stakeholders from academic, government and private organizations were interviewed. Data was analyzed using thematic analysis through five cyclical steps: identifying core issues to develop a codebook, coding data using MAXQDA software, conducting inter-coder agreement, descriptive analysis, and categorizing major themes found in the data.

Results: Four major areas of capacity building for patient and provider levels were identified: lack of knowledge amongst patients and providers surrounding FP; the need for a standardized process for providers that includes FP in postpartum and post abortion care; the need for integrated infrastructure that allows for seamless counseling and provision of FP methods in health facilities; and, the need for sufficient supplies and equipment to successfully provide FP. Potential capacity building strategies for these areas included: multi-pronged education campaigns; education outreach initiatives, and comprehensive FP continued education.

Discussion: These results indicate that while challenges for integrating family planning into postpartum and post abortion care are well known, it is important that government, non-government organizations, health facilities, providers and community health workers must work together in order for integration of FP to be successful in Togo. Future steps for integration include gathering patient perspectives of their perceived barriers to integration FP, the role of men in FP decisions and what challenges urban health facilities face for integrating FP.

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Introduction

Among the 1.9 billion women of reproductive age (15 to 49 years old) worldwide, 1.1 billion have a need for family planning (World Health Organization, 2020). Of these 1.1 billion women, 842 million are using some form of contraceptive method, while 270 million still have an unmet need for contraception, with 172 million women not using any form of family planning despite their desire to delay pregnancy (United Nations & Department of Economic Social Affairs, 2020). Unmet need for family planning is defined as sexually active women of reproductive age who are not using any form of contraception while also reporting not wanting any more children or a desire to delay their next pregnancy for at least two years (United Nations & Department of Economic Social Affairs, 2020). The desire for family planning has seen an exponential increase over the past couple decades with only 900 million women desiring family planning in 2000, and 1.1 billion in 2020 (World Health Organization, 2020). Research has found that young adolescent maternal age and progressing maternal age increased the risk for maternal and infant mortality (Brown et al., 2015). Maternal mortality has been linked to adolescent pregnancies due to pelvic underdevelopment and a pregnancy that occurs after the age of 35 has shown a significant risk of mortality, with older women having the highest risk of mortality due to other health conditions being a risk to the pregnancy.

The rate and consequences of maternal mortality is one that plagues the world but is a significant cause of death within Western Africa. While there has been a significant decline in the maternal mortality rate in Western Africa from 1070 per 100,000 in 1990 to 679 per 100,000 in 2015, this rate is significantly higher than the rest of the world (Gunawardena et al., 2018). One way that the decline in maternal mortality has been achieved in other settings is by integrating family planning into postpartum and post abortion care. Family planning prevents

unwanted or unexpected pregnancies from occurring, as well as protecting against mortality through better birth spacing (Bauserman et al., 2020). When considering postpartum care, birth spacing is significant in reducing maternal mortality. When the time between pregnancies and births is too short, it does not allow for the woman to fully recover and increases a women's risk of anemia, placental abruption, placenta previa and uterine abruption as well as an increase in infant mortality (Bauserman et al., 2020). For post abortion and miscarriage, a woman's fertility returns after two to three weeks (Huber, 2019). By integrating family planning into post abortion care it decreases the chance for another unwanted or unexpected pregnancy.

In 2014, Togo became one of over 30 countries that pledged support to Family Planning 2020 (FP2020) within their country to try to decrease the maternal mortality ratio (Napo-Koura, 2015). By making this pledge, the country has established that family planning will be an essential element of Togo's overall health care plan.

This thesis aims to explore key stakeholder's perceptions on effectively integrating family planning into postpartum and post abortion health services to reduce maternal mortality. Key stakeholders of interest include, the Ministry of Health directors, reproductive health NGOs, reproductive health care providers and medical school professors. Examining the current capacity of the health care system to integrate family planning into postpartum and post abortion care will be examined from the perspectives of these key stakeholders within Togo's reproductive health system. This thesis will determine if this commitment to family planning is feasible with the resources that are available or address where improvements can be made to accomplish integrating family planning into postpartum and post abortion care.

Family Planning

Family planning refers to a full range of fertility and contraception services and policies within the sexual and reproductive health care system (UNFPA, 2022). It is a human rights-based approach to sexual and reproductive health that focuses on the equity and empowerment of women that allows them to make choices and decisions about their own bodies. It emphasizes the autonomy of women's bodies as well as the impacts on the development of nations by allowing women the chance to finish their education, enter the workforce, and challenge social and gender norms (UNFPA, 2022). Family planning is a core component of a women's social and economic empowerment that can have a significant impact on a person's community, family wellbeing, and on a nation's development. Access to services give women the opportunity to achieve educational goals, increase labor participation, and break the cycle of poverty. It also gives women the freedom to attain their desired number of pregnancies and children, as well as the resources and education about the benefits of timing and spacing those pregnancies and ensures that a person's reproductive decisions and intentions are supported (UNFPA, 2022). According to the WHO's Director for Sexual and Reproductive Health and Rights, Dr. Pascale Allotey, "Family planning self-actualization, empowerment, as well as health and wellbeing, and reduces maternal and infant deaths through the prevention of unintended pregnancy and unsafe abortion." (World Health Organization, 2022b).

In the past, family planning was centered on married couples and their responsibility to space births and pregnancies to ensure a safe delivery (UNFPA, 2022).The term "birth spacing" refers to the use of contraception in order to allow two to three years to pass between each pregnancy (Conde-Agudelo et al., 2007). Pregnancies that occur too close to each other increase the risk of premature birth, placental abruption, low birth weight, congenital disorders, and

neonatal and infant mortality (Conde-Agudelo et al., 2007). Birth spacing has been found to decrease infant mortality rates by 50% (Damtie et al., 2021). For women, short birth intervals also have an increased risk of hypertensive disorders during pregnancy, anemia and third trimester bleeding as well as a link to maternal mortality.

