

TECHNICAL REPORT

Strengthening Social and Behavior Change Monitoring and Evaluation for Family Planning in Francophone West Africa

APRIL 2020



Acknowledgments

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Strengthening Social and Behavior Change Monitoring and Evaluation for Family Planning in Francophone West Africa

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List of Acronyms

CBD	Community-based distribution
DHS	Demographic and Health Survey
FP	Family planning
HTSP	Healthy timing and spacing of pregnancy
IPC	Interpersonal communication
mCPR	Modern contraceptive prevalence rate
PMA	Performance Monitoring and Accountability
SBC	Social and behavior change
RH	Reproductive health
USAID	US Agency for International Development
WABA	West Africa Breakthrough ACTION

Table of Contents

List of Acronyms	ii
Background	1
Objectives	4
Methods	5
Structured key informant interviews	5
Analysis	5
Results	7
Summary of insights derived from heat maps	11
Summary of intermediate and outcome level indicators	12
Assessment against SBC indicator bank	13
Recommendations	16
Recommendations for governments	16
Recommendations for donors	16
Recommendations for research and measurement partners	17
Recommendations for implementers	17
Recommendations for the SBC indicator bank for family planning and service delivery	18
Limitations	18
Appendices	19
Appendix 1: List of contacts	20
Appendix 2: Questionnaire for stakeholders	24
Appendix 3: Indicator matrix of FP investments across the four WABA/Amplify-FP countries	25
Appendix 4: Summary presentation of FP stakeholder investments across the four WABA/Amplify-FP countries	25
Appendix 5: References	25

Background

High maternal morbidity and mortality rates continue to burden francophone West Africa, a sub-region characterized by having the highest fertility rates in the world and a low contraceptive prevalence. Family planning (FP) reduces the number of maternal deaths because it reduces the chance of pregnancy and associated complications, such as the risk of having an unsafe abortion; delays first pregnancy among young women who have premature pelvic development; and reduces the risks from high parity and closely spaced pregnancies.¹ In 2011, nine governments of francophone West African countries,^a along with technical and financial partners, formed the Ouagadougou Partnership to accelerate progress in the use of FP services in the region. Since its inception, country governments, donors, and technical partners have worked to strengthen FP and reproductive health (RH) programs, predominantly through investments in procurement and supply of commodities and improved service delivery, with less investment in social

and behavior change (SBC)^b interventions.^c Breakthrough ACTION—a USAID flagship investment aiming to improve global coordination and implementation of SBC programs—interviewed FP stakeholders to better understand obstacles to SBC inclusion in investments and determined that there are two main barriers: (1) a lack of awareness that SBC is needed to improve outcomes, and (2) a belief that SBC does not generate the same return on investments as service delivery and procurement investments options.²

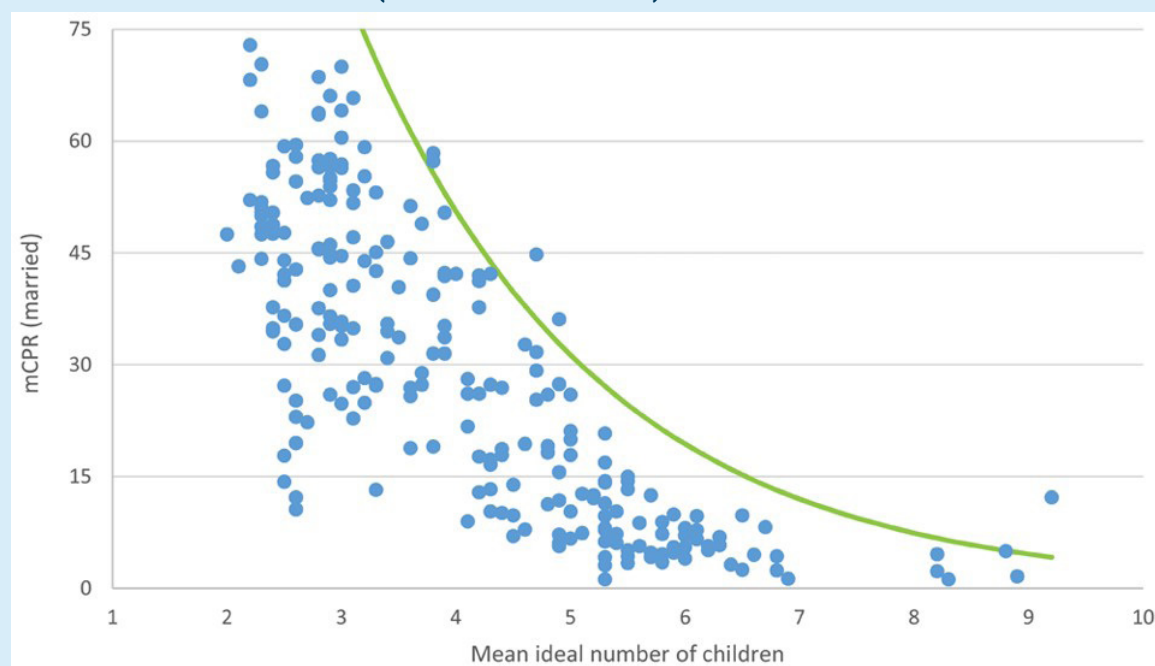
This limited awareness of the role of SBC in improving FP outcomes reflects a lack of understanding of how access and demand factors interact. In 2017, Weinberger et al. analyzed the maximum contraceptive prevalence “demand curve” to show the relationship between the modern contraceptive prevalence rate (mCPR) and mean ideal number of children to assess the balance between access and demand interventions (Figure 1).³

^aBenin, Burkina Faso, Côte d’Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, and Togo

^bActivities used to raise awareness, reduce misinformation, and address the barriers that prevent individuals, families, and communities from practicing lifesaving behaviors to improve health outcomes.

^c<https://map.partenariatouaga.org/>

FIGURE 1 THE MAXIMUM CONTRACEPTIVE PREVALENCE DEMAND CURVE: RELATIONSHIP BETWEEN MCPR (MARRIED/IN-UNION) AND MEAN IDEAL NUMBER OF CHILDREN³



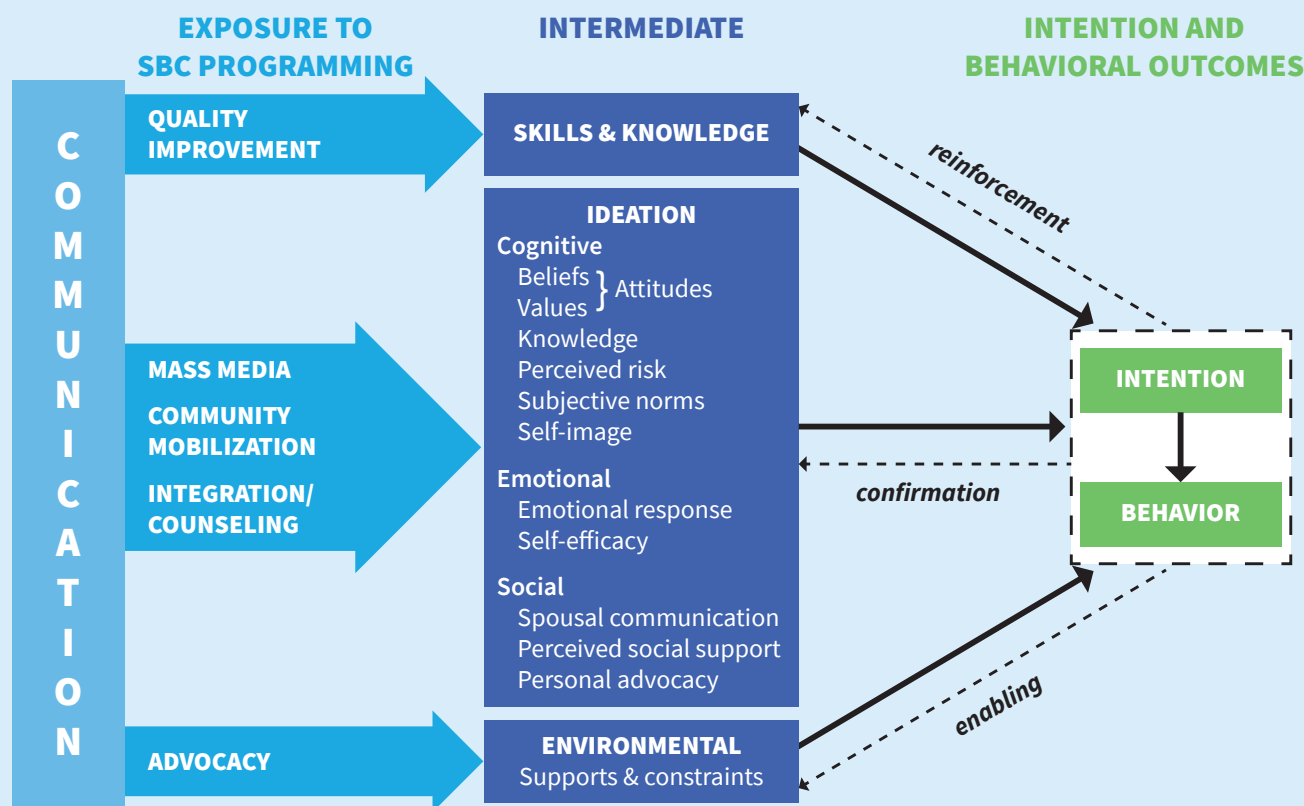
The curve represents the maximum mCPR that is likely given existing fertility intentions and related norms. In countries where there is a high mean ideal number of children, mCPR may remain low without investment in SBC to create demand.³ While there is still a need to build the strength of the SBC evidence base through rigorous study designs, a growing body of evidence suggests that SBC interventions increase use of modern contraceptives and, ultimately, generate a positive return on investments.⁴ Evidence suggests that SBC interventions can directly increase contraceptive uptake as well as increase contraceptive use through pathways that address intermediate indicators such as attitudes and communication around family planning (Figure 2). However, some SBC interventions are more effective than others, and the effectiveness of SBC interventions varies depending on the existing mCPR and intermediate knowledge, attitudes, beliefs, and risk perceptions.⁴

