



Agir pour la Planification Familiale

PROJECT BRIEF NO. 8 · JANUARY 2018

Using Baseline Data to Develop an In-Country Strategy for Improving Family Planning Use and Service Delivery in Côte d'Ivoire

CONTEXT

In 2013, 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 family planning (FP) and reproductive health (RH) in selected urban and peri-urban areas of Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo. In Côte d'Ivoire, the project is working in Abidjan and the surrounding localities of Anyama, Bingerville, and Dabou.

METHODS

Aim and Objectives

Before project implementation, AgirPF conducted a baseline assessment study in Côte d'Ivoire 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. The baseline assessment in Côte d'Ivoire was conducted in the regional project's second year, which corresponded to the project's first year of operation in Côte d'Ivoire.

Design, Methods, and Sample

The study incorporated a quasi-experimental design, including a nonequivalent nonintervention group (AgirPF, 2015). Study groups ("zones") included facilities in the Abidjan Health Center (Adjamé-Attécoubé-Plateau, Yopougon Ouest-Songon, Yopougon Est, Abobo Est, Abobo Ouest, Treichville-Marcory, Koumassi-Port Bouet-Vridi, and Cocody-Bingerville) and the surrounding localities of Anyama, Bingerville, Songon, and Dabou and their catchment populations. There were 82 intervention sites and 50 nonintervention sites.

All efforts were made to match the groups on key characteristics, including facility type and age distribution of the catchment population. In addition, the project collected data to assess the extent of contamination and spillover between the intervention and nonintervention zones. The study consisted of five parts:

1. A randomized household survey of men aged 15–59 and women aged 15–49
2. A facility assessment that covered all intervention facilities and a matched sample of nonintervention facilities
3. A survey of all providers present at the facilities on the day of the facility assessment (approximately two per facility)
4. Key informant interviews with members of the district management team and with staff of civil society and nongovernmental organizations (NGOs)
5. Interviews with community health workers associated with surveyed facilities

The study assessed FP services as well as the availability of youth-friendly services (YFS). The Western Institutional Review Board and the Côte d'Ivoire national ethics committee reviewed the study protocol. Study participants provided written

informed consent before interviews. Participants' names and other identifying information were not collected.