While birth spacing is still an important aspect of family planning policies and programs, recently the focus of family planning programming and policies has increased to include adolescent and young women, in addition to couples, into their programs and policies. This can include contraception and birth control that hopes to avoid or delay pregnancies. Family planning also encompasses health information for those experiencing infertility, where services can focus on what is causing infertility and support couples with getting pregnant (UNFPA, 2022). Men are also a focal point of family planning by engaging them in reproductive and sexual health conversations such as avoiding pregnancy and prevention of sexually transmitted diseases. Family planning also encompasses a full range of prevention of sexually transmitted infections (STI's), post rape care, post abortion and miscarriage care, and menstruation regulation (UNFPA, 2022). For many individuals, it is the starting point for sexual and reproductive health care services (UNFPA, 2022). When the full range of family planning services are implemented in a respectful and meaningful way, women and men are given the opportunity to make educated decisions about their bodies and their sexual and reproductive health which result in a decrease in maternal mortality and an increase in the quality of life of women and families.

Integration of Family Planning into Sexual and Reproductive Health Services

Integrating different health care services is a response to the original fragmented form of health care that separates services based on provider-centered models of care (World Health

Organization, 2006). Integrating health care services directly contributes to equitable access to care, better distribution of health outcomes, enhanced well-being, and quality of life. This enhancement has a link to economic, social, and individual benefits such as fewer hospitalizations, better adherence to care and increased patient satisfaction (World Health Organization, 2006). Integration is also a cost-effective way to provide care (World Health Organization, 2006). There are 17 core characteristics of integrated people-centric health care. Some of these characteristics are respectful, equitable, sustainable, coordinated, empowering, and goal oriented care (World Health Organization, 2006). These core characteristics hope to develop a form of health care that addresses the prevention of illnesses and injuries, as well as care that is endowed with rights and responsibilities that protect patients in all aspects of their life within the care they seek (World Health Organization, 2018).

For sexual and reproductive health services, there are five focal points of care: maternal and newborn health, family planning, prevention of unsafe abortion, management of reproductive tract infections (RTI's) and sexually transmitted infections and promoting sexual health. To have an integrated health system, care and resources must address all five components for adults as well as for adolescents. Creating strong links between these services with other primary care and related social services will increase the effectiveness and efficiency of the health care system. The goal of integrating care is to meet people's needs for accessible, acceptable, convenient, and patient-centered comprehensive care that is culturally sensitive (World Health Organization, 2006).

Postpartum Family Planning

Postpartum family planning (PPFP) is defined as the prevention of unplanned or closely spaced pregnancies that can occur within 12 months of childbirth (World Health Organization &

United States Agency for International Development, 2013). Postpartum women are one of the largest groups of women with unmet need for family planning, yet there are not many services or programs that target this population. The intended focus of PPFP is to support longer birth intervals for those who want more children in the future and to help support those who have reached their intended family size and no longer wish to have more children. According to a study that looked at Demographic and Health Survey data from 27 different countries, 50% of women had an unmet need for family planning (Pasha et al., 2015). Amongst the 65% of women who expressed their desire for another child, 91% wanted to delay that pregnancy by another year, yet 70% were not using any form of modern contraception (Pasha et al., 2015). Family planning can also prevent more than 30% of maternal mortalities and 10% of child mortality if pregnancies were spaced more than 24 months apart (Cleland et al., 2006). For the under-five mortality rate, if pregnancies had a 24-month interval between pregnancies, the mortality rate would decrease by 13% and if they waited 36 months the mortality rate would decrease by 25% (World Vision International, 2018). For women, when they reach their desired family size, PPFP is designed to help with preventing any more pregnancies. A study that analyzed data from 46 counties over a ten-year period, found that the risk for maternal mortality rose with each additional child up to four or more (Stover & Ross, 2010). This study also found that maternal deaths decreased an average between 7-35% depending on the number of children a woman had, with the biggest decrease found with women who had few children (Stover & Ross, 2010).

Postpartum family planning has three goals: 1. To help women decide which form of contraception is correct for them, 2. to initiate the use of contraception after birth, and 3. to continue contraceptive use for 2 years after childbirth (World Health Organization & United States Agency for International Development, 2013). There are several challenges in meeting

these three goals of family planning. It requires continued care from the initial childbirth, until two years after to continue administering antenatal care as well as adherence to contraception. While breastfeeding can induce lactational amenorrhea, it is still possible to become pregnant while breastfeeding if ovulation has taken place (World Health Organization & United States Agency for International Development, 2013). For women who do not breastfeed or who combine breastfeeding with formula feeding, the ability to become pregnant returns 45 days after childbirth. A form of contraception for the postpartum period is also important as ovulation can return before a women's menstruation returns post childbirth (World Health Organization & United States Agency for International Development, 2013). Another challenge to implementing postpartum family planning is social and cultural norms, whereby there is an expectation of returning to sexual intercourse after childbirth (World Health Organization & United States Agency for International Development, 2013).

Only certain forms of contraception can be used in the immediate postpartum period. Forms of contraception for PFPP are lactational amenorrhea method (LAM), copper based intrauterine contraceptive devices (IUD's), tubal occlusion, oral contraceptive pills (progestin only), condoms, and emergency contraception within specific guidelines based on the length of time since childbirth and based on their breastfeeding status (World Health Organization & United States Agency for International Development, 2013).This information is imperative for women to receive within the first couple of weeks after childbirth in order to prevent a future unplanned or unwanted pregnancy.

There are several points of contact that have been identified as appropriate integration areas for PPFP. These areas of care are antenatal visits, labor and delivery, predischarge from the hospital, postnatal care, and immunization and child health visits (World Health Organization &

United States Agency for International Development, 2013). During ANC women can be given information on the importance of a facility birth, as well as family planning information such as getting contraception immediately after the birth. This is also where women can be educated about their options when it comes to their current pregnancy and make decisions on whether to terminate the pregnancy or carry it to term. ANC is an important form of care for integration as it creates a link between community-based care and facility-based care (World Health Organization & United States Agency for International Development, 2013). For the labor and delivery point of care, this is where women can be given the opportunity to get immediate forms of contraception like IUDs and tubal occlusion, as well as get fertility counseling and family planning. Labor and delivery integration is especially important in areas where health care access is a barrier as it allows for immediate family planning choices as well as does not require return or follow-up visits (World Health Organization & United States Agency for International Development, 2013).

