



Agir pour la Planification Familiale

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USING BASELINE DATA TO DEVELOP A REGIONAL STRATEGY FOR IMPROVING FAMILY PLANNING USE AND SERVICE DELIVERY IN WEST AFRICA

Family planning (FP) saves lives—allowing individuals and couples to decide if to have children, when to have them, and how many to have. The renewed global investment in FP in recent years reflects FP’s critical and demonstrable benefits to health, as well as to economic and social well-being. In 2011, when the Ougadougou Partnership was launched in Dakar, Senegal, stakeholders across the West African region committed to reaching an additional 1 million FP users by 2015 (Ougadougou Partnership, 2012). At the 2012 London Summit on Family Planning, the global community committed to reaching an additional 120 million users in the world’s 69 poorest countries, and in 2014 these efforts contributed to an additional 8.4 million new FP users globally (FP2020 & United Nations Foundation, 2014).

Despite progress, much remains to be done to meet these ambitious commitments. West Africa lags behind many other countries, with high fertility, low contraceptive use, and high unmet need. According to the most recent population-based data, the modern contraceptive prevalence rate (mCPR) is 14–34% in urban areas of Burkina Faso, Côte d’Ivoire, Mauritania, Niger, and Togo, while unmet need ranges from 21% to 35%. Therefore, achieving the commitments of both FP2020 and the Ougadougou Partnership will require new strategies to ensure that individuals across the region can share in the health and socioeconomic benefits of these increased investments.

THE AGIRPF PROJECT

Context

In 2013, to support advancement toward this critical development goal, the United States Agency for International Development (USAID)/West Africa Regional Health Office awarded a five-year, \$29

million project, Agir pour la Planification Familiale (AgirPF), to EngenderHealth with its core partner, Avenir Health (formerly Futures Institute). The goal of AgirPF is to enable individuals and couples to make, and voluntarily act on, informed decisions about FP, in selected urban and peri-urban areas of Burkina Faso, Côte d’Ivoire, Mauritania, Niger, and Togo (Figure 1).



Figure 1: AgirPF project countries and cities



Emphasis on High-Impact Practices

Key to AgirPF’s success will be to test, scale up, and replicate high-impact practices in a holistic manner (USAID & K4Health, 2015). Many FP programs focus on increasing the supply of services, in part to meet high unmet demand. However, that is rarely sufficient to sustain long-term use and quality services that meet the needs and respect the rights of individuals. It is also critical to address the resource and policy context within which FP programs operate, as well as the sociocultural environment (RESPOND Project, 2014).

Regional Focus

West African countries face many shared problems that cannot be solved effectively or sustainably by any national government alone and thus require a regional approach. For example, the large populations of West Africa (367 million) will more than double, to 909 million, by 2050 (USAID, 2014). Meeting the unmet FP needs of this projected youth bulge will be a shared

responsibility, one best addressed through regional cooperation and information sharing.

METHODS

Aim and Objectives

Between June 2014 and April 2015, AgirPF conducted a baseline assessment study in four of its five countries (Burkina Faso, Côte d’Ivoire, Niger, and Togo) to help inform future project programming, provide a benchmark for comparisons over time, and identify priority areas and existing strengths and best practices on which to build. (Data will be collected in Mauritania in October–November 2015.)

Design, Methods, and Sample

The study incorporated a quasi-experimental design—including a nonequivalent nonintervention group. Study groups (“zones”) included facilities and their

Table 1: Percentage of facilities offering selected FP and PAC services

	Burkina Faso		Niger		Togo		Côte d'Ivoire	
	Intervention	Nonintervention	Intervention	Nonintervention	Intervention	Nonintervention	Intervention	Nonintervention
<i>N (sample size)</i>	52	31	38	36	48	24	81	50
Short-acting methods								
Combined pill	96	100	95	97	98	83	67	80
Injectables (DMPA)	100	100	92	94	100	100	74	94
Male condom	96	94	79	50	79	67	26	49
Female condom	88	81	42	22	35	17	18	30
Emergency contraceptive pill	72	74	40	33	58	42	25	46
SDM	79	74	13	25	58	29	12	22
Long-acting/permanent methods								
Female sterilization	12	3	0	0	4	0	4	4
Male sterilization	10	3	0	0	6	0	4	4
Implant (Jadelle)	96	87	63	44	85	67	17	32
IUD	77	65	45	42	75	63	12	26
Postpartum IUD	35	32	37	14	n/a	n/a	10	22
At least one LA/PM	98	100	95	97	100	100	74	94
PAC services	75	68	66	72	48	29	47	64

