



Implementing and Innovating Upon Best Practices for Family Planning and Reproductive Health Results: Experiences from West Africa Breakthrough ACTION



Context and Purpose

The West Africa Breakthrough ACTION (WABA) project is a five-year (2018–2023) field support buy-in to the Breakthrough ACTION cooperative agreement funded through the U.S. Agency for International Development (USAID) West Africa Regional Health Office. Its main objective is to leverage social and behavior change (SBC) approaches to increase modern family planning (FP) access and informed, voluntary use in Burkina Faso, Côte d'Ivoire, Niger, and Togo. In each of these countries, WABA supports technical working groups of FP decision makers and implementers to increase SBC capacity in FP, partners with district health and community structures to increase access to quality FP services, and implements multi-faceted campaigns to overcome social and other barriers to FP information and methods.

This brief provides a deep dive into three distinct WABA activities:

- Community dialogues (CDs) and facility site walkthroughs, a multi-sectoral and community engagement approach to improve FP service quality via community-driven solutions.
- FP provider behavior change (PBC) tool development to respond to regional and country-specific challenges identified to offer quality FP services.
- The *Confiance Totale* radio campaign, which encouraged confidence in FP services and methods during the COVID-19 pandemic.

For each, the brief provides details on the activity's design at a more general level, and then shares country-specific examples to dive deeper into the activity, results, and discussion on SBC for FP best practices and lessons learned. The goal of this document is to share promising, proven, or innovative approaches that have led to more effective FP programs with other SBC decision makers and implementers to strengthen SBC for FP program design in the West Africa region in the future.



Community members gather during a new family planning counseling tool pilot in Zinder, Niger. Photo credit: Amadou Oumarou. All rights reserved.

Acronyms used in this document

AgirPF	Agir pour la Planification Familiale / Acting for Family Planning project	FP	Family Planning
AmplifyPF	Amplify Planification Familiale / Amplify Family Planning project	HCD	Human-centered design
CD	Community dialogue	MCH	Maternal and child health
CTARs	Comités Techniques Appui aux Réseaux Intégrés d'Apprentissage / Technical Committees Supporting Integrated Learning Networks	NGO	Nongovernmental organization
COGES	Comités de Gestion des Établissements Sanitaires / Health Facility Management Committees	PBC	Provider behavior change
		RH	Reproductive health
		SBC	Social and behavior change
		USAID	U.S. Agency for International Development
		WABA	West Africa Breakthrough ACTION

01

Community Engagement Approaches to Improve FP and RH

Community Engagement as the Cornerstone of Improving Health Outcomes

Building on the techniques used by the [Agir pour la Planification Familiale](#) (AgirPF; English: Acting for Family Planning) project, which used health center walkthroughs to inform community leaders about FP services in five West African countries¹, WABA developed an approach to further engage communities to improve informed, voluntary FP and reproductive health (RH) service use. The approach leverages existing community strengths and resources to identify and address local challenges, rather than relying on external support. Since 2020, WABA has worked directly with community members, officials, and leaders in 19 health districts across Burkina Faso, Togo, Côte d'Ivoire, and Niger, to identify FP/RH service use barriers, identify local solutions, and dedicate community-mobilized resources to overcome them.

Throughout, WABA has collaborated with the USAID regional FP service delivery project Amplify Family Planning (AmplifyPF);

multi-sectoral district FP/RH Technical Committees Supporting Integrated Learning Networks (*Comités Techniques Appui aux Réseaux Intégrées d'Apprentissage*; CTARs)²; and health center community accountability committees (*Comités de Gestion des Établissements Sanitaires*; COGES)³ to center local perspectives and ownership at every turn.

Activity Design: Engaged Communities Take Action

WABA's community engagement approach comprises four iterative activities: community data review, CDs, health facility site walkthroughs, and action plan development.

As a first step, WABA works with CTARs to convene key regional, district, and municipal stakeholders responsible for overseeing FP/RH outcomes and health facility service delivery. Together, these actors review and analyze health indicator data and identify any areas of concern, such as low rates of antenatal care visits,

¹ Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo

² The AmplifyPF project created the CTARs to assist districts to implement district-wide FP/RH health plans. CTARs include district health officials and local health system management structure representatives. Since 2021, AmplifyPF and WABA have continuously worked with CTARs, equipping them with the community engagement techniques, materials, and advocacy skills needed to continue beyond the life of the projects.

³ The COGES are pre-existing, locally appointed accountability boards, made up of community members. Their main role is to help inform and oversee, at the health center level, the implementation of local health plans

modern FP method adoption, or FP service use. The health district, supported by AmplifyPF, then works with these stakeholders to tease out key FP/RH issues or behaviors that might contribute to these challenges. These discussions help determine what topics to explore more deeply in CDs and site walkthroughs. These same stakeholders, with WABA's support, re-review the data periodically—sometimes semi-annually or annually, or according to the calendar of planned activities per district—to prepare for future cycles of CDs and site walkthroughs.

Equipped with a better sense of the FP/RH service delivery context, CTARs—supported by WABA and AmplifyPF—then organize CDs in their respective district at the health center catchment area level. These dialogues offer local community officials an opportunity to gain community input on FP service quality improvement. They also give community members and service providers a forum to share their experiences with one another and talk about factors that discourage FP/RH service use. Approximately 100 community members—including religious leaders, community group heads, women's associations, youth groups, and other prominent, interested groups—and primary health center staff participate in CDs. What makes this approach particularly unique is how facilitators manage these dialogues to ensure they remain as honest yet diplomatic as possible, to avoid a sense of finger-pointing or blame between community members or leaders and service providers. To accomplish this, community members and providers first participate in separate facilitated discussions, allowing each to share their frank FP/RH service feedback. Once each group has had a separate dialogue, the two groups share and discuss their findings, again with a facilitator, to share their side

and allow a non-confrontational discussion and to foster listening between the two groups. While WABA and the CTARs strive for a gender balance when recruiting participants to ensure that both men and women are heard—for example, by reaching out to both women- and men-led community networks or groups—often more women attend.

Following this larger session, the COGES and community leaders work with other local leaders to recommend a subset of the CD participants—usually individuals influential in their respective community or religious networks—attend site walkthroughs at a local health center. Often, other community leaders who might be able to identify or advocate for community resources, are also invited to participate. These guided visits offer some stakeholders their first look inside the health clinics. Here, they can ask their questions directly to a health provider, and see first-hand what challenges exist to offer quality services.

At the end of the site walkthrough, the CTAR works with participants to develop a community action plan based on challenges identified during those events. The action plan includes specific problems, prioritized by importance and according to what the community themselves can address rather than waiting for the government, and corresponding local solutions. These action plans are posted in the office of the health center director, and CTAR members monitor the achievement of the action plan. Specifically, they monitor what they have accomplished and what still needs to be completed or included the next action plan cycle to improve the desired outcomes further.

Across the four WABA implementation countries, this community mobilization approach has successfully engaged communities in collective problem solving. After openly discussing FP service use challenges and visiting the health facility, community members are more empathetic to health providers' needs and constraints and are more eager to work together to find solutions. Community stakeholders take actions that contribute to improving the health facility, and advocate for municipal and district authorities to seek solutions beyond their control, such as increasing staff or securing medical equipment. Health personnel, too, see the benefit of harnessing the goodwill and collaboration of the communities they serve. Health providers and whole facilities understand better how the population feels about health services and what they want from their health services.

