

# (re)solve IN BURKINA FASO



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# INTRODUCTION TO (re)solve

## 1

- + What is (re)solve?
- + Why is (re)solve unique?
- + Why work in Burkina Faso?
- + What is the (re)solve approach?

# WHAT IS (re)solve?

**Launched in 2016, (re)solve is a four-year project funded by the Bill & Melinda Gates Foundation. It is led by Pathfinder International in partnership with Camber Collective, The International Center for Research on Women, and ideas42, and is active in Bangladesh, Burkina Faso, and Ethiopia.**

(re)solve combines expertise from consumer insights, behavioral design, and public health to discover what stops women from using contraception when they express a desire to avoid pregnancy, and yet do not use a modern contraceptive method.

(re)solve challenges current assumptions about contraceptive decision-making; tests new approaches based on local, contextualized behavioral insights; and generates adaptable, scalable, user-responsive solutions that address unmet need for family planning.



**PATHFINDER INTERNATIONAL** uses large-scale *evidence-based* family planning programming approaches through existing country projects. These projects provide the platform from which (re)solve implements its solutions.

**CAMBER COLLECTIVE** uses a market segmentation approach to identify population segments marked by behavioral and/or attitudinal differences which inform solutions catered to each segment's needs. Camber typically identifies segments through large-scale, quantitative surveys.

**IDEAS42** uses behavioral design to develop and test innovative solutions that reshape people's environment to positively influence their behavior. ideas42 designs for behavioral bottlenecks identified through qualitative interviews and observations.

**INTERNATIONAL CENTER FOR RESEARCH ON WOMEN (ICRW)** uses a gender-focused research and evaluation approach to determine the efficacy and impact of programs. ICRW is conducting process and impact evaluations of (re)solve solutions.

# WHY IS (re)solve UNIQUE?

Although much progress has been made in addressing non-use of contraception through traditional behavior change programming, these programs are limited by assumptions about what prevents women from using contraception.

At (re)solve's heart is the conviction that one size does not fit all. (re)solve designs and customizes data-informed family planning solutions to the needs, motivations, and lived experiences of the women and girls we serve. We believe that women and girls deserve products and services designed for them.

## Innovative approaches

- + Segmentation & Consumer Insights
- + Behavioral Design
- + Learning Loops & Adaptation
- + Testing Solutions

## (re)solve DEFINITIONS

**BEHAVIORAL BOTTLENECK:** barrier that prevents an individual from making a decision or taking action that would otherwise meet their needs (i.e. using a contraceptive method to avoid unintended pregnancy).

**BEHAVIORAL DESIGN:** an approach that leverages insights from behavioral economics, social psychology, human-centered design, and other disciplines to develop and test innovative solutions that reshape people's environment to positively influence their behavior.

**CONSUMER INSIGHTS:** a field that focuses on interpreting trends in human attitudes, beliefs, and behaviors, which aims to increase the effectiveness of a product or service. Its main purpose is to understand why the consumer cares for the product or service, as well as their underlying mindsets, moods, motivations, desires, and aspirations that motivate and trigger consumer behaviors.

**CROSS-DISCIPLINARY APPROACH:** mixing of various disciplines—public health/demography approaches, market segmentation, and behavioral science/behavioral design—that address the age-old question of why women at risk of pregnancy are not using modern contraception.

**INSIGHT:** data-driven understanding about behaviors or the drivers of behaviors related to contraception.

**SEGMENTATION:** the activity of dividing a larger population into sub-groups of people (known as segments) based on some type of shared characteristics, such as shared needs, common interests, similar lifestyles or even similar demographic profiles.

# WHY WORK IN BURKINA FASO?

## Unmet demand

Burkina Faso's modern contraceptive prevalence rate has increased more than threefold since 1993 to 26.4%<sup>1</sup> in 2018, but total fertility rate remains almost constant.

Women are having about the number of children they want (5.5 desired, 6.0 actual). But pockets of unmet demand<sup>2</sup> exist, especially among young women. The adolescent fertility rate is high at 104 per 1,000<sup>3</sup> women aged 15-19. 57%<sup>4</sup> of pregnancies among this age group are unintended.

(re)solve seeks to better understand the needs of our target population, what the key behavioral dynamics are that define them and their family planning decisions, and what solutions may be effective in reducing their unmet demand for contraception.

Pathfinder has an established presence in Burkina Faso, and, at project start, was already implementing Project Yam Yankré (PYY). (re)solve was able to work in PYY regions, eventually focusing on unmarried girls who are students in Ouagadougou and Bobo-Dioulasso. These girls are an important focus for Pathfinder. (re)solve sought to learn more about the behavioral dynamics that affect them and what drives their intention to use or not to use contraception.

1 <https://www.pma2020.org/sites/default/files/PMA2020-Burkina-R5-FP-Brief-En.pdf>

2 Unmet demand is the gap between want and use of modern FP among those women and girls for whom pregnancy would pose a problem.

3 <https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BF>

4 [https://www.guttmacher.org/sites/default/files/report\\_pdf/rib3-04.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/rib3-04.pdf)



