West Africa Breakthrough ACTION: Cameroon Bottleneck Analysis Final Report

Submitted to: United States Agency for International Development

Submitted by: Johns Hopkins Center for Communication Programs

October 9, 2024

Cooperative Agreement #AID-OAA-A-17-00017

USAID
FROM THE AMERICAN PEOPLE

Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

Table of Contents

Executive Summary

In May 2024, WABA 2 used the Bottleneck Analysis SBC Module, developed by the World Health Organization, to gain a comprehensive understanding of the key bottlenecks to the scale up of evidence-based SBC for FP in Cameroon. This process involved a detailed review of key family planning program indicators from the 2018 Cameroon Demographic and Health Survey (DHS), the identification and review of a case study of evidence-based SBC for FP in Cameroon, 20 key informant interviews with key stakeholders in FP programming in Cameroon, and an interactive consensus building workshop that brought together representatives of key partners to review the aforementioned information together and come to a collaborative understanding of the main issues hindering SBC for FP in Cameroon. In addition, the WABA 2 team supplemented the bottleneck analysis approach with an adapted SBC check-in tool, whereby key informants assessed and reported on their organization's capacity to conduct key activities related to the planning, implementation, monitoring, evaluation, and learning related to SBC for FP.

Results from the Bottleneck analysis identified nine key challenges hindering the scale up of evidence-based SBC. They are presented as follows according to thematic area:

Governance and Financing:

- Leadership and Commitment: Insufficient leadership and commitment to support the scaling up of SBC for FP.
- Guidance formulation: Lack of directives (policies, guidelines, and tools) to support the scaling up of SBC for FP.
- Budgeting: Lack of sufficient budget available at all levels to support a strategy for scaling up of SBC for FP.

People and Information:

- Communication, knowledge, and awareness: Low level of knowledge and awareness of recommended SBC policies and practices.
- SBC for clients: Non-existence of documents on SBC about FP.
- Health promotion: Non-existence of SBC's FP interventions in health promotion activities.

Medicines, Technology, and Service Delivery

- Training and education: Insufficient training in SBC for FP.
- Capacity: Low technical capacity of FP service providers in terms of SBC.
- Role: Non-inclusion of SBC interventions in FP service providers' job descriptions.

For each of these bottlenecks, the invited stakeholders identified the root causes for each of the bottlenecks and recommended potential solutions and organizations who could provide the necessary support (listed in tables 2, 3, and 4). This report provides an overview of the process and outcomes of the BNA as well as recommendations for next steps as well as improving the approach overall.

Overview of BNA Process

The West Africa Breakthrough ACTION (WABA) researcher from the Center for Communication Programs was provided with the Bottleneck Analysis protocol developed and implemented by the WHO in Pakistan. Of the three modules, WABA focused on the implementation of the SBC module to facilitate the understanding of major bottlenecks to the roll out and scale up of evidence-based SBC programming in Cameroon. After reviewing and adapting the process for the context, WABA continued with the preparatory stage of consolidating available data, consolidating SBC and FP related policies and guidelines, and administering the Key Informant Interviews. Each of these components are presented separately below.

In addition to the implementation of the bottleneck analysis protocol, WABA also adapted the SBC Check-In tool developed under HC3 and administered it to representatives of stakeholder organizations. The aim of this supplement was to assess the capacity of the organizations to plan, implement, and monitor SBC interventions to identify the strengths, gaps, and areas for training and intervention.

Preparation Phase

Data Review

To understand the context of family planning programming in Cameroon, WABA conducted a secondary analysis of the data from the 2018 Demographic and Health Survey, the most recent DHS conducted in Cameroon. Each of the key indicators was disaggregated by age (<20 and 20-49) and locale (urban and rural). These data were presented during the consensus workshop in Kribi, following the Key Informant Interviews (KII).

Policy and Guideline Alignment

While policies were requested from the government-based FP stakeholders, they shared some documents available such as Demographic Health Survey (2018), National Strategic Plan for Reproductive Health, Maternal, Child and Nutritional Health (2016-2020), Family Planning Operational Plan (2016-2020), Norms and Standards in Reproductive Health and Family Planning in Cameroon, Communication Plan for Adolescents and Young People in Cameroon (2023-2026). In addition, the government is currently developing the national plan of action related to MCH, which will cover the period of 2024- 2030. However, these strategies were received late in the BNA planning process, and it was not possible to do the policy alignment in advance of the workshop and they were reviewed together at the workshop.

Case Study

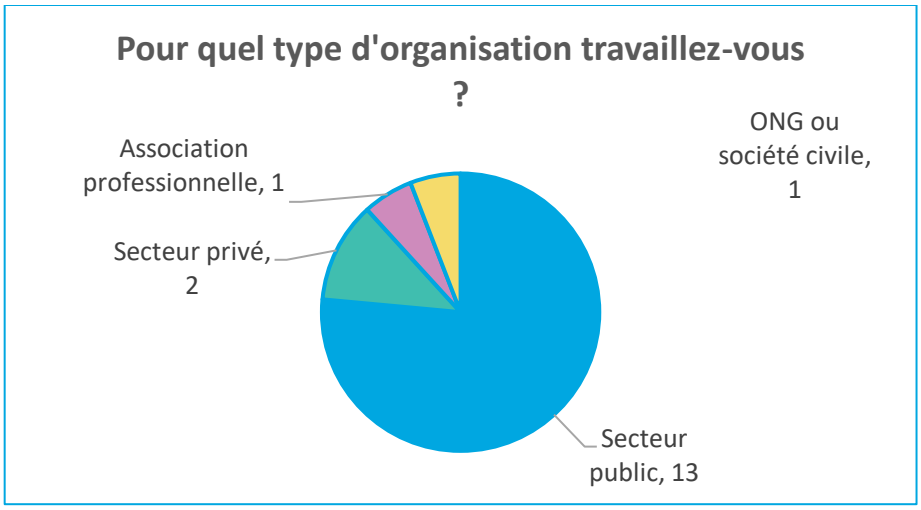
It was challenging to find recent examples of evidence-based SBC in the peer-reviewed literature. However, the *100% Jeune* campaign, implemented by the *Association Camerounaise pour le Marketing Social* (ACMS) in the early 2000's was identified as a good historical example of SBC programming. This program was funded by the Bill and Melinda Gates Foundation with the objective of encouraging urban youth to adopt healthier sexual behaviors and reducing obstacles to condom use and to abstinence. The campaign focused on communication and social marketing to youth between the ages of 15 and 24 who lived in Douala and Yaoundé and used both mass media and interpersonal communication to encourage the youth to use condoms or abstain from sexual activity. Of importance to the workshop, the approach was based on the results of formative research, incorporated constructs from health behavior change theory, and pre-tested all messages and materials before launching them. While Breakthrough ACTION had intended that ACMS present the overview of their campaign and its achievements, they were ultimately not available and therefore Breakthrough ACTION provided an overview of this case study as a good example of SBC for FP.

Key Informant Interviews

Breakthrough ACTION Cameroon with the Family Health Department staff administered 17 key informant surveys in Littoral and Center regions to representatives from the government and non-governmental organizations. All participants were read an oral agreement script and responded that they were comfortable with continuing with the survey. Each participant was asked to rank each of the potential bottlenecks from 1 (strongly agree) to 5 (strongly disagree). Potential bottlenecks included an overall statement and then supporting statements below. Participants who felt that the statement did not apply to them were able to note this and skip the question. The interviews were administered face-to-face, and the stakeholder responses were entered into KOBO Collect.

