HIP | FAMILY PLANNING HIGH IMPACT PRACTICES

HIP TAG 2014
June 4-5, 2014

Population Council, New York

One Dag Hammarskjold Plaza,
9th floor
New York, NY

IPPF International Planned Parenthood Federation

UNFPA

USAID FROM THE AMERICAN PEOPLE

World Health Organization

Table of Contents

Technical Advisory Group Meeting Report

Day 1

Welcome

The meeting was opened by representatives from the four co-sponsoring organizations: Nuriye Ortayli, UNFPA; Shawn Malarcher, USAID; Vicente Diaz, IPPF; and Suzanne Reier, WHO. Each representative discussed how the HIPs align with their organization's strategic direction, the importance of focused attention on implementation and utilization of the HIPs, and priorities for the future.

Jennifer Friedman provided an overview of the agenda and John Pile took the role of Chair for the day.

Updates

Suzanne Reier provided a review of work supported by IBP and the IBP Task Team on HIP implementation. The Task Team identified 3 main areas of work: better communication through networks, facilitate in-country dialogues around HIPs, and documentation of HIP utilization, scale-up, and impact. IBP is currently integrating HIPs into the IBP mid-point assessment, supporting HIP dissemination through IBP Partners (Chemonics, PSI, JHPIEGO, MSH), developing HIP documentation guidance, and contributing to HIP material development.

Maggwa Baker discussed the work of the FP2020 Country Engagement Working Group (CEWG). Maggwa reviewed the three work streams of the CEWG. Collaboration with the HIP work fits most directly with work stream 3 which aims to facilitate uptake and implementation of high impact practices. The CEWG can play a role in fostering dissemination and access to HIP briefs and information by linking to material where appropriate. Currently, the CEWG is collaborating with the HIP Partnership to develop a "decision-making" tool to assist countries in prioritizing HIPs for their context. The CEWG is also working to identify additional mechanisms to share lessons learned which do not fit within the HIP framework. A key challenge will be to distinguish this learning from the HIPs.

Shawn Malarcher provided an update on progress since the 2013 TAG. Over the last year, the HIP Partnership continues to strengthened with the engagement of four new endorsing organizations, continued work of the HIP Task Team, and finalization of six new briefs – FP/immunization integration, working with drug shops, policy, finance, mHealth, and mobile outreach services. Most briefs are available in French and Spanish and we hope to add Portuguese translations very soon. Ms. Malarcher then reviewed the process for selecting the new topics for 2015 – galvanizing commitment and adolescents. Commitment was the one remaining HIP from the original list selected in 2010. Therefore, we have begun a process for identifying new HIPs or themes for briefs. All suggested themes were discussed at the HIPs Partner's meeting in February 2014. These were narrowed to 4 potential candidates which

were then voted on by endorsing partners. Adolescents was the clear priority. This topic presents a new challenge for the TAG as "adolescents" is not a "practice" and the HIP partners will have to identify a new process for developing this theme. It will be an iterative process and needs to be somewhat flexible to allow for adjustments along the way. This issue was discussed further on day two during the discussion of the concept paper.

Discussion

The TAG discussed the need for a document that describes the overarching principles of the HIPs, like method choice, gender, rights, quality, and equity. This document could be used by the authors to help shape the information included in briefs and the TAG in their review of evidence.

Participants emphasized the need to keep briefs up-to-date to ensure they are most useful and relevant to programs.

The TAG reiterated the need for more attention and work on the implementation/utilization of the HIP briefs and supports the efforts of the IBP and FP2020 in this area.

Standards of Evidence

Recommendations from the Croydon Meeting

Ian Askew and Karen Hardee provided an overview of recommendations from the *Second Consultation on Developing Standards for Identifying Evidence-based Practices in Reproductive Health* (full report available at http://www.popcouncil.org/uploads/pdfs/2014STEPUP_ConsultationStandards.pdf). A third meeting is planned to engage policy-makers in defining what type of evidence is most useful for informing their decision making process and peer review journal editors to discuss options for expanding the breadth of evidence and learning that gets published.

Participants appreciated the recommendations from the meeting and encouraged the sponsors to seek publication for wider dissemination. The group discussed a number of options for strengthening the HIP process such as, independent appraisal of the current HIP briefs, including a conceptual framework in each of the service delivery briefs to better define the causal pathways, strengthen the "fire wall" between those generating evidence and the TAG, and preregistration of research protocols.