For postnatal care, PPFP allows for conversations surrounding birth spacing and the risks of fertility returning. This point of contact is especially important for community-based interventions especially if the birth was at home rather than a facility. Finally, infant health checkups and immunization visits are the most common and frequent forms of contact a woman makes during the first year after birth. These care visits are important for initial and continued counseling on the importance of birth spacing, contraception, and family planning. Addressing family planning issues during these specific points of contact with women who are pregnant and after they have given birth are identified as key areas for integration and are a necessary point for the health and safety for women (World Health Organization & United States Agency for International Development, 2013).

Post Abortion Care Family Planning

Of the 121 million unintended pregnancies that occurred between 2015 to 2019, over 60% ended in abortion in four subregions of Sub Saharan Africa (Bankole et al., 2020). In these four sub-regions, there are an estimated 33 abortions per 1000 women aged 15-49 (Bankole et al., 2020). The annual number of abortions in the region has almost doubled with 4.4 million happening in 1995-1999 to 8.0 million during 2015-2019 (Bankole et al., 2020).

While induced abortion is a serious concern, it is to be noted that spontaneous abortions, colloquially known as miscarriages, are also a major concern for post abortion care. Miscarriages in Africa are harder to measure due to cultural and religious stigma that surrounds the loss of a pregnancy, whereby they remain under-reported. Some of these beliefs are that the pregnant women have been cursed by witchcraft or evil spirits. Women can also be seen as promiscuous, and the loss of her pregnancy is due to God punishing her for her actions (Ayebare et al., 2021). Even with the stigma surrounding induced or spontaneous abortions, counseling and family planning can help from a future loss and lead to better communication and understanding of abortion within the communities (Ayebare et al., 2021).

Post abortion family planning refers to the care and services a woman receives after an induced or spontaneous abortion (World Health Organization, 2022a). Post abortion care (PAC) has two immediate and primary components and one secondary component. The first two immediate components of PAC are the emergency care required to address an induced or spontaneous abortion and the second is giving the necessary family planning and contraception counseling that informs and empowers the woman on her next steps with her sexual and reproductive health. This step also includes testing for sexually transmitted infections and HIV (World Health Organization, 2022a). The secondary component of PAC is addressing and

educating the community to increase community support and community empowerment surrounding induced or spontaneous abortions (World Health Organization, 2022a).

PAC is also a form of high impact family planning (High Impact Practices in Family Planning (HIP) (High Impact Practices in Family Planning (HIP), 2019). High impact family planning practices are a set of evidence-based family planning practices that have been vetted by experts with the goal of achieving specific family planning outcomes like reduction in unintended pregnancies, uptake in contraception use and reduction in overall fertility. Studies have shown that when women are counseled at post abortion about family planning and contraception methods, the majority of women leave with a method of contraception (High Impact Practices in Family Planning (HIP), 2019).

Induced and spontaneous abortions are common across the world. They account for a fourth of pregnancies where globally induced abortions have increased from 50.2 million in 1990-1994 to 55.9 million from 2010 to 2014 (High Impact Practices in Family Planning (HIP), 2019). The conditions in which most induced abortions are performed are less than ideal and lead to severe complications and even death. For Africa, abortions are between 15% to 30% of yearly hospital gynecological admissions (High Impact Practices in Family Planning (HIP), 2019). These admittances are from complications due to unsafe abortions that have been performed. Family planning and contraception counseling is especially important for this demographic. For first trimester induced or spontaneous abortions, fertility can return within two weeks and within 4 weeks of a second trimester abortion (High Impact Practices in Family Planning (HIP), 2019). It has been found that those who have one unintended pregnancy that ended in an induced abortion have a higher risk of having a second or third unintended pregnancy and women who leave reproductive care services without fully understanding their risks for future conception

have three times higher chance of having another pregnancy compared to women who leave with family planning counseling. (High Impact Practices in Family Planning (HIP), 2019).

Overview of Togo

This study was conducted in the small West African country of Togo officially named the Togolese Republic. Bordered by Ghana, Benin, and Burkina Faso, it sits on the Gulf of Guinea. It spans about 57,000 square kilometers (22,000 square miles) with a population of about 8,492,333 (2022 est.) (CIA, 2023). Due to it being connected to the coast, Togo was an important coastal port for the slave trade and was a German colony (1884-1914) until after the first World War when it became a French colony (1914-1960) until gaining independence in 1960. While Togo is a democracy, the same family and political party has had political rule since 1967, which has led to multiple civil demonstrations and a push for democratic reforms through free elections and presidential term limits (CIA, 2023). Togo has an estimated 37 ethnic groups with the majority being Adja-Ewe/Mina at 42.4% and 29.5% Kabye/Tem (2013-2014 estimates) (CIA, 2023). The official language is French, and it has two major languages in the north: Kabye (Kabiye) and Dogoma, and two in the south: Ewe and Mina. There are several religions in Togo: 42.3% of the population are Christian, 36.9% folk religion, 14% Muslim, and less than 1% of their population are Hindu, Buddhist, Jewish or other and 6.2% report no religious affinity (2020 estimate) (CIA, 2023).

Togo is in the Least Developed Country Category determined by the UN (UN, 2021). Least developed countries (LDCs) are low-income countries that have severe structural obstacles that inhibit sustainable development (UN, 2021). They have high economic and environmental shocks and low levels of human assets. Due to this categorization, LCDs have access to international support measures to help address areas of development assistance and trade. Togo's

Gross National Income per capita is $867 and their Human Asset Index is 58.8. To graduate from the status of LCD their GNI must exceed $1,222 and HAI must exceed 66 (UN, 2021). They must also improve on their Economic and environmental vulnerability index in order to graduate from this list.