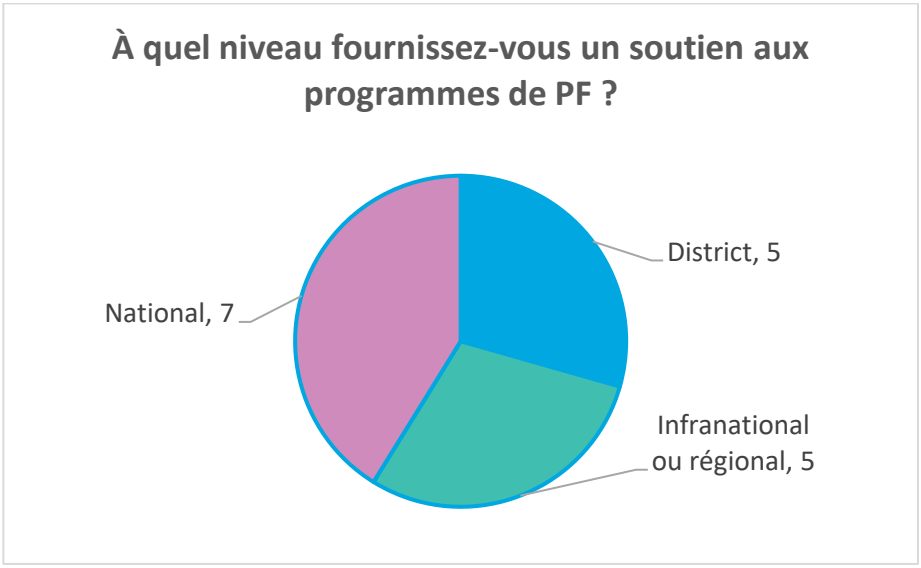
The characteristics of the participants are presented in the figures below. Among the 17 participants, most (n=13) were from the public sector, with one NGO, one professional association, and two private sector partners also participating. The distribution of these participants is presented in Figure 1.

Figure 1: Key informant interviews: Participant Organizational Affiliations



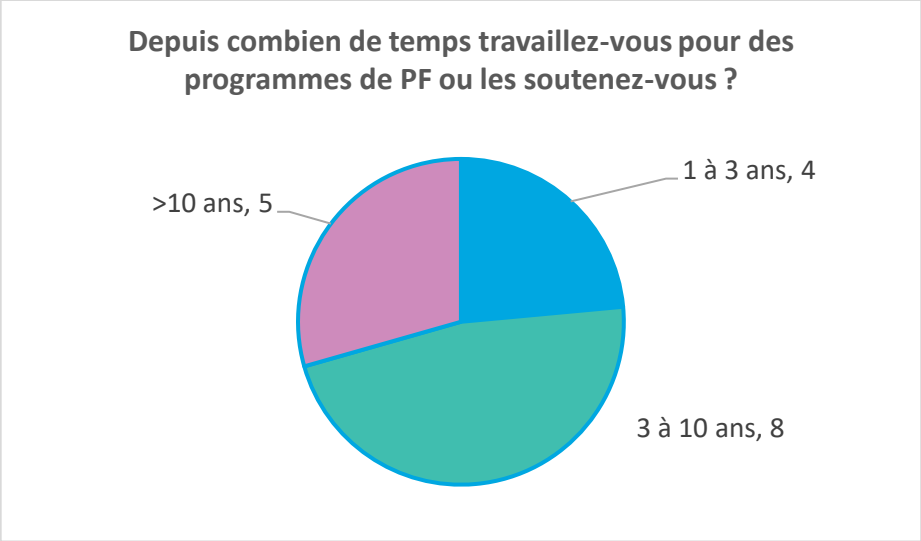
The largest proportion of the KII participants represented the national level of programming (n=7). Equal numbers of participants represented the district level and the regional level (n=5 for each).

Figure 2: Participant organizational level of support for FP



Finally, participants were asked for the number of years that they have been working in the field of family planning. Of the 17 participants, 8 reported that they had been in the field for between 3 and 10 years but some participants had less experience (n=4) and others had more than ten years of experience (n=5). This is presented in Figure 3.

Figure 3: Number of years that participants have worked on family planning programs



Once completed Breakthrough ACTION Cameroon download and analyzed the scores for each of the potential bottlenecks. Mean scores were calculated for each potential bottleneck and are included in Table 1 below, with higher scores color coded in red to indicate that these may be important bottlenecks. The priority bottlenecks according to the key informant interviews included insurance, spending allocation, guidelines and tools, training and education, and roles.

Table 1: Key Informant Surveys on Priority Bottlenecks in Cameroon

Framework theme	Category	Mean score	n
Implementation	Implementation status	3.63	16
Governance	Leadership and Commitment	2.00	15
Governance	Accountability	2.94	17
Governance	Regulation	3.46	15
Governance	Guidance Formulation	3.81	16
Financing	Budgeting	3.71	14
Financing	Donors	3.59	17
Financing	Insurance	4.29	14
Financing	Spending allocation	4.38	13
Financing	Planning	3.85	13
Financing	Equity	3.91	11
People	Communication, knowledge, and awareness	3.60	15
People	Acceptability	3.07	14
People	Consultation	3.00	16
People	Coordination	3.25	16
People	Networks	3.15	13
People	Community engagement	3.13	16
Information	Reporting	3.29	14
Information	Data & HMIS	3.31	16
Information	Guidelines and tools	4.21	14
Information	Client SBC/IEC	3.06	16

Information	Health promotion	1.94	17
Medicines& Technology	Infrastructure	2.76	17
Medicines& Technology	Supplies	3.56	16
Service delivery	Management	3.00	15
Service delivery	Supervision	3.31	16
Service delivery	Teamwork and coordination	1.69	16
Service delivery	Service organization & scheduling	2.00	15
Service delivery	Referral systems	1.88	16
Service delivery	Fees	3.50	17
Human resources	Training and education	4.41	17
Human resources	Capacity	3.94	17
Human resources	Roles	4.06	17
Human resources	Skills & Competencies	3.76	17
Human resources	Motivation	2.93	15

Consensus Workshop

Breakthrough ACTION in support to the Family Health Department, held the consensus building workshop from May 29-31 in Kribi, Cameroon at the Jully Hotel. Participants included representatives from the Ministry of Health (Department of Family Health, Health Promotion Department, Communication cell of the MoH, Littoral Regional Delegation of Public Health, health districts of Akonolinga, Nkolndongo, NkongSamba and Deido), civil society, professional associations, and the media.

Figure 4: Consensus building workshop participant photo

The meeting agenda is included in this brief in Annex 1. Breakthrough ACTION began the workshop with a presentation on the core components of Social and Behavior Change (SBC), a presentation of the DHS analysis (referenced in the data review), and an overview of the *100% Jeune* campaign as a key case study in SBC for FP for the workshop.

WABA then introduced the concept of bottlenecks and the bottleneck analysis. WABA also presented the results of the key informant interviews, which suggested potential bottlenecks that may be hindering scale up of SBC.

Breakthrough ACTION then divided the participants into three groups that aligned with the categorization of key bottlenecks: 1- Governance and financing, 2- People and information, and 3- Medications, human resources, and service delivery. Annex 2 presents a breakdown of the participants' organizations and designations by group. Breakthrough ACTION asked each group to rank the bottlenecks in order of their importance as key factors impeding scale up of evidence-based SBC in Cameroon.