Despite the promise of SBC approaches, when SBC programs are implemented, SBC measurement tools and indicators measuring the domains described in Figure 2 are not systematically applied to monitor and evaluate FP/RH program performance. Global FP partnerships, such as FP2020 and the Ouagadougou Partnership, have

regular measurement and reporting systems in place to ensure the latest data are available to support decisions and improve results of FP programs. However, their core indicators focus primarily on contraceptive uptake and service delivery outcomes such as availability of contraceptive methods at facilities.

Availability of SBC-related data, including standardized indicators, would provide several advantages to countries, programs, and global partnerships. First, SBC data are needed for program design, and to continuously monitor program quality and efficiency. Without this information, it is challenging to identify problems and make corrections. Second, SBC data can be used to show that programs have their intended short term and long term effects, which can be used to advocate for further investment. This is particularly true in the Ouagadougou Partnership countries, where many countries still have a high mean ideal number of children and low contraceptive prevalence rates. In addition, standardized SBC indicators at the country level can facilitate collection and aggregation of information at the national level, while regional standardization provides countries with the opportunity to benchmark their progress against other countries. Finally, routine monitoring systems

FIGURE 2 IDEATIONAL MODEL ADAPTED FROM (KINCAID 2000)⁵



USAID'S SBC INVESTMENTS IN FRANCOPHONE WEST AFRICA

West Africa Breakthrough ACTION (WABA) is a regional U.S. Agency for International Development (USAID)-funded initiative aiming to increase coordination and effectiveness of SBC interventions in four countries: Burkina Faso, Côte d'Ivoire, Niger, and Togo. WABA works in partnership with Amplify-FP, another USAID-funded project, to strengthen service delivery in these four countries. These investments provide an entry point to explore the SBC programmatic landscape within the region and to identify and document the indicators used in the region, as well as the extent to which important SBC indicators are considered for programmatic attention. Breakthrough RESEARCH, USAID's flagship SBC research project, leveraged this entry point to conduct a mapping of FP investments, technical approaches, and indicators in the four WABA/Amplify-FP countries to better understand the FP landscape in the region and, ultimately, contribute to improving SBC measures.

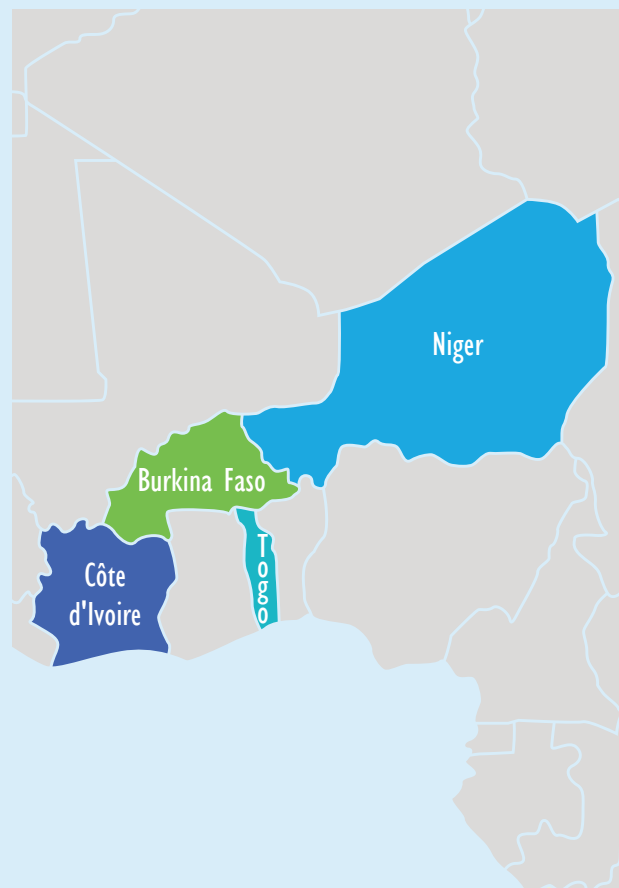
using standardized SBC data could be used to design and evaluate programs without the need for one off data collection activities, which could generate cost-savings.

Breakthrough RESEARCH conducted the indicator mapping activity in the four WABA/Amplify-FP countries: Burkina Faso, Côte d'Ivoire, Niger, and Togo (Figure 3). According to the most recent *2018 Performance Monitoring and Accountability* (PMA) and *2013–14 Togo Demographic and Health* (DHS)^d surveys, the Francophone West Africa region has some of the highest fertility rates in the world and low demand for family planning. Niger, at 7.6 average births per woman, is the highest in the world. The mCPR among all women (married and unmarried) is roughly 25 percent (27% in Burkina Faso, 25% in Côte d'Ivoire, 22% in Niger, and 20% in Togo). The mCPR is closer to 33 percent for married women in all four countries. Unmet need remains quite low in Niger (10%), and is somewhat higher in Burkina Faso (19%), Côte d'Ivoire (22%), and Togo (35%).^e However, awareness of modern methods is moderately high—over half of women (between 51% and 69%) are aware of six or more modern methods.

^dPMA2020 did not conduct surveys in Togo and so the most recent data are from the 2013–2014 DHS survey

^eWomen with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior. Unmet need could be low because women are using contraception. With low mCPR, we interpret low unmet need to suggest there is low demand for FP.

**FIGURE 3 MAP OF WEST AFRICA
BREAKTHROUGH ACTION FOCAL
COUNTRIES**



Objectives

This report summarizes findings from a mapping of FP investments, technical approaches, and indicators; identifies indicator gaps; and makes recommendations to governments, donors, researchers, and implementers to improve measurement of SBC activities within the broader FP programmatic landscape.

Specifically, we address the following questions:

- What was the landscape of USAID and other donor investments in FP in the five preceding years?
- To what extent are FP indicators collected on 1) programmatic reach, 2) determinants of behavior (factors including knowledge, attitudes, perceived risk, self-efficacy, social norms, spousal communication), 3) service delivery including supply chain, 4) FP-related behaviors (e.g., postpartum FP acceptance and uptake), 5) regional/national/policy, and 6) cost in the four WABA countries?
- What gaps exist and what additional SBC indicators can WABA, Amplify-FP and other relevant projects in the region incorporate into their monitoring and evaluation systems to increase the utility of routine data?