⁴ Compiling an accurate count of action plans is challenging, because each country and CTAR manages the process differently. In Togo, for example, the action plans were continuous over the life of the project, adding new problems to old action plans iteratively. In other countries, CTARs initiated new plans with each site walkthrough.

Community engagement approach to improve use of FP and RH services

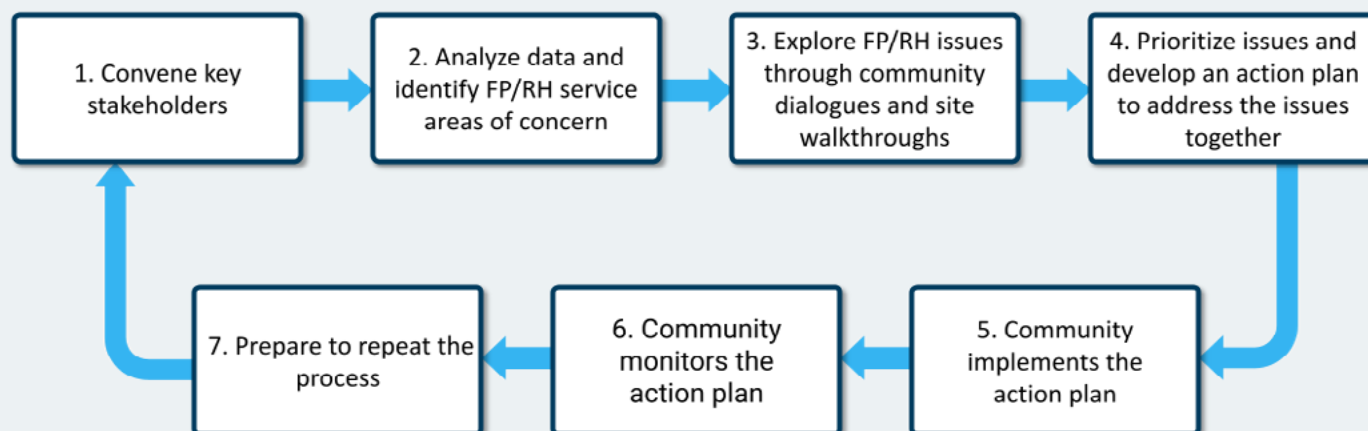


Figure 1 - WABA built on techniques used by the AgirPF project to develop a process, summarized here, to further engage communities to improve informed, voluntary FP/RH service use.

The COGES participate in the entire community engagement process according to their respective health center. They also take part in the community action plan development and monitoring on a more local level.

Results: Local Resource Mobilization for Tangible Improvements

From 2020 to 2023, over 18,550 people participated in more than 150 CDs and 235 site walkthroughs in the four countries. Among the action plans⁴ created through this process, communities have identified, mobilized, and employed their own resources to address more than 200 FP/RH service access challenges. Some service access challenges related directly to a poor opinion of the local health facility itself, which directly impacted FP service quality, access, and use. Thus, WABA often appreciated the need to improve aesthetic, hygienic, or structural factors (such as building latrines, and addressing electricity and water shortages) in addition to addressing direct FP concerns, as separating FP

services from the health center as a whole is not always possible. In **Niger**, where FP uptake is limited and there are many barriers to accessing health services, WABA has documented almost US\$70,000 in community-based contributions that include in-kind labor, building materials, donations secured from external sources and advocacy to the government for promised services such as health personnel and boreholes for accessing water. In Zinder, Niger, WABA found that over the course of one year, 70 percent of action plans had been completed.

In Kissambana, Niger, in response to community members' low awareness about the benefits of FP/RH and maternal health services, health workers conducted 66 information sessions to advise community members about the importance of antenatal care, assisted deliveries, and spacing children to maintain the health of the mother and child. Because maternal and child health (MCH) services are more commonly used in Niger compared to FP services, these information sessions provided key opportunities to link MCH to the benefits of using FP services, and to promoting informed, voluntary FP method use. The community also

negotiated with the electric company to reduce the outstanding bill from US\$833 to US\$29. With the funds saved, the health center can focus on other pressing needs such as the purchase of medical equipment and FP and reproductive health supplies. The facility also purchased curtains to provide privacy to FP and reproductive health clients. Because water access was a problem at the health center that affects all services including sterilizing FP implements and maintaining a hygienic environment, the community began purchasing water in containers, delivered by wheelbarrow, while they wait for the municipality to drill down and install a water point. The community also built a house on the health center's compound for the health workers so a provider could be present at all times in case of emergency, increasing service availability.

Similarly, in Mirriah district, Niger, when one midwife became discouraged because the municipality did not cover her salary as promised, the health management committee used the funds they collected to pay her US\$1 for each delivery. While not a salary, this payment motivated her to continue working; she feels valued and wants to help women have safe deliveries. Such actions not only ensure that crucial MCH services are available to communities, but also demonstrate to health workers the goodwill of their clients toward their work and strengthens a sometimes tense relationship between these two groups that prevents quality FP service delivery or access. In Mirriah and other areas, community members complained about male nurses providing FP services. The municipality heard these complaints and appointed a female nurse to work in the health center so that everyone felt comfortable receiving FP services.

Other communities across Burkina Faso, Côte d'Ivoire, Niger, and Togo have built observation rooms for women to have privacy during FP consultations or childbirth; purchased needed FP and medical supplies; and advocated with the municipal and district authorities for needed human resources and equipment. Health

providers, meanwhile, are working hard to provide a more welcoming atmosphere and reduce waiting times for FP clients.

Challenges, Key Observations, and Lessons Learned

Though program costs are low by nongovernmental organization (NGO) project standards, district health departments do not have dedicated funding to support community engagement. By embedding the community engagement and mobilization activities within the district-level government system in each country, WABA, together with AmplifyPF, aim to create a sustainable approach that will continue after the project ends. Government officials are very interested in replicating this process and expanding it beyond health, because they see how effectively it engages communities and motivates them to identify and collectively solve problems. Since most district health teams do not have the funds available to pay program costs such as participant transport, health agent travel, and per diem costs, AmplifyPF conducted advocacy training for the CTARs to help them allocate resources to continue the community engagement process. District health teams and municipalities could advocate for dedicated funding to cover supervision visits to community health centers where they could facilitate CDs, site walkthroughs, and iterative cycles of community action planning.

Community Dialogues Provide a safe and open forum to discuss sensitive topics, such as FP/RH

When the CTAR organized the CDs, it was often the first time people discussed FP/RH issues openly. In Togo, for example, the CTAR organized CDs using the message "Adopt and use your FP method without worry." In these dialogues, community members and health providers brainstormed solutions to challenges such as fear of side effects, rumors about different FP methods, and

Community members feel empowered to speak up during site walkthroughs, because they feel invited to do so; the open, dynamic atmosphere during CDs also helps them prepare to express themselves. In Burkina Faso, a community association leader remarked, "Health workers target only women for FP, while you know that women cannot decide without their husbands. Change your ways of communicating, or the problem will always be there." This observation helped health workers understand the need to adopt approaches to include men.