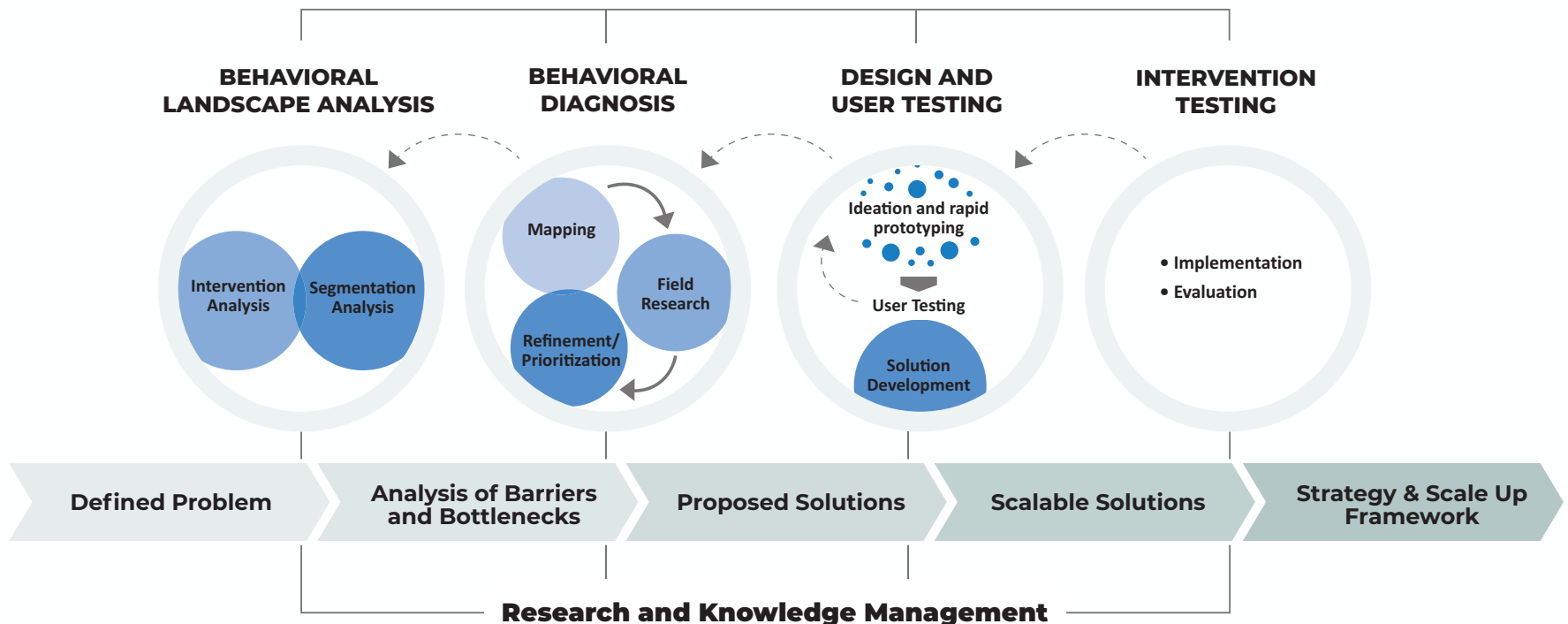
Photo by Sarah Lance

## TARGETED REGIONS AND DISTRICTS



# WHAT IS THE (re)solve APPROACH?

## The (re)solve Framework



# QUANTITATIVE ANALYSIS AND SEGMENTATION IN BURKINA FASO

## 2

- + General insights from quantitative analysis
- + Goal of segmentation
- + Approach to segmentation
- + Segments identified

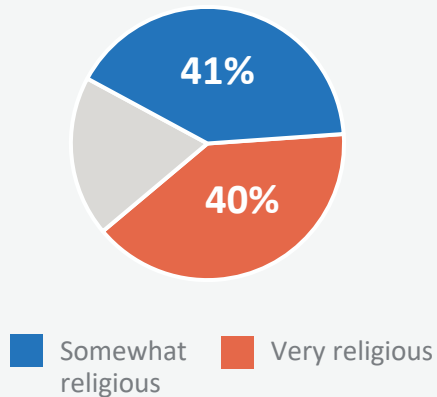


# GENERAL INSIGHTS FROM QUANTITATIVE ANALYSIS

YOUTH IN BURKINA FASO ADHERE TO RELIGIOUS BELIEFS THAT CAN BE IN CONFLICT WITH THEIR BEHAVIORS AND ATTITUDES, LEADING TO UNMET DEMAND FOR CONTRACEPTION.

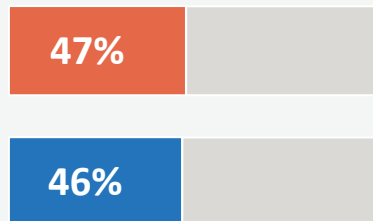
## VALUES

**81%** of youth identify as very religious or somewhat religious



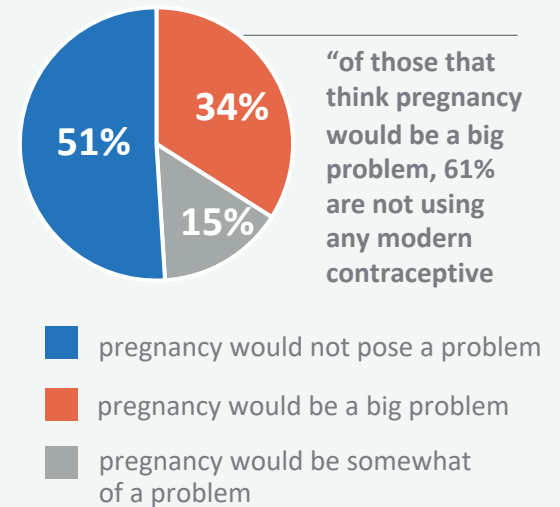
## DESIRES

**47%** of unmarried youth are sexually active



**46%** of youth believe it's normal for unmarried couples to have sex

## UNMET DEMAND



## WHY AREN'T YOUTH USING CONTRACEPTION?

- + Not exposed to family planning
- + Strong perception of provider bias
- + Perceive western oppression related to family planning
- + Embarrassed to discuss family planning
- + Limited autonomy
- + Concerns about stigma

# GENERAL INSIGHTS FROM QUANTITATIVE ANALYSIS

## Creating a family and social approval are the centerpieces of relationships

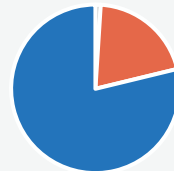
KEY VALUES FOR A RELATIONSHIP INCLUDE...

...AND THESE SEEM TO BE HIGHLY AGREED UPON

TOTAL YOUTH IDENTIFYING THE VALUE AS IMPORTANT

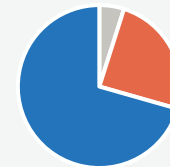
KEY VALUES FOR A RELATIONSHIP INCLUDE...

HAVING CHILDREN



20%  
somewhat important  
78%  
very important

99%



97% of women say that motherhood is the most important accomplishment of a woman's life

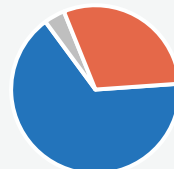
BEING A GOOD PARENT



16%  
somewhat important  
83%  
very important

99%

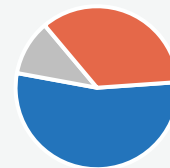
FIDELITY



30%  
somewhat important  
66%  
very important

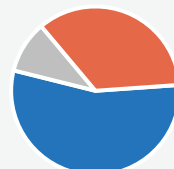
96%

HOWEVER...



89% of youth believe that if they have a smaller family, they can give their children a better life