Methods

Structured key informant interviews

Structured key informant interviews with FP stakeholders (primarily project/country directors and monitoring and evaluation officers) in each country were conducted November through December 2019. The purpose of the interviews was to obtain information on FP investments and relevant documents on FP indicators. An initial list of key stakeholder names and contact details were based on discussions with USAID and Breakthrough ACTION. FP stakeholders came from government agencies, financial partners (i.e., USAID, Bill & Melinda Gates Foundation, and World Bank), for profit and not for profit international and local non-governmental organizations, civil society organizations, the media, and local associations operating over the past five years.

Consultants reviewed the stakeholder lists generated with the general secretariat of the Ministry of Public Health, departments of statistics, and FP to ensure government support and to identify additional stakeholders. The consultants made three attempts to organize an appointment with stakeholders. If they were unsuccessful, information was listed as missing for this respondent, as indicated in **Appendix 1**. Stakeholders were asked if they knew of any other stakeholders working on family planning and reproductive health that should be contacted, enabling a snowball sampling approach.

During the stakeholder interviews, the consultants administered the structured interview questions (**Appendix 2**). The consultants requested documentation pertaining to the activity objectives, program descriptions, monitoring-evaluation and learning plans, indicator reference sheets, and other documents. Information on existing data sources such as PMA, DHS, and DHISII indicators was collected as well.

Analysis

Matrix of FP indicators collected

Consultants reviewed and synthesized documents into a descriptive report and compiled a list of all indicators into a matrix for each country. The country indicator matrices

were aggregated and summarized into one master indicator matrix excel file (**Appendix 3**). For each indicator, the matrix provides the partner/donor collecting data on the indicator, frequency of data collection, geographic level, definition of the indicator, and year data collection started. As reflected in Table 1, we classified by whether they were SBC-related; the type of indicator by output, programmatic reach, intermediate, and outcomes; and

TABLE 1 INDICATOR DEFINITIONS

SBC-related indicators: measure SBC processes and techniques to motivate and increase uptake and/or maintenance of health service-related behaviors among intended audiences

Type of indicator:

- Output—occurs as a result (direct product) of a program's activities
- Programmatic reach—# or % of beneficiaries exposed to an intervention
- Intermediate—ideational factors that are considered as contributing to behavioral and health outcomes
- Outcome—desired behavioral or health effect on target audience; may also include unintended behavioral or health effects

Socio-ecological level:

- Individual—reported at the beneficiary level, including intermediate behavior and health outcomes
- Community—capturing activities at the community level such as community mobilization, community-based distribution (CBD) of contraception, and engagement with community leaders
- Facility—reporting on service delivery providers (SDP), pharmacy, or other FP distribution points not including service delivery in mobile units or CBD
- Project—only relevant to the management of a project
- National—reporting national-level plans in place, policies, national TV and other channels, and government expenditures
- Regional—cover more than one country (not within country)

the socio-ecological level of the indicator.^f The type of indicator is captured to reflect steps in the pathway to achieving outcomes. In a project's theory of change, outputs antecede intermediate outcomes and intermediate outcomes antecede behavioral and health outcomes.⁶ The socio-ecological levels reflect that most public health challenges are too complex to be adequately understood and addressed from single-level analyses.⁷ As a result, the socio-ecological model provides a more comprehensive approach and integrates multiple levels of influence to impact health behavior and, ultimately, health outcomes. Those levels of influence include individual factors, community, facility, and national/regional.

Table 2 illustrates the master indicator matrix. Counts of indicators by type and socio-ecological level were summarized in heat maps to visually explore prevalence of specific types of indicators as well as gaps.

Breakthrough ACTION SBC indicator bank

In addition to the indicators collected through interviews with key stakeholders, we leveraged the SBC indicator bank for FP and service delivery, developed by Breakthrough ACTION to identify illustrative quality indicators

for global programs using SBC approaches to address FP challenges. The Breakthrough ACTION **indicator bank** provides a sample of indicators for use in SBC programs. The indicator bank builds on well-known indicator sources such as the **MEASURE Evaluation's FP/RH Indicator Database** as well as from PMA 2020's recommended FP indicators. While the indicator bank provides suggested indicators, it recognizes that countries and stakeholders may need to adjust based on the context.

We compared the master indicator matrix to the Breakthrough ACTION SBC indicator bank. We then identified the SBC indicator bank indicators included in the master indicator matrix and identified the type and socio-ecological level of these indicators. Results were presented again in heat maps to visually explore prevalence of specific types of indicators as well as gaps.

^f<https://breakthroughactionandresearch.org/resources/social-and-behavior-change-indicator-bank-for-family-planning-and-service-delivery/>

TABLE 2 ILLUSTRATIVE INDICATORS BY TYPE

	OUTPUT	REACH	INTERMEDIATE	OUTCOME
Individual	Number of male condoms distributed	Percent of audience who recall hearing or seeing a specific product, practice, or service	Percentage of intended audience who believe that most people in their community approve of people like them using FP	Percentage of women of reproductive age in union who are using, or whose male partner is using, a modern FP method
Community	Number of community-level activities for FP conducted in project sites	Number of community members participating in community-level activities for FP in the last 6 months	Percentage of community leaders who believe they are capable of advocating for FP use (self-efficacy)	Percentage of villages in a district with community-based distribution of contraceptives
Facility	Number of providers trained in high quality counseling	Percentage of health care providers in the facility exposed to a quality improvement intervention	Percentage of providers at maternal and child health service delivery points who know the range of contraceptive options that do not interfere with breastfeeding	Percentage of providers who provided FP counseling according to quality standards
National/policy	Number of workshops conducted with government leaders to speak out in favor of FP	Number of government leaders trained to speak out in favor of FP	Number of government leaders who feel they are able to speak out in favor of FP	National FP communication strategy approved by the ministry

Results

FP investments in the four countries are driven by government-led strategies and coordination efforts. The governments are supported by a range of partners, who provide financial and technical assistance in developing policy and advocacy approaches, as well as work directly on the ground addressing supply and demand barriers. There are also partners who guide and implement research, monitoring, and evaluation to inform program implementation and impact. The private sector, civil society, and women's and youth's associations also play an active role in service provision and implementation of activities related to demand generation, and in advocacy. A summary of investments by type and country are described in **Appendix 4**.

Table 3 provides a summary of the number of stakeholders contacted in each country, the number providing information, and the response rate.

TABLE 3 NUMBER AND RESPONSE RATE OF STAKEHOLDERS BY COUNTRY

	NUMBER OF STAKEHOLDERS IDENTIFIED	NUMBER PROVIDING INFORMATION	RESPONSE RATE (%)
Burkina Faso	32	16	50
Côte d'Ivoire	18	11	61
Niger	15	11	73
Togo	22	17	77

We collected a total of 1,508 indicators from 55 stakeholder/projects operating in four countries over the last five years. Table 4 provides the number of indicators collected for each stakeholder/project. Only about half of all indicators included indicator definitions and information on the frequency with which data were reported. Among the 45 percent of indicators that reported frequency of data collection, about half of those indicators were reported on a monthly or quarterly basis; differences in frequency of reporting were seen by type of indicator. Output level indicators were most frequently reported quarterly, while intermediate level indicators and outcome indicators were more frequently reported annually. Indicators that were disaggregated were most frequently at the individual level. Where available, disaggregation was commonly reported by marital status, sex, and age.

We prepared heat maps by type of indicator and the socio-ecological level reported. We first looked at all indicators (Table 5) and then indicators specific to SBC programs for all four countries (Table 6). We also collected FP project management related indicators, but they are excluded from the analysis because they were primarily collected for project accountability purposes and were less relevant for the purposes of this documentation.