SUPPLY

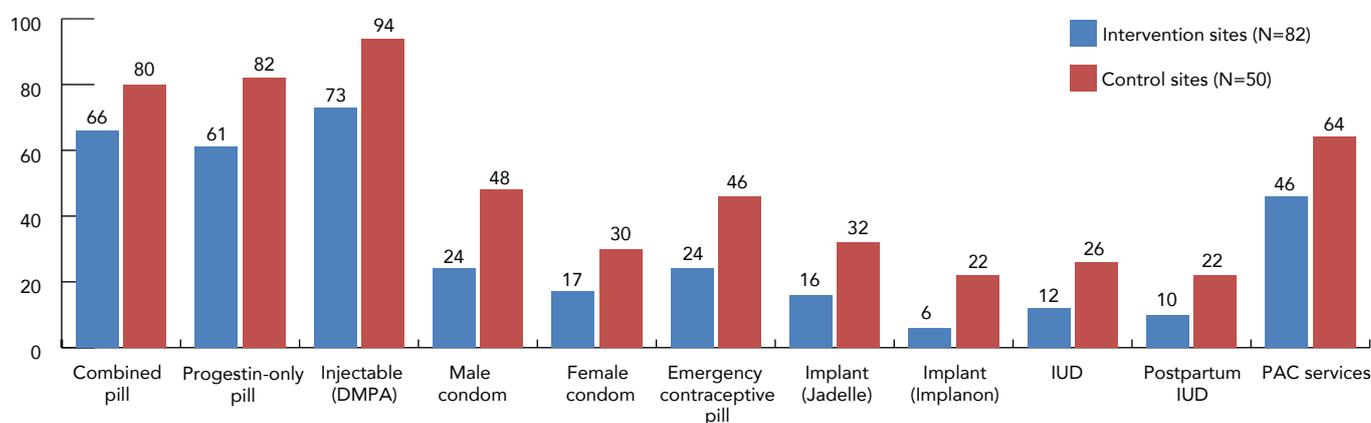
FP Availability

Intervention sites in Côte d'Ivoire offered fewer FP services than did nonintervention sites (Figure 1). The majority of intervention sites offered oral contraceptives (combined pills 66%, progestin-only pills 61%) and injectables (73%). The availability of long-acting methods was lower: Eighty-four percent of intervention facilities did not provide implants (Jadelle); of these facilities, 42% did not have the necessary equipment for implant insertion and removal, and 63% did not have a trained provider. In terms of intrauterine devices (IUDs), 88% of intervention facilities did not provide the method; of these facilities, 50% lacked the necessary equipment for IUD insertion and removal and 55% had no trained provider. No facility provided male and female sterilization services.

Postabortion Care and Postpartum FP Services

Postabortion care (PAC) services were available at 53% of sites (46% of intervention sites and 64% of

Figure 1: Percentage of facilities offering selected FP methods and PAC services



nonintervention sites). Postpartum IUD insertion was offered at 14% of sites (10% of intervention sites and 22% of nonintervention sites). Data on other forms of postpartum FP were not collected.

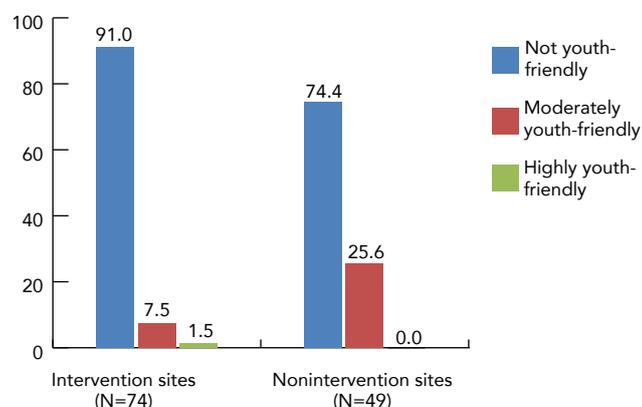
Most providers (70% in intervention sites and 76% in nonintervention sites) received initial training in PAC. However, very few of these providers received updates or follow-up training in PAC (19% at intervention sites and 27% at nonintervention sites).

Equipment Availability

The availability of essential equipment in examination rooms was poor in Côte d'Ivoire. Examination lamps were available at only 27% of intervention sites. Privacy screens in FP consultation rooms were available at 87% of intervention sites. Despite the high number of facilities offering PAC services, only 4% of them (none of the intervention sites and 10% of nonintervention sites) had all of the essential equipment needed for PAC services.

Just 6% of intervention sites had an anatomical model for training staff on the provision of IUD insertion and removal services, compared with 18% for nonintervention sites. In addition, only 11% of intervention sites had an arm model for training staff on implant insertion and removal, compared with 18% of nonintervention facilities.

Figure 2. Percentage distribution of sites, by their youth-friendliness score, according to type of site