Family Planning, Postpartum and Post abortion Family Planning in Togo

Togo's under-five mortality rate is 62.6 per 1,000 births (2021) (UNICEF, 2020) and the most recent maternal mortality ratio is 396 per 100,000 live births (2017) (World Bank, 2019). Due to the risk and high mortality rates amongst women and children, Togo made a commitment in 2014 to "Family Planning 2020 (FP2020)" to make family planning a priority of the country in order to address the high rates of maternal and infant mortality within their country. With funding from USAID, EngenderHealth created the *Agir Pour La Planification Familiale* (AgirPF) program that supported the governments in five African countries to integrate family planning into their sexual and reproductive health care system (EngenderHealth, 2013-2018). In 2014, there were approximately 290,000 women using a form of modern contraception in Togo. Due to the number of women who were using a modern method of contraception it is estimated that 100,000 unintended pregnancies were avoided, and 39,000 unsafe abortions and 290 maternal deaths were averted (Track 20, 2022). Since 2014, these numbers have seen a significant increase. The number of women who are using some form of modern contraception has almost doubled to 490,000 in 2022 (Track 20, 2022). Due to this level of contraception use, 180,000 unintended pregnancies were averted, and 64,000 unsafe abortions and 490 maternal deaths were averted (Track 20, 2022). Even with these numbers, there are still a significant number of women who are not using a modern form of contraception or do not have any knowledge about family planning.

Togo's national family planning and reproductive health policy is included in the Law on Reproductive Health (2006); the Policy and Standards in Reproductive Health, Family Planning, and Sexually Transmitted Infections (2009); the National Health Development Plan 2012–2015 (2012); and the Action Plan for Repositioning Family Planning in Togo 2013–2017 (2013). These documents aim to increase the financing and resources dedicated to incorporating family planning into other forms of health care.

In 2013, Agir pour la planification familial (AgirPF) was launched by EngenderHealth and the Togolese Ministry of Health. This 5-year USAID/West Africa project that took place from 2013 to 2018, aimed to increase access to family planning with an emphasis on integrating family planning into postpartum and post abortion services. AgirPF was implemented in urban and peri-urban areas within five West African countries: Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo.

Study Objectives

Given Togo's commitment to integrate family planning into their sexual and reproductive health care systems, there is a need to explore the capacity of reproductive health care services to integrate family planning into postpartum and post abortion care in Togo, West Africa. This thesis aims to examine perceptions of 41 key stakeholders, including Ministry of Health Officials, Health Facility Directors, NGO and Health Care workers and reproductive health medical educators, on the feasibility of the health care system to integrate family planning into postpartum and post abortion care. Data for this study is based on research that was conducted as part of a larger case study completed by EngenderHealth's *AgirPF* in April to August 2016.

Methods

Study Site

This study took place between July to August 2016 and was conducted Lomé (pop. 749,700), Sokodé (pop. 117,811) and Kara (pop. 104,207), the three largest urban areas and cities in Togo (Worldometer, 2020). During February to June 2016, *AgirPF* started the integration of family planning into 35 health facilities and taught health care providers about postpartum intrauterine device insertion. This situation provided a unique opportunity to analyze the capacity of integration across all levels of the Togolese health care system. *AgirPF* implemented the family planning programs in urban and peri-urban areas only in the three study cities in Togo, which is why they were chosen for this study. In addition to the Ministry of Health, *AgirPF* also partnered with and identified key stakeholders within the Schools of Midwifery, Nursing Assistant Nursing/Midwifery and Medicine, health facilities, and NGOs and international organizations within these chosen cities.

Study Design

A mixed methods design was used for the original study, which comprised key informant interviews and a monitoring and evaluating survey conducted concurrently. Data for this thesis focuses only on the section of these key informant interviews that focus on evaluating the capacity of integrating family planning into the postpartum and post abortion care in Togo.

Data Collection

A purposive sample of n=41 key informants, was recruited to include data from different reproductive health services. The goal was to gain diverse perspectives from a range of

reproductive health services on the integration of family planning into different reproductive health services in the country. To acquire this diverse sample, key informants were recruited from academic, government and private institutions, including faculty at Schools of Medicine, Nursing and Midwifery (n=3), NGO and international organization health care workers (n=9), directors of hospitals (n=9), health care providers (n=14) and politicians who work in reproductive health services (n=7). The sample size for each institution was determined through several different factors. The three faculty were the only three individuals who teach reproductive health at the Schools of Medicine, Nursing and Midwifery in Togo. Similarly, the NGO workers were r from all 9 non-government organizations that *AgirPF* worked with. The number of healthcare workers and politicians were determined participant availability, however there was a distinct effort to contact many different types of healthcare workers from different health care facilities and levels. The diversity of participants was intended to elicit varied perspectives with individuals who have various degrees of contact with the program activities and training that had been conducted by *AgirPF* for integrating family planning services into the reproductive health care system. Study participants were recruited by *AgirPF* in collaboration with the Togolese Ministry of Health, and other reproductive health Non-Government Organizations and health facilities.

Due to the varying nature of each participant's expertise and understanding of the reproductive health care system in Togo, five different semi-structured interview guides were developed. During the piloting when a single guide was used, it was found that different participants were unable to give their perspectives on certain aspects of the reproductive health care system based on their job qualifications and training. This led to the development of five interview guides. There were a set of common topics asked to all participants about multiple

aspects of family planning and integrated family planning in Togo. Then, questions were tailored towards the expertise of the stakeholders in the different interview guides, to gain an understanding of the perspectives of each type of health care service. This enabled richer data to be collected from all participants. For this paper, the focus was only on questions pertaining to the perceptions of key stakeholders on the capacity of the health care system to integrate family planning into postpartum and post abortion health care services.

Interviews were conducted face-to-face by a team of five Togolese social scientists from the Demographic Research Unit. Interviews took between 30 to 150 minutes, were conducted in French, and audio recorded. The time and place of the interview were chosen by the participants.

Data Analysis

The interview recordings were transcribed verbatim in French by the Togolese team and deidentified. The transcripts were reviewed for accuracy and completeness as the transcription process occurred. For this analysis, only data pertaining to the capacity of integrating family planning were used and copied into a Word document to be translated into English by a bilingual translator. The translation was reviewed for accuracy by the study team.