“Community dialogues and site walkthroughs that I attended are a very important means of change in the communities. Here, at the beginning, people thought that you came to bring them money or solve their problems as an NGO, but after the multiple examples that were discussed, the community committed itself to look for solutions together before exposing those that are beyond them at the district level.”
– Community member, Niamey 5 health district

men’s fears that FP will lead to their partners’ infidelity. Heads of health teams and local municipal officials praised WABA and the CTAR for inviting providers and the community to brainstorm solutions to these challenges, noting, *“This is the first time that everyone has gotten together to discuss the FP services offered in the center.”*

The community mobilization approach creates new, open lines of communication between community leaders and health agents, which paves the way for finding common ground and taking action. Previously, the COGES local facility health management committees did not intentionally include religious leaders or women’s groups. The participation of these stakeholders in the WABA community mobilization activities reinforces the role and strength of the community engagement process. CDs offer the health center staff and COGES a way to talk to more people at the same time—and get people engaged. People attend these CDs and site walkthroughs because they understand they can contribute not only to the discussion, but to problem solving within their own community, and they are motivated to make positive changes.

When community members are brought into how the health center/health system functions, they feel more engaged and own solutions. Organizing the site walkthroughs has opened the community’s eyes about the challenges health providers face.

As Boubacar Amadou from Magama 1 health area in Niamey, Niger, noted, *“We have been insulting the providers for years, and many husbands prevent their wives from going to this [integrated health center], because after childbirth, it is not possible to have the birth certificate. It is only now that we understand that it is not their fault, it is the city hall’s fault. Forgive us, we will change our attitude.”* Outcomes like this are important, because the more men in Niger believe that a health center’s services are valuable and of good quality, the more likely they might be to support their wives to access MCH and RH services, which can include postpartum FP services. Further, when municipalities see the community addressing a specific problem, in at least one case, the municipality has put solving that challenge higher on the priority list to address, rather than wait for or rely on larger government intervention.

02

Improving FP Service Delivery by Focusing on the Client-Provider Interaction

Understanding the Family Planning Service Delivery Context

Health care providers play a central role in a population's access to quality care, their trust in health services, and in overall use of health services. Providers' knowledge, biases, attitudes, and well-being at work highly impact their clients' experience, health decisions, and opinion of a service. In February 2020, Breakthrough RESEARCH published a [landscape analysis](#) of the FP PBC priorities for Ouagadougou Partnership countries. The study highlighted the influence of health providers on client FP outcomes and found that very few studies looked at provider bias or provider motivation. The review recommended that "interventions should aim to address attitudinal barriers including provider bias using SBC approaches."

In response, WABA conducted a study to better understand the challenges health professionals and health systems face in ensuring quality FP service delivery in WABA implementation countries. Several challenges were identified across the four countries on multiple levels of the [Provider Behavior Ecosystem Map](#) (see Figure 2).

- At the service delivery **work environment** level, key challenges included some providers' incomplete knowledge of available FP methods, lack of motivation (caused by high workloads, lack of personnel, insufficient equipment and job

aids, poor physical work environment, tardy or missing salary payments, and insufficient support and supervision), and judgmental remarks toward clients (especially adolescents and young women).

- At the **client experience** level, clients reported a lack of inclusion in their own FP decision making, insufficient descriptions of the methods, and poor client confidentiality within facilities.
- At the **social norms and community context** level, misconceptions and negative beliefs about FP methods among clients, their male partners, and providers hindered FP method trust and uptake.
- At the **health system and governance** level, poor health center management (lack of materials, poor internal coordination, and communication) negatively impacted providers' service delivery and well-being at work.

In addition to the Breakthrough RESEARCH and WABA studies, WABA also considered the series of FP service delivery challenges identified through WABA community engagement activities (see previous section) when understanding the FP service environment, including the lack of men's involvement in the use of health services, the rumors about modern contraception, and the negative attitudes of providers towards their clients. These insights laid the groundwork for PBC activities across the four WABA implementation countries, which were focused on improving the FP service delivery experience for all involved parties.

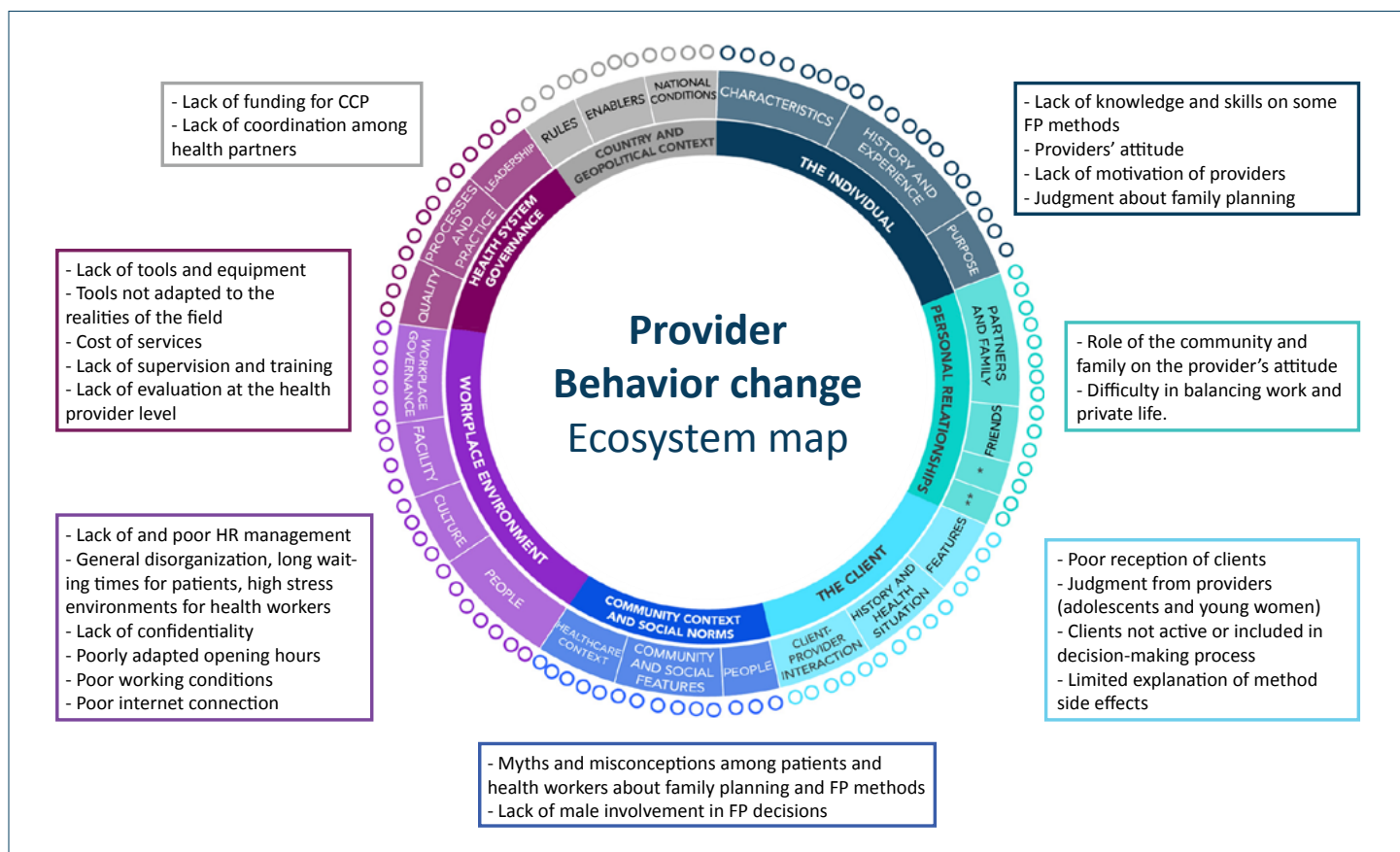


Figure 2 - Provider Behavior Ecosystem Map

Activity Design: Applying Existing Solutions to Strengthen the Provider-Client Relationship

Based on the Breakthrough ACTION [SBC Flow Chart](#), WABA launched its design process by organizing four **intent workshops**—one per country—to explore priority provider-based FP service use challenges. The SBC Flow Chart guided teams through a process (Define, Design & Test, and Apply) to identify possible PBC solutions. Once potential solutions were identified, WABA employed a “Go, Tweak, Turn” approach to adapt existing tools

to address those solutions, and then test those adapted tools or interventions in the respective WABA country.