catchment populations. All efforts were made to match the groups on key characteristics, including facility-type and age distribution of the catchment population. In addition, data on key variables were collected to assess the extent of contamination and spillover between intervention and nonintervention zones. This was particularly important because project activities are not isolated to intervention facilities and their catchment populations, meaning that activities target populations facilitate health-systems strengthening throughout the project areas.

The study consisted of five parts: a randomized household survey of men aged 15–59 and women aged 15–49; a facility survey that covered all intervention facilities and a matched sample of control facilities; a survey of all providers present at the facility on the day of the facility assessment (approximately two per facility); key informant interviews with members of the district management team and staff of civil society and nongovernmental organizations (NGOs); and a survey of every other community health worker associated with a study facility. More complete information about the methods, key variables, and

study samples can be found in the full baseline report (AgirPF, 2015).

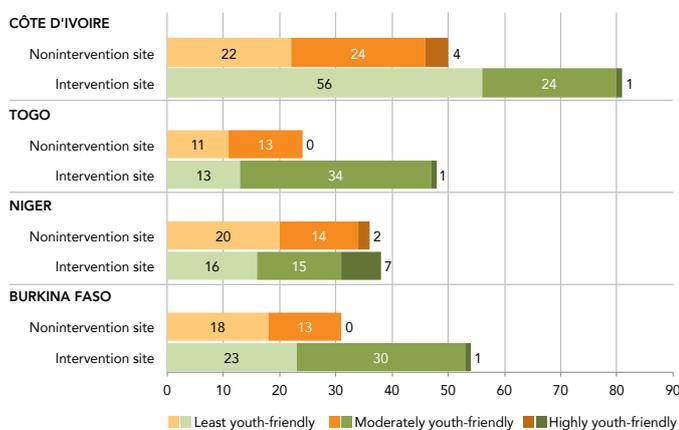
The study was reviewed by the Western Institutional Review Board and national ethics committees in each study country. Each study participant provided written informed consent before any interview was conducted. Participants' names and other identifying information were not collected. Data collection, data management, and preliminary analysis were conducted by independent research agencies in each country. During data collection, AgirFP staff conducted regular monitoring with field visits.

SUPPLY

FP and PAC Service Availability

A wide range of FP services were available at study facilities in both the intervention and nonintervention areas across the study countries, although the number and type varied (Table 1). In Burkina Faso, oral contraceptives, injectables (mainly depot-

Figure 2: No. of clinics, by extent of youth-friendliness, four AgirPF countries



medroxyprogesterone acetate [DMPA]), and the male condom were offered at almost all facilities (90% or more). Implants and female condoms were offered at the majority of facilities as well. Notably, postabortion care (PAC) services (i.e., including manual vacuum aspiration [MVA]) were available at the majority of facilities, despite most of these being primary health centers. On the other hand, the large majority of facilities did not offer male sterilization, female sterilization, or postpartum insertion of the intrauterine device (IUD).

In Togo, the majority of all facilities offered combined pills, injectables (DMPA), implants, the IUD, and male condoms. Fewer facilities offered female condoms and PAC services; sterilization (male or female) was offered in close to none.

In Niger, short-acting methods (combined oral contraceptives and injectables) were almost universally offered. Between 40% and 80% of facilities provided the IUD, implants, male condoms, the postpartum IUD, and emergency contraceptives. The standard days method (SDM) was not available in the majority of facilities. Sterilization (male or female) was not offered at any facilities in Niger.

Facilities in Côte d'Ivoire offered fewer FP services than those in the other three countries, particularly

in the intervention area. While the majority of facilities provided the pill and injectables, other methods were offered only sporadically. However, nearly three-quarters of intervention facilities and nearly 100% of nonintervention facilities offered at least one long-acting or permanent method (LA/PM).