While the bottleneck analysis protocol had the groups rank each of the bottlenecks from 1 to 10 (or 14 depending on the number of bottlenecks in each group) individually before sharing their scores and rationale, the participants in the workshop felt strongly that they preferred to do the ranking in consensus. Each group then presented their five most important bottlenecks that serve as a barrier to SBC scale up to the entire group. The larger group was provided an opportunity to ask and answer questions related to the presenting group's ranking. Once these presentations were completed, members of the larger group voted on the top three most important bottlenecks (of the top five presented) using color-coded post-it notes. The red post-it notes was the bottleneck that they felt was the highest priority, yellow represented the middle, and green/blue was the lowest priority bottleneck of the three. Once the voting was completed, the votes were tallied and compiled for each group to generate a list of the three key bottlenecks for each group. The top five bottlenecks for each of the groups are presented below, with those with an asterisk designating that they were selected as final bottlenecks by the larger group.

Group 1: Governance and Financing

1. **Leadership:** There is strong leadership and commitment to support scale-up of SBC for FP*
2. **Budgeting:** There is adequate budget available at all levels for scale-up of SBC for FP.*
3. **Guidance formulation:** There is sufficient guidance (including policies, guidelines and tools) to support scale up of SBC for FP*
4. **Planning:** There is a coherent national plan for SBC scale-up.
5. **Spending allocation:** Government expenditure on SBC matches the allocated budget.

Group 2: People and Information

1. **Communication, knowledge, and awareness:** There is a high level of knowledge and awareness of recommended SBC policies and practices. *

2. **Client SBC/IEC materials:** SBC materials exist to support SBC for FP.*
3. **Social norms regarding FP use:** Communication on FP is integrated with health promotion activities. *
4. **Community engagement:** There is adequate community engagement on SBC for FP.
5. **Guidelines and tools:** Updated guidance on SBC for FP is available and widely used.

Group 3: Medicines/Technology, Service Delivery, and Human Resources

1. **Skills and Competencies:** FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches for SBC. *
2. **Training and education:** There is adequate training on SBC for FP.*
3. **Capacity:** Staff working on FP across the health system have capacity to deliver SBC for FP.*
4. **Motivation:** Health workers involved in SBC have positive attitudes towards the policy.
5. **Referral systems:** There are effective referral systems between community outreach workers/SBC agents/CHWs and static health facilities.

WABA 2 noted that while the key informants marked health promotion as an area of strength, the stakeholders in group two felt that it was one of the primary bottlenecks that needed to be addressed. This discrepancy was attributed to differing perspectives on the definition of communication; while the key informants referred to general health communication, within the workshop, the participants responded specifically about SBC as defined in the opening presentation.

Once the three bottlenecks for each group were identified, each group went through the process of identifying the root causes of each of the bottlenecks using the approach of the five why's. Using this approach, they built out trees that began from the three priority bottlenecks and ended with the root causes.

Figure 5: Root Cause Analysis Group Work

Once the root causes were identified, participants worked in their teams again to recommend solutions to the root causes associated with each of the three bottlenecks. Participants were guided to focus (to the extent possible) on solutions that were highly feasible and highly impactful. Below, WABA has consolidated tables for each of the three groups that reflect the priority bottlenecks, the root causes that they identified through the tree diagrams, the recommended solutions, and the organizations that they identified could support these efforts.

Table 2: Bottlenecks, Root Causes, and Solutions Proposed by Group 1

Group 1: Leadership and Governance				
Bottleneck	**Description**	**Root Causes Identified**	**Proposed Solutions**	**Organizations that can support**
Leadership and commitment	Insufficient leadership and commitment to support the scaling up for SBC for FP.	SBC is a relatively new approach in Cameroon, which has traditionally been using a Communication for Development (C4D) approach.	• Develop guidance documents (National Strategic Plan and Operational Plan for HCM) • Train trainers on SBC at central and regional level.	• MoH* • Ministry of the social affairs • Ministry of Woman and Family • Ministry of Youth and Civic education • Traditional and religious leaders • CSO • USAID • UNFPA • UNICEF • Other funders • Implementing partners
		There is insufficient financing available for SBC for FP.	• Advocate for increased funding for the integration of SBC interventions for FP at all levels of the health pyramid.	• MoH* • MINCOM • MINFI • USAID • UNFPA • UNICEF • Other funders • Implementing partners
		Tools for SBC are not adequately developed	• Update existing communication tools and others supporting documents on SBC for Family planning.	• MoH • MINCOM • USAID* • UNFPA • UNICEF • Other funders
		Religious leaders have not been involved to the extent necessary.	• Advocate for the integration of SBC in the FP domain at the various stakeholder levels (MOH, other sectors, religious and traditional	• MoH* • MINAT • MINFI • USAID • UNFPA

			leaders, CSO, technical and financial partners).	• UNICEF • Other funders
Guidance formulation	Lack of directives (policies, guidelines, and tools) to support the scaling up of SBC for FP	Inadequate advocacy for inclusion of SBC into national guidance documents.	• Include SBC into the national guidance documents.	• MoH* • MINCOM • USAID • UNICEF • UNFPA • WHO
		Absence of guidance documents.	• Develop guidance documents (National Strategic Plan and Operational Plan for HCM)	• MoH* • Ministry of the social affairs • Ministry of Woman and Family • Ministry of Youth and Civic education • Traditional and religious leaders • CSO • USAID • UNFPA • UNICEF • Other funders
		Inadequate communication and coordination about SBC across the MOH.	• Advocate for the integration of SBC in the FP domain at the various stakeholder levels (MOH, other sectors, religious and traditional leaders, CSO, technical and financial partners).	
		SBC is a relatively new approach in Cameroon, which has traditionally been using a Communication for Development (C4D) approach.	• Develop guidance documents (National Strategic Plan and Operational Plan for HCM) • Train trainers on SBC at central and regional level.	
Budgeting	Lack of sufficient budget available at all levels to support a strategy for scaling up SBC for FP	Insufficient awareness of SBC among the key stakeholders.	• Change guidance in key documents from C4D to SBC • Advocate for increased funding for the integration of SBC interventions for FP at all levels of the health pyramid.	• MoH* • MINCOM • USAID • UNFPA • UNICEF • Other funders
		Lack of update on guidance in key documents from C4D to SBC		

Table 3: Bottlenecks, Root Causes, and Solutions Proposed by Group 2

Group 2: People and Information				
Bottleneck	**Description**	**Root Causes Identified**	**Proposed Solutions**	**Organizations that can support**
Communication, knowledge & awareness	Low level of knowledge and awareness of recommended SBC policies and practices	Needs to be integrated into individual, social, and structural levels	Reinforce communication on SBC in FP domain at from the central to the operational level of the administrative system.	• MoH* • Ministry of communication • Ministry of Finance • Ministry of Territorial Administration • Ministry of Social Affairs • Ministry of Woman and Family • USAID • UNFPA • Other funders
		Absence of community level engagement policy	Establish a policy and effective plan on community engagement on SBC interventions according to family planning.	
		Inadequate resources	Allocate budget for the communication on SBC in FP domain at from the central to the operational level of the administrative system.	
SBC/IEC for clients	Non-existence of documents on SBC about FP	Inadequate community consultation	Design, draw up, validate, produce and disseminate normative and operational documents on the SBC in terms of family planning.	• MoH* • MINCOM • Ministry of Territorial Administration • Ministry of Social Affairs • Ministry of Woman and Family • USAID • UNFPA • Other funders
		Inadequate research	Design, draw up, validate, produce and disseminate normative and operational documents on the SBC in terms of family planning.	
Health promotion	Non-existence of SBC's FP interventions in health promotion activities	SBC not integrated into overall national budget.	Advocate for increased budget to sustain the mentorship at field level.	• MoH* • MINCOM • MINFI • USAID • UNFPA • Other funders
		New approach	• Build the capacity of FP service providers on SBC interventions. • Reinforce the coordination and mentorship system.	

