THE respond PROJECT

USAID FROM THE AMERICAN PEOPLE

PROJECT BRIEF
June 2013/No. 15

Expanding Contraceptive Choice in West Africa:

Building the Capacity of Local Nongovernmental Organizations to Program Holistically

OVERVIEW

Voluntary family planning (FP) is among the most cost-effective ways to protect women's and children's health and contribute to national development (Jacobstein et al., 2013). Rates of contraceptive use in West Africa are among the lowest in the world, with women reporting poor access to contraception, low levels of approval of FP by their partners, and familiarity with few methods (Cleland, Ndugwa, & Zulu, 2011). As a result, millions of women in the region have an unmet need for FP—meaning they want to space or limit births but are not using FP. In Benin, only 8% of married women of reproductive age use modern contraception, and an alarmingly high percentage—30%—have an unmet need for FP (INSAE & ICF International, 2012; INSAE & Macro International, 2007). In Burkina Faso, 15% use modern contraception and 24% have an unmet need (INSD & ICF International, 2012). Among married women in Togo, modern contraceptive use is just 13%, while unmet need is 31% (DGSCN, 2011).

Most public-sector health care facilities in West Africa offer a limited range of FP methods. Although hormonal implants and the intrauterine device (IUD) are highly effective and convenient, few women are able to access and use them. Just 1.5% of married women in Benin, 3.4% in Burkina Faso, and 1.4% in Togo use these long-acting reversible methods (INSAE & ICF International, 2012; INSD & ICF International, 2012; DGSCN, 2007). In Burkina Faso, only 29% of married women and 24% of married men have heard of the IUD (INSD & ICF International, 2012). When the range of contraceptive options known by and available to clients is restricted, they are less able to choose the method that suits their reproductive intentions, medical history, and life circumstances.

Local nongovernmental organizations (NGOs) can play an important role in expanding contraceptive access and choice. Member associations (MAs) of the International Planned Parenthood Federation (IPPF) network collaborate with and complement the public sector. The Beninese Association for the Promotion of the Family (ABPF) provides FP services—including long-acting methods—at eight clinics across the country; the Burkinabe Association for Family Well-Being (ABBEF) operates six such clinics; and the Togolese Association for Family Well-Being (ATBEF) operates five.

With funding from the U.S. Agency for International Development (USAID), the RESPOND Project provided technical assistance (TA) and funded small grants to build the capacity of ABPF, ABBEF, and ATBEF to expand access to a wide range of FP services. The intervention entailed six steps, which took place from April 2011 to April 2013:

1. The MAs **assessed their capacity** for FP programming (April–July 2011).
2. Managers from the MAs **participated in an organizational capacity building and design workshop** (September 2011).
3. Providers and supervisors from the MAs **received training** to improve FP services (April–September 2012).
4. The MAs **carried out holistic action plans** with small-grant funding (May 2012–Feburary 2013).
5. The MAs **conducted a second self-assessment** of their capacity to deliver FP services (January–February 2013).
6. The MAs **shared their experiences** with each other at a South-to-South consultative meeting (April 2013).