Clarifying Criteria for determining "proven" versus "promising" HIPs

Jennifer Friedman, John Pile and Ian Askew reviewed the current criteria for determining "proven" and "promising" HIPs (see Annex C). They also reviewed a number of frameworks for reviewing and rating health interventions. They noted Luoto et al. found significant differences in the recommendations resulting from the use of established frameworks. The group recommended careful consideration of the domains used for the HIP reviews as this selection will affect the recommendations and evidence review of the group.

Participants considered several options. First, does the “proven”, “promising”, and “emerging” classification make sense? There was general consensus to keep this classification as it allows for a wider range of HIPs and articulates the need for more evidence on certain practices with a specific research agenda. The group also considered removing the enabling environment from the HIP list as they are based on correlation rather than a direct causal link and have a fundamentally different evidence-base than service delivery HIPs. Consistent with earlier TAG meetings, the group felt that the enabling environment was essential to well-functioning service delivery and therefore must be kept together.

The group noted that “proven” practices are likely to be things that are easier to evaluate and therefore, a strict criteria for “proven” approaches would be more biased. Given the variety and complexity of HIPs the group wants to work with, it is unlikely one framework will meet all our needs. However, participants felt we need to do a better job of communicating the current process and continue to look for opportunities to strengthen it. The group also wanted to review the domains used for reviewing HIPs and make recommendations for adjustments. It was decided that the current guidelines for authors will be shared with the group in order to review the current domains and make recommendations for adjustments.

Standards for measuring access for underserved populations

Sara Stratton, Maxine Eber, and Ian Askew gave an overview of how the HIPs currently assess reaching the “underserved” (see Annex D). The group highlighted the wide and varied approaches to presenting evidence in the current briefs and raised a number of important questions. Do we expect all HIPs to reach the “underserved”? What do we mean by “underserved”? By the current definition more than half the population would be considered “underserved”. Our main outcome measure of being “served” is contraceptive use, but this does not take into account other important aspects of access, such as method choice, quality of care, equity etc.

The TAG discussed the pros and cons of establishing a more narrow definition of being “underserved”. The group came to consensus that the current approach allows authors and investigators to define “underserved populations” in the context in which they work. In this way, the briefs are able to capture the full breath of population groups which might benefit from various practices. The group encouraged more explicit description of which HIPs are expected to reach “underserved” populations and that these populations are clearly described in briefs and derivative products. This opinion was countered with the need to provide better guidance on appropriate methods for equity analysis, so that future research will provide better information on this issue. The TAG reached consensus that not all HIPs are expected to explicitly focus on the “underserved”. With greater focus on a total market approach there is a need for a variety of service delivery approaches which serve different segments of the population.

Measuring Sustainability

Karen Hardee, Minki Chatterji, and Suzanne Reier reviewed various approaches to assessing sustainability (See Annex E). Key questions for the group included: Is there a time frame for assessing sustainability? Does "sustainable" mean supported by the public sector? Are all practices intended to be sustained in perpetuity?

The group discussed options for developing a screening process for assessing HIPs and providing guidance to authors on how to address sustainability in the briefs. The group felt that it was more appropriate to shift the focus on "how to make HIPs sustainable" and/or when should programs consider sustainability. Currently the "proven" HIPs include a box on considerations for "scale-up". The group felt that this could be strengthened with more focus on sustainability.

Enabling Environment

Linda Cahaelen, Jay Gribble, and Erin Mielke provided an overview of what type of information/evidence was provided in the current HIP briefs (see Annex F). The group found substantial variation across the HIP briefs.

The TAG decided variations in the enabling environment briefs was appropriate given the range of topics covered. Some briefs, such as the Health Communication, may benefit from derivative products that give more detail on the various approaches. The TAG also discussed the benefits of having a one-page summary for each brief specifically developed for policy-makers.

Brief Review: Leadership and Management

Nandita Thatte, Temitayo Ifafore, and Reshma Trasi gave an overview of the brief and highlighted some of the decisions the authors made in presenting the evidence. The brief intentionally focused on leadership and management at the service delivery level as the authors felt aspects of leadership and management at the national and sub-district level were addressed in other briefs.

Vicente Diaz and Victoria Jennings served as discussants for this briefs. Both discussants thought the authors did a good job of presenting a complex subject and that leadership and management was an essential component of an effective health system. Cost effectiveness was not addressed in the briefs and is a critical issue for decision-makers and they recognize that this omission is likely due to a lack of evidence in this area. Approaches to measuring aspects of leadership and management were also unclear in the brief. Are some aspects more critical than others? The "practice" was not clearly described. What does program implementation look like? The specific inputs are likely to be very context specific. Leadership and management are different approaches and may require different interventions. The relationship of some aspects in the brief was not articulated, for example, "quality improvement" and work-force investments. How do these fit with leadership and management? The discussants felt it was not essential that the authors demonstrate causality between investments in leadership and management and contraceptive uptake or other outcome measure. It would be more helpful to

outline specifics on how programs can strengthen leadership and management. The “Tips” on page 8 are in this direction.