Table 4: Bottlenecks, Root Causes, and Solutions Proposed by Group 3

Group 3: Medicines and Technology, Service Delivery, and Human Resources				
Bottleneck	**Description**	**Root Causes Identified**	**Proposed Solutions**	**Who can support**
Training and education	Insufficient training in SBC for FP.	There is not a capacity strengthening policy.	• Integrating the SBC component into the academic training curriculum for health professionals. • Elaborate and produce training documents on SBC for the family planning. • Drawing up and implementing a capacity-building plan for health professionals on SBC family planning interventions.	• MoH • Ministry of Higher Education • MINCOM • Ministry of Territorial Administration • Ministry of Social Affairs • Ministry of Woman and Family • USAID • UNFPA • Other funders
Capacity	Low technical capacity of FP service providers in terms of SBC.	Non-integration of the SBC component in the FP national strategy.	• Drawing up a FP SBC national strategy	• MoH • MINCOM
		Failures of previous approaches	• Train FP service providers on SBC interventions. • Drawing up SOP, job aids and other communication tools for FP's SBC interventions.	• Ministry of Territorial Administration • Ministry of Social Affairs • Ministry of Woman and Family • USAID • UNFPA • Other funders
Role	Non-inclusion of SBC interventions in FP service providers' job descriptions.	New approach in communication for health	• Integrate PF SBC interventions in the services providers job descriptions	• MoH

Capacity Assessment Results and Discussion

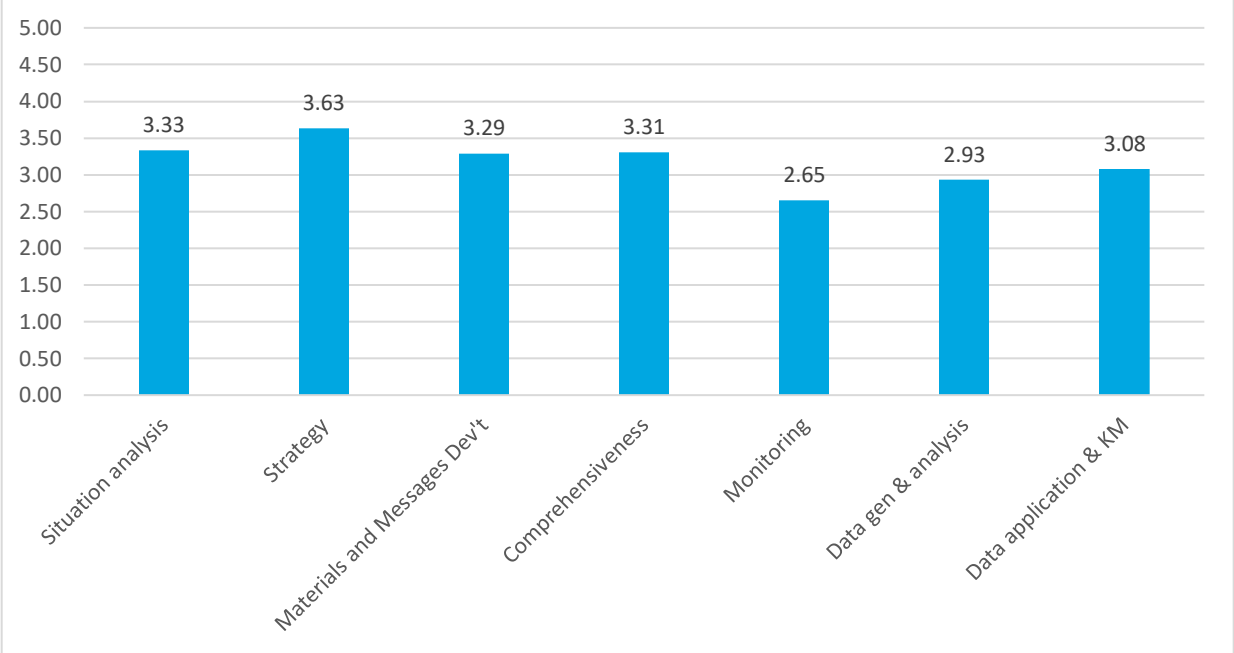
Approach

Breakthrough ACTION Cameroon and Family Health Department staff administered 12 capacity assessment surveys to stakeholders from the government and mostly NGOs. Each participant provided informed oral consent to participate in the survey. The aim was to evaluate organization abilities on SBC intervention planning, implementation, monitoring and evaluation and data use for program dynamics. Each respondent was asked on the level capacity of their organization on statement according to the evaluation components.

Results

Figure 6 presents the mean scores for each of the specific SBC domains, with higher scores reflecting a higher perceived organizational capacity in the domain. Those who reported that a given domain was not applicable were removed from the denominator in calculating the arithmetic means.

Figure 6: Capacity Assessment Results by SBC Domain



Most participants said that they used secondary data to meet their information needs, especially concerning the socio-demographic and behavioral characteristics of the target audience, as well as the available and preferred communication channels. Therefore, the scores were relatively higher on the planning and implementation components of the assessment. Low scores were recorded on monitoring, data generation and analysis, date use and knowledge management.

Preparation and Planning Scores

As presented in Figure 7, scores were relatively high on the situation analysis component of the planning domain. Scores ranged from 2.0 to 4.25. The mean score on situation analysis was 3.33.