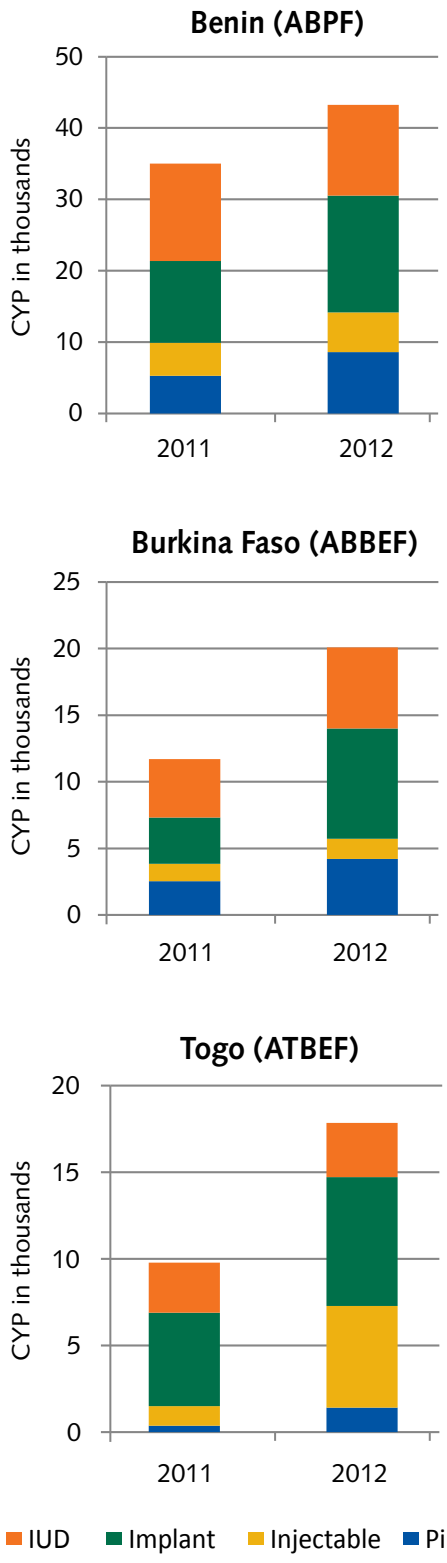
METHODS

To review the process and document the results of this capacity building approach, RESPOND researchers examined information from the capacity self-assessments, FP service statistics, progress reports, and interviews with 43 key informants—10 members of the MAs' administration, 14 providers, 16 clients, and three peer educators/champions.

RESULTS

From 2011 to 2012, all three MAs saw marked increases in the number of couple-years of protection (CYPs)[1] they provided. In Benin, CYPs from the pill, injectables, implants, and IUDs increased by 24%, from 35,017 in 2011 to 43,249 in 2012 (Figure 1). In Burkina Faso, CYPs from the four methods climbed by 72%, from 11,699 to 20,077. The increase was particularly large for implants: ABBEF provided 2.4 times more CYPs from implants in 2012 (8,265) than in 2011 (3,485). In Togo, CYPs from the four methods rose by 83%, from 9,770 in 2011 to 17,847 in 2012. A rise in injectable use accounted for 59% of the increased CYP in 2012 for ATBEF.

FIGURE 1. CYPs PROVIDED BY IPPF MAs, BENIN, BURKINA FASO AND TOGO, 2011–2012



[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 protection provided by the method.

Overall, managers attributed the CYP increases to the activities they led with the grant funding from RESPOND, as well as funding they leveraged from other sources. In Benin, besides the activities led with support from RESPOND, ABPF began a large FP project funded by the Dutch embassy in 2012. In Burkina Faso, mobile services with RESPOND funding expanded the range of methods offered in rural areas and were a major contributor to the increase. In Togo, ATBEF was one of two local NGOs to initiate community-based distribution of the injectable in late 2011—first through AWARE II and later through RESPOND.

PROCESS

Initial Capacity Self-Assessment

The first step toward achieving these results was a participatory self-assessment of each MA's organizational capacity to deliver FP services that include long-acting methods. RESPOND developed the Organizational Capacity Assessment Tool (OCAT) and process to help the MAs quickly appraise their capacity and identify areas for improvement (RESPOND Project, 2012). Between April and July 2011, RESPOND facilitated the self-assessment process. RESPOND involved MA management to increase their commitment to making changes and build their future capacity to assess their strengths and weaknesses. First, 9–10 managers and FP providers from each MA individually completed a questionnaire rating their organization's capacity with regard to 20 objectives. Then, they discussed the ratings as a team and came to a consensus on their organization's score for each objective.

The self-assessment tool was structured around EngenderHealth's Supply–Enabling Environment–Demand (SEED) Programming Model™, a holistic framework based on the principle that FP programs will be more successful and sustainable if they include synergistic interventions that:

- Strengthen the **supply** of FP services, by extending their reach and improving their quality
- 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 questions in the tool addressed the three components of SEED, as well as a fourth category, programmatic leadership and management.