TABLE 4 NUMBER OF ALL INDICATORS BY COUNTRY AND STAKEHOLDER/PROJECT (N=1,508)[†]

	BURKINA FASO N=539	CÔTE D'IVOIRE N=406	NIGER N=266	TOGO N=297
Government				
MoH National FP acceleration plan/ Government (FP national budget action plan [PANB])	188	98	67	47
Annuaire Statistique de la Santé is compiled by the Ministry of Health; data mainly come from health centers	9	NA	NR	34
Direction of statistics	NR	NA	15	20 [‡]
National program coordination for maternal and child health (DC-PNSME)	NR	16	NA	NA
Regional projects (USAID)				
Breakthrough ACTION	61	31	32	44
Amplify-FP	21	4	4	21
Health Policy Project	44	44	44	45
Regional projects (non-USAID)				
Track20	18	20	NR	22
PMA2020	22	3	3	NA
SWEDD	18	42	NR	NA
Civil society and local organizations				
IPPF affiliate (i.e., AIBEF, ATBEF, ABBEF)	10	26	NR	17
Social marketing organizations (i.e., PROMACO, AIMAS, Animas Sutura)	NR	118	22	NR
ARSIP (religious civil society)	NA	4	NA	NA
ABSFM	17	NA	NA	NA
ADESCO (support for community health development)	NA	NA	NA	20
CSO Platform + HIV/Health	NA	NA	NA	2
ROSCI (Network of RH/FP CSOs)	NA	NA	NA	7
Other investments				
Closing the gap	70	NA	NA	NA
Engender health	24	NR	NR	NR
PSI	NA	NR	31	NA
Pathfinder IMPACT	NA	NA	25	NA
Development food security activities (DFSAs) (Care, CRS, Save)	NR	NA	23	NA
Large anonymous donors	21	NA	NA	NA
GIZ/Sante Integree	NA	NA	NR	9
UNFPA	NR	NR	NR	6
Other	16	NA	NA	3

[†]Not application (NA); No response (NR); [‡]INSED (Institut National de la Statistique et des Etudes Economiques et Demographique)

**TABLE 5 HEAT MAP OF ALL INDICATORS BY COUNTRY, TYPE, AND SOCIO-ECOLOGICAL LEVEL
(N=1,508)**

CÔTE D'IVOIRE	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	14	26	26	74	
Community	67	7	0	1	
Facility	81	0	0	3	
Regional/national/policy	44	0	7	26	

Total number of indicators: 406

Excludes 30 project indicators

BURKINA FASO	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	11	27	27	145	
Community	30	1	1	1	
Facility	68	0	0	2	
Regional/national/policy	120	15	8	26	

Total number of indicators: 539

Excludes 57 project indicators

TOGO	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	4	9	21	55	
Community	14	0	0	1	
Facility	28	0	0	0	
Regional/national/policy	93	1	8	30	

Total number of indicators: 297

Excludes 33 project indicators

NIGER	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	2	10	39	36	
Community	26	0	1	2	
Facility	33	0	0	1	
Regional/national/policy	60	3	8	28	

Total number of indicators: 266

Excludes 17 project indicators

TABLE 6 HEAT MAP OF SBC-SPECIFIC INDICATORS BY COUNTRY, TYPE, AND SOCIO-ECOLOGICAL MODEL (N=810)

CÔTE D'IVOIRE SBC	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	0	20	25	60	
Community	56	7	0	1	
Facility	5	0	0	1	
Regional/national/policy	20	0	0	0	

Total number of indicators 199

Excludes 4 project indicators

BURKINA FASO SBC	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	8	26	27	138	
Community	20	1	1	1	
Facility	19	0	0	0	
Regional/national/policy	83	15	0	0	

Total number of indicators 356

Excludes 17 project indicators

TOGO SBC	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	1	9	20	49	
Community	12	0	0	1	
Facility	7	0	0	0	
Regional/national/policy	29	1	1	2	

Total number of indicators 135

Excludes 3 project indicators

NIGER SBC	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	0	9	34	31	
Community	14	0	1	2	
Facility	3	0	0	0	
Regional/national/policy	19	3	1	1	

Total number of indicators 120

Excludes 2 project indicators

Total N for SBC-related 810

Summary of insights derived from heat maps

The predominant number of indicators collected in each country were at the output level.

Overall, we found the highest concentration of indicators at the output level reflecting the ease and comparative low cost of collecting data related to programmatic activities. Output level indicators provide an opportunity to measure the extent to which the program adhered to the original project design during implementation (fidelity), including the level of activities delivered and participation (dose delivered and received). Output level indicators were captured across socio-ecological levels. However, when we restricted the analysis to SBC indicators, we found fewer output level indicators at the individual level. This may be because individual output level indicators are based on the result of a programmatic activity, which is similar in definition to programmatic reach and focuses on beneficiaries exposed to a programmatic intervention (refer to Table 2 for illustrative indicators on individual output and reach).

There are few measures related to reach or exposure of beneficiaries to interventions.

Despite collecting over 1,500 indicators across four countries, we found relatively few indicators that measured exposure to interventions. Among those identified, almost all were concentrated at the individual level. Burkina Faso registered the greatest number of reach indicators, mostly consisting of more general measures of exposure to FP information, messages, and interventions by type of channel (i.e., mass media, toll-free numbers, community events, interpersonal communication, microprograms, etc.). Côte d'Ivoire and Togo, with fewer indicators, had a variety of indicators that represented both specific measures of exposure to a project-based intervention and general indicators of exposure to any FP message. By contrast, reach indicators compiled for Niger were all project based and specific to certain interventions. Measures of exposure observed tracked whether exposure had occurred only, and not level of exposure, making secondary analyses related to dose response difficult to carry out.

Among the ideational factors measured, most focus on awareness, knowledge, and partner communication.

Among the intermediate indicators collected, the majority measured awareness and knowledge (i.e., awareness/knowledge of FP methods, knowledge of side effects, knowledge of the benefits of FP, knowledge on where to get an FP method), and partner communication and support (i.e., women were able to talk to husbands about using modern FP, decision making about FP (with partner or independently), women's perceived support by husbands for FP, men committed to FP promotion/women's rights).

Intermediate indicators measuring ideational factors such as attitudes, self-efficacy, risk perceptions, and social norms were not widely represented.

Understanding ideational factors such as attitudes, self-efficacy, risk perceptions, and social norms, and measuring their relative contribution to behavioral uptake in each setting, is essential in designing effective SBC programming and monitoring its progress. However, despite their importance, relatively few ideational indicators were captured outside awareness of contraception, and they were all concentrated at the individual level. The lack of intermediate indicators at the community level indicates that there may be a need to focus on capturing more normative measures of behavior change, as awareness of methods without favorable attitudes and enabling social norms is insufficient for behavior change.

Although most programs typically target all reproductive age women, there are some indicators that focus on key audiences such as adolescents or women who are post-partum or receiving post-abortion care. However, there are few indicators that address audiences such as older women or high parity women.

Some projects focus on target populations that are at greater risk of an unintended pregnancy, such as adolescents and women who were recently pregnant, resulting in specific measures to monitor progress in addressing their needs. However, we did not find many indicators that focused on high impact practices, such as limiting family size or avoiding high risk pregnancies over the age of 35, where more efforts may be needed to address behavioral determinants and increase demand for family planning.

Nationally representative household surveys lack SBC-relevant measures beyond knowledge, such as program exposure and behavioral determinants, which limits their use for SBC program design and evaluation.

The availability of household surveys through PMA, and DHS provided opportunities to collect information related to behavioral outcomes, such as contraceptive prevalence, unmet need for contraception, postpartum family planning, and method discontinuation. The surveys have not traditionally focused on measures of exposure to programming and/or ideational factors beyond knowledge that determine FP uptake and continued use. The lack of SBC-relevant measures makes these surveys of limited use for program design and evaluation.

Among the indicators relevant to SBC programs, there were few indicators relevant to SBC programming at the provider level, such as attitudes, beliefs, and communication practices.

While there are many service delivery indicators, there are few indicators at the facility level related to SBC, particularly when focusing on reach, intermediate, and outcome level indicators. This may reflect limited investment or measurement of SBC-related programs targeting provider behavior change.

There were very few indicators that measured costs.

Despite capturing over 1,500 indicators, we identified few indicators related to cost. The measures focused on cost-effectiveness ratio per couple years of protection and dollar amount mobilized through in-kind contributions to support the scale-up of integrated learning networks and high impact practices.

The limited number of policy indicators, particularly at the outcome level, may reflect measurement challenges.

Achieving success at the policy level is challenging to report quantitatively, as this often reflects a lengthy process of engagement across stakeholders. However, monitoring political will, policy changes, coalition building, and resource allocation is important to ensure that an effective, enabling environment is in place to support demand creation.