The group would like to review the brief once recommended edits are completed.

Recommended revisions:

- The TAG believes that the current focus on capacity building is insufficient to establish the support and structures needed to build leadership and management in a program. Restructure the brief to focus on how to strengthen systems that support leadership and management rather than capacity building. This will also require changing the title and phrasing of the HIP.
- While the TAG appreciated the authors attempt to simplify the brief by focusing at the service delivery level, the group found that the current approach omits important considerations for leadership and management at other levels of the health system. Incorporate application of leadership and management at all levels of the health system (Consider the policy brief as a potential model).
- Consider including some discussion of decentralization and how this effects leadership and management approaches.
- Include links to other enabling environment HIP, particularly policy and commitment.
- Several TAG members found the discussion of quality improvement disconnected and confusing. The TAG considers QI one of several tools to improve leadership and management. Consider recasting QI within the brief.
- Much can be learned from the wider evidence-base on leadership and management. The overt focus on examples from the field of FP restricts the variety of examples included. Provide a wider range of examples from other leadership and management approaches.
- In the table include evidence of impact on proximate factors. Particularly those included in the framework.
- Restructure the “Tips” section to highlight how specific approaches address challenges for leadership and management, for example in supervision and logistics.
- Focus on the entire health system not only human resource and link to other briefs as appropriate.
- The examples from Ethiopia and Rwanda are generic and do not provide strong rationale for the role of leadership and management in influencing the changes in contraceptive use. Reconsider the statements about Ethiopia and Rwanda and consider other examples were the contribution of improvements in leadership and management were more evident.

Day 2

Victoria Jennings took over as meeting Chair for day two.

Brief Review: Voucher

Ben Bellows provided an overview of the brief.

Eugene Kongnyuy and Venkatraman Chandra-Mouli served as discussants. The reviewers noted substantial differences in reported impact measures. The discussants found stronger evidence of benefits to the population, including improved uptake of contraceptive, ability to target subsidies, and reduce out of pocket payments. Other assertions had little or no evidence for support, including improves quality and as a precursor to health insurance. There was no discussion of risks. Scalability was unclear and most programs appeared to be donor supported. The "Tips" were more appropriate for implementers than decision-makers and it was unclear how method-specific voucher programs ensure voluntary choice. Cost-effectiveness of voucher program is a key issue for decision-makers and any evidence in this area should be highlighted. If evidence is not available, this should be a critical research gap.

The group agreed to proceed with the voucher brief as an "emerging practice" emphasizing that more evidence is needed to demonstrate the cost-effectiveness and value-added of FP voucher programs.

Recommended revisions:

- The specific role of vouchers in reducing barriers and facilitating access to LARCs and PMs is muddled with theoretical contributions of voucher programs. The brief would benefit from a conceptual framework.
- The TAG found the description of the CHW's role confusing and overly complex. Simplify and clarify the role of the CHW worker in a voucher programs.
- Describe mechanisms that are used by voucher programs to monitor method choice and voluntarism. Such as including outcome measures other than reporting the number of a specific method provided in voucher program reporting.
- The background section provides too much detail on the mechanisms of a voucher program. Simplify this description and add more on the context of voucher programs.
- Include the diagram from the overview presentation in the brief.
- Include any insight and if possible any example regarding how to evolve voucher programs from NGO pilot programs to large public sector implementation.
- Discuss the options and or mechanism need to be considered for sustainability
- Include any details on differences in working with public versus private sector programs.
- The section on e-voucher seems inappropriate. If the aim of the voucher program is to reach the poorest of the poor, they are unlikely to have cell phones for e-vouchers. Either drop or provide better rationale for this section.

- Provide more detail on the programs described in Table 2. Who is providing integrated services and how? Delete Pakistan from this table. The program is not integrated. Consider including the Pakistan data in another place, potentially the background section.
- Delete Table 3.
- Provide some explanation of how voucher programs work in rural area where there are few providers.
- The explanation that voucher programs ensure choice through referral systems is unrealistic given the current state of referral systems. Rephase.
- Research question #4 is the most critical. Move this to question #1.

Girls in School

Shefa Skidar and Shannon Taylor provided an overview of the brief. Some of the key decision points for the authors included, a clear focus on investments that keep girls in school and the effects of engagement in formal schooling on sexual and reproductive health rather than attempting to describe the more complex bidirectional relationship of sexual and reproductive health and education. This decision was taken with the intention to raise awareness and knowledge within the family planning community about the importance of investing in this social determinant. The aim of the brief was to highlight that the health community could do more than advocate. The health community could be a partner in investments that contribute to keeping girls in school.