APPROVAL OF OTHERS



35%  
somewhat important  
55%  
very important

90%

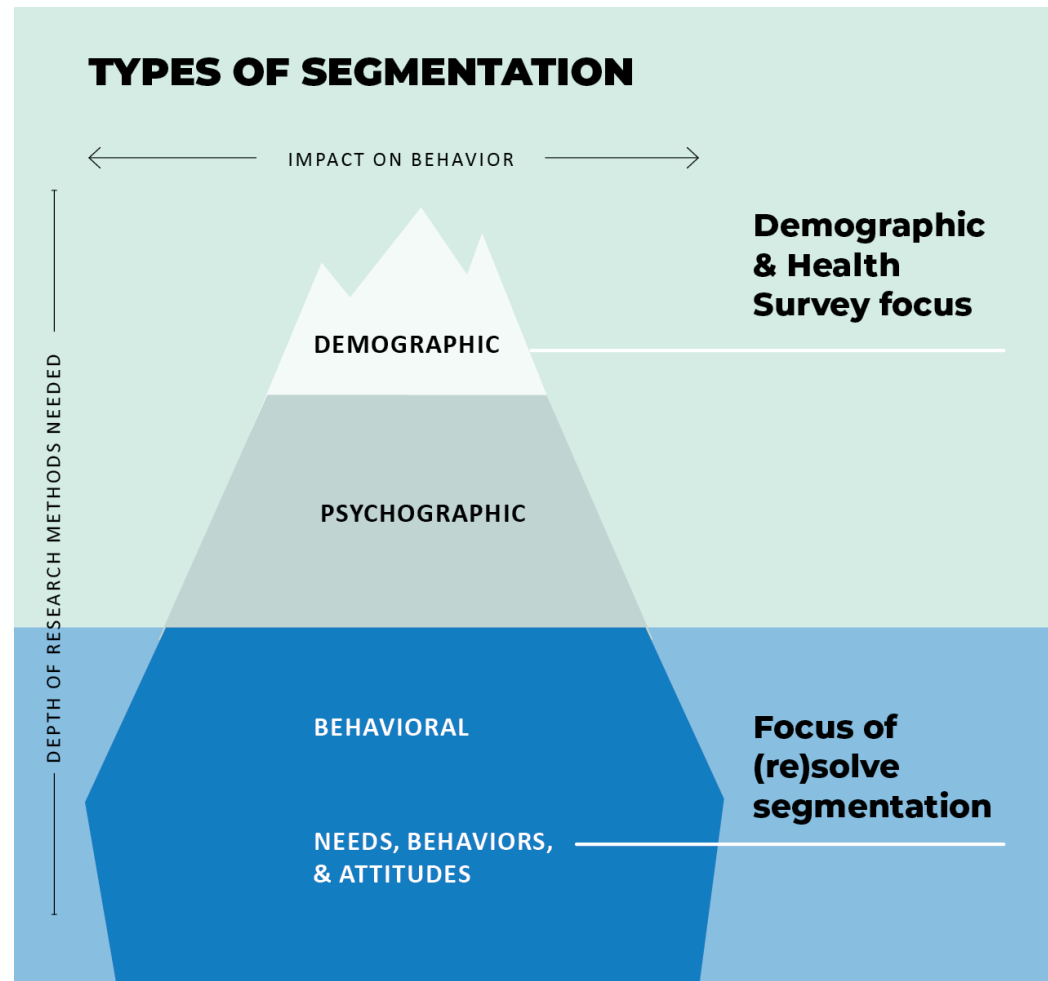
# GOAL OF SEGMENTATION

**(re)solve seeks to reach Burkinabe girls with an unmet demand<sup>1</sup> for family planning.**

Through segmentation, (re)solve sought to better understand who the target populations are and what drives them to use or not use family planning—that is, where the unmet demand exists in Burkina Faso—and what key dynamics define them.

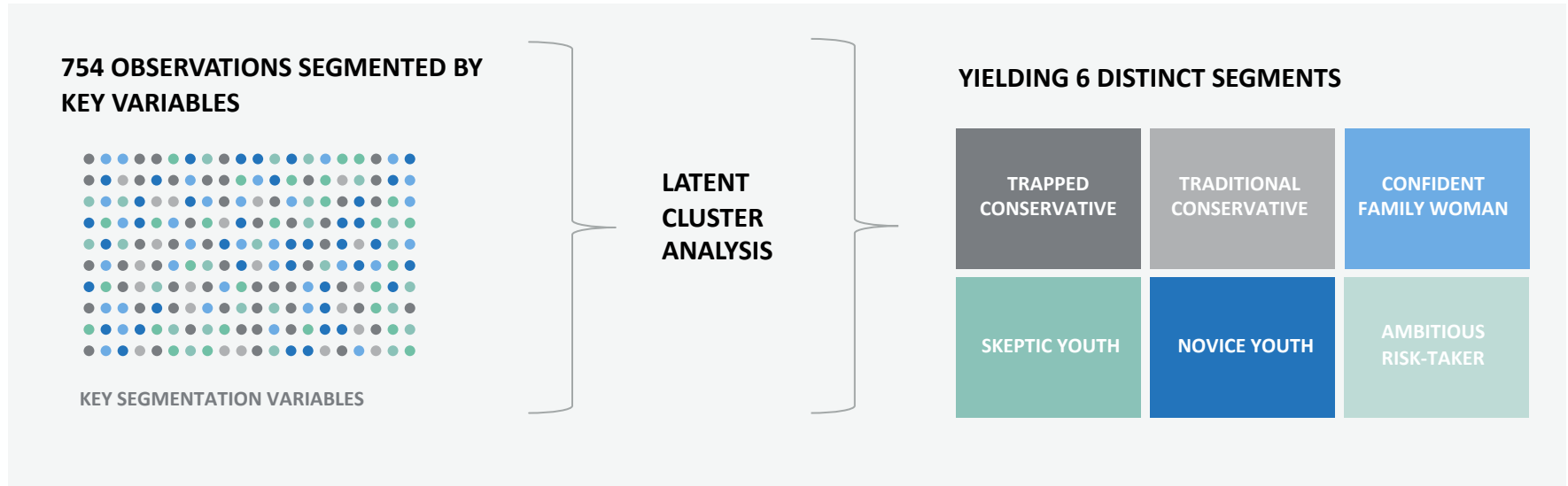
Segmentation focused on the needs, behaviors, and attitudes of different subgroups within a population with the assumption that these determinants have the most impact on behavior and addressing unmet demand.

<sup>1</sup> Unmet demand constitutes those women who are sexually active, who say that pregnancy would be a problem, and are not using a modern contraceptive method.



# APPROACH TO SEGMENTATION

(re)solve identified six segments or archetypes based on demographics, personal agency, and attitudes and norms



# SEGMENTS IDENTIFIED

Women in each segment experienced these drivers of intention to different degrees. (re)solve used three multi-driver axes to compare segments:

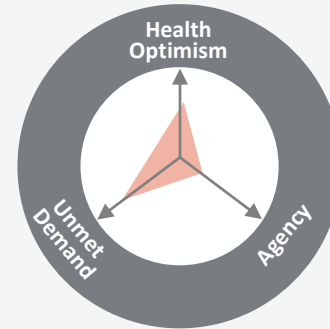
**HEALTH OPTIMISM:** degree of openness in her outlook on health and family planning (FP) (health proactivity, perceived provider bias, and perception of western influence on FP)

**UNMET DEMAND:** gap between want and use of modern FP (for whom pregnancy would pose a problem)

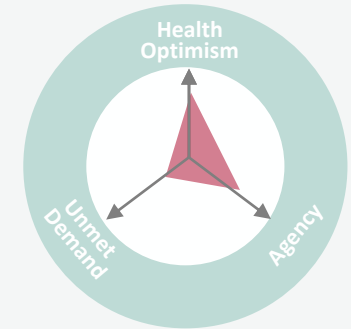
**AGENCY:** ability and desire to make own decisions about FP (perceived control/voice in health decisions, autonomy in FP decision-making, ability to decide when to have sex with partner, will use FP without partner permission, willingness to try something new)

Our solutions address many of the drivers of intention and their variable influence across segments.

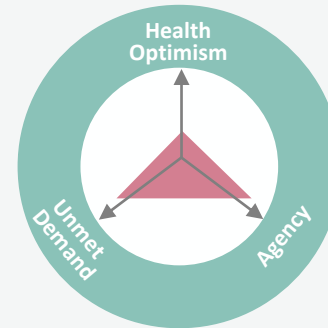
TRAPPED CONSERVATIVE



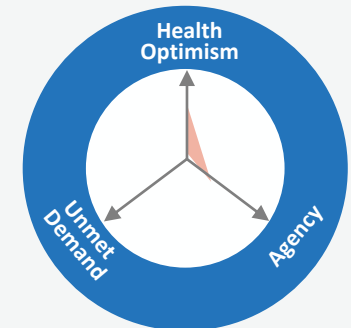
AMBITIOUS RISK-TAKER



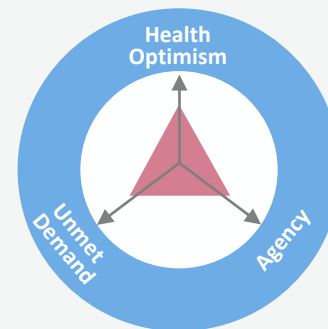
SKEPTIC YOUTH



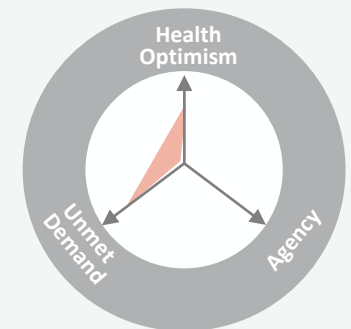
NOVICE YOUTH



CONFIDENT FAMILY WOMAN



TRADITIONAL CONSERVATIVE



# BEHAVIORAL DIAGNOSIS IN BURKINA FASO

## 3

- + Goal of behavioral diagnosis
- + Approach to behavioral diagnosis
- + Multiple bottlenecks
- + Mapping the bottlenecks by segment

# GOAL OF BEHAVIORAL DIAGNOSIS



## Generate hypotheses and test them empirically

Through the structured process of behavioral mapping we generate hypotheses on the behavioral drivers (bottlenecks) of nonuse which stretch our thinking. Qualitative research and observation enables us to test and refine these behavioral bottlenecks and their underlying drivers.