The self-assessments revealed a number of programmatic gaps, including the need to:

- Improve service quality for the provision of long-acting methods
- Engage men in FP
- Offer long-acting methods at more affordable prices
- Spread awareness of long-acting methods
- Promote community acceptance of FP
- Develop a clear strategic plan to increase access to and use of long-acting methods

Organizational Capacity Building and Design Workshop

In September 2011, RESPOND held a workshop in Accra, Ghana, for 5–6 members of each MA's leadership. During the workshop, participants received a contraceptive technology update (CTU), learned about the SEED model, analyzed barriers to contraceptive choice, and discussed their self-assessment results. They developed one-year action plans to address their programmatic gaps and expand access to FP, including long-acting methods. MA staff highlighted how crucial it was to learn about the SEED model; as one participant said, "Now we see the system that influences FP use. It is really important to structure programs around this framework." Following the workshop, the MAs received small grants from RESPOND as a springboard to support the implementation of their action plans from mid-2012 to early 2013.

Strengthening Supply

RESPOND provided training and TA to the MAs' service providers and supervisors in FP counseling (39 participants), in CTUs (including clinical training in providing long-acting methods) (39 participants), and in facilitative supervision (19 participants, in Benin and Burkina Faso).

The counseling training introduced MAs to the REDI counseling approach, which uses a process of building rapport between provider and client, exploring the client's needs, and helping the client make decisions about how to meet those needs. Providers across all three countries expressed appreciation for how the REDI counseling approach engaged clients and providers in a discussion of which method would best suit the client's needs—something that did not typically happen before.

The CTU covered the latest international standards for contraception and infection prevention. Although all MA clinics had some capacity to offer long-acting methods before the intervention, one-third of the participants had recently been hired and did not have prior training on these methods. In addition, some other participants had not had a CTU in 5–6 years. By the end of the training, all participants demonstrated proficiency in offering long-acting methods. Providers unanimously reported that the training was helpful and cited a number of changes they made to improve service quality, such as their techniques for implant insertion and the management of side effects. Providers in Benin learned how to make more efficient use of expendable supplies during the training, allowing the MA to save money.

Facilitative supervision emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and supervisee. In the two countries where supervisors received facilitative supervision training, they reported having learned that the purpose of supervision is to resolve problems, not to blame providers or police them. They felt that supervision visits are more productive now and cause less stress and tension. A provider in Benin commented, "Now they give us feedback about what we did well and how to improve. Before, the feedback wasn't immediate; you received a report months later. If feedback isn't immediate, you don't remember and recognize what to change." Supervisors for all three MAs now give on-the-spot feedback as well as a report.

Family planning client at ABPF clinic, Porto-Novo, Benin

Fostering an Enabling Environment

As outlined in their action plans, the MAs used the small-grant funding from RESPOND to design and implement activities to create a more favorable FP environment. Recognizing the influence of religion over social norms in their countries, all three MAs reached out to religious leaders for the first time. In Benin, 250 religious and community leaders attended an advocacy meeting on the benefits of FP. Twenty religious leaders in Burkina Faso and 60 in Togo participated in training to become champions for birth spacing. The training addressed the importance of male involvement in FP, the benefits of birth spacing, an overview of modern contraceptive methods, and a discussion of rumors and taboos about FP. The champions included Catholic priests and Protestant pastors, Muslim imams, and leaders of traditional religions, who delivered positive messages about FP during religious services and held educational sessions on FP for adults and youth.

The MA in Togo, ATBEF, began targeting men with messages about FP after their capacity assessment identified male engagement as a weakness. They held 16 talks for men in the places where they congregate, such as bus stations and motorcycle taxi stands, to foster male support for FP. With the help of the religious leaders whom ATBEF trained as champions, they also spoke in churches and mosques. Service providers and champions presented the advantages of FP and dispelled myths about side effects. Through 16 talks over a period of three months, they reached 128 bus taxi drivers, 117 motorcycle taxi drivers, 318 Christian congregants, and 132 Muslim congregants in Lomé.

On "men's consultation days," the MA in Burkina Faso offered free reproductive health (RH) services, including FP. While free services were also available to women on these days, the ABBEF advertised the

event on the radio as being intended for men and couples. While the MA had held men's consultation days before, ABBEF greatly increased the frequency of these consultations. Client response was positive, with ABBEF providing 837 clients, including 558 men, with FP services. From 2011 to 2012, ABBBEF saw a 38% rise in the number of male FP clients, from 4,254 in 2011 to 5,882 in 2012.