Source: Côte d'Ivoire Baseline Study, AgirPF/EngenderHealth, 2015

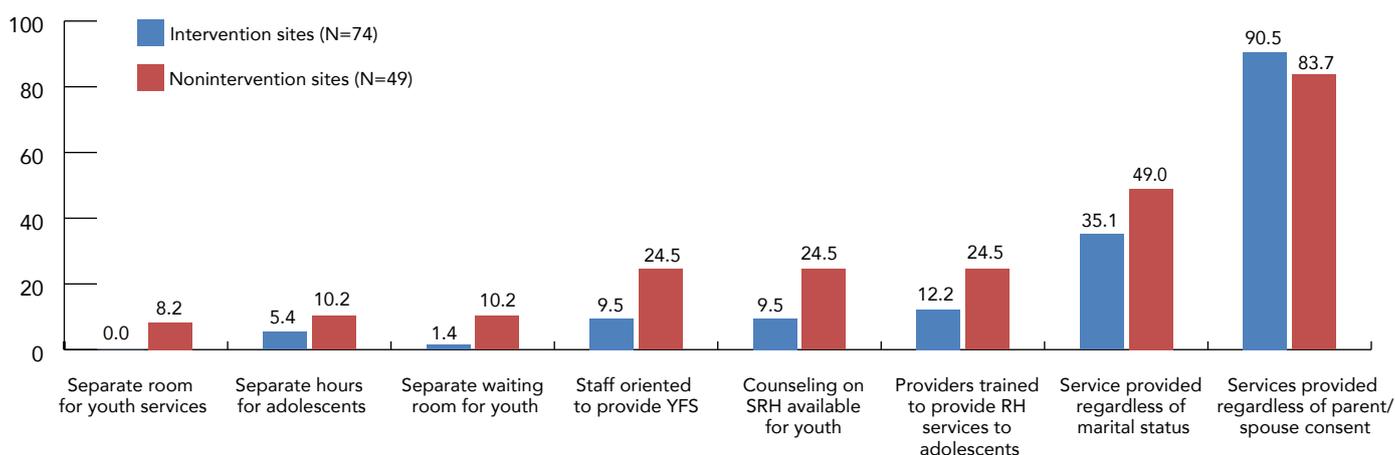
Youth-Friendly Services

The baseline study assessed nine aspects of YFS delivery: (1) existence of protocols that create barriers for providing YFS; (2) provision of services to youth without consideration of their marital status; (3) provision of services regardless of parental/spousal consent; (4) provision of counseling on safe sex, pregnancy prevention, and prevention of sexually transmitted infections (STIs), including HIV (including double protection); (5) orientation of all staff to provide YFS; (6) training of providers to offer YFS; (7) existence of designated waiting rooms for youth; (8) existence of a designated room for providing YFS; and (9) a designated time for providing YFS.

Criteria 2 through 9 were used to compute a composite indicator to measure the youth-friendliness of services that would be comparable across AgirPF's intervention countries. Each facility received a point for responding positively to questions 2–9 and 0 otherwise. Facilities were then coded as “not youth-friendly” if their overall score was 0–2, “moderately youth-friendly” if their score was 3–5, and “highly youth-friendly” if their score was 6–8. The score was computed only for sites that responded to all eight questions (74 intervention sites out of 82 and 49 nonintervention sites out of 50), excluding sites with missing answers.

Most of the surveyed sites were not youth-friendly, and the situation was worse at the intervention sites. Overall, 91% of the intervention sites and 74% of the nonintervention sites were not youth-friendly at all. Only 7.5% of the intervention sites and 25.6% of the nonintervention sites were moderately youth-friendly. Only one intervention site was highly youth-friendly, compared with none of the nonintervention sites (Figure 2).

Figure 3. Percentage of sites with selected youth-friendliness characteristics, by zone



Source: Côte d'Ivoire Baseline Study, AgirPF/EngenderHealth, 2015

By criteria, both intervention and nonintervention facilities had few characteristics conducive to youth-friendly services, except the fact of providing services regardless of parental or spousal consent (Figure 3). Overall, the intervention sites were less youth-friendly than the nonintervention sites. Moreover, five intervention sites and five nonintervention sites had protocols that create barriers for providing youth-friendly services.

ENABLING ENVIRONMENT

Provider-Imposed Barriers

Although this is not required by law, providers reported using criteria such as clients' age, marital status, and number of children when deciding whether and which FP services to provide. More than 60% of providers (at both intervention and nonintervention sites) said that there is an age below which they would not prescribe FP methods, including the pill and injectables; 48% said that being sexually active was not sufficient to receive FP services. Many providers (51% at intervention sites and 46% at nonintervention sites) reported that they would not provide an IUD to an unmarried woman. Similarly, 54% of providers at intervention sites and 51% at nonintervention sites would not provide an implant (Jadelle®) to an unmarried woman.

Although parental consent is not required by protocol to provide any FP method to minors, some providers required parental consent for minors to receive the pill (18% at both intervention sites and nonintervention sites), injectables (16% and 22%, respectively), the hormonal implant Implanon (12% and 23%), and the Jadelle implant (12% and 22%).

Some providers believed women should not receive an FP method until they have had a child (16% at intervention sites and 13% at nonintervention sites). Many providers (30% at intervention sites and 46% at nonintervention sites) said that there were methods they never prescribed no matter the circumstances. Among these providers, 64% at intervention sites and 83% at nonintervention sites said they would not prescribe female or male sterilization, while 15% and 6% said they would not prescribe an IUD.