## Enrich insights from segmentation

A mixed methods approach allows us to more fully understand the lives of girls and how they make decisions, not only about contraceptive use, but how these decisions fit into her life. Using a profiling tool to link respondents to segments helps us understand which bottlenecks affect which segments and where they may share challenges.



## Establish direction for design

The ultimate objective of diagnosis is to set the direction for design. The underlying drivers that we identify as triggering bottlenecks are what we will be looking to change or affect through our designs. This allows us to move into design with evidence-based design challenges.

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**UNDERLYING DRIVERS** are elements in the environment that trigger or contribute to the behavioral bottleneck.

# APPROACH TO BEHAVIORAL DIAGNOSIS

TYPE OF INTERVIEW	NUMBER*
Young unmarried girls	21
Young married girls	19
Young unmarried boys	15
Partners of youth, older than 25	11
Parents	11
Health providers	8
Key informants in the community	4
<b>TOTAL</b>	<b>89</b>

**2 focus groups** with unmarried girls and  
**5 observations at health facilities**

\*Segments represented: trapped conservative – 7; skeptic youth – 3; confident family woman – 5; ambitious risk taker – 11; novice youth – 4; traditional conservative – 5



Photo by Sarah Lance

## Behavioral Mapping

Generate hypotheses around the behavioral bottlenecks that may be contributing to the problem of nonuse of FP and underlying drivers that trigger those bottlenecks.

## Instrument Development

Develop interview, focus group, and observation guides based on the hypotheses generated during behavioral mapping.

## Fieldwork

Conduct site visit in districts with high concentrations of priority segments and strong PYY presence.

## Analysis and Prioritization of Bottlenecks

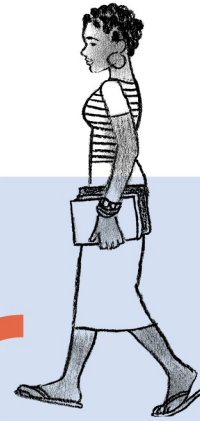
Code interview transcripts and notes, assess evidence, and refine and prioritize the bottlenecks and underlying drivers to target during design.





# MULTIPLE BOTTLENECKS

prevent girls from making and acting on pregnancy and contraceptive uptake decisions\*



**Rhythm Method works well for me. Why switch?**

I've heard the side effects of contraceptives are terrible

I can't predict when I'm going to have sex next. It just happens.

**If I get pregnant maybe my boyfriend will marry me?**

I have several partners and I fear they'll think I'm "loose" if I use a method

What will my parents do if I get pregnant?

My boyfriend sometimes uses a condom. I'm safe.

Injectables made my aunt's sister-in-law infertile.

The health provider is going to judge me.

**What if my neighbor sees me at the health facility?**

I don't have sex very often. I'll be OK without a contraceptive.

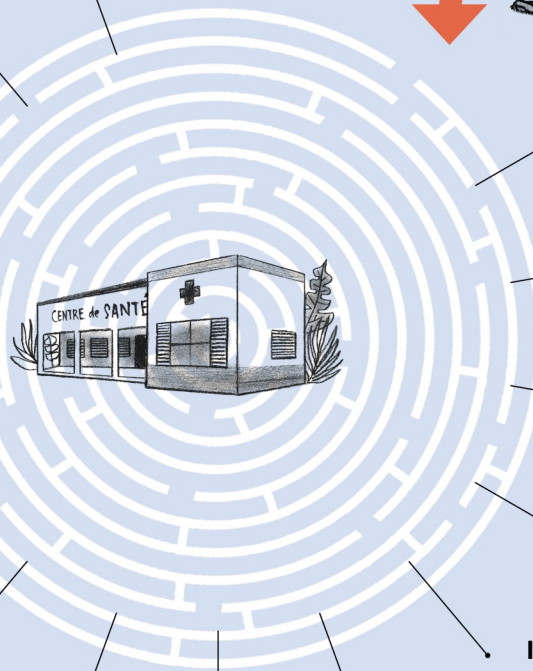
Smart girls know their cycle and I'm smart so I won't get pregnant.

I'm not planning a family.

I am not sick. Why would I go to the health facility?

I avoid sex on risky days so why would I use contraceptives?

**What if implants get lost in my body?**



Note: Examples of barriers reported by women  
Illustrations by Jamie Hogan

# MAPPING THE BOTTLENECKS BY SEGMENT

indicated that we should pivot to and focus on unmarried girls

BOTTLENECK	Skeptical Youth	Ambitious Risk Taker	Novice Youth	Confident Family Woman	Trapped Conservative	Traditional Conservative
<b>BOTTLENECK 1:</b> Girls do not explicitly think about all of the consequences of sex.	X	X				
<b>BOTTLENECK 2:</b> Girls may be unsure if they want to avoid pregnancy because they are unclear what their own situation would be should they become pregnant.	X	X	X			
<b>BOTTLENECK 3:</b> Girls do not think they need to consider using contraceptives because they perceive that there is a low risk of getting pregnant.	X	X				
<b>BOTTLENECK 4:</b> Girls do not think that contraceptives are intended for girls like them.	X	X	X			
<b>BOTTLENECK 5:</b> Girls decide not to use contraceptives because they fear the reaction of partners and others should they find out that they are using.	X	X	X	X	X	
<b>BOTTLENECK 6:</b> Girls decide not to use contraceptives because there are more appealing options available in the choice set to avoid pregnancy.	X	X				
<b>BOTTLENECK 7:</b> Girls decide not to use contraceptives because the risk of infertility, no matter how small, is too great.	X	X		X	X	X
<b>BOTTLENECK 8:</b> Girls do not go to the health facility because there are no cues to do so.	X	X	X			
<b>BOTTLENECK 9:</b> Girls do not go to the health facility because they fear partners or others will find out they are using contraceptives.		X	X	X		X

■ Unmarried girls
 ■ Married girls

# DESIGN & USER TESTING IN BURKINA FASO

## 4

+ Design process

+ (re)solve Solutions

EVOLUTION OF PROTOTYPES

FAILED PROTOTYPES

SOLUTION: PART 1

SOLUTION: PART 2

SOLUTION: PART 3

# DESIGN PROCESS

**The prioritized behavioral bottlenecks and underlying drivers served as the primary input to designing solutions that would address intention to use modern contraceptives among unmarried girls and encourage her to go to a health facility.**



Photo by Madeline Kau

## Ideation

In the first phase, ideation, we generated myriad potential solution ideas to address the findings from behavioral diagnosis. Ideas42 staff generated design ideas individually. Afterward, we participated in group ideation exercises to generate additional ideas and strengthen existing ones.