Data was analyzed using thematic analysis. Thematic analysis involves identifying common and overarching themes within qualitative data. A theme is something that is found in the data that is important to the research question and represents a level of responses that have similarly repeated patterns within the data set (Braun & Clarke, 2006). Thematic analysis involved the following five steps, which were not conducted sequentially but in a circular, and repeated manner where some steps were revisited or occurred at the same time. The first step was reviewing and memoing data to develop a codebook of core topics discussed. A third of the

data was reviewed to create a preliminary codebook. The data was systematically read, and core issues were identified, and memos written on the transcript that were then reviewed to develop codes. These codes were then compiled into a comprehensive codebook. The codebook included inductive issues found within the data, as well as deductive issues developed from existing literature. The team then collectively reviewed the codebook to remove inconsistencies, repetitions, and refine unclear codes. The second step involved coding all data using the codebook in MAXQDA software. This software allows for efficient and standardized application of codes to the textual data. The third step was conducting inter-coder agreement to ensure consistent coding of data between analysts. Codes were also added, and code definitions evolved during this time as additional issues were identified, and clarity of the codes became more evident. The fourth step was descriptive analysis where broad ideas found within the data were identified and written down with a focus on capacity building. The final step was categorizing these issues of identified areas for capacity building to successfully integrate family planning into postpartum and post abortion care into four major themes of knowledge, standardization, infrastructure, and supplies.

Results

There are four areas of the healthcare system identified by key informants that need strengthening to effectively integrate family planning into postpartum and post abortion care in Togo. These include the lack of knowledge amongst patients and providers surrounding family planning, the need for a standardized process for providers that includes family planning in postpartum and post abortion care, specialized integrated infrastructure within health facilities that allows for seamless counseling and provision of family planning methods, and sufficient supplies and equipment to provide family planning in all health facilities, illustrated in Figure 1.

These four areas that have been identified work together in that they build off each other and without capacity building in all four together, family planning will not be able to be fully integrated into postpartum and post abortion care. The lack of knowledge is the core area that needs capacity building and without it being addressed, capacity building in the other three areas will not be successful. If women do not know about the existence of family planning, then there will not be a demand for family planning that providers have to supply with a standardized process. If there is no demand for services, then there is no need for integrated infrastructure or for the equipment and supplies needed for providing family planning. While all four need each other for the success of integration, if the lack of knowledge is not first addressed then the any capacity building in the other three areas will be unsuccessful and unnecessary.

Figure 1. Components of effective integration of FP into PPC and PAC

Capacity Building Needs

Knowledge of Family Planning

The foundational area that was identified by the key informants as needing capacity building is the need for knowledge and expansion of information for family planning for patients and providers.

For family planning patients, there is a lack of knowledge surrounding what family planning is, different forms of family planning methods available, where to receive a family planning method, how to receive a family planning method, and the reasons and benefits for using family planning after having a child or a spontaneous or nonspontaneous abortion. Many women, especially those in hard-to-reach communities, do not give birth in a healthcare facility. Many also do not know the necessity to go to a health facility after giving birth or after a miscarriage. This situation leads to many women never having the opportunity to learn about

family planning from a health care provider or receive a family planning method. For those who experience a spontaneous or nonspontaneous abortion, many do not go to a facility for fear of stigma or judgment from health care providers or from anyone that might recognize them while they are in the facility. One Health Care worker said *"So when they arrive, we chat with them but maybe we need to explain more so that people understand because a person who becomes pregnant, … In her head maybe she's thinking that when she opens her mouth to communicate with someone, we're going to hit her, we're going to insult her, we're going to belittle her, so if there's already that , it's like a kind of stigma ."* Both cases result in women not receiving the care they need after a birth or a miscarriage, and they do not receive the counseling necessary about the dangers of an intended or unintended pregnancy so close to their last pregnancy. Additionally, many women might be told that they need a family planning method but are not provided enough information about why contraception after childbirth or miscarriage is important for their health. For example, a Health Director stated: *"You have to explain why it is so important, the risks involved with getting pregnant too soon after a birth or an abortion and how family planning helps the body to heal and prepare for a future pregnancy…".* Without this knowledge, women will not be able to receive a family planning method and successfully integrating family planning into postpartum and post abortion care will not be possible.

There were also aspects of knowledge lacking from health care providers. Providers lack knowledge on the importance of educating and communicating efficiently to every patient about family planning and the different methods a woman can choose from. While the options might be mentioned to some women after they give birth or have a miscarriage, many providers do not know the importance of counseling every single woman that they see after birth, which leads to haphazard information delivery. Furthermore, providers might not know how important it is to

explain all the benefits of family planning as well as the consequences of not using a family planning method. There are many misconceptions within the communities on what family planning is and what the side effects of different methods might be. Many of these misconceptions could be addressed with effective education and counseling. One Health Director said "*Personally, I admit that I was a student, I did my specialty, I was aware of (family) planning but, tell me a single gynecologist who is interested in planning, do you know of any? You see that we are not interested yet -, it is a tool that we should master."* If providers do not know the importance of integrating family planning into their daily work, then women will continue to not receive knowledge needed about family planning.

Without this expansion of patient and provider knowledge on the importance of family planning, the goal of fully integrating family planning into postpartum and post abortion care will not be feasible. If women continue to lack the knowledge about the existence of family planning methods and why they are important not for only their health, but for the health of their babies and any future pregnancies, then they will continue to not come to health care facilities after birth or miscarriage and maternal and infant mortality rates in Togo will be unchanged. The knowledge that family planning exists and its importance for the health of women, is the foundation that must be prioritized first for the success of any further capacity building for other identified areas. If women do not know it exists, then they will not ask for it, and there will be no demand for providers to meet these needs, thus integrating family planning will not succeed. There are many reasons why this lack of knowledge of family planning in patients exists in Togo. Most of these reasons relate back to several socio-cultural factors in Togo that act as challenges for this area of capacity building. Culturally, many fertility decisions are decided by men, so if a man does not want the wife to use a family planning method or wishes to have

another child quickly, then she will not accept any method of contraception. If they must travel back to the health care facility to receive a method or if the husband must go somewhere else to pick up the chosen method, this usually means that the woman will not return or receive a family planning method. Also, if the cost is too high or requires them to take off another day of work to come and receive the method, then the woman would also not choose to accept the cost of the method in place of feeding her children or choose to travel back. Additionally, there are religious challenges. The predominant religion in Togo is Christian and many Christians do not believe in using family planning methods.