Summary of intermediate and outcome level indicators

Overall, we found a broad range of indicators reported across type and level. We identified the most frequently used intermediate and outcomes indicators. Output and reach indicators were excluded from this summary, as they are defined by activities that vary with each program. Table 7 presents the intermediate and outcome indicators that were most frequently reported across countries. Of the 121 intermediate level indicators collected, four indicators (representing nearly 20% of all intermediate indicators) were consistently reported across stakeholders and countries. Three measures focused on family planning knowledge, and one indicator focused on spousal support. Among the 340 outcome level indicators, the most frequent indicators (representing nearly 40% of all outcome indicators) focused on contraceptive use reported in terms of new users, total number of users, and contraceptive prevalence rates. There were also several frequently used measures related to discontinuation and unmet need.

TABLE 7 FREQUENTLY REPORTED INTERMEDIATE AND OUTCOME LEVEL FP INDICATORS AMONG ALL INTERMEDIATE AND OUTCOME INDICATORS REPORTED IN THE INDICATOR MATRIX

INTERMEDIATE LEVEL INDICATORS	FREQUENCY N=121 (%)
Knowledge about FP methods	11 (9)
Awareness of 3+ modern contraceptive methods	7 (6)
Adolescent or youth with sexual and RH knowledge	4 (3)
Spousal support for FP	3 (3)
OUTCOME LEVEL INDICATORS	FREQUENCY N=340 (%)
Additional modern contraceptive users/new FP users	31 (9)
Modern contraceptive users/use rate	27 (8)
(Modern) contraceptive prevalence	23 (7)
FP uptake after abortion	13 (4)
Unsafe abortions averted due to modern contraception	5 (2)
Modern contraceptive discontinuation/FP discontinuation/abandonment	9 (3)
Unmet need for family planning	8 (2)
Postpartum FP uptake	9 (3)
Maternal deaths averted due to modern contraception	5 (2)

Assessment against SBC indicator bank

Next, we compare against the SBC indicator bank for FP and service delivery. While a standardized and validated compendium of SBC indicators does not yet exist, we use this indicator bank as a benchmark for understanding to what extent stakeholders in each country make use of indicators that monitor and inform SBC programs.

Table 8 provides an illustration of the extent to which indicators available in the SBC indicator bank are represented by the indicators collected in the indicator matrix. The numerator is the number of unique indicators by

type and level from the indicator matrix. The denominator is the total number of indicators by type and level, as reflected in the SBC for service delivery indicator bank. The SBC indicator bank includes 72 indicators. We found that stakeholders across the four countries used, to varying degrees, 48 percent of the indicators included in the indicator bank. Approximately 21 percent of the indicators in the indicator bank were similar to the indicators found in the matrix, and 31 percent did not match.

SBC indicator bank indicators

Among output level indicators captured in the indicator mapping, we found countries were not measuring some individual and facility level indicators related to

TABLE 8 PERCENTAGE OF INDICATORS FROM SBC INDICATOR BANK REPRESENTED IN INDICATOR MATRIX (N=71) (FOR EXAMPLE, 100% PERCENT OF INDICATORS IN THE SBC INDICATOR BANK WERE REPRESENTED IN THE INDICATOR MATRIX AT THE INDIVIDUAL REACH LEVEL IN COTE D'IVOIRE)

CÔTE D'IVOIRE	OUTPUT	REACH	INTERMEDIATE	OUTCOME
Individual	—	100%	42%	64%
Community	100%	100%	—	—
Facility	53%	—	0%	—
Regional/national/policy	40%	—	—	0%
Total number of indicators			38	

BURKINA FASO	OUTPUT	REACH	INTERMEDIATE	OUTCOME
Individual	—	75%	29%	57%
Community	100%	100%	—	—
Facility	40%	—	0%	—
Regional/national/policy	60%	—	—	0%
Total number of indicators			32	

TOGO	OUTPUT	REACH	INTERMEDIATE	OUTCOME
Individual	—	75%	25%	57%
Community	100%	100%	—	—
Facility	33%	—	0%	—
Regional/national/policy	80%	—	—	0%
Total number of indicators			31	

NIGER	OUTPUT	REACH	INTERMEDIATE	OUTCOME
Individual	—	50%	13%	36%
Community	67%	100%	—	—
Facility	27%	—	0%	—
Regional/national/policy	20%	—	—	0%
Total number of indicators			18	

counseling and quality that were included in the SBC indicator bank. Some examples of SBC indicator bank output indicators not captured in our matrices include: number/percent of women who delivered in a facility and received counseling on FP prior to discharge; percentage of women of reproductive age that were informed of other FP methods besides their preferred method, among those that visited an FP provider in the past 12 months; percent of long-acting or permanent method counseling sessions that were deemed high quality and comprehensive.

We found community level output indicators from the SBC indicator bank were well represented, but there were fewer indicators that focused on the individual, facility, and policy level in the matrix.

SBC indicator bank intermediate indicators

We also found disconnects in intermediate indicators when comparing indicators monitored and indicators in the SBC indicator bank. For example, among the indicators in the SBC indicator bank, there were indicators related to favorable attitudes toward FP, perceived norms, perceived support, perceived self-efficacy, quality of care, and provider knowledge that were not captured during the indicator mapping. Nonetheless, we did find overlap between intermediate indicators collected and in the indicator bank. For example, knowledge of FP methods, intention to adopt FP, and talking to others (friend, relative, community, provider) about FP. We did not find many community or policy intermediate level indicators.

SBC indicator bank outcome indicators

Individual outcome indicators from the indicator bank were commonly included, but outcome level indicators from the community and facility level were not well represented. Outcome level indicators collected during the indicator mapping that were also included in the SBC indicator bank included use of FP, FP continuation and discontinuation rates, postpartum FP, and post-abortion FP. We did not find indicators on method switching, government leaders who speak out in favor of FP, and women exposed to counseling who subsequently adopted an FP method.

Table 9 presents a list of indicators in the SBC data bank that are not currently being used by stakeholders. The indicators were identified based on a comparison of indicators collected and compiled in the indicator matrix against indicators recommended in the SBC service

delivery indicator bank. Based on this comparison, a number of observations emerged. First, the SBC indicator bank did not include indicators in several categories including: intermediate and outcome level indicators at the community level; reach and outcome indicators at the facility level; and reach and intermediate indicators at the national/policy level. While this suggests that there is less demand for these types of indicators, it may still be useful to consider adopting some of these indicators at a country level to ensure that progress in these areas is systematically tracked.

Another observation from the table is that while there are intermediate facility level indicators and outcome national/policy level indicators in the SBC indicator data bank, the indicator mapping did not identify any of these indicators in use. More effort may be required by countries to consider these types of indicators in their monitoring plans. And, the SBC indicator bank may need to review their indicators in these categories to ensure they are reflecting the practice in the field. We also noted that intermediate indicators at the individual level, while available in the SBC indicator bank, were not well reflected in the indicators collected through the indicator mapping.

Among the areas where there was significant overlap, we determined that the community indicators at the individual and reach level in the SBC indicator data bank were nearly universally used in all four countries. We also noted a strong overlap among outcome indicators at the individual level. This is largely due to the availability of household surveys that capture standardized indicators.