Essential Equipment for Key Services

Among facilities providing implants, the availability of essential equipment was low. Equipment for inserting Implanon appears to have been higher but more variable than that for inserting Jadelle or Sino-implant (II); between 22% and 72% of facilities providing Implanon were equipped, compared with 0–50% for Jadelle or Sino-implant (II). The availability of equipment to remove implants was similarly low in all countries: About one-third of facilities in Burkina Faso and Niger were equipped to remove implants. In comparison, none of the nonintervention facilities in Togo and 40% of nonintervention facilities and 11% of intervention facilities in Côte d'Ivoire were so equipped.

The availability of essential equipment for IUD insertion was also low in three countries (approximately one-third of facilities in Burkina Faso and Côte d'Ivoire and fewer than one-third in Niger). In contrast, in Togo, more than two-thirds of facilities had such equipment.

Table 2: Among providers for whom young age is a criterion for FP provision, percentage giving various reasons

	Burkina Faso		Côte d'Ivoire		Niger		Togo	
	Intrv.	Nonintrv.	Intrv.	Nonintrv.	Intrv.	Nonintrv.	Intrv.	Nonintrv.
<i>N (sample size)</i>	62	36	84	69	29	24	72	33
National law does not allow it.	3	3	4	6	10	8	23	9
Health center/clinic policy does not allow it.	3	0	2	10	3	4	4	3
I do not believe the woman/man should be sexually active at that age.	50	47	72	67	52	71	63	58
A woman should have had one or more children before deciding to use FP.	59	50	43	32	38	25	63	58
A man should have had one or more children before deciding to use FP.	49	44	29	20	28	4	54	55
Other	36	33	24	22	17	13	20	30

Due to the lack of health personnel trained to provide sterilization, the availability of equipment for sterilization was assessed only in a small number of facilities across the four countries.

No facilities had all of the essential equipment for PAC provision in Burkina Faso, Côte d'Ivoire, and Togo, despite the availability of trained health personnel. Only two nonintervention facilities in Niger had essential equipment for PAC provision.

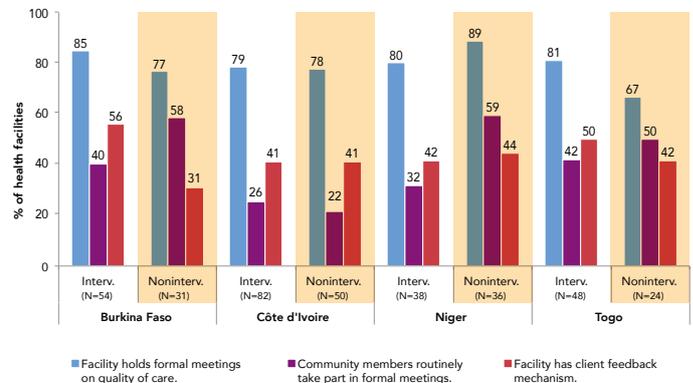
Examination/Procedure Room Equipment

The availability of essential FP equipment and supplies in examination rooms varied; in general, it was poorer in Côte d'Ivoire than in the other countries. A few items were nearly universally unavailable in some countries, such as the arm rest for implant insertion and the handheld uterine model. The proportion of facilities with essential equipment and supplies was very small in all four countries; in Burkina Faso and Côte d'Ivoire, fewer than 10% of facilities had all essential items in examination rooms at the time of the assessment.

Youth-Friendly Services

Eight aspects of “youth-friendly” service (YFS) delivery were assessed: (1) separate hours for youth; (2) a separate space for youth services; (3) a separate waiting room for youth; (4) training of providers in YFS; (5) orientation of staff in YFS; (6) youth counseling on sexuality, safer sex, pregnancy prevention, and prevention of sexually transmitted infections (STIs), including HIV; (7) requirement for parental/spouse consent for youth; and (8) provision of services to youth regardless of their marital status. Across the four countries, the majority of the facilities were classified as only “moderately” or “least” youth-friendly (Figure 2). Only in Niger were a sizable minority of facilities considered “highly” youth-friendly. In Côte d'Ivoire, the intervention area had significantly more least-youth-friendly facilities than the nonintervention area.