For women who experience a miscarriage, there are additional socio-cultural challenges she might face when she goes for care in a healthcare facility. Many unintended pregnancies occur in adolescent women. Adolescents fear that they will be stigmatized if they come into a clinic pregnant and are recognized by someone. They also fear that they might be judged for seeking to terminate a pregnancy by the providers, as abortion is not legal in Togo. This leads to many women not coming to health facilities to avoid such stigma. If these socio-cultural barriers that lead to a lack of knowledge about family planning are not addressed, then integration of family planning will be challenging.

Standardized Process for FP in PPC and PAC

The second area identified as needing capacity building to successfully integrate family planning into PPC and PAC is the need to create standardized procedures in health care facilities for family planning during postpartum and post abortion.

There is a need to create a standardized procedure that ensures that every woman at every visit receives counseling about family planning and the opportunity to select a contraceptive method. This is especially important for women who come in for post abortion care. There is a

strong stigma amongst some health care providers with spontaneous and nonspontaneous abortions in Togo, significantly for adolescent women who come in for this type of care. This results in many women not receiving any form of family planning counseling when this is a population that needs it the most to prevent any future unintended pregnancies. By establishing a standardized protocol that requires family planning counseling in every case of postpartum and post abortion, this removes the potential bias that some women might experience and ensures that every woman has the chance to choose a family planning method.

Integrated Infrastructure

The third area that was identified as needing capacity building for the success of integrating family planning is the need for integrated infrastructure within health care facilities that allows for the counseling and provision of family planning to occur in one secure area.

There is often no designated room or area that is used for postpartum and post abortion areas that are equipped to provide family planning counseling and education. For postpartum and post-abortion care this would mean that the procedure, the counseling, and the provision of contraception could all occur all in one space during the visit. This means that right after the woman gets the procedural care (e.g., a vaginal birth or c-section, or a dilation and evacuation), she then receives counseling and education right after and then the materials and supplies needed for the chosen method are available in the same space and can be provided immediately. This means that she can have an IUD inserted, receive her oral contraceptives or condoms right there in the same room without having to come back or go somewhere else.

When counseling or providing family planning methods are not integrated in the standard postpartum and post abortion care, this results in women having to take additional steps to

receive this care. At many facilities, family planning is only offered on certain days and times, which means that women who visit at other times miss the opportunity to learn about family planning and receive a method or they are told to return to the health facility on family planning days. Asking for this additional day for care puts an additional burden onto women, who may not return for several reasons such as distance to the facility, time to get there, having to bring other small children with them, or having to take another day off work. This is especially true for women in hard-to-reach populations or those who are unable to afford the cost of care. By not having this care integrated into postpartum and post abortion areas in the health facility, these women are not receiving the counseling and education needed to make an informed decision to accept a family planning method or they do make the decision for one but then they are asked to return a different day because the clinic cannot accommodate them or provide the method at that time. Often, the woman does not return even if they know about the importance of family planning.

For post abortion care, a designated area that is away from busier areas in the health facilities are especially important due to the stigma and fear of judgment that comes with spontaneous and non-spontaneous abortions in Togo. Many women avoid going to facilities at all due to stigma, therefore asking them to return a second time for contraception can increase the anxiety for women for being recognized by someone if they return for care. By having the procedure, the education and the provision of a method all be in one room and provided at one time, there may be a higher chance that women will accept family planning, decreasing the chance of an unintended or dangerous pregnancy.

Sufficient Supplies and Equipment

The final area identified for capacity building is the need to increase the supplies, resources, equipment, and staff for family planning. While some health facilities are at capacity for supplies and equipment, many health facilities in Togo lack family planning methods, including IUDs, other contraceptive implants, condoms, oral contraceptives, and contraceptive injections. This lack of supplies can also include the necessary equipment needed to perform IUD insertions or tubal ligations. Many facilities are also severely understaffed and do not have the staff to provide family planning into their daily services. Other facilities might have the human resources, but they are not trained in family planning procedures or counseling necessary for family planning. This is most evident for post abortion care as not many providers have the education in providing family planning. New family planning methods are also coming out and many providers lack the knowledge to do these procedures like IUD insertions.

This area for capacity building relies heavily on the government and outside sources for financial support. Most financial resources for integrating family planning in Togo rely on outside sources like international organizations and grants. A politician from the Ministry of Health said, "*The Togolese government, partners such as the World Health Organization, United Nations agencies, the Global Fund, and other private organizations provide the majority of funding for reproductive health services."* Similarly, most family planning supplies like contraceptive methods come from external international organizations with one NGO Worker saying *"contraceptive products are largely provided by UNFPA in large part. USAID intervenes but it is UNFPA which is the first donor in terms of contraceptive product"*. One of the main problems with this is that the money that is received through these organizations might not

always align with needs that Togo has identified. For example, if a multi-year program funded by an international organization is offered but is based on neighboring countries' needs and not Togo's, there is a dilemma where the program might not fully align with the needs of Togo due to it being in collaboration with other neighboring countries. However, if Togo does not accept the program due to it not fully aligning with their specific need, then they miss out on the resources and funding that might not completely align with their needs but could still be beneficial for the country.

Strategies for Capacity Building for Successful Integration of FP

The lack of knowledge of family planning, the need for standardized procedures, integrated infrastructure and sufficient supplies were identified as the main areas for capacity building. However, to successfully integrate family planning, several possible strategies may be considered, specifically to address the lack of knowledge described above, illustrated in Figure 2. There is a need to improve knowledge surrounding family planning for both patients and providers. For patients, the core areas where knowledge is most lacking is the existence of family planning and the different methods available and the other is the misinformation and lack of trusted sources for information in their communities. Key informants suggested that a multi-pronged media education campaign and education outreach initiatives could be possible solutions for these two core areas. For providers, there is a need to address implicit bias when it comes to counseling and how that can impact the success of integration. This education can be coupled with the technical training for administering family planning methods.