Community Engagement

Sixteen percent of intervention and 24% of nonintervention sites reported holding formal meetings to discuss the quality of services with community members, and 39% of intervention and 40% of nonintervention sites had any type of client feedback system (for example, informal feedback meetings held with the community). The health district facilities with the highest community participation rates were Abobo Est (37.5%) and Yopougon Ouest–Songon (33.3%). The health

districts of Adjamé-Attecoubé-Plateau and Treichville-Marcory reported no inclusion of community members in measuring health program performance.

Availability of Guidelines at Facilities

The availability of national RH service protocols was low across all health facilities. According to providers interviewed during facility audits, the FP procedures manual was not available at 59% of intervention sites and 56% of nonintervention sites.

The PAC procedures manual was also not available at 61% of study sites. Out of 10 intervention health districts, the document on PAC was only available at facilities in three health districts (Koumassi-Port Bouet-Vridi, Yopougon Est, and Yopougon Ouest-Songon).

Perspectives from Key Informants

When asked about barriers to increasing FP uptake at the service delivery level, health district managers mostly spoke about the issues of contraceptive supply or availability of trained providers. Other barriers identified by managers were the lack of communication about FP, cultural barriers, and rumors about FP methods.

DEMAND

FP Discussion with Partners

A majority of women aged 15–49 had discussed FP methods with their partners (77% at intervention sites and 82% at nonintervention sites) (Table 1, page 6). However, women discussed few other topics with their partners; very few women (8% of those surveyed) shared with their partners the experience of other clients who had chosen FP.

Contraceptive Prevalence

The contraceptive prevalence rate (CPR) was slightly higher at intervention sites (39%) than at nonintervention sites (32%). Overall, the modern

contraceptive prevalence rate (mCPR) was 28% and the traditional CPR was 8%. The mCPR for youth (those aged 15–19) was 23%.

Exposure to FP Messages

The household survey questionnaire collected data regarding exposure to media and FP messages, including through the following sources: radio, television, newspaper, magazine, poster/billboard/leaflet, and community events. The types of media to which women were exposed was consistent throughout intervention and nonintervention sites. In both cases, the medium with the highest exposure was television (41% at intervention sites and 34% at nonintervention sites); the second highest level of exposure was to posters/billboards/leaflets, including those found at health facilities (20% at intervention sites and 14% at nonintervention sites). The third highest level of exposure to FP messages was through radio (19% and 15%, respectively).

FP Knowledge

The majority of women in Abidjan had heard of at least one FP method, including 89% of women surveyed in intervention communities and 84% of women in nonintervention communities.

PROGRAM IMPLEMENTATION

In light of the baseline study findings, the AgirPF team in Côte d'Ivoire is focusing programming efforts to improve the availability and quality of FP services, including postpartum and postabortion FP; YFS; community engagement; the availability of guidelines at facilities; and comprehensive information on FP.

Emphasis on High-Impact Practices

High-impact practices (HIPs) in FP are practices that have been identified by a technical advisory group of international experts as practices which—when implemented, scaled up, and institutionalized—will likely maximize investments in a comprehensive FP

Table 1: Percentage of women aged 15–49 who reported discussing various topics with their partner

Characteristic	Topic					
	FP methods (%)	Discussion with a service provider (%)	Place where methods can be obtained (%)	Discussion with clients who have chosen FP (%)	Adoption of long-acting/permanent methods (%)	Other FP topics (%)
All women surveyed	80	31	28	8	24	9
Type of site						
Intervention	77	31	28	9	24	10
Nonintervention	82	30	28	7	24	6
District						
Dabou	66	54	29	14	26	3
Adjamé-Attécoubé-Plateau	85	27	21	6	27	8
Yopougon Ouest–Songon	81	36	22	5	25	11
Yopougon Est	85	32	40	19	23	6
Cocody-Bingerville	80	28	25	5	23	10
Anyama	73	33	34	5	25	14
Abobo Est	87	29	29	9	12	9
Abobo Ouest	81	21	30	14	14	9
Treichville-Marcory	84	20	32	8	20	4
Koumassi-Port Bouet-Vridi	68	27	25	3	39	5
Age						
15–19	82	29	38	11	13	11
20–24	74	24	36	8	21	4
25–29	80	28	24	9	21	6
30–34	78	33	22	7	28	12
35–39	81	33	27	7	28	13
40–44	81	48	30	11	26	11
45–49	73	45	18	18	54	0
No data	0	0	100	0	100	0