## Synthesis

During the next phase, synthesis, we first consolidated ideas and design concepts. The project then rated each overarching design concept across several criteria. As a set, the top selected ideas were prototyped for user testing.

## Prototyping

Prototyping the designs involved elaborating on each idea at a greater level of detail. We then built rough prototypes of each idea using word processing or presentation software.

## User Testing

User testing consisted of two site visits. During the first site visit, we conducted workshops with the Project Yam Yankré team, in Ouagadougou and Bobo-Dioulasso, and other local and national stakeholders. We also played the board game in Bobo with a group of young girls and separately with a group of teachers. This site visits allowed us to understand the feasibility and acceptability of the prototypes and to refine these based on feedback.

The objective of the second site visit was to gather direct feedback from more girls and health workers in response to the refined prototypes, and to observe simulated use of the prototypes where possible. To that end, we trained local community health workers (CHWs) to facilitate game play with girls. We solicited feedback from Project Yam Yankré, CHWs, and girls on the general concepts, content, format, acceptability, and perceived effectiveness of the prototypes.

# (re)solve SOLUTIONS

eliminate multiple barriers for girls in Burkina Faso



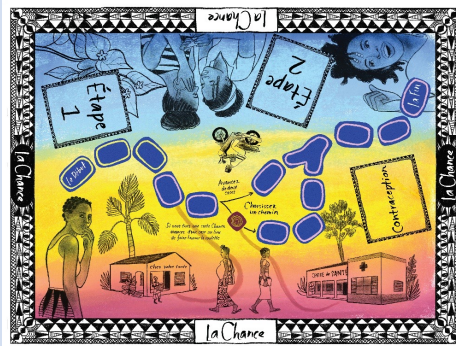
## THE POSTER AND NAMETAG

Addresses her concerns of being seen at the health facility by giving her a visible “excuse” for why she is there and allowing her to find providers with the name tag quickly

## THE PASSPORT

Addresses stigma by encouraging girls to visit the facility with friends by giving her multiple passports

Addresses stigma by providing her with an on-hand “excuse” to show others as to why she is at the facility



## THE BOARD GAME

Corrects myths and misconceptions about specific methods through trivia-based learning and group dialogue

Elevates her pregnancy risk by providing opportunities for her to experience this risk through real-life scenarios

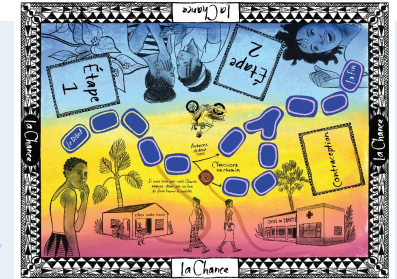
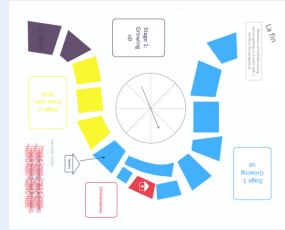
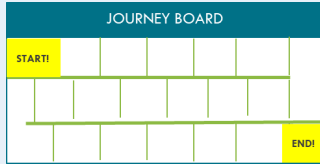
Helps her understand the personal, relational, and social trade-offs associated with an unintended pregnancy by simulating decision-making in the game

Addresses her concerns of being seen at the health facility by highlighting strategies on how to seek care discreetly



# EVOLUTION: GAME BOARD

UPDATES BASED ON FEEDBACK



# 1

## FEEDBACK

An internal testing of a poker-style game showed that complicated game rules could prevent end-user engagement.

Multiple game parts could be lost during transportation between schools.

We pivoted the game format to make it easier to understand, and more engaging and portable.

# 2

## FEEDBACK

The girls preferred spinning a top over rolling a die (tested in previous versions), because the time it takes to wait for the top to fall is crucial for generating a sense of anticipation.

# 3

## FEEDBACK

Girls preferred to learn the rules by playing.

Girls found the scenarios realistic. Cards reminded them of a real story they had heard or experienced.

Girls quickly gained comfort with embarrassing words.

Trivia cards were typically not very difficult for girls, and throughout user testing we increased the complexity of the questions.

# 4

## SOLUTION

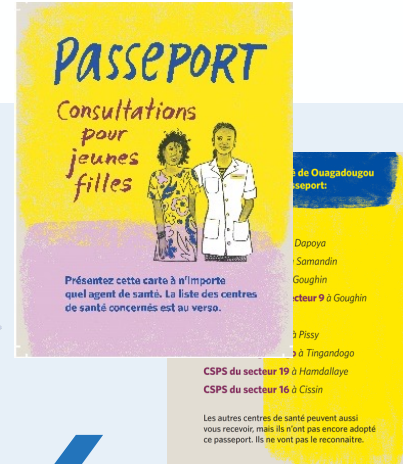
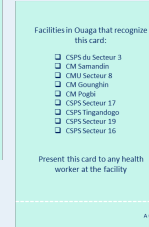
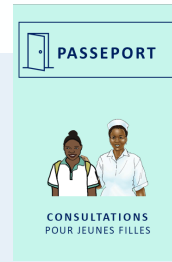
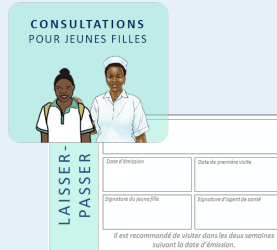
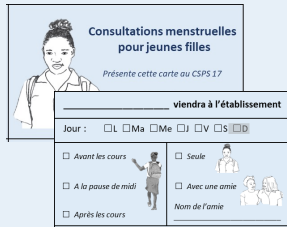
Final design includes original art inspired by Burkinabe fabrics and photographs of girls.

The color palette was approved by girls.

The name of the game was suggested by girls.

# EVOLUTION: PASSPORT

UPDATES BASED ON FEEDBACK



# 1

## FEEDBACK

Girls wanted the image on the front to clearly reference a consultation between a girl and a health worker.

The back of the card contains plan-making prompts and empty date fields to encourage girls to finalize their plan to visit the facility. These components were not understood by the girls and were removed.

# 2

## FEEDBACK

Girls asked, "Where can we go for health services?"

We were concerned about parents' reactions if they found these cards with girls' names written on it. Would they assume that their daughter was sexually active? We removed this field.

Girls and health workers wanted a card that could be used more than once, like a passport, to allow multiple facility visits.

# 3

## FEEDBACK

Girls and providers liked the list of location-specific health facilities that will honor the "passport."

Most girls did not want a pink passport. Nor did they want differently colored passports to distinguish those that played the game and those they gave to friends.

Girls asked that we not put the girl on the passport in uniform so they could give the passport to friends not in school.

# 4

## SOLUTION

The final version mirrors the colors and images in the board game.

The passports in Bobo-Dioulasso and Ouagadougou have the names of facilities where PYY has been working.

# EVOLUTION: POSTER

UPDATES BASED ON FEEDBACK

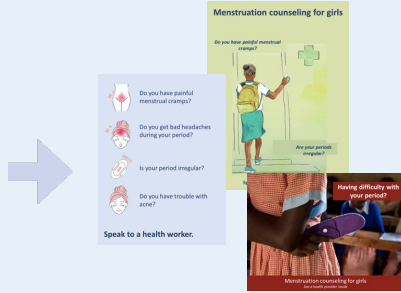


# 1

## FEEDBACK

This is an early prototype of poster advertising counseling for menstruation and other issues.