The kick-off intent workshops used human-centered design (HCD) participatory methods. During the workshops, local stakeholders—including MOH representatives, FP providers, and FP clients—aligned on FP service delivery's current state in their communities, their desired future state, and the challenges preventing this progression.⁵ Participants together imagined how new solutions might bring an important change to the current situation.

The SBC Flow Chart is a tool used by Breakthrough ACTION for program design that uses primary research to create locally derived solutions through an iterative process. In an effort to save time and resources, and use existing solutions based on similar challenges, WABA has initiated the Go, Tweak, Turn approach. Go, Tweak, Turn proposes a decision-tree where “Go” is used when a good existing solution exists; “Tweak,” when an existing solution could be tweaked and applied; and “Turn” when a solution may need to be considerably revised to adapt it to the present needs.

⁵ Intent statements for each country can be found at https://pdfhost.io/v/hVerqTnys_JAN22_BAWABA_declarationsdintentionpptx

Family Planning service delivery challenge prioritized in each country during intent workshops:

- **Togo:** Poor service organization and client flow between services in health centers
- **Côte d'Ivoire:** Lack of a standardized comprehensive counseling tool
- **Niger:** Lack of provider motivation, and need for a simplified segmentation counseling tool
- **Burkina Faso:** Inconsistent provider motivation

Following the intent workshops, and based on each country's identified challenges, WABA inventoried dozens of PBC tools and approaches from all over the world⁶ to help participants imagine new ways to solve PBC challenges they have faced for years. The country team leaders facilitated a **Marketplace of Ideas** in each country, sharing the relevant PBC tools and approaches identified as having potential to address the respective PBC challenges. Via co-creation activities, WABA helped participants think through how a given tool or approach might (1) solve the prioritized challenge, and (2) work in the local context.

Following the Marketplace of Ideas, WABA built a **framework to assess adaptation needs** for three to four tools chosen by each country. The framework contained four key questions or elements to further assess selected tools:

1. How might the tool be improved to better respond to the specific service delivery challenge?
2. What opportunities might be missed by using a specific tool?
3. What might the improved tool look like?
4. Should selected tools should be developed and tested separately or blended and tested together?

Depending on the challenges and corresponding tools, some teams conducted additional research to understand better how to

adapt the tools or propose new ones, before going to prototyping and testing. For example, in Côte d'Ivoire, where providers lamented the lack of a standardized FP counseling tool, providers were interviewed to better understand the specific counseling challenges they faced, and usefulness of the counseling tools that were available.

Throughout the process, WABA provided virtual technical assistance, as travel was restricted due to COVID-19. WABA focused on building HCD capacity among in-country teams to conduct the solution adaptation process with local partners, and the prototyping and testing process. This participatory approach suited the activity extremely well as the local team had important knowledge of the cultural context and held the relationships with service providers and local service delivery partners.

Focus on Burkina Faso: A Holistic Approach to FP Service Delivery

To address the complex topic of provider motivation, the Burkina Faso team opted for a comprehensive approach based on three pillars: empathy, communication, and a satisfaction assessment. The team focused on the following shifts (see table below):

From...[current status]	To...[future state]
The current organization of FP services does not allow the development of a person-centered approach to their clients. This affects communication with clients, who feel uninformed and misunderstood.	Providers are better able to communicate with each other and with their clients. This improves coordination within the service, and promotes a person-centered approach based on the provider-client relationship.
The monitoring and support of providers is insufficient and of poor quality. This has a negative impact on their motivation to offer a quality service.	Providers benefit from a personalized supervision based on their own self-evaluation, that of their clients, and the service manager. The recognition resulting from this supervision motivates them to offer a quality service.

⁶ The inventory included any tools that Breakthrough ACTION implementing partners, including the Johns Hopkins Center for Communication Programs, Camber, Save the Children, ideas42, and ThinkPlace, knew about, had contributed to, or had developed.

To address these challenges, strongly rooted in the providers' motivation, WABA adapted and created seven solutions, guided by a single innovation-inspiring question:

How can we improve provider motivation to communicate better with one another and with their clients, so they can better deliver high-quality FP counseling and services?

The WABA Burkina Faso team facilitated the design and testing of seven prototypes (Figure 3) with FP patients, providers, supervisors, and facility managers, divided along the three steps of the service delivery process: before, during, and after the client FP consultation.

WABA conducted two rounds of rapid tests with stakeholders, as well as an in depth, two-month pilot of the tools in-situ with providers, in eight health facilities to reach most audience types (providers, clients, and service supervisors in both urban and rural areas).

Each round aimed at testing the interventions' against typical indicators of success used in HCD programs—including desirability, viability, and feasibility (Figure 4)—and was followed by adaptations based on user feedback (e.g., place more visuals in client-focused interventions to solve literacy or language barriers, or simplify the client satisfaction evaluation process).

The final prototypes were then packaged under the name “YASSOMA,” meaning “of quality” or “approved” in Mooré. The prototypes comprise three kits for an exceptional counseling experience:

- The YASSOMA **Start-up and guidance kit** contains promotional tools, start-up training for health care facilities, and a support guide.
- The YASSOMA **Empathy kit** contains a card deck and a monthly training to strengthen provider empathy toward one another and toward clients (training, follow up, and motivation). It also contains a desk tool to help providers remember good practices during the consultation.
- The YASSOMA **Satisfaction kit** includes solutions for improving the quality of FP counseling, and for maintaining and tracking those improvements (client, provider and supervisor evaluation, monitoring, and recognition).

In a final iteration, WABA developed an implementation package for use in Burkina Faso and other countries with similar challenges (Figure 5). The package includes all YASSOMA materials, an implementation guide, and advocacy slide decks to encourage YASSOMA's scale-up with government and local health stakeholders.