Figure 3: Percentage of health facilities practicing various forms of community engagement in FP service delivery



ENABLING ENVIRONMENT

Provider-Imposed Barriers

Although not required by law, providers reported using such criteria as client’s age, marital status, and number of children when deciding whether and which FP services to provide. In Burkina Faso, Niger, and Togo, regardless of FP method, marital status was the most frequently mentioned criterion for FP provision (76–94%, depending on method or zone). In those countries, client’s age (how young and how old), parental consent (for clients under age 18), number of children, and husband’s consent were also mentioned by a significant minority of providers as factors taken into consideration. In Côte d'Ivoire, the large majority of providers reported that they would consider the client’s age and marital status before prescribing the pill and injectables; the majority did not report a client’s youth to be a barrier to prescribing male condoms or emergency contraceptives.

When asked why they would not prescribe FP methods to a client younger than a minimum age (Table 2), the majority of providers in Niger and Côte d'Ivoire reported that they did not believe women

and men should be sexually active at that age. In Burkina Faso and Togo, the majority of providers also mentioned that a woman or a man should have had one or more children before deciding to use FP. Only a very small minority of providers across all four countries believed that the national law or health facility policy did not allow this.

Community Engagement

In all four countries, most facilities reported holding formal meetings to discuss the quality of service delivery (67–89%) (Figure 3). However, about half or fewer of the facilities convening meetings reported that community members routinely participated (31–56%). More than half of intervention facilities reported that they have a client feedback system in place, compared with 31% of nonintervention facilities.

Availability of Guidelines at Facilities

The availability of national reproductive health service protocols was poor across all countries, but

particularly so in Togo and Côte d'Ivoire (none of the nonintervention facilities in Togo and fewer than 10% of facilities in both zones in Côte d'Ivoire). The availability of FP and counseling protocols was similarly inadequate in the majority of facilities across the four countries. Fewer than 10% of facilities had the protocol on response to female clients who were victims of intimate partner violence. Across all study countries, next to no facilities observed in the facility assessment had all four protocols in place (from 0% in Togo to 8% in Niger).

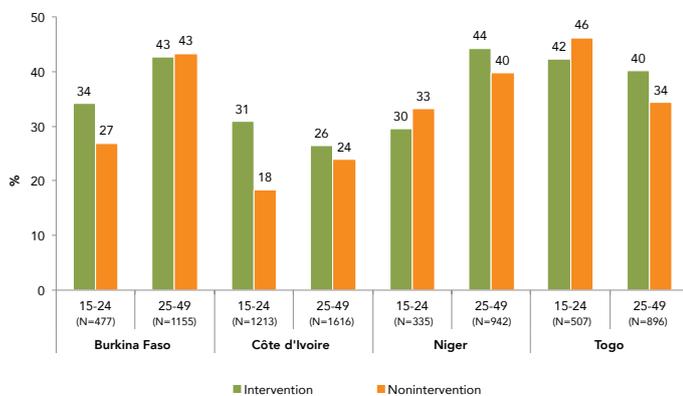
Perspectives from Key Informants

When asked about barriers to increasing FP service provision at the service delivery level, key informants in general spoke to issues of either supply of contraceptives or availability of trained providers. The reasons for not providing oral contraceptives were mainly a lack of supplies in Togo and a lack of staff training and supplies in Côte d'Ivoire. In Togo, the lack of demand was also mentioned as a reason. Across all four countries, reasons for not providing the IUD

Table 3: Profile of women participants and their modern contraceptive use, discussions of FP with partners, and exposure to FP messages