We tested different images, but girls understood these to be in reference to a new disease or another unrelated health issue.



# 2

## FEEDBACK

Girls asked, “What about girls who are out of school?”

Girls asked us to show a girl talking to a health provider.

A picture of a pad in her hand was not understood.

Most relevant health issues for the girls included “Des boutons” (acne or pimples), cramps, and excessive bleeding.



# 3

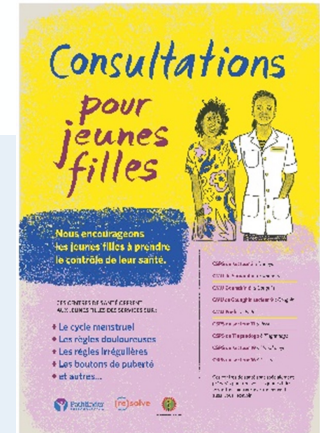
## FEEDBACK

Girls did not want the girl to look like she was in school. They felt it excluded other girls.

Providers asked that we remove the headscarf for the health provider.

Girls asked us to add names of health facilities so they would know where to go.

Girls asked us to place posters in schools.



# 4

## SOLUTION

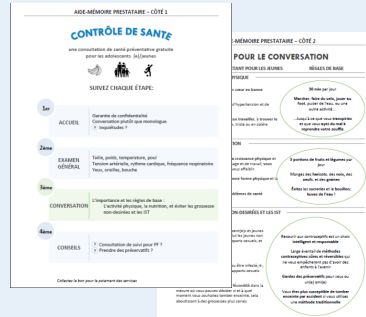
The final version mirrors the colors and images in the board game.

The posters placed in schools show the list of health facilities that honor the passport.



# FAILED PROTOTYPES

UPDATES BASED ON FEEDBACK



## Appointment Card

### FEATURES INCLUDED:

- + A spot to indicate if you have a buddy, and if they will accompany you to the facility
- + Name and phone number of the health worker
- + Info to register for an SMS program
- + Number to call for questions and information about sexual and reproductive health
- + ID # for tracking purposes

## Memory Aid for Wellness Check-Up

### FEATURES INCLUDED:

- + Welcome
- + General examination
- + Guide for conversation on physical activity, nutrition, and avoiding unintended pregnancies and sexually transmitted infections

The wellness check-up and appointment card were dropped from the solution set because health workers in Burkina Faso do not have the time or resources to offer services beyond those that they already offer.

These two solutions were replaced with two new ones: the passport and a poster advertising menstruation counseling in the maternity ward.

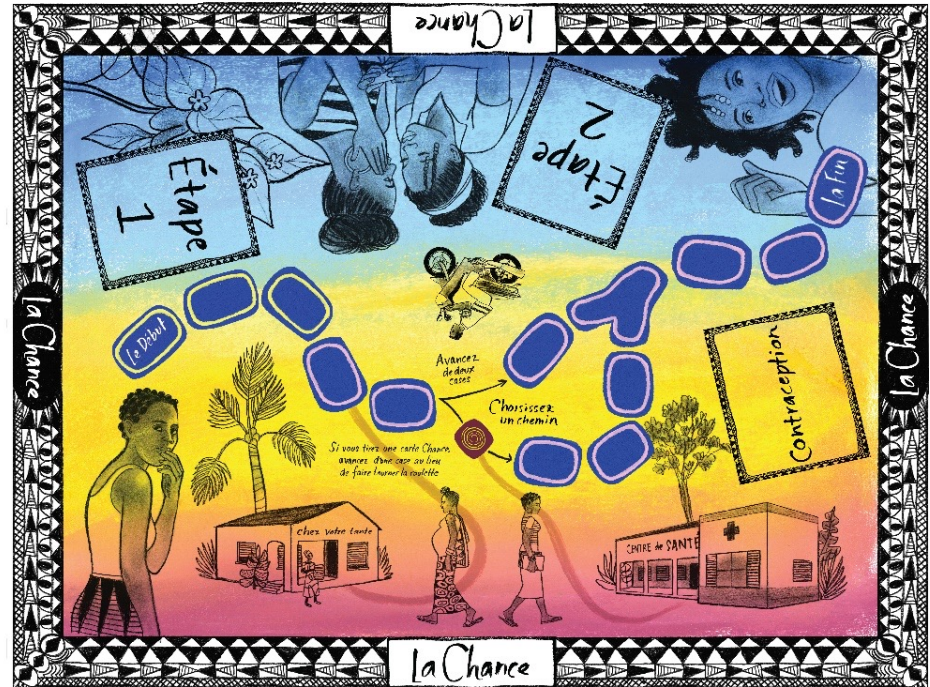
# SOLUTION: PART 1

## BOARD GAME

The board game, *La Chance*, is played with three teams of two school girls each from 3ème and 4ème (9<sup>th</sup> and 10<sup>th</sup> grades). The game is played in a classroom and facilitated by a trained community health worker. After the game ends, the facilitator leads a brief discussion on what the girls learned and answers any questions they may have.

## OBJECTIVES

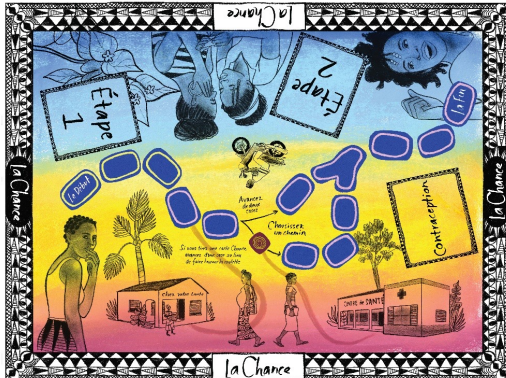
- + Adjust girls' misperceptions of their own pregnancy risk through "experiencing" real-life scenarios.
- + Adjust girls' misperceptions around fertility and contraceptives.
- + Increase girls' comfort speaking and asking questions about sensitive topics.
- + Prompt girls to visit the health facility and provide them with strategies to feel more comfortable doing so.



# SOLUTION: PART 2

## GAME COMPONENTS

- + Girls must reach the end of the board to win. Along the way they pick different cards and choose their path.
- + Girls are faced with a choice in the game, to take the "long path" to get contraceptives or the short path where they stay at risk of pregnancy for the duration.



BOARD GAME



TRIVIA, CONTRACEPTION, AND CONVINC CARD

- + Once girls get pregnant in the game, they can always choose to use contraceptives when they return to the path to learn from the experience.
- + Girls learn through trivia cards and confront and discuss myths and beliefs while taking on the role of advice-giver with Convince cards.
- + Girls read sex scenarios and spin a top to see if they end up pregnant or not, if they get pregnant they are sent backwards to Auntie's house to make the consequences real.



SPINNING TOP WITH PREGNANT GIRLS ON TWO OF THE FOUR SIDES



WOODEN 'AVATARS' OF GIRLS



DECODER GLASS FOR TRIVIA CARDS REVEAL CORRECT ANSWERS

# SOLUTION: PART 3

## HEALTH FACILITY PASSPORT

Girls receive three copies of the health facility passport after playing the game: one for themselves and two to give to friends or family members. The passport serves as a simple reminder to go to the facility and can make a health facility visit feel special since they were one of few girls who received a passport.