TABLE 9 LIST OF ADDITIONAL INDICATORS FOR POSSIBLE INCORPORATION INTO SBC MONITORING SYSTEMS

INDICATOR	TYPE	LEVEL
Number of SBC interventions implemented to support or improve FP services	Output	Facility
Number of government leaders who speak out in favor of FP	Outcome	National
Percentage of women of reproductive age that were informed of other FP methods besides their preferred method, among those that visited an FP provider in the past 12 months (or a specified reference period)	Output	Facility
Percentage of intended audience members with favorable attitudes toward FP providers	Intermediate	Individual
Percentage of intended audience who believe that most people in their community approve of people like them using FP	Intermediate	Individual
Percentage of intended audience with favorable attitudes toward FP	Intermediate	Individual
Percentage of intended audience with favorable attitudes toward modern FP methods	Intermediate	Individual
Percentage of individuals of reproductive age who are confident in their ability to use FP	Intermediate	Individual
Percentage of intended audience who approve of FP use	Intermediate	Individual
Percentage of intended audience who believe that their religious leaders would approve of people like them using FP	Intermediate	Individual
Percentage of intended audience who believe that their spouse/partner would approve of them using FP to space pregnancies	Intermediate	Individual
Percentage of intended audience who discussed FP with their spouse/partner in the last 12 months and think their spouse/partner values their opinion on whether to use FP	Intermediate	Individual
Percentage of women of reproductive age who would refer others to their FP provider, among those who have visited a FP provider in the last 12 months	Intermediate	Individual
Percentage of FP service providers reporting the use of FP communication materials in the past three months (or a specified reference period)	Output	Facility
Percentage of individuals of the intended audience who talked about FP with their spouse/partner in the last 12 months (or a specified reference period)	Intermediate	Individual
Percent of maternal and child health services clients who received counseling about the lactational amenorrhea method (LAM)	Output	Individual
Number/percent of women who delivered in a facility and received counseling on FP prior to discharge	Output	Individual
Method switching	Outcome	Individual
Reasons for discontinuation of contraceptive methods	Outcome	Individual
Percent of audience with a favorable (or unfavorable) attitude toward the product, practice, or service	Intermediate	Individual
Percent of providers at maternal and child health service delivery points who know the range of contraceptive options that do not interfere with breastfeeding	Intermediate	Facility
10-item process quality measure index	Intermediate	Facility
Percent of married women under age 18 exposed to healthy timing and spacing of pregnancy (HTSP) counseling/education who subsequently adopted an FP method to delay first pregnancy	Reach	Individual
Percent of health and non-health workers trained in HTSP who can state the three HTSP recommendations, by type of trainee	Intermediate	Facility
Percent of women with a child under age two exposed to HTSP counseling/education who subsequently adopted an FP method in order to space their next pregnancy	Outcome	Individual
Percent of long-acting or permanent method counseling sessions that were deemed high quality and comprehensive	Output	Individual

Recommendations

Findings from this indicator mapping exercise have led to insights to inform SBC investments and SBC monitoring and evaluation. The following recommendations are based on the results of this review.

Recommendations for governments

- Government routine monitoring systems should track key SBC indicators. Monitoring of key SBC indicators by governments can provide insights into barriers and facilitators of health behaviors. This can lead to improved targeting of SBC and service delivery programming. Community-based health workers may be an untapped or underutilized cadre to collect this information. Often community-based health workers were already collecting and transmitting data to health facilities or districts but were not currently collecting SBC-relevant indicators. A successful example of a partnership between a government and financial and technical partners comes from Ghana. USAID's investment "Communicate for Health" brought together a consortium of partners and developed a roadmap for a robust monitoring and evaluation system. The process resulted in 33 SBC indicators developed, 22 of which are now routinely captured in the DHMIS2 platform.⁸
- Adoption of standardized SBC measures, such as those in the FP indicator bank, would allow for more reliable and valid national reporting, as well as cross-country comparability in these key measures. This would lead to a clearer understanding of the behavioral drivers that require attention in each country and allow for cross-country fertilization of programmatic approaches that effectively address barriers to advance access and utilization of family planning service. Countries such as Côte d'Ivoire are currently in the process of revising their national health indicators. It is recommended that partners involved in the implementation of FP projects be included in this process to contribute insights and come to consensus regarding the important indicators to include moving forward. Joint reflection is needed to agree on measures not yet standardized, such as estimating the contraceptive products sold by private pharmacies or the contextually-specific priority SBC measures.

- Governments should continue to invest in data quality assessments and explore innovative methods to improve data quality. There is increasing integration of mobile data collection to obtain more timely, complete, and reliable data. Machine learning approaches are being integrated into data analysis to find data faults and gaps. Governments should consider assigning staff as focal points for technological adaption and promoting the pilot testing and adoption of innovative approaches.
- Data will only be valued if it is used. Ministries who invest in collecting routine data and monitoring reporting systems should leverage the data for decision making and promote their use across all levels of the health system. They should make their expectations of complete and high-quality data clear, and regularly review data in internal and public meetings to show how the data are being used. Translation of complex data into dashboards, data maps, and visualizations make this process compelling and amendable to a lay audience. How data can be used effectively is not a goal that is reached immediately, but a process explored in collaboration with stakeholders and partners.

Recommendations for donors

- Donors should request comprehensive monitoring and evaluation plans and indicator reference sheets from all implementing partners. It is essential that the implementing partners have a clear data collection and analysis system with indicator definitions, data source, and frequency of data collection clearly defined. When possible, standardized indicators should be promoted to increase comparability across project platforms and partners. Requiring transparency of program documentation and agreed upon open data policies is critical for program monitoring and evaluation.
- Donors should consider investing in project specific, household-based surveys that collect a greater number of SBC-relevant indicators than large national surveys such as DHS and PMA are able to. These datasets, when publicly available, become an important source of SBC-relevant data for other

stakeholders as well. Such surveys are better aligned with monitoring program impact on intermediate and longer-term outcomes and, when aligned with program design and implementation plans, can be used for rigorously assessing the effectiveness and cost-effectiveness of programs.

- Donors should regularly convene and coordinate monitoring, evaluation, and learning partners nationally and regionally to facilitate the standardization of monitoring and evaluation plans, SBC indicators, and innovation in data collection methods, and ensure data-informed programmatic learnings are shared. These convenings could be facilitated and coordinated by a technical assistance partner with expertise in monitoring, evaluation, and learning.
- Donors should consider supporting governments to develop standardized systems to monitor data quality through targeted technical assistance.
- Donors should work with governments and implementing partners to ensure that SBC-related indicators are routinely monitored in global and regional partnerships supporting FP.
- Donors may consider further investing in knowledge management and research utilization projects to help stakeholders make the most of available data sources for program and policy decision making.

Recommendations for research and measurement partners

- FP stakeholders should participate in the development of a regional monitoring and evaluation framework that is inclusive of SBC programmatic investments and commit to incorporating applicable frameworks into their monitoring, evaluation, and learning plans.
- Large, recurring surveys such as the PMA surveys should incorporate measures for programmatic reach (particularly for large campaigns), as well as intermediate indicators beyond awareness of FP methods, such as knowledge, attitudes, self-efficacy, and social norms, as it may be more challenging for individual projects or programs to do so.
- Projects should also capture better data on men, FP/RH related intermediate indicators, and how these are changing over time, as much of the current data collection efforts focus on women.

Recommendations for implementers

- Programs should commit to documentation transparency and open data to maximize the value of data collected for monitoring and evaluation. Timely provision of data for review, secondary analysis, and research utilization would maximize the value and impact of data.
- Programs should identify through a theory of change development process at the design stage and identify behavioral drivers to be addressed by programming to assess progress in achieving longer-term program outcomes and impact.
- There is a need for improved and more consistent measurement of program reach, particularly objective (exposure) rather than subjective (reported reach), to better understand service utilization data and to assess impact and the unit costs of reaching individuals for cost-effectiveness assessments.
- Where reached by interventions, projects should capture better data on key influencers to better understand how the enabling environment may facilitate or impede behavioral outcomes. Key influencers could include religious leaders, community leaders, male partners, extended family, depending on context.
- Routine monitoring data are important to establish the fidelity of program implementation. In addition to common output measures (such as number of community dialogue events held), we recommend that projects adopt indicators that measure quality of implementation (such as number of community dialogues that included at least three priority themes).
- There is a dearth of cost-related measures available to inform programs. Programs should leverage the availability of SBC costing guidelines to collect cost data and develop cost measures that can support advocacy, program prioritization, and agenda setting.
- While the goal of facilities is to improve outcomes for clients, there is a need to measure intermediate indicators such as changes to providers' knowledge, attitudes, and behaviors.
- SBC and service delivery partners would benefit from jointly reviewing supply- versus demand-side data. When reviewed jointly, partners may better map results, interpret findings, and identify programmatic needs.