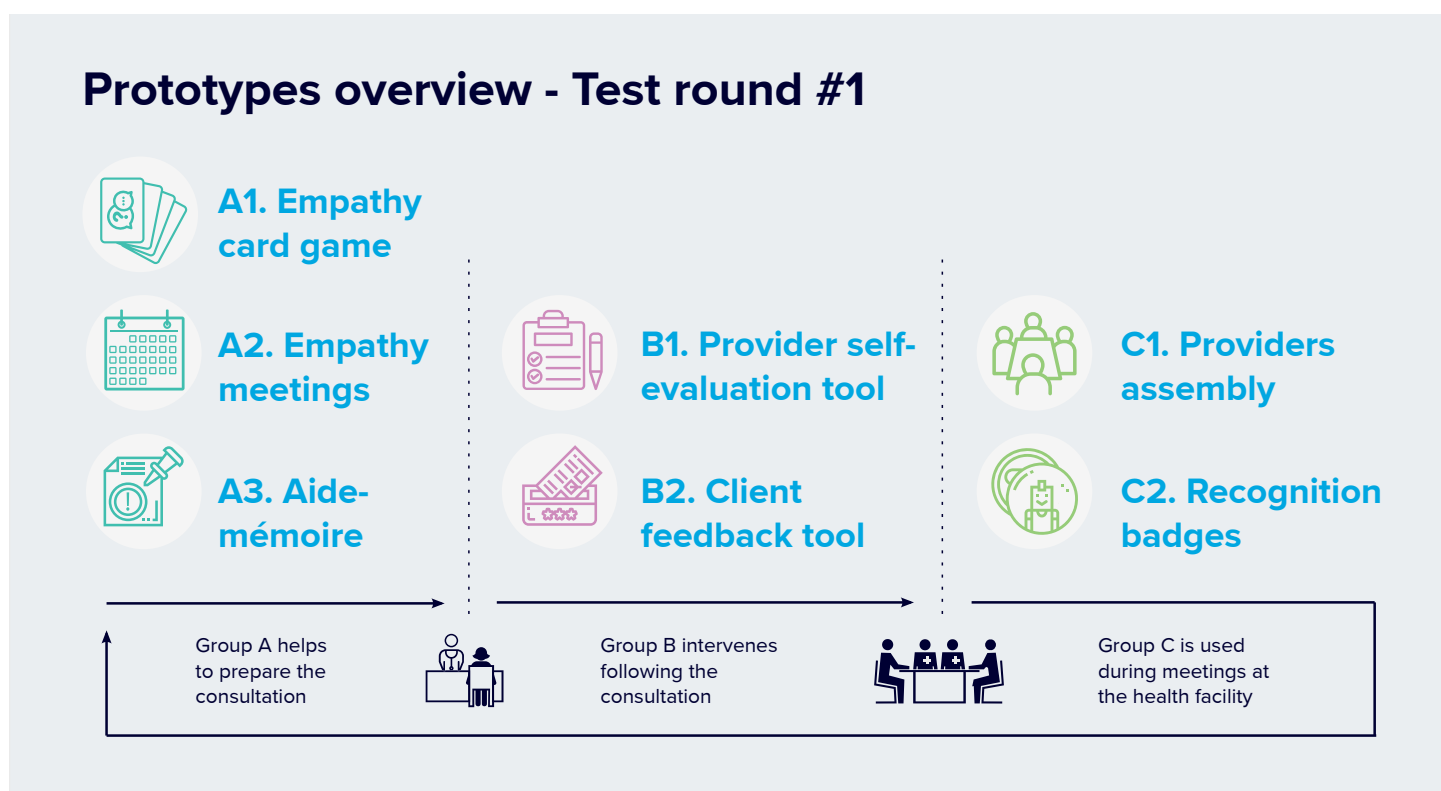


Figure 3 - An overview of the seven Burkina Faso PBC prototypes, divided into three categories—for providers to use in preparation for future FP consultation; for providers and clients to use directly following an FP consultation; and for health center staff to use, long-term, based on overall FP consultation quality.

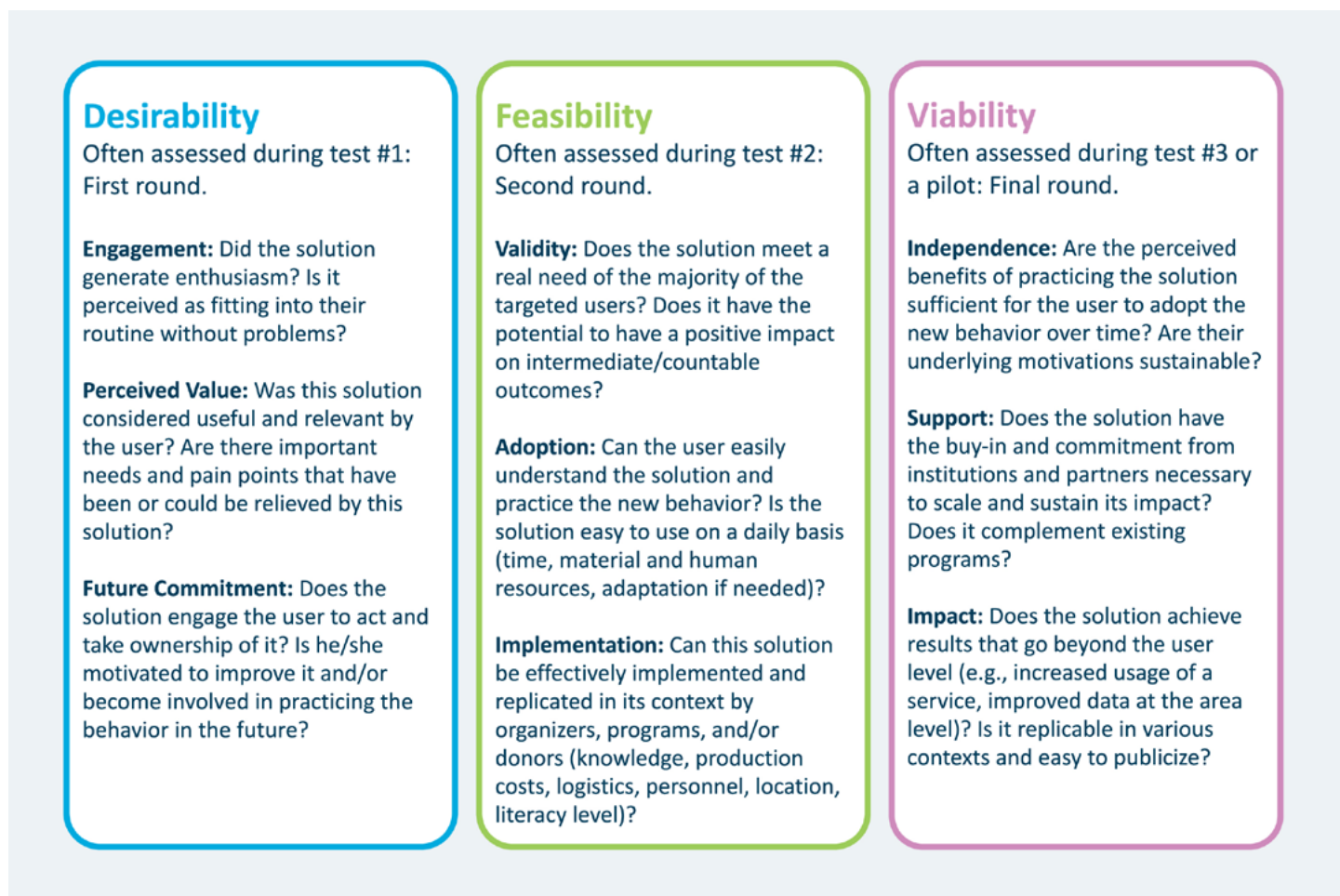


Figure 4 - Typical indicators of success used in Human-centered Design programs, at different stages of prototype testing.

Early Results in Burkina Faso: An Improved Experience of Care

The YASSOMA pilot preliminary results revealed that all kits were used and positively received, despite providers' and supervisors' heavy daily workload and time constraints. Clients reported an improvement in providers' attitude, saying providers listened more and were more empathetic. Providers also reportedly began exchanging on WhatsApp on their own initiative, to exchange on topics they did not often discuss previously, including empathy toward clients and colleagues, biases influencing their work, and client care experiences. The use of the word "YASSOMA" also organically gained local recognition in the community and reached other health centers, who showed curiosity and eagerness to adopt the tools. One of the key pilot results was an increase in FP visits, which was reported by several pilot sites.