### OBJECTIVES

- + Prompt girls to visit a health facility with a specific plan.
- + Add value and novelty to health facility visit, from the perspective of girls.
- + Address anticipated stigma by helping girls to feel more comfortable at the health facility.
- + Reduce the amount of time girls might be seen by acquaintances at the health facility, thereby reducing girls' potential feelings of shame or embarrassment.
- + Reduce ambiguity about what girls can expect when visiting a health facility.
- + Encourage joint action by having girls invite other friends to go with them to the facility.



## POSTERS

Game facilitators instruct girls to look for the posters at the health facility if they are unsure of where to go. The posters also advertise services other than contraceptives that young girls might seek in the maternity ward.

### OBJECTIVES

- + Provide girls with a guidepost for where to go to decrease fear and ambiguity once at the health facility.
- + Create a sense of ambient belonging by depicting young, unmarried girls, and increase participation.
- + Reduce perceived stigma by including the text "The Ministries of Health and Education encourage youth to take control of their health."

## NAME TAGS

Game facilitators tell girls that health workers will be wearing identifying nametags with the recognizable logo.

### OBJECTIVES

- + Increase girls' feelings of self-efficacy and agency upon recognition of a familiar image.
- + Engender the perception that the health worker has personally committed to providing youth services.

# IMPLEMENTATION AND EVALUATION IN BURKINA FASO

## 5

- + Implementation and evaluation overview
- + Uptake of solutions
- + Attitudes towards contraception
- + Social norms
- + Attitudes towards health workers
- + Summary and recommendations

# IMPLEMENTATION AND EVALUATION OVERVIEW

We conducted a randomized controlled trial (RCT) to test if the solutions would change girls' perceptions, attitudes, intentions, follow-up behaviors and use of family planning (impact evaluation). We also collected data to understand how the implementation affected the results.

## IMPLEMENTATION:

- + **16 secondary schools** - eight in each of the regions in Bobo-Dioulasso and Ouagadougou were randomly selected to implement the (re)solve intervention.
- + **Principals and parent teacher associations** were introduced to the game.
- + **Meetings for parents** were held in every school to answer questions or concerns the parents may have
- + **32 community-based facilitators** were trained in Bobo-Dioulasso and Ouagadougou
- + **Health providers and administrative staff** from 18 health facilities were oriented to (re)solve solutions and providers were given name tags.
- + **More than 3000 girls in grades 4<sup>ème</sup> and 3<sup>ème</sup>** (9th and 10th grade) played the game between December 2019 and March 2020.
- + **More than 11,000 passports** were distributed.



Photo by Sarah Lance

## WE CONDUCTED:

- + **2,372 quantitative surveys** with girls at baseline and 2,072 at endline.
- + **40+ in-depth interviews (IDIs)** with girls at baseline and endline.
- + **35 endline IDIs** with implementing staff.
- + **14 endline Key Informant Interviews** with experts.

# UPTAKE OF SOLUTIONS

## in intervention schools

### OF INTERVENTION-SCHOOL GIRLS (N=1,013):

- + 96.2% (N=947) reported ever playing the game.
- + 96.7% (N=950) received a passport.
- + 97.2% (N=803) received 2 passports to give to other girls, as intended.
- + 194 girls (19.2% of total) reported having gone to a health facility in the last seven months (during (re)solve implementation) for contraceptive information or services.

### THE EXPERIENCE OF GIRLS AT PARTICIPATING HEALTH FACILITIES IS PRESENTED IN TABLE 1.

**TABLE 1. Experience of girls at (re)solve health facilities**

	TOTAL N (%)	
<b>Saw posters at health center (N=194)</b>	178 (91.8%)	
<b>Method received at health center, as reported by girls (N=194)</b>	Modern method <sup>a</sup>	36 (18.6%)
	Condoms <sup>b</sup>	13 (6.7%)
	Abstinence	58 (29.9%)
	Other methods or preferred not to respond <sup>c</sup>	87 (44.8%)
<b>Reasons for not visiting health center for contraception information or services (among the N=809 girls who did not go)</b>	Not sexually active	331 (40.9%)
	Already using a method	15 (1.9%)
	Not interested	66 (8.2%)
	Intended to but busy with school	210 (26.0%)
	Intended to, but COVID-19	89 (11.0%)
	Intended to but (other reasons) <sup>d</sup>	66 (8.2%)
	Other, don't know, or prefer not to respond	32 (4.0%)

a Modern methods include all hormonal methods and emergency contraception.

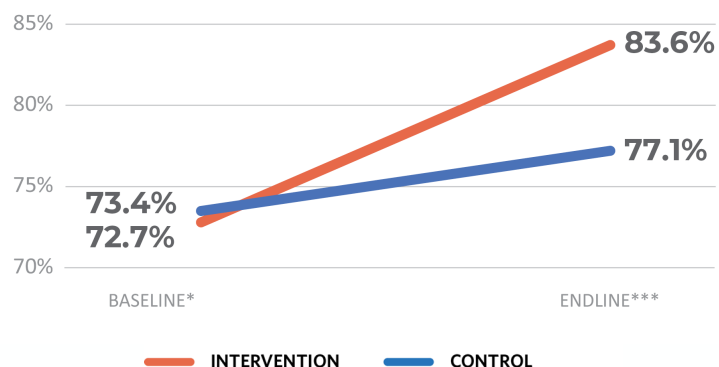
b Condoms include male and female condoms.

c Other methods include 67 girls reporting “prefer not to answer.”

d Other reasons include lack of means, transport, and support.

# ATTITUDES TOWARDS CONTRACEPTION

**FIGURE 1.** Girls who agree that contraception is the best option for them (N=2,044)



The percentage of intervention-school girls who agreed that “**contraception is the best option for me**” increased from 72.7% to 83.6% (Figure 1). At endline, we observed statistically significant differences between the intervention and control groups in level of agreement with both statements (both  $p < .001$ ).

Statistically significant at \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$   
Girls are considered to agree with the statement if they responded “agree” or “strongly agree.”



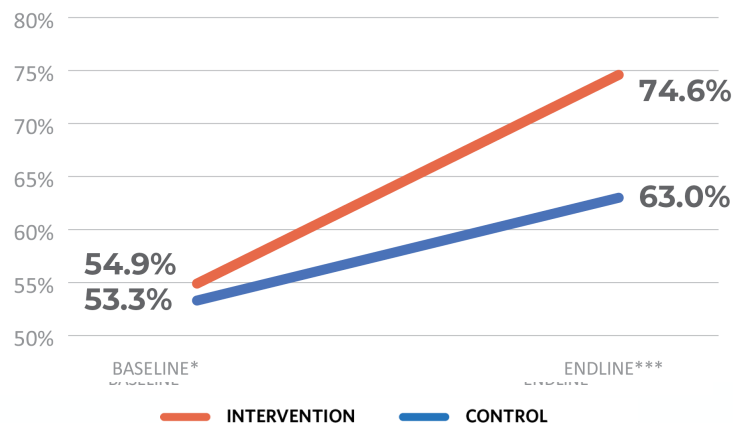
**I THOUGHT THAT [CONTRACEPTION] WAS NOT A GOOD THING...** and that

what people were saying about it was not the truth.

I thought contraceptives weren't safe to avoid getting pregnant. But after the game, that changed.”