Cultivating Demand

As part of their action plans, the MAs pursued a variety of strategies to expand access to information about FP, including long-acting methods. A key strategy for all three MAs was communication through volunteer peer educators. Evidence shows that RH information received from peers is more trusted and better understood than that coming from nonpeers (Adamchak, 2006).

The peer education strategy differed for each MA. In Benin, ABPF previously trained 100 youth peer educators to distribute condoms and raise awareness about FP, but they found that transportation constraints limited their geographic reach. With support from RESPOND, ABPF provided its youth clinics with 26 bicycles to increase peer educators' mobility. ABBEF trained 36 satisfied FP clients in Burkina Faso, and ATBEF trained 15 in Togo to serve as champions. To promote FP use, champions in Burkina Faso held 777 public talks and 32 community theater events, in collaboration with local theater troupes and providers. In Togo, client champions conducted 209 public talks and 599 home visits, reaching a total of 6,934 adults with FP messages. They referred 680 women, 218 of whom received FP services at ATBEF's five clinics across Togo. It was the first time ATBEF had worked with satisfied clients as champions. Seeing the success of the approach, the MAs plan to continue involving clients in their efforts raise awareness about FP.

"The training interested me a lot. It gave me an opportunity to understand the methods better. It helped me explain to people in my neighborhood."

— A peer educator in Togo

The MA in Benin, in particular, saw demand generation as a weakness in their self-assessment and focused on it in their action plan. ABPF produced four television spots advertising their FP services. The spots aired 100 times on a private national television station and played regularly in ABPF clinic waiting rooms. ABPF also designed posters promoting FP for their clinics, as well as pamphlets on contraceptive methods for distribution at their clinics and during outreach activities. A total of 5,000 pamphlets and 500 posters were made available in their clinics. A client in Benin said she uses the pamphlets to help explain FP methods to her friends and refer them to ABPF.

The MAs in Burkina Faso and Togo participated alongside Ministry of Health (MOH) representatives in message development workshops that produced posters, pamphlets, and radio spots. The MA in Togo printed 1,500 posters and 5,000 pamphlets. In Burkina Faso, the MA reproduced 300 posters, 1,250 pamphlets, and 70 counseling guides. A Togolese radio station aired 17 FP talk shows led by ATBEF providers. Also in Togo, 205 students attended an event at the University of Lomé to discuss FP with ATBEF providers.

All three MAs also made use of a series of documentary films showing true stories of couples in Burkina Faso who decided to use long-acting and permanent FP methods. The films, which were produced by RESPOND in 2012, highlight how couples communicated about and arrived at their decision to use a specific long-acting or permanent method. The MAs in all three countries, but especially Burkina Faso, showed these films in their clinic waiting rooms. The films reached clients who came for a variety of RH services, including men who came on men's consultation days. After showing the films, providers facilitated a discussion about FP methods and community attitudes. A male client in Burkina Faso reported that he had previously thought vasectomy and female sterilization were dangerous, but now he saw that the couples in the film were healthy and happy after their choice. He said he saw that vasectomy was a real option that he would consider in the future, once he is ready to stop having children.

Mobile Services

A key strategy in the MAs' action plans was mobile service delivery to underserved areas. MA service providers traveled to public-sector health facilities and nonclinical locations to offer a wider range of methods than is normally available in those locations. The MA in Togo offered services out of a specially

equipped mobile service van. Mobile services were always offered in collaboration with community leaders and the MOH.

All three elements of SEED came together for mobile outreach. The MAs strengthened supply by extending the geographic reach of service availability. They promoted an enabling environment by meeting with religious and community leaders prior to mobile service trips, to gain their acceptance and support. During mobile outreach, all methods were offered at a reduced price in Benin and for free in Burkina Faso and Togo. Reducing cost barriers further improved the environment for voluntary FP. In addition, the MAs cultivated demand by holding talks and theater events about FP in the communities where they offered mobile services. In Togo, town callers announced upcoming mobile service days with a gong.

Although each of the MAs had conducted a small number of mobile outreach trips before, the grant funding allowed them to scale up the approach. In Benin, ABPF had not previously worked with peer educators to spread the word about mobile services. With support from RESPOND, they involved peer educators, and the average client load on a mobile service day increased from eight clients in 2011 to 23 in 2012.