Figure 7: Situational Analysis Scores by Organization

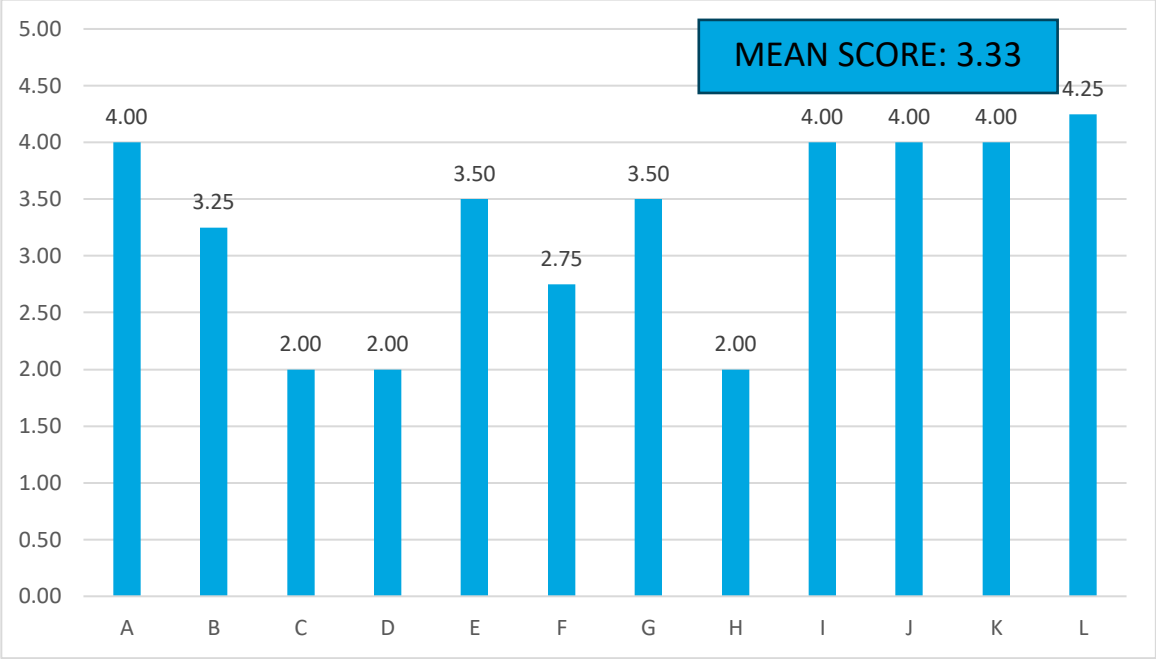
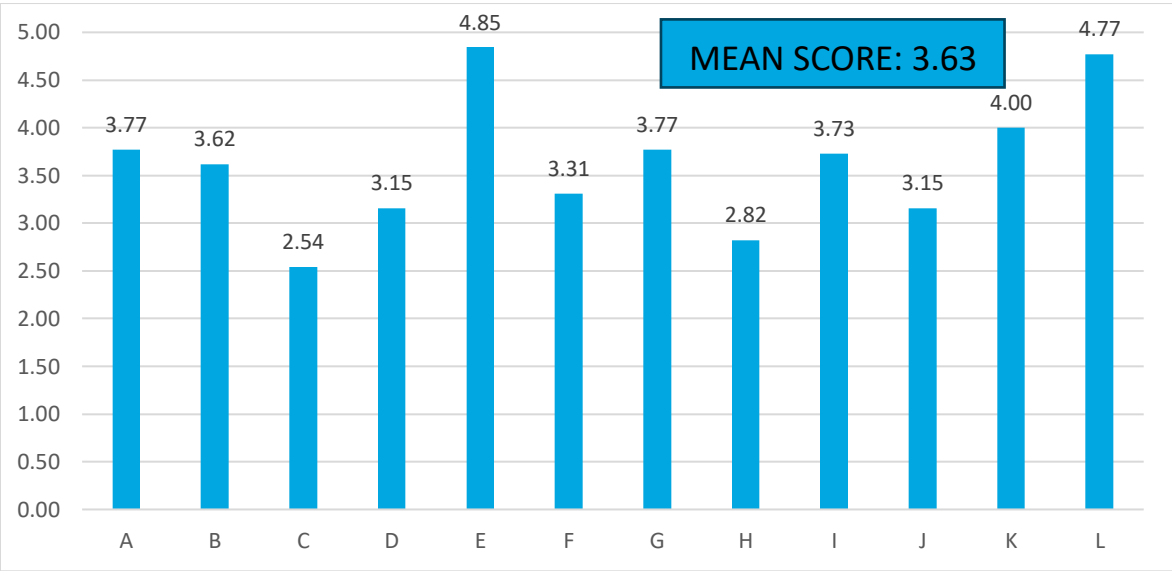


Figure 8 presents the scores on strategy development capacity by organization. These scores were the highest across the three components with a mean of 3.63.

Figure 8: Strategy Capacity Scores by Organization



Implementation Scores

Implementation of SBC interventions include the domains of materials and message development, comprehensiveness, and program monitoring. Figure 9 demonstrates the variability in scores within the materials and message development domain, which ranged from 1 (very low capacity) to 5 (very high capacity).

Figure 9: Materials and Message Development Capacity Scores by Organization

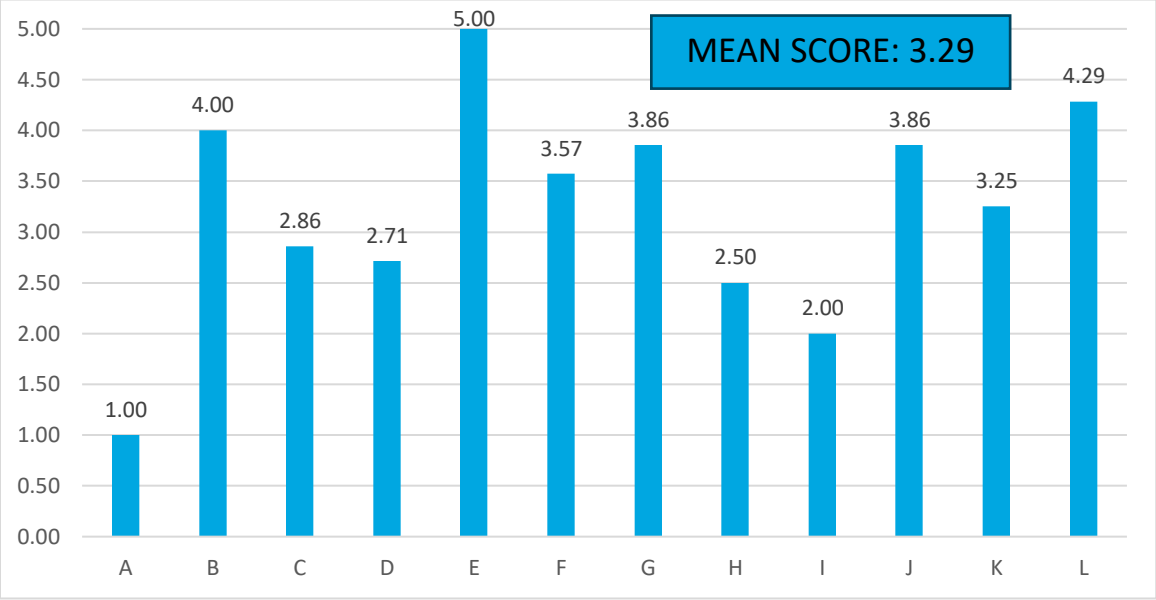


Figure ten presents the distribution of scores within the domain of comprehensiveness of SBC implementation by organization. Scores on this domain ranged from 2 to 4.64 with a mean of 3.31.