	Burkina Faso		Niger		Togo		Côte d'Ivoire	
	Intervention	Nonintervention	Intervention	Nonintervention	Intervention	Nonintervention	Intervention	Nonintervention
Participant profile	N=1,364	N=795	N=714	N=714	N=1,079	N=528	N=1,911	N=1,104
% married	58	61	89	94	62	65	19	18
% living together	12	6	n/a	n/a	3	4	31	31
% single	27	26	6	3	31	28	49	49
% divorced, separated, widowed	3	6	5	3	4	4	1	1
Mean age [SD]	27.5 [27.0, 27.9]	28.4 [27.8, 29.0]	29.9 [29.4, 30.5]	29.9 [29.4, 30.5]	28.3 [27.8, 28.8]	28.5 [27.7, 29.2]	26.6 [26.3, 27.0]	26.2 [25.7, 26.7]
Number of living children, mean [SD]	2.5 [2.4, 2.6]	2.9 [2.8, 3.1]	3.9 [3.7, 4.1]	3.8 [3.6, 3.9]	2.5 [2.3, 2.6]	2.6 [2.4, 2.8]	1.5 [1.4, 1.5]	1.5 [1.4, 1.6]
Desired family size, mean [SD]	4.3 [4.2, 4.4]	4.5 [4.3, 4.6]	8.6 [8.2, 9.0]	8.9 [8.6, 9.2]	3.8 [3.7-3.9]	3.9 [3.8, 4.1]	4.2 [4.2, 4.3]	4.4 [4.3, 4.6]
% discussed FP with partner	42	38	36	47	37	35	34	33
Exposure to FP messages								
% radio	36	52	55	50	27	23	18	14
% TV	52	49	43	44	17	17	41	34
% using modern contraception	N=1,035	N=597	N=601	N=676	N=950	N=452	N=1,394	N=785
mCPR	50.9	48.6	45.1	43.4	46.0	44.5	40.4	33.9
Sterilization (male or female)	0.2	0.5	1.8	1.4	0.7	0.0	0.2	0.0
IUD	1.9	1.7	1.2	0.9	1.3	1.5	0.4	0.1
Implant	11.6	12.7	5.2	5.8	6.6	11.7	0.9	1.0
Injectable	9.1	9.2	9.0	10.4	6.2	5.7	7.3	6.6
Pill	10.7	9.1	25.3	22.6	3.0	3.1	9.8	9.4
Condom	15.2	13.6	0.0	0.2	22.6	19.6	20.4	15.4
SDM	1.8	1.7	0.2	0.0	4.6	1.8	0.4	0.6
Other	0.4	0.2	2.5	2.2	0.9	1.1	1.0	0.6

Figure 4: Percentage of women using a modern FP method, by age-group



were a lack of staff training and a lack of supplies. The majority of facilities not currently providing implants mostly mentioned lack of supplies as the main reason and lack of staff training in some instances. Provider attitudes were not mentioned frequently as barriers.

Concerning community-level barriers to FP use, key informants reported that FP is accepted by many social groups and is understood to be a policy priority, especially to reduce maternal and child mortality. However, social and cultural barriers were perceived as influencing the low uptake of FP across all four countries. These barriers include: lack of awareness in the community as to the health and economic benefits of FP, negative public perception toward FP, and religious resistance to the use of FP. Also mentioned frequently was the community norm for large families and the strong influence that norm has on an individual's reproductive intentions.

DEMAND

Reproductive Health Status and Desired Fertility

In all four countries, the majority of women desired large families (four or more children), and most already have had two or more living children. Women

in Burkina Faso and Togo have an average of 2–3 living children; in comparison, women have had an average of four children in Niger and fewer than two, on average, in Côte d'Ivoire (Table 3, page 6). This difference may be explained by the slightly higher average age of women in Niger and the slightly lower average in Côte d'Ivoire (30 vs. 26). A difference in marital status between these two countries may also explain the range in the number of living children. Although women in Côte d'Ivoire were younger and many of them single, their desired number of children did not differ from that among women in Burkina Faso and Togo. The desired number of children in those three countries was between four and five children; women in Niger reported a significantly higher desired family size (8–9).

Contraceptive Prevalence

The mCPR among all women ranged from 35% in Côte d'Ivoire to 51% in Burkina Faso. In all countries but Niger, mCPR tended to be lower among women younger than 25 than among those 25 or older; however, in Côte d'Ivoire, younger women in the intervention zone had a higher mCPR than those in the nonintervention zone (31% vs. 18%) (Figure 4).

Modern method use varied across the countries and by age (Table 3). In Burkina Faso, the majority of younger FP users currently use male condoms; older users more commonly use hormonal methods. In Togo, the male condom is the most commonly used method; it is the method used by the majority of users younger than 30 in the intervention communities and younger than 25 in the nonintervention communities. Among older women in all countries, the use of condoms tends to decrease as the use of hormonal methods increases. In Togo, the pill is used less frequently than other hormonal methods. About 5% of women there use SDM, regardless of age.

In Côte d'Ivoire, method use shifted from the condom among users younger than 25 toward hormonal methods at older ages. The pill was the

most commonly used hormonal method, followed by injectables; use of implants was minimal.