The MA in Burkina Faso had never offered free services before, even in previous mobile outreach. A clinic manager in Burkina Faso said that he was struck by the vast demand for free contraception during mobile services. "People came from 25, 30 km away for the free services they heard about on the radio," he reported. One day, as he and his fellow providers were packing up the gynecological exam table at the end of mobile service day, a woman hurried toward them with a baby on her back and a toddler trailing behind. "We told her that we were about to leave, but that we would be back another day. She said, 'By the time you come back, I might be dead.'" Her haunting message suggested that she understood the high risk of maternal mortality in rural Burkina Faso. The providers agreed to unpack the equipment to give her counseling and the method of her choosing, the implant.

Client at an ABBEF clinic in Koudougou, Burkina Faso

For the ABPF administration, this reinforced the importance of programming based on the SEED model.

Collectively, the three MAs' mobile services reached 4,626 clients and contributed 12,143 CYPs, with 57% of mobile service clients choosing the implant, 18% the injectable, 17% the pill, and 8% the IUD. ABPF in Benin served 419 clients during 18 mobile service visits. In Burkina Faso, ABBEF focused heavily on mobile services, serving 2,868 clients during 112 visits. ATBEF in Togo reached 1,339 clients during 61 visits.

Second Capacity Assessment

As their grant funding came to a close in early 2013, the MAs conducted a second round of capacity assessments to identify changes and ongoing needs. As with the initial assessment, MAs scored themselves on a scale of 1 to 8, with 8 indicating that the objective had been fully achieved. Table 1 shows the eight objectives in which the MAs' self-assessed capacity improved the most.

Consultative Meeting

In April 2013, four key staff of each MA came together in Cotonou, Benin, to reflect upon and share experiences in a two-day South-to-South consultative meeting. They were joined by a representative of the IPPF/Africa Regional Office and four RESPOND staff. The meeting gave MAs an opportunity to learn about each other's approaches and results, discuss challenges, and chart a course for scaling up successes within their institutions and the larger IPPF network in Africa. On

Table 1. MAs' self-assessment scores in April–July 2011 and January–February 2013, and average change

Objective	2011	2013	Change
Our organization ensures that its clinic-based providers have the necessary skills to provide IUDs and implants with the highest standard of quality.	6.0	7.1	+1.1
Our organization has a system to ensure that services are inclusive of men.	5.7	6.5	+0.8
Our organization ensures that clinics provide affordable IUDs/implants.	4.3	6.9	+2.6
Clients receive high-quality, comprehensive counseling for IUDs/implants.	6.3	7.0	+0.7
Our organization incorporates a behavior change communication (BCC) strategy and BCC activities that inform the community on IUDs/implants.	5.0	7.0	+2.0
Champions for IUDs/implants are identified, enabled, and supported in serving as advocates.	3.3	5.9	+2.6
Our organization has a strategic or long-range plan in place to increase access to and use of IUDs/implants.	6.0	7.1	+1.1
Our organization's programmatic decisions regarding IUDs/implants are based on data from management information systems.	5.7	7.2	+1.5

anonymous evaluation forms, all 13 participants expressed great appreciation for the opportunity to exchange experiences.

Institutionalizing Best Practices

In total, the three MAs won $2.2 million in new funding using the SEED model as the organizing framework for proposals they submitted to other donors after receiving training from RESPOND. The MA in Benin won two projects, including a four-year project from the Dutch embassy with a budget of 1.5 million euros. They said that the Dutch embassy specifically commented that they appreciated the SEED structure. All three MAs won SEED-based projects from the United Nations Population Fund (UNFPA), with budgets of $30,000 (Benin), $100,000 (Burkina Faso), and $125,000 (Togo). All of the MAs plan to continue using the SEED model as the basis for future programming, and all said they will use the organizational capacity assessment tool again in the future to monitor changes in capacity and identify remaining areas for improvement.

Each MA institutionalized the practices introduced by RESPOND and in some cases conducted training programs with other donors or used on-the-job training to spread these practices to providers who were not able to attend RESPOND trainings. The five staff in Burkina Faso and Togo who were trained as trainers have conducted counseling and clinical FP trainings for their MOHs with funding from other donors. In addition, all three MAs leveraged funding to offer mobile services in 2013.