Challenges, Key Observations, and Lessons Learned

Increased provider empathy, recognition, and supportive supervision can improve provider motivation

In Burkina Faso, combining empathy capacity building tools (card game, monthly training, and in-consult reminder) with satisfaction tools (provider-client-supervisor assessment and reward badges for providers) proves to be a successful way to stimulate providers' motivation. The recognition elements, based on the FP service provider's own assessment of their service delivery, and on the client's and supervisor's feedback, seem to be a durable incentive for providers to improve their relationship with clients. Also, the rapid improvements to the overall quality of counseling also seems to have triggered long-term interest in YASSOMA tools among all cohorts. YASSOMA has tapped into a new source of provider behavior change potential: their empathy for each other. Rather than teaching providers how best to provide FP services, it is possible to support them holistically—as professionals and as human beings—so they feel more equipped to view and support their colleagues and clients in a similarly compassionate light.

YASSOMA

The tools of an exceptional family planning service



START-UP & GUIDANCE KIT

- Awareness and promotion materials
- Initial training for health centers
- YASSOMA support and monitoring Guide



EMPATHY KIT



Card game

This card game is designed to help health workers, supervisors and/or family planning managers learn and practice empathy.



Formation continue

Presented in a calendar format, this ongoing training explores the 12 themes that compose empathy. By focusing on one of the themes each month of the year, health workers are able to deepen their knowledge and skills in practicing empathy.



Reminder

This desk stand brochure is a reminder of the learnings from this kit, in simple steps that a health worker can follow to ensure a good relationship with the client during the consultation.



SATISFACTION KIT



Client feedback tool

With these coupons, clients are able to provide feedback to the health worker after the consultation regarding the worker's communication and empathy.



Agent self-evaluation

This notebook is dedicated to measuring each agent's progress in empathy and communication. By giving not only a grade but also concrete elements to improve, this notebook encourages reflection and progress.



Monthly review

Through a "360°" evaluation that includes client feedback, a self-evaluation and the service manager's evaluation, agents can receive a badge of recognition and together define how to improve over the months.



Figure 5 - The YASSOMA package includes three distinct kits.

Quotes from YASSOMA pilot participants:

"It's good to be concerned about us clients, it allows us to be heard."
– Client

"It's good to have someone evaluate you. You can know your mistakes and try to correct them."

"I also have noticed that attendance has increased."
– FP provider

"[The Empathy card game] allows me to change my behavior towards my colleagues and towards my patients. We've created a WhatsApp group. At home, we choose a theme and play."
– FP provider

"Clients have advertised our center after using the YASSOMA tools! All the women who come for a consultation, whatever the type, ask for the coupon to evaluate the provider. When they leave, they tell the neighborhood that there is a possibility to evaluate the provider at the center, and the attendance has increased."
– Healthcare center administrator

“Shortcuts” can lead to innovations, but also to longer roads; be open to the journey

Using existing solutions was a great start for WABA PBC overall. Each team was able to learn from the solutions, successes, and shortcomings, and adapted or combined their strongest elements: e.g., the [Empathways](#) tool—originally designed to increase provider empathy for young FP clients, and whose format and content were very well-received by providers in Burkina Faso—proved a real springboard for the cards ultimately adapted to and included in the YASSOMA enrichment kit.

From a collaboration perspective, connecting four countries with similar challenges and their teams through regular calls and shareback sessions enabled team members with different skill sets to continuously enrich their respective activities (e.g., avoid mishaps, share expertise, or combine efforts).

Testing and adapting iterations were also factors of success. Two rounds of tests and a pilot allowed the WABA Burkina Faso Team to develop refined interventions based on strong user feedback, ready to be scaled up.

However, some aspects of the Go, Tweak, Turn approach led to gaps in the process. WABA used the outputs of community engagement activities to inform its in-depth challenges, rather than conducting primary research to gain a local understanding of the problems from key cohorts (FP providers and clients) in each country. By not uncovering new insights, all teams had to add a step later on in their process to avoid assumptions: they organized validation workshops with FP providers, clients, and other local stakeholders, and kept the entire group of stakeholders informed and engaged in the design journey.

A strong learning from the Burkina Faso process is that HCD has notable capacity to enhance data collection for tool improvement. Close coordination was necessary for building understanding between the HCD experts, the WABA team in Ouagadougou, and the hired research team in Ouagadougou. The research team conducting the tests and pilot assessments, for example, had only a vague understanding of how open-ended questions can help probe more deeply to uncover motivations behind an observation. This lack of understanding made user feedback on the prototypes harder to interpret and subsequently, made prioritizing edits to the prototypes more challenging. Devoting more time and resources in the activity plan for capacity strengthening, for example in HCD testing and discovery techniques, could address such contextual issues in future planning. Where possible, these capacity strengthening activities or workshops should occur on site. However, due to the COVID-19 pandemic, WABA staff based outside of Burkina Faso delivered all technical assistance virtually.

Embracing new concepts takes time, space, and courage to practice

One of the main Burkina Faso PBC activity conclusions is that beginning with an in-depth startup training in each participating health center is an effective way to pave the way for future activities. While many prior FP interventions focused on access to FP information and services, YASSOMA focuses on client-provider interactions, communication among providers on all service delivery levels, affecting the quality of users' experience. The novel content and approach brought by the YASSOMA tools was at first very new and uncomfortable for most providers (e.g., self-assessing one's own progress, or exchanging personal views and experiences with colleagues). However, across the eight health facilities that tested the prototypes, participants found YASSOMA useful and that it had a positive impact on FP services and client-provider relationships. WABA therefore recommends including the YASSOMA Start-up and Guidance Kit to any YASSOMA implementation, as it provides training modules for FP service providers on the included tools and monitoring practices. Part of any YASSOMA training must be dedicated to transmitting an open and courageous mindset, encouraging providers to try new things and build ownership of the tools by witnessing first-hand the impact on their service.

03

Confiance Totale: Broadcasting Confidence in Family Planning Services and Methods

Theory First

Kincaid's Ideational Model of social and behavior change interventions posits that tailored communication can result in improvements in skills and knowledge on a given topic and shift attitudes, perceived norms, self-efficacy, and social support/influence.^{7,8} Based on this theory, WABA designed the *Confiance Totale* (English: Total Confidence) campaign: a series of radio public service announcements (PSAs) aimed to increase knowledge about the benefits of FP methods and services, and thereby improve listeners' intention to use (and ultimately adopt a method of) modern contraception, according to their specific need.

***Confiance Totale* Intervention: Broadcasting trust in FP methods and services**

Originally, the campaign consisted of two radio PSAs, which promoted having confidence in the safety and efficacy of FP methods and in health centers and healthcare providers. Prior to any broadcasts, however, the COVID-19 pandemic struck. Given collective anxiety and uncertainty around the virus and

its transmission in the community, the global public health community was concerned about whether and how individuals would access necessary health services at health facilities, which might be also treating sick or contagious individuals. Specifically, WABA and other partners were concerned about how women would access health services in the context of stay-at-home orders and fears of disease transmission. The project thus saw an opportunity to share messages that would promote intermediary factors shown to lead to FP uptake, including couple communication about FP and planning for FP method access, use, and uptake. The program quickly pivoted to create seven new PSAs around these themes, which also encouraged FP access and use in the context of COVID-19 via messages around mask-wearing while at clinics and pharmacies, calling existing FP method information hotlines, and asking providers for multiple months' supply of a chosen FP method when possible.