Figure 2. Possible Capacity Building Solutions for Lack of Knowledge found in Patients and Providers

Multi-Pronged Education Campaign of Family Planning

The lack of knowledge of the existence of family planning, the benefits of it and the dangers of not using family planning is a foundational and important area for capacity building. Without capacity building in this area, even if Togo had all the financial and material resources available, if women do not know that family planning exists or why they need it, there will be no change in the maternal and infant mortality that could have been prevented by using a family planning method. Several key informants identified that a multi-pronged mass media campaign could help with building capacity in this area. While it was acknowledged that there are informational billboards being used, the concern is that these billboards do not reach the populations that are illiterate and those who do not speak the national language. To overcome this barrier and to reach larger populations, detailed radio advertisements that are in several of the more popular languages have been suggested. These ads could cover a vast range of information including what family planning is, why it is important, and the dangers. They could also address birth spacing and different forms of contraception including how condoms can be used for not only STDs and how emergency contraception and the morning after pill can be used as early preventative measures to try and mitigate the need for more extensive interference. Additionally, these advertisements could cover how family planning is important for not only women but how it benefits men, current children, and any future children that they wish to have.

Education Outreach Initiatives

In addition to this multi-pronged media campaign, several key informants identified that there is an opportunity to use community health workers as educators on family planning. Many

community health workers have strong ties to their communities and have rapport and trust with their communities. By educating them on the importance of family planning and the dangers of not using family planning, community health care workers could be used as a first step in the health care system and lay the foundation for the success of family planning integration at the community level. They could be utilized to start the deconstruction of misconceptions and fears surrounding family planning methods, as well as talk about the morning after pill and emergency contraception specifically for adolescents. One Ministry of Health Official remarked *"if no one visits, it's because they are unaware that this service is offered in the centers. Therefore, you must educate the public, which is why community health workers are so actively involved in the programming of this post abortion care concept and frequently interact with the public."* Community and religious leaders were also identified as being possible educators that could be helpful with spreading information about the importance of family planning.

Comprehensive Family Planning Continued Education

To address the need for education targeted towards providers and their role in counseling about the importance of family planning, several key informants suggested that there be continued education seminars and training. Like the work that EngenderHealth has done in the past, where they go to different health centers and train providers on how to administer different family planning methods, like IUD insertion, there is a need to include bias specific education. Providers need to be taught how their possible bias or judgment of certain women is working against that goal of integrating family planning, especially for young adolescent women and those who come in for post abortion care. These women are at the highest risk for continued unintended pregnancies and if they are not given the counseling they need because of provider

bias, or because they don't come in, in the first place due to fear of judgment then successful integration will never occur. Provider specific training surrounding these biases coupled with the training they would receive for the technical aspects of family planning would ensure that providers are gaining the specialized knowledge needed to administer family planning methods as well as the implicit bias training needed to overcome identified barriers.

Discussion

This study aimed to understand the feasibility of integrating family planning into postpartum and post abortion health care in Togo. Results identified four key areas that need capacity building to effectively integrate family planning into existing post abortion care services.

In this study the foundational area amongst the identified by the key informants as the four areas that need capacity building for the success of integration, is the need for knowledge amongst patients about the existence and the different methods of family planning, the dangers of not using family planning and the benefits of family planning. This foundational area has also been found in many other studies as a barrier for the success of integrating family planning. Ackerson and Zielinski found that fear and mistrust of contraception methods due to a lack of knowledge and misconceptions were some of the biggest deterrents of using family planning methods in Sub-Saharan Africa (Ackerson & Zielinski, 2017). This fear and spreading of misinformation acting as a barrier for integrating family planning was also found in Burkina Faso and the Democratic Republic of the Congo (Tran et al., 2018). A study conducted in Ethiopia, found that a low educational status of the woman has a high correlation with the lack of family planning knowledge and higher rates of unmet family planning needs (AT et al., 2021). The lack of knowledge amongst health care providers in the importance of counseling about

family planning and the impact of their implicit bias on patients, was also found in a study conducted in Zambia where undesirable health care provider attitudes acted as a barrier for family planning integration (Silumbwe et al., 2018).

For the need for a standardized process for providers that includes family planning in postpartum and post abortion care, a systematic review conducted in Western Africa found that after a standardized procedure and specialized training was implemented and conducted for health care providers, these providers had a better understanding of the importance of counseling, and how to properly counsel. This study focused on cases of adolescents and post abortion care and found that with this education and procedure, adolescents and women coming for post abortion care received higher rates of family planning counseling and accepted a family planning method when they left the facility (Gunawardena et al., 2018). This was also significant because these bias and counseling training were coupled with the technical training for administering contraception methods and found success with having both of these aspects being taught at the same time (Gunawardena et al., 2018).

The need for specialized integrated infrastructure within health facilities that allows for seamless counseling and provision of family planning methods has not been studied specifically, however needs that relate to this area for capacity building have been found. A study in Malawi found that many women do come to health facilities with the knowledge of a specific family planning method that they want, but are turned away from these health facilities and are asked to return on specific family planning days because the facility cannot often meet this need (Peterson et al., 2022). This denial and lack of capacity of these health facilities result in many women not returning for family planning. Additionally, having one set day for family planning each week did not give women the confidentiality they desired and resulted in the woman choosing her

privacy over going to family planning day, even if she desired a method (Peterson et al., 2022). Having integrated infrastructure that has capacity to meet women's needs more than just one day a week would help with this barrier for integration.

The need for supplies and equipment is a known issue for integration of family planning into postpartum and post abortion care across many countries throughout the world. Studies conducted in Ethiopia, Malawi and Zambia all found that the lack of supplies and equipment acted as a barrier for meeting the need for family planning and that there is a need for capacity building in this area for family planning integration to be successful (Ouedraogo et al., 2021); (Peterson et al., 2022); (Silumbwe et al., 2018). Without supplies, then the integration of family planning into postpartum and post abortion care will never be successful

Similar to the identified needs, the suggested solutions for capacity building for the success of family planning integration were identified by the key informants have also been found in other literature. A study that analyzed data from Liberia, Ghana and Senegal found that radio messages are an effective tool in communicating health care messages to Sub-Saharan African women (Ahn et al., 2022). The impact of community health care workers and community leaders and their use for integrating family planning have also been identified as a viable tool for family planning integration as a first step for the success of integration. Using the trust and connection that community health workers build with the women in their communities, can be used as way to start conversation about family planning, begin to dismantle misconceptions about family planning and even administer family planning methods and begin integration of family planning out in the community which will support integration of family planning in health facilities. A study conducted in Niger found that young adult women who were visited by a community health worker were more likely to use a modern form of

contraception (Brooks et al., 2019). A different study found that in Burkina Faso when community health workers are included in task sharing with being able to distribute contraception methods, there is a significant increase in users of family planning methods (Ouedraogo et al., 2021). Finally, a study that looked at 49 Sub-Saharan African countries found that women have a higher level of trust in community leaders and would refer to what they said before health providers (Ackerson & Zielinski, 2017). Using community health workers, as a first step for integration of family planning into postpartum and post abortion family planning helps with the identified need of knowledge surrounding family planning amongst patients and by starting these conversations amongst trusted community health workers, integration of family planning into postpartum and post abortion care could be successful.