NEXT STEPS AND RECOMMENDATIONS

Targeted training and TA, coupled with action plans based on the SEED model, can enable local NGOs to improve service quality, expand access, and serve more clients with a range of FP methods. Together with IPPF/Africa, RESPOND is developing a strategy to scale up the successful innovations from the RESPOND program within the wider IPPF network. RESPOND will enhance the capacity of IPPF to replicate these innovations by partnering with the three MAs as they transfer their skills and approaches to others in West Africa.

When replicating the approach, RESPOND and other capacity-building organizations should consider the following recommendations:

- Provide MAs a forum in which to share SEED-based strategies. A forum allows participants to present what they did to engage men, train champions, and conduct free mobile services, to exchange tools, and to offer guidance for the replication of these strategies.
- Align the intervention with the contraceptive procurement cycle. Although no MAs experienced stock-outs during the project, management staff reported that it was challenging to procure an adequate stock of contraceptives to meet the increasing demand for long-acting methods. TA should be provided to MAs to help them project stock levels based on anticipated demand increases.
- Provide additional training in infection prevention. The MA in Burkina Faso received a five-day training in infection prevention before their training in

clinical FP. In Benin and Togo, infection prevention practices were integrated into the training on clinical FP, but providers there reported a need for a separate, additional training on infection prevention. One supervisor reported that providers in Benin had not received infection prevention training in over 10 years.

- Build capacity for activities to address the enabling environment and demand for FP. Inspired by the SEED model, the MAs took the initiative to implement a variety of BCC strategies, including some that were new to them. Providing TA for BCC work was beyond the scope of this project but could be incorporated into future projects.

REFERENCES

Adamchak, S. E. 2006. Youth peer education in reproductive health and HIV/AIDS: Progress, process, and programming for the future. *Youth Issues Paper 7.* Arlington, VA: Family Health International/Youth Net Program.

Cleland, J. G., Ndugwa, R. P., and Zulu, E. M. 2011. Family planning in sub-Saharan Africa: Progress or stagnation? *Bulletin of the World Health Organization*, 89:137–143.

Direction Générale de la Statistique et de la Comptabilité Nationale (DGSCN) [Togo]. 2007. *Résultats de l'enquête nationale à indicateurs multiples (MICS) Togo 2006: Rapport final.* Lomé, Togo: DGSCN.

DGSCN [Togo]. 2011. *Togo Enquête par grappes à indicateurs multiples (MICS) 2010: Résultats préliminaires.* Lomé, Togo: DGSCN.

Institut National de la Statistique et de l'Analyse Économique (INSAE) [Bénin] and Macro International Inc. 2007. *Enquête Démographique et de Santé (EDSB-III) - Bénin 2006.* Calverton, Maryland, USA: INSAE and Macro International Inc.

INSAE [Bénin] and ICF International. 2012. *Enquête Démographique et de Sante et a indicateurs multiples du Benin (EDS-MICS IV) 2011-2012: Rapport préliminaire.* Cotonou, Benin: INSAE and ICF International.

Institut National de la Statistique et de la Démographie (INSD) [Burkina Faso] and ICF International. 2012. *Enquête Démographique et de Santé et à Indicateurs Multiples du Burkina Faso 2010.* Calverton, Maryland, USA: INSD and ICF International.

Jacobstein, R., Curtis, C., Spieler, J., and Radloff, S. 2013. Meeting the need for modern contraception: Effective solutions to a pressing global challenge. *International Journal of Gynecology and Obstetrics,* 121(1):S9–S15.

The RESPOND Project. 2012. *Organizational Capacity Assessment for Family Planning Programming—Long-Acting Methods (IUDs/Implants).* New York: EngenderHealth (RESPOND Project).

Suggested citation:
The RESPOND Project. 2013. Expanding contraceptive choice in West Africa: building the capacity of local nongovernmental organizations to program holistically. *RESPOND Project Brief No. 15.* June. New York: EngenderHealth (The RESPOND Project).

Managing Partner: EngenderHealth; Associated Partners: FHI 360; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council

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This publication was made possible by the generous support of the American People through the U.S. Agency for International Development (USAID), under the terms of the cooperative agreement GPO-A-000-08-00007-00. The contents are the responsibility of the RESPOND Project/EngenderHealth and do not necessarily reflect the views of USAID or the United States Government.

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