Figure 10: Comprehensiveness Capacity Scores by Organization

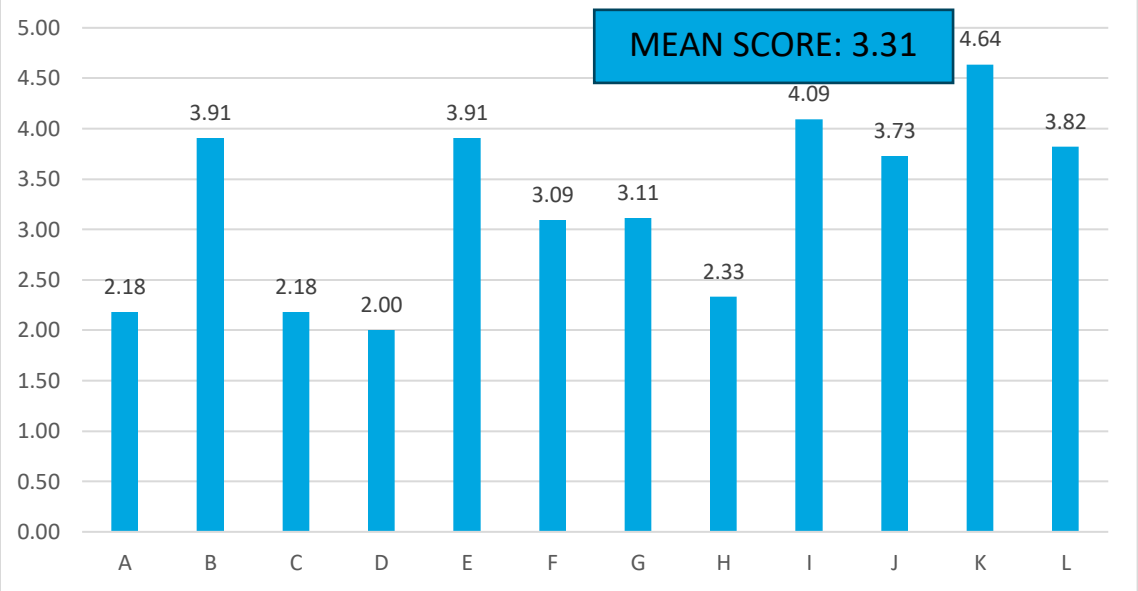
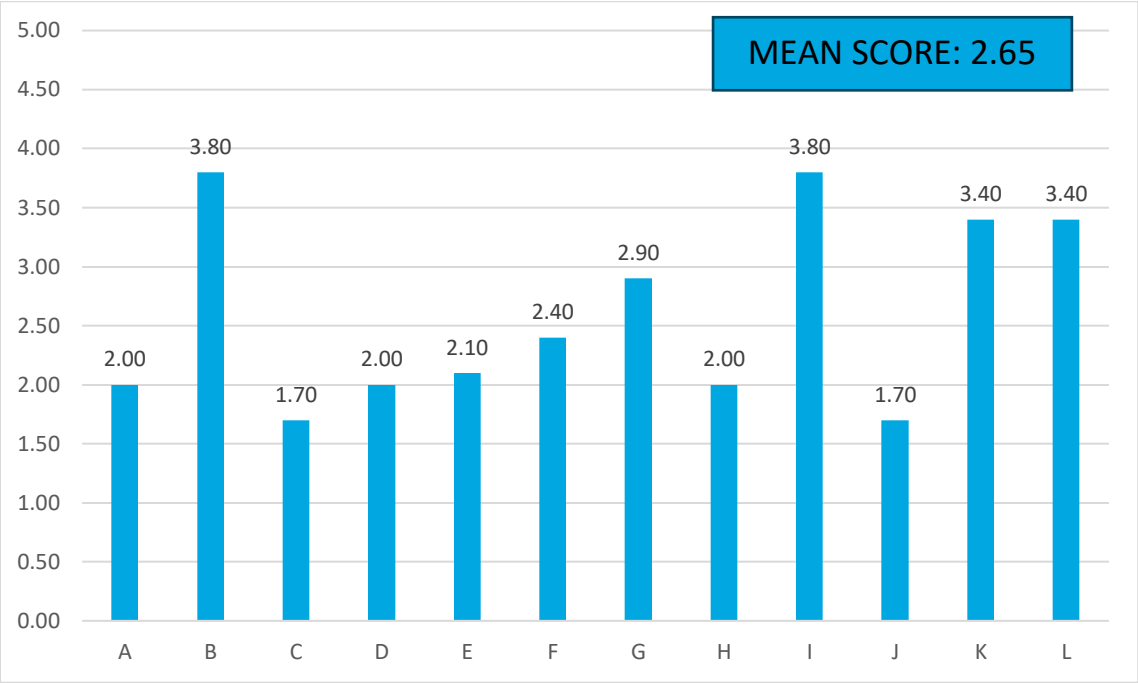


Figure 11 presents the monitoring capacity of each organization, which was the lowest of all domains with a mean score of 2.65. These scores ranged from 1.70 to 3.80.

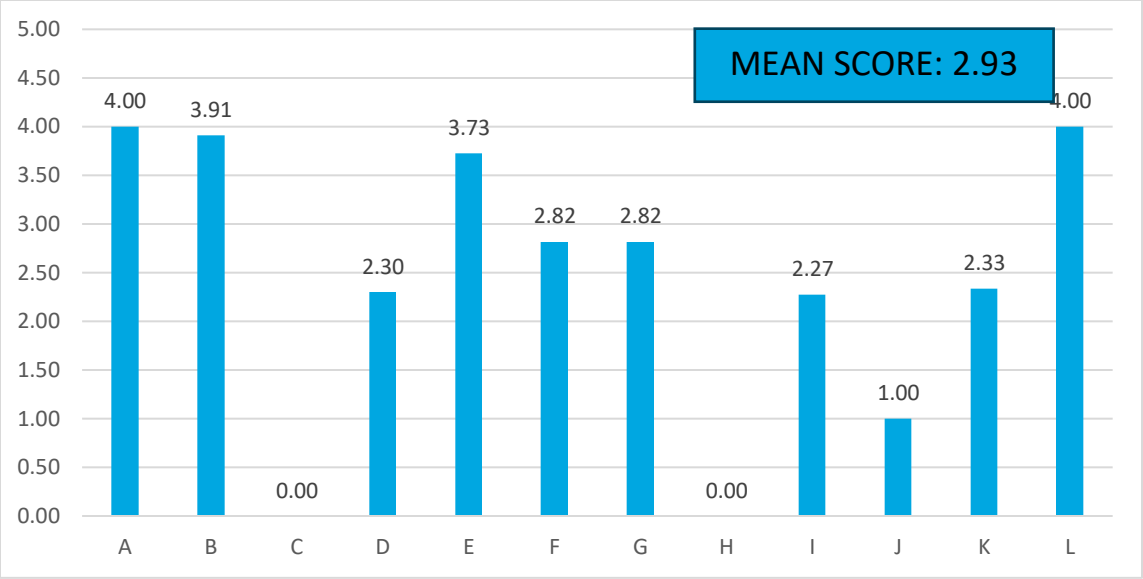
Figure 11: Monitoring Capacity by Organization



Evaluation and Data Use Scores

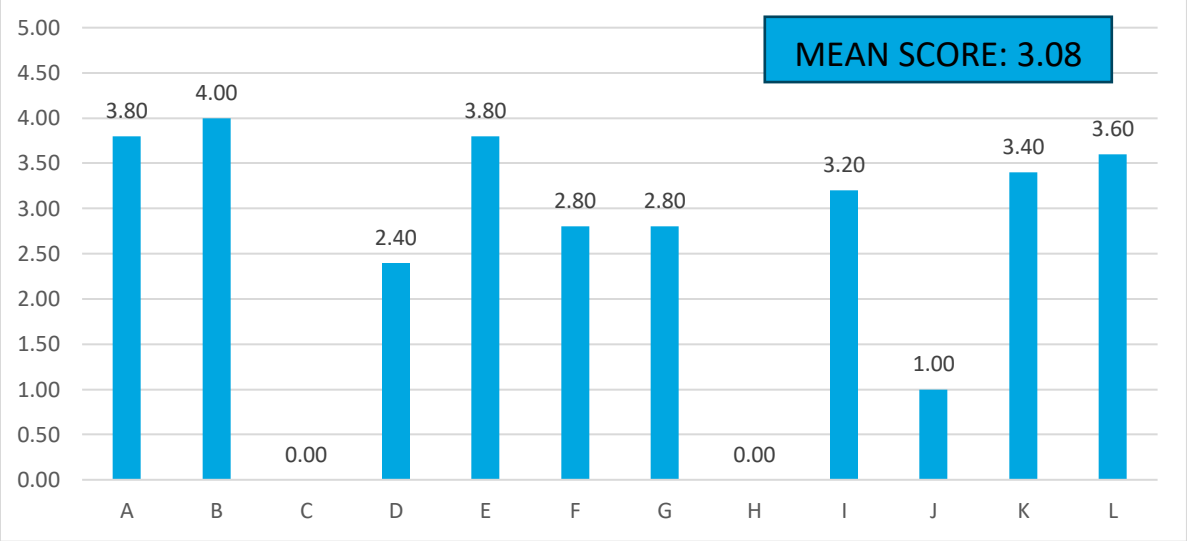
As an area, the evaluation and data use scores were lowest for the organizations that participated in this assessment. Figure 12 presents scores per organization as they relate to data generation and data analysis. Two participants (C and H) reported that this entire domain was not applicable to their organization and these zeros were removed from the overall mean. However, further information is needed in order to understand why the collection, analysis and use of data was deemed to be not applicable for these organizations.