Ultimately, WABA created nine [45-second radio PSAs](#) that promoted the ideas of FP method safety and effectiveness, provided by caring and competent healthcare workers, even during the COVID-19 pandemic. These PSAs were aired in Burkina Faso, Côte d'Ivoire, Niger, and Togo using the Saturation+

⁷ Intent Kincaid, D.L. (2000). Mass media, ideation, and behavior: A longitudinal analysis of contraceptive change in the Philippines. *Communication Research*, 27(6), 723-763.

⁸ Kincaid, D. L., Delate, R., Storey, D., & Figueroa, M. E. (2012). Closing the gaps in practice and in theory. In R. E. Rice & C. K. Atkins (Eds.), *Public Communication Campaigns* (4th ed., Ser. 4, pp. 305–319). Sage. <https://doi.org/10.4135/9781544308449>

The *Confiance Totale* radio public service announcements (PSAs) promoted confidence in family planning (FP) methods and services, couple communication about FP use, postpartum FP, and healthy birth spacing.

The PSAs conveyed these messages and modeled conversations about these topics via scripted conversations—at times poignant, at times casual or humorous—read by actors, between a husband and wife, a couple and a provider, and conversations between friends.

Saturation+ Methodology

Development Media International (DMI) established the Saturation+ approach, which is based on the importance of three main principles for a successful behavior change campaign⁹:

- *Saturation*, meaning broadcast intensity, or the frequency of broadcasts.
- *Science*, or how many times you expect people to hear or be exposed to your message according to broadcast frequency.
- *Stories*, referring to the way a message is crafted and delivered to ensure it is relevant, attractive, and memorable.

methodology. According to this approach, it is recommended to broadcast messages in local languages six to 12 times per day for radio spots, three times per day for TV spots, and at least once per day for other formats⁹ over 120–180 days.

WABA conducted Saturation+ campaigns in all four countries in 2020. Between August 28 and October 15, 2020, Breakthrough RESEARCH [conducted a mobile phone survey](#) to evaluate potential effects of this campaign in Côte d'Ivoire. The results of this evaluation pointed to campaign effectiveness, but in a very crowded, “noisy” media market. Project staff believed they could get more conclusive results in another country where the media market was less busy. As a result, WABA re-broadcast eight PSAs in Togo from July 2021 to December 2021 on local radio stations. Each spot was broadcast on seven radio stations and in the three most commonly used languages 15 times per day between the hours of 5:50 a.m. and 10:00 p.m.

WABA refined the evaluation approach used in Côte d'Ivoire, which was affected by the COVID-19 epidemic and therefore used the mobile phone survey approach, when planning for evaluation in Togo. Instead of using a phone survey, for example, WABA evaluated campaign recognition and impact using a traditional household survey. The household survey allowed WABA to survey a larger population segment, including those with and without access to mobile phones, to add additional questions to the data collection tool, and to include both prompted and unprompted exposure questions. Measures of unprompted exposure asked if a given respondent had ever heard the *Confiance Totale* messages while measures of prompted exposure used the PSAs' chime to trigger the respondent's memory and provide an example of such a message. [The evaluation in Togo](#) also allowed the team to explore the extent to which the approach was effective in the Togolese context, where the radio environment was less “crowded” with other content compared to Côte d'Ivoire, and where WABA could broadcast on commercial radio stations, which was cost prohibitive in Côte d'Ivoire.

⁹ Murray, J., Remes, P., Ilboudou, R., Belem, M., Salouka, S., Snell, W., Wood, C., Lavoie, M., Deboise, L., & Head, R. (2015). The Saturation+ approach to behavior change: Case study of a child survival radio campaign in Burkina Faso. *Global Health, Science, and Practice*, 3(4), 544-556.



The *Confiance Totale* radio spots also became part of a multi-media campaign, and helped promote FP service use and trust in areas where WABA collaborated with the AmplifyPF project to improve service quality.

Evaluation Methods

The Togo quantitative study was conducted among a total of 2,200 adult respondents in Agoé Nyivè in Lomé district and Blitta Ville in Blitta district, who were between the ages of 18 and 49, and who reported that they had sex within the six months prior to the survey.

Results: Paving Paths to FP Behavior change

Among those who reported that they ever listened to the radio (n = 1,682), 41.3% reported that they had heard the *Confiance Totale* PSAs at least once on the radio. When they were prompted with the *Confiance Totale* chime featured in each PSA and with a complete *Confiance Totale* PSA with the chime and the full message, this percentage rose to 55.8% and 44.7% respectively.

Overall, exposure to *Confiance Totale* among this sample was high and that this exposure was significantly associated with key outcomes of interest. Participants who heard *Confiance Totale* were 1.45 times more likely to have spoken to their partner in the last month ($p < 0.001$). Participants who were exposed to

Among those who reported that they ever listened to the radio, 41.3% reported they had heard the *Confiance Totale* PSAs.

Exposure was associated with :

- having spoken to a partner about FP
- current FP method use

Those who heard the PSAs more often were more likely to report :

- intending to use FP
- intending to visit a health facility

Confiance Totale had 1.39 times the odds of currently using (or their partner currently using) FP ($p = 0.023$).

Campaign impact differed between men and women in Togo. Men reported higher self-efficacy, FP knowledge, communication with their partner, and reproductive autonomy than women in the sample. These differences may be due to men's relatively higher position in society and their decision-making power. Women who had been exposed to the campaign had higher odds of speaking to a health care provider in the last month, higher odds of communicating with their partner in the past month, and more accepting FP attitudes generally and postpartum FP attitudes.

In addition, a significant dose-response relationship appeared between the frequency of exposure to the radio spots and intention to use FP, and intention to go to a health facility. That is, those who heard the spots more often were more likely to report intending to use FP or go to the health facility ($p < 0.001$).

These results contrast with those of the evaluation in Côte d'Ivoire, where fewer than 20% of participants recalled being exposed to the *Confiance Totale* campaign. Consistent with the Togo evaluation, exposure to the campaign in Côte d'Ivoire was associated with a host of ideational and behavioral outcomes including the following: belief in the safety of FP, spousal communication about FP, high perceived self-efficacy to communicate with partner about FP, intent to communicate with partner about FP, intent to go to health facility to seek FP information, communication about FP with a health provider in the previous month, and current use of FP.

Successes, Limitations, and Lessons Learned

The Saturation+ methodology is an effective SBC approach, including in emergency contexts

The results of the *Confiance Totale* evaluations, both in Côte d'Ivoire and in Togo, demonstrated the effectiveness of using the Saturation+ methodology for frequent airing of radio spots

and the associations between being exposed to this material, and the ideational and behavioral outcomes of interest. WABA designed, refined, and implemented the program during early days of the COVID-19 pandemic, creating an opportunity to reach those in need of FP information and services without potentially dangerous interpersonal communication. While the designs of these studies do not allow for the determination of whether this relationship is truly causal, the results of these studies generate promising evidence of potential impact. Accordingly, in the months following the evaluation, the same radio spots were broadcast to further promote FP service use and trust in areas where the AmplifyPF project worked with select health facilities to improve service quality.