Unlike in other countries, condom use in Niger is close to nil. Instead, the majority of contraceptive users rely on the pill, across all age-groups. Injectable use increases with age, but the pill remains the most commonly used method among older users in Niger.

In terms of LA/PMs, use also varied across the countries and was highest in Burkina Faso (approximately 14%) and lowest in Côte d'Ivoire (less than 2%). Among the LA/PMs, implants were most commonly used (by anywhere from 12% in Burkina Faso to 1% in Côte d'Ivoire), while sterilization use was uncommon (from 0% in Côte d'Ivoire to 2% in Niger). There were almost no users of male sterilization in any country (data not shown).

FP Knowledge

Almost all women across the four countries had heard of an FP method (from 83% in Côte d'Ivoire to 96% in Niger). In particular, the majority of women in all countries reported that they had heard of short-acting methods, such as the pill and injectables. However, there were also key differences. For example, a majority of women in Burkina Faso reported knowing about the IUD and implants, but comparatively fewer women knew about those methods in Côte d'Ivoire, Niger, and Togo. Although a majority of women in Niger had heard of the male condom, they were less likely to know about the condom than were women in the three other countries. Across all four, sterilization, spermicides, and emergency contraceptive pills were less well-known than the pill, injectables, the IUD, and implants.

FP Discussion Among Partners

A minority of women reported having discussed FP with their husband or partner (from 33% in Côte d'Ivoire to 47% in Niger) (Table 3), although married/cohabitating women were slightly more likely to report

such a discussion (data not shown). In Burkina Faso, 52% of married/cohabitating women in intervention communities reported having discussed FP methods with their husband/partner, compared with 43% of married/cohabitating women in nonintervention communities ($p = .004$). In Niger, a similar trend was observed: Close to 50% of married/cohabitating women in nonintervention communities reported engaging in such a discussion, compared with 39% in intervention communities ($p < .001$). In Côte d'Ivoire, approximately 40% of married/cohabitating women in each study zone reported having had FP discussions with their husband.

Exposure to FP Messages

Exposure to FP messages varied significantly across and within countries (Table 3). In Burkina Faso, approximately three-quarters of women in intervention and nonintervention communities reported having heard an FP message. The majority reported hearing messages through TV and radio, but the percentage of women receiving a message via radio was greater in nonintervention communities than in intervention communities. In Côte d'Ivoire, just over half of women in intervention communities reported having received FP messages, compared with under half in the intervention communities (51% vs 42%, respectively). The majority of women heard FP messages through TV in both intervention and nonintervention communities. In Togo, approximately one-third of women reported that they had heard FP messages, the majority through radio; in Niger, more than three-quarters reported having heard FP messages, the majority through radio or TV.

CONCLUSIONS

Regional and Country-Specific Strengths and Gaps

The results of this baseline study demonstrate that regionally there exists a good infrastructure of service delivery points offering a wide range of FP services. However, a number of factors contribute to the unavailability of services, including: the lack of essential equipment and supplies, the lack of staff training and confidence (particularly in Côte d'Ivoire), and health providers' attitudes about providing FP services to adolescents and unmarried women. A number of demand-side and enabling environment factors also emerged from the results, most importantly deeply rooted gender and social norms that contribute to lower FP use. The following are key recommendations arising from the baseline analyses:

Regional

- Improving access to sterilization services is an option, but it may not be easy, as this is often an area reserved for gynecologists and surgeons.
- Health facilities need to implement strategies to remove barriers to providing services to youth, adolescents, and the unmarried, particularly in Côte d'Ivoire, but also in the other countries.
- Social and behavior change communication (SBCC) campaigns and trainings may be needed to remove health provider-imposed barriers (age, marital status) to the prescription of FP methods.
- Health facilities will need to have service protocols in place, and providers need to know and adhere to the national and international guidelines in FP service provision.

- An end-of-project evaluation should take into account that there were statistically significant differences in women's characteristics between the intervention and nonintervention sites in Côte d'Ivoire, Niger, and Togo, and careful analyses will be needed before drawing a conclusion about the impact of AgirPF.

Burkina Faso

- The accessibility and availability of the IUD—in particular, the postpartum IUD—and of PAC services could be improved dramatically, given the country's relatively high institutional delivery rate.
- Provider training must include information on the Burkina Faso's reproductive health law concerning barriers to service provision.