Figure 12: Data Generation and Analysis Capacity by Organization



Finally, Figure 13 presents the overall capacity scores for data application and knowledge management across the organizations that participated in the assessment. Again, organizations C and H reported that this entire domain was not applicable for their organization and these zeros were removed from the mean. Apart from these organizations, the scores ranged from one to four.

Figure 13: Data Application and Knowledge Management Capacity by Organization



To remedy this relatively low capacity in family planning SBC, respondents shared several opportunities for capacity building, including the availability of staff, the use of coordination meetings, training seminars and field mentoring. They also praised the support of technical and financial partners and called for additional investment to set up a sustainable plan to build capacity in this area. WABA also shared the SBC Learning Central link and courses as a resource that can provide support.

Recommendations and Way Forward for FP Programs

The workshop resulted in five key recommendations, which are outlined in Table 10 below:

Table 10: Overarching recommendations and responsibilities following the BNA consensus building workshop

SN	Recommendations	Responsible	Deadline
1	The inclusion of SBC in policy and operational documents.	- Ministry of Public Health - Ministry of Communication	ASAP
2	Advocacy for increased funding for the integration of SBC interventions for FP at all levels of the health pyramid.	- Ministry of Public Health	ASAP
3	Training of national trainers, technical staff and FP service providers, the media and other stakeholders on SBC for FP.	- Ministry of Public Health - Ministry of Communication	ASAP
4	Integration of SBC into the training curricula for health workers.	- Ministry of Public Health - Ministry of Higher Education	ASAP
5	The inclusion of the various stakeholders (CBOs and CSOs of young adolescents and women of childbearing age as a priority) during the design, development and validation workshops for the policy and operational documents.	- Ministry of Public Health	ASAP

Of the five overarching recommendations detailed in the table above, two are already being implemented:

The inclusion of SBC in policy and operational documents: Following the workshop, there was increased commitment to including SBC in key policy and operational documents, particularly the National Strategic Plan for Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (2024-2030). Beyond this key guiding document, the FP Operational plan and the FP SOP Manual are also being revised and the group recommended the inclusion of SBC in both documents as well. WABA 2 will advocate for the inclusion of the identified key SBC interventions in those documents. In addition,

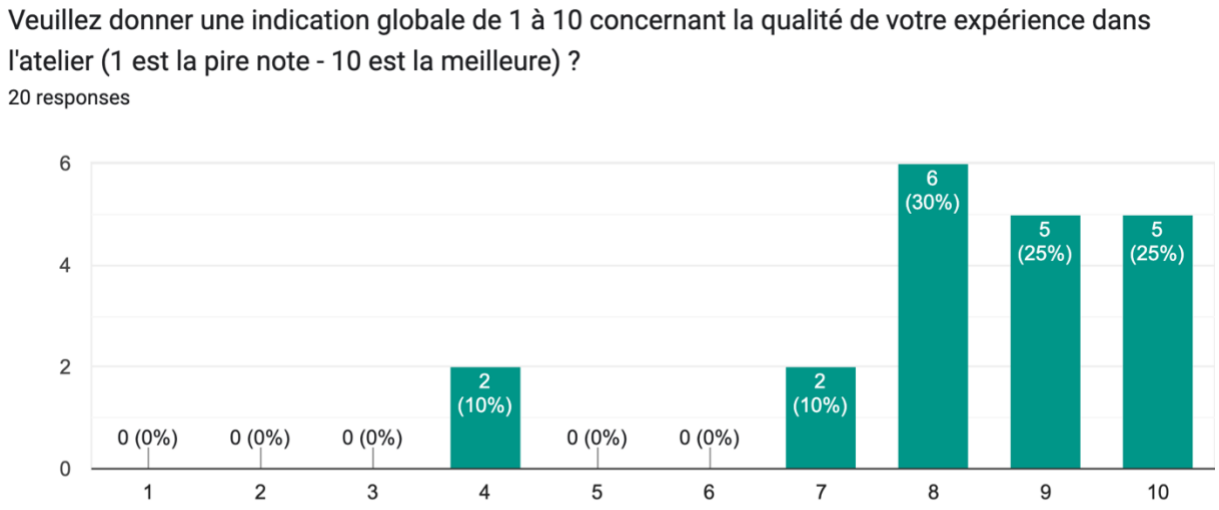
WABA 2 plans to support the Ministry of Health in the development of the National SBC Strategy for Cameroon in October 2024.

The inclusion of the various stakeholders during the design, development and validation workshops for the policy and operational documents: The Ministry of Public Health (Family Health Department) is currently updating the map of stakeholders involved in family planning programming in Cameroon. This mapping will include representatives of organizations promoting the interests and involvement of end-users including women of reproductive age and adolescents. This updated stakeholder mapping will provide a foundation of those who will be invited to capacity strengthening activities and those who will receive a direct invitation to the SBC e-learning platform.

Participant Feedback on BNA Process

At the end of the workshop, WABA administered a five-question survey to gather participant feedback on their experience in the workshop and on the BNA approach. We first asked the participants to provide an overall ranking for the quality of their experience in the workshop between 1 (worst) and 10 (best). The mean score for the 20 participants was 8.25 with a range from 4 (n=2) to 10 (n=5).

Figure 14: Participant ranking of the quality of their experience in the BNA workshop



Many of the participants appreciated the interactive nature of the group work and the exchanges that they were able to have during the workshop. They thought that the methodology was innovative and excellent- particularly the approaches for identifying the root causes and the potential solutions. Many participants also appreciated the overall presentation on SBC at the start of the workshop. They felt that this set the stage for the workshop by providing a comprehensive understanding of SBC and its potential for impact in the community.

In terms of recommendations and things that could have been improved, participants thought that the presentations and documents should have been shared with the team in advance of the workshop. Several participants thought that the workshop should have been extended to allow for a deeper understanding and analysis of opportunities to integrate SBC into FP. Some participants made some specific recommendations for sessions that they would have wanted to be integrated into the workshop. These included: examples of SBC in other countries, an overall synthesis of family planning programs, and a presentation on the shift from Communication for Development (C4D) to SBC.

We also asked the participants about actions that they themselves could take to improve SBC for FP. Most of the participants mentioned sharing the information about SBC and the lessons learned with

their colleagues, their supervisors, and professional associations. Participants mentioned that they planned to raise the profile of SBC for FP and that they would recommend integrating it into the work of health providers.

To increase family planning acceptance and use in the community, participants recommended ongoing training of the stakeholder organizations and members of the community. Some participants mentioned the need for advocacy at high levels among key decision-makers and leaders for a focus on SBC. They also recommended a complete shift away from C4D and towards adoption of SBC. Many of the participants also suggested the need to train providers and the community and some recommended that this could be done through a cascade approach (training of trainers).

Recommendations for the BNA approach

Through the implementation of the Bottleneck Analysis approach, WABA developed some recommendations for future implementation. The strength of the BNA approach is its interactive and engaging approach, which promotes buy in from the participants. We found it to include an exhaustive list of bottlenecks and thought that the exercise of group based ranking generated interesting conversations within and between the groups.

Workshop Preparation Recommendations:

- Policies and Strategies: We were unable to access the government policies and strategies but if we had, it may have been politically sensitive to report the extent to which these documents reflected SBC best practices back to the authors of these documents. We propose that a future workshop might ask the government representatives to reflect on this themselves (following an orientation on SBC if needed) and then make these presentations to the group.
- Case Study: While it is possible to make a presentation on the case study based on peer reviewed literature, where possible, we recommend that the organization who led the intervention or campaign should be asked to present this to the participants. The facilitator(s) can then emphasize the components of the intervention that made it a good example (evidence based, audience segmentation, monitoring, evaluation, learning etc).