While all areas identified in this study by the key informants as areas that need capacity building for the success of family planning integration are well known and have been identified in other countries, it is important that they be addressed in Togo in order to have successful integration of family planning.

Limitations

There are a few limitations for this study. First, this study was originally conducted in 2016. Additionally, the study only collected the perspectives of health care professionals and did not collect the patient's perspective who could identify different areas that need capacity building. Finally, this study was conducted in health facilities in urban areas in three major cities in Togo and might not fully represent what the more rural areas within the country might need.

Conclusion

The areas identified for capacity building to integrate family planning into postpartum and post abortion care are not new concepts for Sub-Saharan Africa. While many studies have

been conducted into why integration might not be successful throughout the continent, it is important to understand these areas that need to be addressed for each country specifically. While Togo is unique in how its health care issues affect their population and how they must respond to these issues, the areas identified in this research by the key information as areas that need capacity building in order for the success of integrating family planning are not unique, as similar issues have been found in other countries. The lack of knowledge amongst patients and providers about family planning, the need for a standardized process for providers that includes family planning in postpartum and post abortion care, specialized integrated infrastructure within health facilities that allows for seamless counseling and provision of family planning methods, and sufficient supplies and equipment to provide family planning in all health facilities are well known issues that have and still do impact many countries throughout Africa. Looking to how other countries address these issues identified as needing capacity building for the success of integrating family planning, like using radio advertisements and utilizing community health workers, could the useful to Togo as initiatives to adapt to their specific needs in order to successfully integrate family planning into postpartum and post abortion health care services.

Public Health Implications

In order for the success of integrating family planning into post-partum and post abortion care, the result of this study suggests that changes are needed at different levels – government, health service, health provider and patient level.

Government

- Financially support health facilities to ensure that they are fully stocked with multiple forms of family planning methods and the proper equipment to administer these methods

- Support health facilities in rural areas and serve hard to reach populations with financial support to have the materials needed as well as the personnel to provide family planning counseling
- Create family planning educational and community outreach initiatives to reach larger populations about the existence of family planning, the benefits of using a family planning method and the dangers of not using a family planning method
- Work with community health workers to create initiatives and programs to train them to be able to counsel about family planning and possibly administer family planning methods
- Utilize mobile healthcare services to reach harder to reach populations to ensure that all communities in Togo are receiving family planning education and services

Health Care Facilities

- Be able to provide family planning methods and counseling at all times so that no woman walks away without being counseled
- Be fully stocked to administer multiple forms of family planning methods to allow women the choice of family planning methods
- Be able to provide the chosen family planning method at the time that the woman is in the health facility, rather than having the woman come back another day or have to travel somewhere else to get their chosen family planning method

Providers

- Health providers need to work on their implicit bias so that women feel comfortable coming to discuss family planning methods, especially post abortion care

- Continue their family planning education and learn how to properly council about family planning and how to administer current family planning methods
- Provide a safe and confidential area that allows women the opportunity to be counseled about family planning
- Provide counseling to every woman that comes in for postpartum and post abortion care so that no woman walks away without the opportunity to choose a family planning method

Patients

- Need targeted information about the existence of family planning, the benefits of family planning, and the dangers of not using a family planning method so they can make an informed decision about what family planning method is best for their lifestyle
- Need to create a strong demand for family planning counseling and family planning methods that result in health care facilities needing to change to meet this demand

Further Suggestions for Research

To fully understand the feasibility for integration, it would be beneficial to explore this topic further and address the limitations that were identified.

To better understand what the specific gaps of knowledge surrounding family planning are in Togo for the creation of capacity building initiatives that address these gaps, there is a need to explore patient perspectives of family planning and the barriers and facilitators they experience. This perspective is important because there may be assumptions on the knowledge that women do or do not have about family planning. If these gaps in knowledge are not specifically known, then educational initiatives may be based on assumptions rather than the actual family planning knowledge they do or don't have. If these gaps are not properly

acknowledged, then integrations will not be successful. The patient perspective must be the central focus for educational initiatives for effective integration of family planning into postpartum and post abortion care. For example, a study conducted in Tanzania identified that one barrier for family planning integration is the need for coupling family planning education with religious teachings to address the identified moral dilemma some women face (Kassim & Ndumbaro, 2022). By knowing that this is a specific barrier that Tanzanian women face for family planning, an educational initiative could be created to address this barrier. Without Togolese women's perspective, capacity building in the lack of knowledge will not be able to be addressed and integration of family planning will not be successful.

Additionally, further research is needed on how men can act as a barrier for integration of family planning in Togo. Men can be barriers or facilitators for successful family planning integration. In Ethiopia, it was found that men provide several layers of support for women such as financial support and transportation (Smith et al., 2022). They were also found to sometimes be the sole decision maker when it comes to family planning (Smith et al., 2022). Understanding their role in family planning decisions for the women in Togo would help with identifying additional educational initiatives and programs that could provide a foundation for the success of integrating family planning into postpartum and post abortion care.

To fully understand where capacity building for health facilities and providers is needed, there is a need to gather information about all types of health facilities throughout Togo. This study focused on urban health facilities within the three largest cities in Togo. While areas for capacity building were identified for these types of facilities, further data are needed to identify capacity building in rural facilities and smaller communities. A study conducted in Egypt found that women who chose family planning methods in rural areas used implants and injections more

often while women in urban areas used IUDs more often (AboRahma et al., 2022). Understanding these differences between urban and rural communities is an important part of capacity building so that supplies, equipment, and provider knowledge initiatives can be tailored to address the specific needs amongst the women throughout Togo and ensure the success of family planning integration into postpartum and post abortion care.

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