Niger

- Reasons why women desire a large family should be investigated and incorporated into SBCC strategies.
- Condom use was particularly low in Niger. Reasons for such a low level of use must be investigated and findings incorporated into SBCC strategies.
- Women should be sensitized to the range of FP methods, to achieve a more balanced contraceptive method mix.
- To strengthen LA/PM service delivery, providers would benefit from retraining on implants, and equipment for and supplies of IUDs and implants need to become more available.
- Community-based health services should be strengthened, to make FP services more available for women with difficulties accessing health care facilities.

Togo

- Demand-side barriers to hormonal methods should be investigated, and findings should be incorporated into SBCC strategies.
- FP providers would benefit from training/retraining in the provision of implants, the IUD, and PAC. Midwives can be trained to provide MVA. The majority of the facilities also need equipment for PAC services.
- Providers may also benefit from sensitization/orientation to serving youth.
- Equipment is needed for implant service provision, and supplies of implants need to be improved at the facilities.

Côte d'Ivoire

- Women (and possibly men) need to be sensitized to FP use and to the need for communication with partners.
- Health facilities need to be equipped with SBCC materials to teach about FP and specific FP methods.
- Providers should be given support to improve their skills and increase their confidence in providing FP services. Retraining may be a good option.
- Providers may also benefit from sensitization activities to serve youth and adolescents.
- Supplies of temporary methods (i.e., male and female condoms, progestin-only and combined pills, and cycle beads), general supply items, and equipment for PAC need to be made more available.

THE WAY FORWARD

The results emphasize the need for program interventions that comprehensively and holistically address the multiple determinants of FP service quality and use and support the ability of individuals and couples to make decisions about childbearing: (i) The supply of services must be increased to meet growing need and to make high-quality services universally accessible and available; (ii) the enabling environment must be strengthened by developing and implementing policies, guidelines, and practices that expand quality service delivery and that support increased demand, including overcoming gender-related and other societal barriers; and (iii) demand for FP services must be increased, including through interventions to address poor service quality and access, policy barriers, and deeply rooted social and gender norms.

To address these gaps and weaknesses, AgirPF will implement a “suite” of high-impact practices (HIPs) in the following strategic areas:

Improving FP service quality, availability, and access

AgirPF will support scale-up of the following interventions:

- Integration of FP into sexual and reproductive health services such as immunization, HIV services, and strengthening the delivery of postabortion FP and postpartum FP
- Mainstreaming of youth-friendly elements into FP service delivery
- Training of services providers in the rapport building, exploration, decision making, and implementing (REDI) counseling framework

Bringing FP services to underserved communities, to reduce financial barriers and enhance voluntary and informed decisions about contraceptive use

AgirPF will deploy mobile and outreach services, conduct FP Special Days, and engage community health workers (CHWs) in the distribution of contraceptives, including the injectable.

Educating and empowering clients and grassroots advocates

AgirPF has chosen specific emerging HIPs to engage and foster FP discussion among partners and to increase quality FP information awareness, so that individuals and couples are more likely to be able to make childbearing decisions.

- AgirPF will use a population segmentation approach to facilitate behavior change toward FP use, as well as EngenderHealth's Men As Partners® (MAP) approach to foster men's involvement in reproductive health service utilization.
- AgirPF will also use EngenderHealth's site walk-through (SWT) approach to inform, inspire, and employ community leaders, civil society, and districts advocates to improve community knowledge and awareness of FP services and to address social and gender norms that influence attitudes toward FP use.
- Finally, mHealth platforms will be used to deliver FP information to CHWs and service providers; SMS appointment reminders to clients; and SMS testimonials by FP champions to potential users. Counseling using the REDI framework will also help to educate and empower clients.

Enabling the FP environment by reducing financial barriers and solving logistics issues.

AgirPF will foster a positive national and community-level enabling environment, galvanizing FP commitment by advocating for policy changes in task shifting to CHWs, in cost reduction of FP commodities, and in increasing FP funding at the national and urban levels.

AgirPF's goal is to encourage a regional approach that can effectively and sustainably address the shared problems faced by countries in the West African region. This suite of HIPs will ensure that AgirPF's countries will serve as models for high-quality FP programming in the region, and ultimately those models will be adopted and taken to scale by national governments across the region.

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