strategy.¹ Key to AgirPF's success is to test, scale up, and replicate HIPs in a holistic manner. 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. Some HIPs to be implemented in Côte d'Ivoire include:

- Use a population segmentation approach to facilitate behavior change toward FP use
- Use EngenderHealth's site walk-through (SWT) approach to inform, inspire, and employ community leaders, civil society, and district advocates to improve community knowledge and awareness of FP services and to address social and gender norms that influence attitudes toward FP use
- Deploy mobile and outreach services
- Conduct FP Special Days
- Build training systems around the Center of Excellence, to have a sustainable local model for best practices capacity building

This suite of HIPs will ensure that AgirPF's countries will serve as models for high-quality FP programming in the region and that ultimately those models will be adopted and taken to scale by national governments across the region.

Postpartum FP and PAC FP Services

AgirPF will train providers and health center managers in logistics, contraceptive product needs assessment, contraceptive technologies, procurement, data collection on contraceptive stocks, and the REDI counseling framework.² AgirPF will orient providers

from 82 facilities on USAID FP and abortion requirements about PAC services, as well as build the capacity of providers to provide FP counseling and services at the same time and same place where women receive PAC services.

Community Capacity Building

AgirPF will also invest in building the capacity of civil society, the private sector, and local NGOs. Sexual and reproductive rights and gender will be integrated into technical and counseling curricula for providers. To address issues regarding accessibility, AgirPF will provide a wide range of free FP services and commodities through mobile outreach services and FP Special Days. AgirPF will build the capacity of providers to integrate FP into postpartum and PAC services and into routine health services (e.g., child immunizations).

Enabling the FP Environment

AgirPF will foster a positive national and community-level enabling environment, galvanizing FP commitment by advocating for policy changes in such areas as task shifting to community health workers, social welfare workers, and health aides; elaboration and adoption of the RH law; and increasing FP funding. AgirPF's goal is to encourage a regional approach that can effectively and sustainably address the shared problems faced by countries in West Africa.

¹ <https://www.k4health.org/topics/high-impact-practices-family-planning>

² REDI stands for Rapport building, Exploration of options, Decision-making support, and Implementing the decision to use a particular method. This framework for counseling is a client-centered approach to help clients choose the best contraceptive with which to achieve their reproductive intentions.

CONCLUSION

To implement an efficient and effective FP project, it is important to have detailed data that describe the current level of knowledge and use of FP services and that inform the adoption of strategies which take into account the strengths and weaknesses of the supply and enabling environment of these services. These data are the foundation of AgirPF and are essential for the implementation, monitoring, and evaluation of the project. They also assist decision makers to ensure that planning and implementation match need in the Ivoirian context.

The following are key recommendations arising from the baseline analyses:

- Demand-side barriers should be further investigated, and findings should be incorporated into social and behavior change communication (SBCC) strategies.
- FP providers would benefit from training/retraining in the provision of implants, IUDs, and postabortion FP.
- National RH service protocols should be available across all health facilities.
- Providers should benefit from sensitization/orientation to serving youth.
- Equipment is needed for implant and IUD services and for postpartum and PAC FP service provision, and supplies of implants and IUDs need to be improved at facilities.
- Women (and possibly men) need to be sensitized to the need for open and comprehensive communication with partners.
- Health facilities need to be equipped with SBCC materials to teach about FP in general and about specific methods.
- Supplies of all methods, general supply items, and equipment for PAC need to be more available.



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Suggested citation: Agir pour la Planification Familiale (AgirPF). 2018. Using baseline data to develop an in-country strategy for improving family planning use and service delivery in Côte d'Ivoire. *Project Brief No. 8*. Abidjan: AgirPF/EngenderHealth.

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