Recommendations for the SBC indicator bank for family planning and service delivery

- At the community level, there is a need to measure intermediate and outcome type indicators, for example, the percentage of community leaders who believe they are capable of advocating for FP use (self-efficacy).
- There is a need for additional SBC facility level measures. In particular, there should be indicators that capture provider exposure to SBC interventions, as well as more indicators that measure provider knowledge, attitudes, norms, and self-efficacy regarding interpersonal communication.
- Inclusion of SBC cost-related indicators is beneficial to all actors in budgeting and advocating for further investment. Such indicators may include: (1) cost per person reached by mass media interventions, (2) cost per person participating for interpersonal communication (IPC) and/or community engagement, (3) cost per couple years protection, (4) cost per pregnancy averted, and (5) cost per disability adjusted life year (DALY) averted.
- While policy indicators may be more difficult to capture quantitatively, we did note that there were few national/policy related indicators that captured reach and intermediate level indicators. It may be useful for the indicator bank to include indicators such as number of government leaders who feel they are able to speak out in favor of FP to better understand the policy context related to SBC.

Limitations

While we attempted to capture a complete list of FP indicators in the four WABA/Amplify-FP countries, we may not have identified all relevant stakeholders. Some stakeholders contacted did not respond or provide the requested information, particularly if they were not recipients of USAID funding. In addition, some indicators used by the government or projects may be duplicated by the institution responsible for data collection. However, information provided was not always complete and we did not have the opportunity to cross check each individual indicator. We also found that some of the program documents had missing data. In these instances, we attempted to resolve outstanding questions with our field-based consultants. We also recognize that indicators are subject to evolve over time as projects adapt to their context, new activities begin, and previous activities conclude. The indicators collected represent a snapshot of information collected at the time of the interview. Finally, we found some indicators did not fall neatly in the indicator type or socio-ecological definitions. In these instances, the team identified the closest definitions and then determined the appropriate code based on a discussion of the strengths and limitations of each classification.

Appendices

Appendix 1: List of contacts

NAME	COUNTRY	TITLE	ORGANIZATION	PROVIDED INFORMATION
Dr Tanoh Gnou	Côte d'Ivoire	Directeur Coordonnateur	Programme National de la Santé de la Mère et de l'Enfant	
Seka	Côte d'Ivoire	Directeur du Suivi Evaluation	Programme National de la Santé de la Mère et de l'Enfant	
Soro Donapoho Amadou	Côte d'Ivoire	Directeur Information Stratégique	Population Services International- Côte d'Ivoire	X
Dr Ernest Konan Yao	Côte d'Ivoire	Directeur Pays	Pathfinder	
Dr Kouadio Kouadio	Côte d'Ivoire	Amplify PF Country Manager	Pathfinder	X
Denise Adou	Côte d'Ivoire	Program Officer West Africa	Breakthrough ACTION	
Hawa Talla	Côte d'Ivoire	Directrice du Projet -The Challenge Initiative (TCI) Afrique de l'Ouest Francophone	IntraHealth International, Senegal	
Monsieur Soro Aboudou Nabiehoua	Côte d'Ivoire	Regional advocacy and Partnership Manager	EngenderHealth CI	X
Oura A Joachim	Côte d'Ivoire	Responsable Suivi Evaluation	Alliance des Religieux pour la Santé Intégrale et la Promotion de la Personne Humaine en Côte d'Ivoire (ARSIP)	X
Ouya Flore Rachelle	Côte d'Ivoire	Assistante du Directeur Exécutif	Alliance des Religieux pour la Santé Intégrale et la Promotion de la Personne Humaine en Côte d'Ivoire (ARSIP)	X
Dr Seydou Outara	Côte d'Ivoire		Programme National de Sante Scolaire et Universitaire (PNSSU)	
Dr Yao-N'dry Akissi Nathalie	Côte d'Ivoire	Director of Programs	Association Ivoirienne Pour le Bien-Etre Familial (AIBEF)	X
Dr N'guessan – Koffi Reine	Côte d'Ivoire	Responsable Marketing et Ventes	Agence Ivoirienne de Marketing Social	X
Goussou Lazare	Côte d'Ivoire	Directeur exécutif	Agence Ivoirienne de Marketing Social	X
Dr Male Momine	Côte d'Ivoire	Direction de l'Informatique et de l'Information Sanitaire (DIIS)/Ministère de la Santé et de l'Hygiène Publique (MSHP)		X
Yecoula Noe	Côte d'Ivoire	Charge du Suivi Évaluation/ Analyste de Données sanitaires, Coordonnateur Adjoint	CATCIS (Cellule d'appui technique au Système sanitaire)	X
Dr Talibo Almouner	Côte d'Ivoire	Program Specialist FP/RHCS	UNFPA CO Côte d'Ivoire	
Dr N'da Constant	Côte d'Ivoire		UNFPA	
Kambire Serges	Côte d'Ivoire	Les jeunes ambassadeurs de PF		
Coulibaly Sibir	Côte d'Ivoire	Directeur Exécutif	ONG Fondation DJEDJE	
Dr Agossou Abram Amétépé	Togo	Directeur de DSME, Ministère de la Santé, Togo	Direction de Santé de la Mère et de l'Enfant (DSME)	X
Napo Dare	Togo	Chargé du Suivi Evaluation DSME-PF, Coordonnateur Track20	DSMI-PF Track20	X
Thomas Deglo	Togo	Représentant JHPIEGO au Togo	JHPIEGO	X
Dr Emmanuel Yawo Agbigbi	Togo	Maternal Health, Reproductive Health and Commodities Security Coordinator	UNFPA/Togo	X

Alina Berendsen	Togo	Conseiller Technique	Projet pour le Renforcement du Système Sanitaire-Sante Reproduction et Droits Sexuels (ProSanté)	X
Hilaire Tokplo	Togo	Country Program Officer	Breakthrough ACTION	X
Abalo Charle Limazie	Togo		Health Policy Plus, Palladium Group	X
Macoumba Thiam	Togo	M&E and Learning Advisor	USAID AmplifyPF Project	X
Dr Komlan Sélom Nossoukpoe	Togo	Directeur de programme	Association Togolaise Pour le Bien-Etre Familial (ATBEF)	X
Koffi Edem Dzotsi	Togo	M&E Unit Director	Association Togolaise Pour le Bien-Etre Familial (ATBEF) ; Ouagadougou Partnership Focal Point for Civil Society	
Yawo Serge Prince-Agbodan	Togo	Coordonnateur Réseau des Organisations de la Société Civile en Santé de la Reproduction et Planification Familiale, Coordinateur pays	Intrahealth	X
Kandasi Griffiths	Togo	Spécialiste de Renforcement des Systèmes de Santé	Santé Intégrée	X
Andrew Lopez	Togo	Directeur des partenariats	Santé Intégrée	X
Jules Broko	Togo	Chargé du Suivi Evaluation	ONG ADESCO	X
Afo Medjessiribi	Togo	Chargé du Suivi Evaluation, Coordinateur par intérim Plateforme	OSC/VIH/PF	X
Komlavi Noulagbessi	Togo	ONG Jourdain Vie et Santé (JVS)	JVS	
Mimboab Yangnenam	Togo	Coordinateur de l'ONG	3ASC	
Dr Kelem Atany	Togo		Plan International Togo	
Mme Essohouna B	Togo		SOS Village d'Enfants Togo Lomé	
Dr Josette Vignon Makong	Niger	Inspire project (Pilot Project)	HKI	
Edwige Hounon	Niger		MSI	
Rose Barnes Covenant	Niger	RISE I PF	PSI	X
Foureratou Yahaya Touraoua	Niger		Animas Sutura	
Dr Marcel Lucien Omar	Niger	Mother / Child Health Directorate (DSME)	Ministry of Public Health	X
Dr Abdou-Ouma Kaltouma	Niger	Family Planning Division		X
Soumana Abdourahim	Niger	DSME Monitoring and Evaluation Division		X
Mr. Mahamidou Illo	Niger	Directorate of Documentation Information, Archives and Public Relations (DIDARP)		
Dr Mounkaila Aïda	Niger	Direction des statistiques		X
Dr Atté	Niger	Direction de la nutrition		X
Badara Sèye	Niger	Breakthrough ACTION	Save the Children	X
Dr Sani Aliou	Niger	Country Director	Pathfinder	
Dr Asma Yaro Gali	Niger		Amplify-PF Project	
Idrissa Adamou	Niger		IMPACT Project	
Dr Mohamed Dicko	Niger	RHCS Technical Specialist	UNFPA, Niger	