(19-year old girl, 3ème, Ouagadougou)

**FIGURE 2.** Girls who agree that they have the confidence to get and use contraception if they want to (N=2,072)



We also saw an increase in girls’ self-efficacy to get and use contraception. The percentage of intervention-school girls reporting confidence to get and use contraception rose from 54.9% to 74.6%. At endline, a statistically significantly larger proportion of girls in the intervention group reported the confidence to obtain and use contraception, compared with girls in the control group (74.6% compared to 63.0%,  $P < .001$ ) (Figure 2).



# SOCIAL NORMS IMPROVED

## but intention to use contraception did not

The percentage of girls reporting social norms around unmarried girls' nonuse of contraception decreased (not shown). Between baseline and endline, the percentage of girls in the intervention group who agreed that it is not normative for unmarried girls to use contraception decreased from 32.1% to 17.7%. At endline, a statistically significantly smaller proportion of girls in the intervention group reported they agreed contraceptive use for unmarried girls is not normative, compared with girls in the control group (17.7% compared to 28.4%,  $P < .001$ ).

Between baseline and endline, we saw a small increase in the percentage of girls from the intervention group reporting they intended to use contraception in the next three months, from 11.2% to 14.1%. However, there were no statistically significant differences between intervention- and control-school girls at baseline or endline ( $P = .08$ ) (Not shown).



**CONTRACEPTION! IT'S FOR ALL GIRLS.** It's a choice. If you want, you can go on use it, and if you don't want, you leave it. Otherwise it's for every girl.... It depends on what you want.”  
(19-year old girl, 3ème, Ouagadougou)

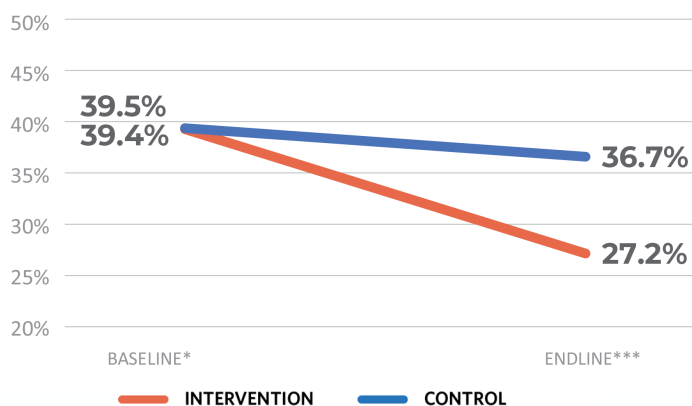
While many girls are in relationships, few reported being currently sexually active. Most seemed naïve about sex and contraception. As a result, many reported that contraception, while not inherently bad, is simply not relevant to them now. Many girls expressed an intention to use family planning in the future—when they are married or finished with school, for instance.



**[I WILL USE CONTRACEPTION IN THE FUTURE],** because at some point I will have sex, and I will have to protect myself to avoid unwanted pregnancies.” (16-year old girl, 3ème, Bobo-Dioulasso)

# ATTITUDES TOWARDS HEALTH WORKERS

**FIGURE 3.** Girls who agree that health care workers do not like to give contraceptive advice to unmarried girls (N=1,988)

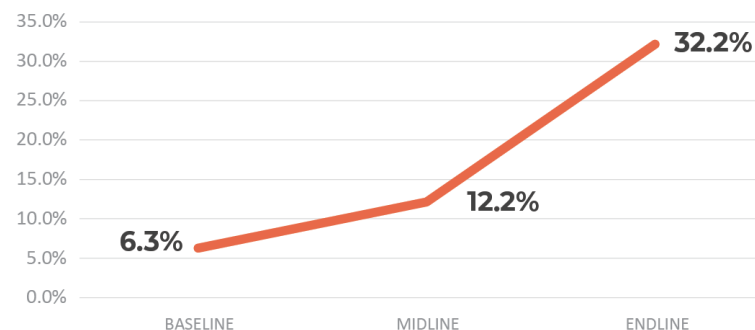


Intervention-school girls reporting agreement that health care workers do not like to give contraceptive advice to unmarried girls decreased from 39.4% to 27.2%. At endline, a statistically significantly smaller proportion of girls in the intervention group reported that they agreed with the statement, compared with girls in the control group (27.2% compared to 36.7%,  $P < .001$ ) (Figure 3).

Statistically significant at \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$

In Fig. 3, girls are considered to agree with the statement if they responded “agree” or “strongly agree.”

**FIGURE 4.** Percentage of intervention-school girls who have ever visited a health facility for SRH information or services (N=999)\*\*\*



Among intervention-school girls, we noted a statistically significant increase in the percentage reporting ever having gone to the health facility for SRH-related reasons, from 6.2% to 32.1% ( $P < .001$ ) (Figure 4). During the game and in subsequent conversations with facilitators, girls asked questions about contraception, menstruation, and sexual health.



**THE AGENTS WELCOMED ME AS SOON AS I PRESENTED MY PASSPORT TO THEM.**

They gave me a place.... I was comfortable, because all the questions were confidential. I felt satisfied.  
(16-year old girl, 3ème, Bobo-Dioulasso)

**WHEN THEY [THE GIRLS] COME WITH THE CARD [PASSPORT], THEY DON'T NEED TO TALK TOO MUCH.**

Because most of our agents have received training for this, so when we see a girl with a card, we quickly approach her to easily guide her.  
(Health worker, Bobo-Dioulasso)

**I WENT [TO THE HEALTH CENTER] TO DETERMINE IF WHAT WE HAVE BEEN TOLD AT SCHOOL IS THE SAME**

[as] what I will hear at the health center then to know about the method of contraception. (16-year old girl, 4ème, Ouagadougou)

**THE GAME... ENTERTAINS [THE GIRLS] AND MAKES THEM CURIOUS**

about sexuality, about contraception, and often it also brings them to [the health center]. Also, with the cards they have, it facilitates their access and counseling. (Health worker, Bobo-Dioulasso)



# SUMMARY AND RECOMMENDATIONS

## SUMMARY OF FINDINGS

- + **(re)solve was well-received by stakeholders and showed promising results** in terms of shifting SRH attitudes, beliefs, norms, and behaviors among unmarried schoolgirls in Bobo-Dioulasso and Ouagadougou.
- + **The game sparked curiosity and challenged myths** about contraceptive use, encouraging girls to begin conversations with facilitators to learn more.
- + **About one in five respondents used their (re)solve passports** to seek information at a health facility.
- + **45 percent of intervention-school girls said that they intended to visit a health center** for contraceptive information or services but had not yet gone because of school, COVID-19, or other reasons. This reported intention shows that girls are interested and eager to learn more.

## RECOMMENDATIONS

- + **Based on initial indicators of success, we see potential for expanding the (re)solve solutions** to other schools and new audiences, such as older and younger girls, out-of-school girls, and boys. Program participants echoed similar calls for replication and expansion.
- + **The intervention will need to be further contextualized and adapted to the needs of each new group.** Future evaluations will need to understand how the intervention differentially affects these diverse groups.
- + **Implementation of (re)solve solutions at scale will require close coordination** between and oversight of the Ministries of Health and Education to ensure successful integration and implementation.
- + **Games can complement demand-generation interventions** and connect youth to health facilities so they can make informed decisions that benefit them.
- + **This evaluation of the (re)solve intervention for Burkinabé schoolgirls adds to the evidence** base on fun, participatory, and feasible approaches to motivate unmarried girls to seek and act on accurate information about SRH and contraception.

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Cover photo by Sarah Lance

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