Context affects methodology and impact

In Côte d'Ivoire, where the spots aired in more urban environments on local radio stations, rather than on broader reaching but cost-prohibitive commercial stations, and where media competition was stronger, exposure to the PSAs was low compared to Togo. Furthermore, the broadcast of the PSAs in Côte d'Ivoire coincided with its presidential election and therefore may have been overshadowed by political messages, whereas Togo's airwaves were comparatively calm. Nonetheless, in both places, exposure to the campaign was associated with significant increases in outcomes of interest including current FP use.

Programs need to document as much as possible

In the future, programs which work to understand the relationship between exposure to media spots and outcomes of interest should undertake more robust research designs. This includes comparison to control communities, longitudinal pre/post intervention data to tease out the temporality of these relationships, and comparing or contextualizing results according to sex and gender norms and dynamics. In these designs, more sophisticated analytic models can also illustrate the relationships between the ideational constructs, social and gender norms, and behavioral outcomes.

For more information on the *Confiance Totale* program and evaluation, please consult the following resources:

- [Confiance Totale radio spots](#)
- [Monitoring the Quality Assurance Branding Campaign Confiance Totale in Côte d'Ivoire](#)
- [Evaluation of the Confiance Totale Campaign in Togo](#)

04

Discussion

While the three activities detailed in this brief are distinct, their successes built upon small, innovative tweaks to common “best practice” cornerstones, and upon the strategic pillars crucial to the entire [Breakthrough ACTION](#) project:

Embrace experimentation and learning in a systematic way

In its PBC activities, WABA took a calculated risk by skipping collecting primary qualitative research to define the design challenges related to client-provider interaction. Using the existing evidence available in the four countries, WABA was able to go directly to the Phases 2 and 3 of the SBC Flow Chart to identify existing PBC solutions for four country contexts. This risk paid off. The project successfully co-created PBC solutions with stakeholders using existing evidence and, in some cases, by adapting existing solutions, using the Go, Tweak, Turn approach. Documenting the success and challenges of this experimental and innovative process creates an opportunity for further experimentation by other projects—and potential cost and time savings—once implementers further refine the Go, Tweak, Turn process.

The Saturation+ methodology¹⁰ used in rural Burkina Faso produced high rates of exposure and related behavioral outcomes. WABA decided to test this method to see if it would

prove as effective in an urban or peri-urban setting. The *Confiance Totale* campaign, broadcast using the Saturation+ methodology, produced lower than expected exposure rates in Côte d’Ivoire. WABA hypothesized that specific challenges had compromised the potential effectiveness of the campaign broadcast methodology. In Côte d’Ivoire, an ongoing contested election and the onset of the COVID-19 pandemic, made the landscape “noisier” than usual. By duplicating the *Confiance Totale* Saturation+ broadcast campaign in Togo, WABA was able to get a better sense of whether the campaign was effective. This approach of continuous curiosity and learning yielded new successes for the project, its collaborators, and potentially other SBC FP practitioners. This work contributed to the evidence around Saturation+ being a best practice, while also identifying some limitations to the approach in specific environments.

Developing FP messages couched in the context of a pandemic was another innovation; the project risked possibly diluting FP message impact by also including COVID-19 contextual elements, including, in one spot, encouraging mask-wearing when seeking FP services. While results might have been higher without the COVID-19 content—a factor difficult to ascertain—Breakthrough ACTION contributed to the evidence that such integrated messages can still produce the desired FP impact.

¹⁰ Murray, J., et al. (2015). The Saturation+ approach [...]. *Global Health, Science, and Practice*. See footnote 9.

Place users and communities at the center

As shared in the CD and site walkthrough example, community stakeholders, and members were central to identifying and finding solutions to real FP service quality problems. The percentage of action plan activities realized speaks to the power of this approach; the magnitude surpasses what WABA, as an external project, would have been able to accomplish alone. Without a doubt, community ownership of this process was cornerstone to the entire process' success. While community engagement and mobilization are already proven approaches in SBC programs, the WABA and AmplifyPF projects furthered the approach by harnessing the potential of communities to solve some of their own problems and mobilizing resources locally to address shortcomings in the health system to provide quality services. The creation of the multi-sectoral CTARs at the district serve to broaden the support and resource mobilization for creating local solutions. In addition, WABA used the FP service quality issues identified during the community engagement activities to inform the PBC design process. The project then developed PBC prototypes based on input from FP providers and clients, and then tested and validated the prototypes with some of these same groups, and clinic supervisors. Only with feedback from the FP service staff and FP clients could each prototype be improved and finalized.

Improve client-provider interactions and experience of care

The client-provider dynamic undeniably impacts any FP consultation outcome. WABA held this fact close in each of the activities described in this brief. The CDs and site walkthroughs brought these two often-at-odds groups together to address FP service delivery challenges that existing structural systems had not, including improvements to the physical facility to make clients feel safer and better cared for, and empathy for the challenges providers face in their work. Further, the fact that both providers and community members were invited first separately, and then together to share their perspectives on the current state and envisioned improvements to FP services was key to helping each group find their voice together, before diplomatically sharing their thoughts through facilitated conversations with the other group.

Then, the PBC packages took these insights steps further, and supported providers to better know and counsel their clients (Niger and Côte d'Ivoire, respectively), clarify and improve client flow through FP and other health clinic services (Togo), and address the emotional and professional needs of FP providers to do their job well (Burkina Faso and Niger). Particularly in Burkina Faso, the project recognized through the PBC process the importance of stepping beyond provider technical training

and into the root issue of provider motivation. Instead of giving the providers the counseling "script" to guide what they said to clients, the PBC package focused more on improving the way providers feel as health professionals, offering care for their clients and their communities at large. Some of the elements of the YASSOMA package, such as the provider recognition badges, are included in the *Confiance Totale* service quality campaign in Togo to instill a sense of pride in FP providers there.

Institutionalize SBC capabilities and networks

In all four countries, WABA currently provides supportive supervision to district health officials, CTARs, or to private structures¹¹ to organize CD and site walkthroughs with communities, to continue the important bridge building between communities and the health system. WABA is also packaging all the resources needed to conduct CDs and site walkthroughs, including discussion guides, Ministry of Health-approved FP method fliers, and more, to ensure each CTAR and district have the tools they need to continue this work. In each country, too, national Ministry of Health officials have been part of the co-creation process of the PBC prototypes and final interventions. Being able to build concepts that become testable prototypes will be an important skill as ministries face other sticky challenges that require a new skill set or knowledge of an approach, like HCD. WABA is advocating with relevant stakeholders in either the public (e.g., ministry) or private (e.g., other implementing partners and NGOs) to implement and scale the identified PBC solutions now. WABA hopes that this will help deepen the ownership, sustainability, and even adaptation of the solutions and the design process as contextual factors shift in the coming years.

Finally, while WABA and its collaborators did not explicitly outline separate outcomes for men and women in each activity, WABA did consider **gender-related determinants of health** in all three activities. In the CDs and site walkthroughs, the project and its collaborators strived to ensure a gender balance among participants to ensure male and female perspectives were elicited and heard. WABA also was intentional about including men and women in PBC prototype co-creation and testing, and representing male and female perspectives, interests, priorities, and voices in the radio spots that would model women as strong, capable figures, and men as supportive partners.

These pillars were central to WABA's success and can serve as guiding principles for other SBC for FP practitioners working in francophone West Africa and beyond.

¹¹ Following the 2022 political coup in Burkina Faso, WABA shifted from working with public and government structures to working directly with private clinics and associations.



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