Abdel Razak Boureima Yeya	Niger	Focal Point HP+ /DSME	Health Policy Project (HP+)	
Zakou Harouna	Niger	Focal Point/DSME	Track 20	
Mahamadou Balarabé	Niger	Projet TCI	Intrahealth	
Dr Karim Maiga Abdou-laye	Niger	General Coordinator	Association Nigérienne pour (ANBEF)	X
M. Ali Adamou	Niger	Monitoring & Evaluation	Association Nigérienne pour (ANBEF)	
Tabiojong Mbeng Benedict	Niger	Head of Nutrition unit	PAM	X
Tijani Bintou	Niger	Nutrition	UNICEF	
Hélène	Niger	Nutrition	ECHO	
Amadou Alzouma	Niger		OMS	
Adamou Moumouni	Niger			
Idrissa Maiga	Niger	Projet Genre Population et Développement au Niger (GPDN)	Agence Française de Développement	X
Ali Boubacar Doungou	Niger	Sahel Women's Empowerment and Demographic Dividend Project (SWEDD)	Banque Mondiale	
Manzo	Niger		ANIMAS SUTURA	X
Kasella Idrissa	Niger		Fonds Mondial	
Oumarou Maigari	Niger	Coordonnatrice	ENABEL	X
Dr Fati Zarmakoye	Niger		LAHIYA MATASSA	X
Issa Sabo	Niger			
Dr Djermakoye Hadiza Jackou	Niger	Coordinatrice Nationale	Programme National de Lutte contre le Paludisme (PNLP - NIGER)	
Mourtala Assao	Niger	Coordinateur National	Programme National de Lutte contre la Tuberculose	
Dr Yara Mintou	Niger		Programme national de lutte contre le SIDA et les hépatites	
Benjamin Babunga	Niger	HAMZARI	CARE	X
Sani Allassane	Niger	Terres Eau Vie	Winrock	X
Abdourahamane Abdou	Niger	Wadara	Save the Children	X
Eric	Niger	GIRMA	CRS	X
Zakari Congo	Burkina Faso	Monitoring and Evaluation Director & Local Compliance Officer	Pathfinder International	X
Gisèle Kabore	Burkina Faso	AFP Project Director	Amplify – FP	X
Jeanne D'arc Paré/ Somé	Burkina Faso	Capacity Strengthening and Community Engagement Advisor	Breakthrough ACTION	X
Cheick Oumar Ouedraogo	Burkina Faso	Project Director –Post Partum Family Planning (PPFP)	Jhpiego	X
Mathurin Dodo	Burkina Faso	Director of Monitoring, Evaluation and RESEARCH (D-MER)	Jhpiego	X
Oscar Koalaga	Burkina Faso	Previous Country Project Director (AgirPF)	EngenderHealth	X
Maka Barry	Burkina Faso	Regional Administrative & Financial Officer	EngenderHealth	X

Richard Boustred	Burkina Faso	West & Central Africa - Regional Director	DKT International	X
Seydou Boudo	Burkina Faso	M&E Officer MS Burkina Faso	Marie Stopes Burkina Faso	X
Aminata Rabo	Burkina Faso	Country Team Leader/PP Global	Planned Parenthood Global (PP Global)	X
Dr. Philippe Sanou	Burkina Faso	SRH Project Director	IntraHealth International	X
Dr. Brahima Bassane	Burkina Faso	HP+ West Africa's regional Deputy Director	Health Policy Plus (HP +)	
Dr. Narcisse Salembere	Burkina Faso	SRH Project Director – Closing the gap	Société des gynécologues et obstétriciens du Burkina (SOGOB)	X
Dr. Ida Kagone	Burkina Faso	Technical Secretary	Secrétariat Technique Chargé de l'Accélération de la Transition Démographique (Ministère de la Santé)	X
Dr. Pierre Yameogo	Burkina Faso	Technical Secretary	Secrétariat Technique Chargé de la Couverture Santé Universelle (Ministère de la Santé)	X
Nadine Tamboura	Burkina Faso	Technical Secretary	Secrétariat Technique Chargé de la Coopération au Développement Sanitaire (Ministère de la Santé)	X
André Yollan Ky	Burkina Faso	Director	Directeur de la Santé de la Famille (Ministère de la Santé)	
Eliane Sow	Burkina Faso	SBC officer / Directorate for the Promotion of Health Education	Direction de la Promotion de l'Éducation Sanitaire (Ministère de la Santé)	X
Saturnin Zoetyande	Burkina Faso	Statistician & M&E	Options (Projet WISH)	X
Simplicie Toe	Burkina Faso	Team Leader—SRH Technical Advocacy group	Groupe Technique Santé de la Reproduction (GT/SR)	X
Angèle Sourabie	Burkina Faso	Program Director	Association Burkinabé pour le Bien Être Familial (ABBEF/IPPF)	X
Mariam Nonguierma	Burkina Faso	President of ABSFME	Association des Sagefemmes et des Maïeuticiens d'État (ABSFME)	X
Mireille Belem	Burkina Faso	Research Officer	Développement Media International (DMI)	X
Francois Laureys	Burkina Faso	VIAMO Country Manager	VIAMO	
Guy Martial Bai	Burkina Faso	Statistician-Research Assistant - Higher Institute of Population Sciences	Institut Supérieur des Sciences de la Population (ISSP – PMA Burkina)	X
Dr. Emmanuelle Sempore	Burkina Faso	Chargé de Mission	Institut National de Santé Publique (INSP)	X
Dr. Danielle Belemsaga	Burkina Faso	Economist & Research Officer	Institut de Recherche en Science de la Santé (IRSS)	X

Appendix 2: Questionnaire for stakeholders

Country:

Structure/organization:

Type of respondent (Project managers and/or monitoring & evaluation managers):

Project title:

Donor:

Questions to ask:

1. What does the health care project (s) do?
2. When did the project start and when / should it end?
3. What are the different areas of intervention of the project?
 - a. Advocacy (strategic use of information to influence policies, practices, attitudes and beliefs that affect people's lives / behavior)
 - b. Service offer (all services and care made available to the population by professionals and health care systems to meet the needs of the population).
 - c. Demand creation - social and behavioral change (strategy that aims to generate interest and desire to buy / use a given product or service)
 - d. Product security (activity that ensures access to quality health products)
 - e. Coordination (harmonization of various activities for the sake of efficiency)
 - f. Research (all actions taken to produce and develop scientific knowledge)
 - g. Monitoring and evaluation (activities that assess the progress made towards achieving the goal and objectives of an intervention, as well as the factors influencing this progress).
4. For each of the above areas of intervention, what specific approaches / strategies do you use?
5. In which zones (regions, departments, districts, etc.) do you operate?
6. Are you implementing all the strategies mentioned in point 3 equally in all these regions, zones, districts? If not, what do you do specifically for each zone?
7. Who is your / who are your implementing partners for the project?
8. What indicators do you use to monitor your activities?
 - a. What process indicators do you use to help you know you are on the right track?
 - b. What outcome indicators do you use to report results?
 - c. Who do you communicate these indicators to?
 - d. How do you define these indicators (ask for a copy of the indicator reference sheets)?
 - e. How do you collect the data that allow you to report on these indicators (what are the sources of data for these indicators)?
 - f. Do you face any problems or challenges when collecting and reporting on these quality indicators? If so, what are the main challenges?
9. Has your project been / will it be evaluated? If yes, what type of evaluation? At what moment ?
10. Are there other actors / projects that you consider relevant for us to meet within the framework of this mapping?

Appendix 3: Indicator matrix of FP investments across the four WABA/Amplify-FP countries

See separate excel file available at: <http://breakthroughactionandresearch.org/wp-content/uploads/2020/04/WABA-FP-IndicatorMap-Appendix3-Matrix.xlsx>

Appendix 4: Summary presentation of FP stakeholder investments across the four WABA/Amplify-FP countries

See separate powerpoint presentation available at: <http://breakthroughactionandresearch.org/wp-content/uploads/2020/04/WABA-FP-IndicatorMap-Appendix4-Summary.pptx>

Appendix 5: References

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