Key Informant Interview Recommendations:

- We noted that while the consensus building workshop included a session on SBC (to ensure that everyone had the same understanding before ranking), this was not included in the key informant interview. We therefore added a few sentences to the start of the interview. However, the areas where the KIIs diverged from the workshop results likely reflected this different level of understanding of SBC.
- We found that programming the survey into Open Data Kit or KOBO Collect allowed for a quick analysis of the bottlenecks from the key informant interviews and recommend this to others.
- Given that many of the participants participated in the KIIs and in the consensus building workshop, the activity seemed to be a bit duplicative without a clear place to link the results of the KIIs to the rankings in the groups. However, we did find a place to compare and discuss the reasons for concordance/divergence.

Consensus Building Workshop Recommendations

- There was a lot of focus on C4D in Cameroon and participants wanted to know how it was different from SBC and where they aligned and diverged. If this could be the case in other countries, recommend adding this component to the SBC Overview presentation.

- In the group three tool, the area of “innovation” was missing from the ranking tool but had been included in the list of potential bottlenecks.
- It was a challenge to get participants to be very specific about the potential solutions and we ended up with a lot of recommendations to “train” and “advocate” and a long list of partners who could support. If possible, it could be helpful to have an illustrative example built into the forms that could guide the participants in terms of the specificity that should be included in their solutions.
- We included the capacity self-assessment as an activity that was administered at the same time as the BNA KIIs. Given all the calls for training and capacity strengthening that came out of the consensus workshop, this was an opportunity to present the results and discuss the specific capacity strengthening needs. This could also be built into the workshop to continue to have a more dynamic discussion organized by organization.

Annex 1: Consensus Workshop Agenda

Agenda de l'atelier de consensus sur l'analyse des goulots d'étranglement du 4-6 juin 2024

Premier jour : Analyse des goulots d'étranglement - Préparer le terrain

Heure	Session	Objectifs	Facilitateur
8h30 - 9h00	Accueil et installation des participants		Tous
9h00 - 9h30	Introduction des participants	Apprendre à se connaître	
9h30-9h45	Mot d'ouverture		Carlene & DSF & Finance
9 h 45 - 10 h 00	Présentation de l'agenda	Partager le plan de l'atelier	Carlene
10h00 - 10h30	Généralités sur la SBC	Présenter les principales politiques et pratiques recommandées et fondées sur des données probantes en matière de SBC	Carlene
10 h 30 - 11 h 00	**Pause café**		
11h00 - 11h30	Revue des données	Présenter le contexte de la PF dans le pays	Larry
11h30 - 12h00	Identification et discussion des politiques et directives	Identifier les documents d'orientation en matière de PF et de SBC.	DSF
12:00 - 12:30	Résultats de l'enquête (interview des informateurs clés)	Présenter les résultats des entretiens individuels menés dans le cadre de l'évaluation des besoins en matière de SBC.	Dana
12:30 - 13:00	Étude de cas : 100% Jeune	Présenter les enseignements tirés des études de cas sur la mise en œuvre de l'EBP	ACMS
13:00 - 14:00	**Pause Déjeuner**		
14:00-14:30	Revue des goulots d'étranglement	Examiner les goulots d'étranglement identifiés dans le cadre de l'examen de l'OMS et identifier les éventuels goulots d'étranglement manquants.	Larry
14:30- 16:00	Présentation des groupes de travail sur les goulots d'étranglement	Groupe 1 : Gouvernance et financement Groupe 2 : Personnes et informations	

		Groupe 3 : Médicaments/ technologie, prestation de services et ressources humaines Examiner l'outil de classement, discuter et évaluer en groupe l'importance des goulots d'étranglement. Hiérarchiser les goulots d'étranglement potentiels qui empêchent l'extension de la SBC.	
16h00- 16h15	**Pause café**		
16h15 -17h00	Travail en groupe sur les goulots d'étranglement.		Tous

Deuxième jour : Analyse des goulots d'étranglement - Identification des causes profondes et des solutions

Heure	**Session**	**Objectifs**	**Facilitateur**
8h30-9h00	Récapitulatif de la première journée		Larry
9h00 - 10h30	Rapport du travail en groupe (30 min chacun)	Présenter les niveaux d'avancement des travaux par groupe.	Tous
10 h 30 - 11 h 00	**Pause café**		
11 h 00 - 13 h 00	Analyse des causes profondes	Élaborer par groupe les causes profondes des principaux goulots d'étranglement	Tous
13h00 – 14h00	**Déjeuner**		
14h00 – 16h00	Identification des solutions	Identifier par groupe les solutions aux principaux goulots d'étranglement	Tous
16h00- 16h15	**Pause café**		
16h15- 5:00	Restitution des travaux de groupe	Présenter les résultats	Tous

Troisième jour : Activité d'évaluation des capacités et prochaines étapes

Heure	**Session**	**Objectifs**	**Facilitateur**
8h30-9h00	Récapitulatif de la journée précédente		DSF

9h00 - 10h30	Examen des résultats agrégés de l'évaluation des capacités	Comprendre le contexte actuel des capacités de la SBC pour la PF	Larry
10 h 30 - 11 h 00	**Pause café**		
11h00 - 12h00	Évaluation des besoins en termes de renforcement de capacité et partage des expériences en SBC	Réfléchir et recommander des domaines de partage et de renforcement des capacités	Tous
12h00 – 12h30	Enquête de satisfaction des participants	Comprendre les expériences des participants à l'atelier	Tous
12h30- 13h00	Mot de fin de l'atelier		DSF
13h00 – 14h00	**Pause déjeuner**		

Annex 2: Consensus Workshop- Represented Organizations

Group 1: Governance and Financing

1. UNFPA représentative
2. Cadre a la DSF
3. Directeur de la Sante Familiale/DSF
4. Chef de service de la mobilisation sociale/DPS
5. Point focal PF/DSF
6. Chef de service de l'éducation pour la sante/DPS
7. Chef de service de la Santé de Reproduction des Adolescents/ DSF
8. STPLMI (tech secretary of mother and child health prevention program)
9. Cadre a la DSF
10. Cadre a la DSF

Group 2: People and Information

1. Point Focal PF SR DS de la DRSPC
2. Point Focal Communication DRSPL
3. 01 Responsable de la PF du CS Montana (DS Akonolinga)
4. 01 Responsable de la PF de l'hopital de district de sante (DS de Deido)
5. Chef de DS de Nkoldongo
6. Chef de DS de Nkongsamba
7. Responsable RENATA (Littoral)
8. Canal 2 International : Responsable de l'emission Check-up (Littoral)
9. Radio Nkul-Ongola : Directeur de la radio (Centre)
10. Charge d'etudes assistant Numero 1/CELCOM

Group 3: Medicines/Technology, Service Delivery and Human Resources

1. Point Focal PF SR DS de la DRSPL
2. Point Focal Communication DRSPC
3. 01 Responsable PF du CSI de Mimboman I (DS de Nkoldongo)
4. 01 Responsable PF du CMA de NLONAKO (DS de Nkongsamba)
5. Chef de DS d'Akonolinga
6. Chef de DS de Deido
7. Responsible Cameroun Baptist Convention Health Board (CBCH/ Centre)
8. Responsable NOLFOWOP (Centre)
9. Responsable ASFAC (Association des sage-femmes et assimilés du Cameroun) / centre)
10. Responsable HOVUCA (Centre)
11. ACMS (Centre)
12. Chef de service de la Sante Maternelle/DSF