Hashina Begum and Maggwa Baker served as discussants. The reviewers noted that the evidence cited in the brief establishes correlation not a causal relationship. Examples in the brief are mostly drawn from the African region, however there are also good examples from Asia.

After incorporating suggested revisions, the group approved of the brief as an enabling environment HIP.

Recommended revisions:

- Change the wording of the HIP – "Keeping girls in school contributes to health and development" and align the appropriate text.
- Specific suggestions were made to demonstrate the bidirectionality of the sexual and reproductive health and education without losing the overall focus of the brief on addressing a key social determinant of SRH. (specific suggestions provided).
- Include more examples from Asia.
- Replace Figure 1 with a graphic illustrating the relationship of educational status and mCPR rather than TFR.
- Table 1 is confusing and summarizes information provided in Table 2. Remove Table 1.
- Delete universal primary education from Table 2. This is not within the manageable interests of health programming.
- Emphasize the intersectoral nature of this work where possible.
- Simplify the section on what doesn't work.

- The second research question is not relevant. Remove it.

Review Concept Notes for 2015 briefs

Galvanizing commitment

The brief intends to describe systematic approaches that lead to developing commitment. What are the levers leading to commitment?

Several TAG members identifying resources that may contribute to the content of the brief including; resources from the Bill and Melinda Gates Foundation, experiences from EngenderHealth working in Jharkand on youth, IPPF has experience with advocacy planning, political analysis and accountability , Reproductive Health Supply Coalition, and FP2020 has a working group that we should link with. The TAG also recommended including mechanisms for accountability in the brief and commitment at multiple levels including grassroots commitment. The brief will need to link without too much duplication with the Policy, Financing, and Leadership and Management briefs. The brief should articulate expected results as well as process. Workplans are another mechanism for measuring commitment. DFID has some work in this area.

Adolescents

The group discussed the concept note prepared for the TAG. The process described is iterative and the "HIPs" have not been identified. The specific topics of the briefs will be selected at the HIP Partners meeting scheduled for October 15. The selection will be based on the reviews which are currently underway and the client profiles.

Gwyn Hainsworth and Elaine Menotti served as discussants for these concept notes. The reviewers noted that some of the evidence in the background paper could be updated with more recent findings. There is also a need to revisit the outcomes of interest. Are you interested in "delayed sexual initiation" or "delayed pregnancy"?

The TAG discussed multiple approaches to assisting countries develop strong programs that meet the needs of adolescents. Suggestions included: developing a separate HIP folder on youth, develop derivative products that address "special considerations for youth" or guidance rather than briefs, or a simple cheat sheet and typology.

The group recommended defining the client profiles at a higher level. Consider the following – married adolescents, urban poor adolescents, and the very young (10 to 14 years old). The group also recommended involving young people as part of the writing teams. IPPF is willing to help with this.

Suggestions for TAG 2015

The size of the TAG was optimal for discussion and discourse; and the continuity of participants helped to facilitate decision-making. The group also found the seating arrangement useful for discourse as participants were able to see and hear each other. The Dropbox and distribution of

material well in advance of the meeting helped to ensure participants were prepared for discussion. The TAG found the review of concept notes particularly useful for being able to influence the briefs before they are developed. The group appreciated the work of the Chairs in keeping the conversation moving and the meeting on time. Teleconferencing was challenging for participants. The group preferred video conferencing if possible. The TAG would also like to revisit the decision-making tool at the next meeting. Dates for the next meeting are set for May 20 and 21st, 2015.

Recommendations:

- The TAG recognizes the importance of certain overarching principles such as gender, equity, rights, quality, and choice; and recommends developing a document to outline these principles. The document will be made available on the website.
- The following process is proposed for updating published briefs. Two briefs will be selected each year for in depth review. The "in depth" review will consist of: 1.) authors or other technical experts will review the brief for updates in terminology and new knowledge; 2.) comments/suggested changes will be solicited from external sources through the internet (K4H and IBP), and 3.) implementation of a continual survey of published literature on HIPs (EVIDENCE). Comments will be reviewed by the TAG planning committee to determine a process for incorporating changes and if a review by the TAG and/or endorsing organizations is necessary.
- The TAG acknowledged the importance of dissemination and utilization of the HIP briefs and requests a report out at the 2015 TAG from the follow-on to the Croydon meeting and the IBP task team on what information is requested by decision-makers and how the briefs are or could be used to help strengthen program implementation.
- The TAG appreciates the Croydon report and encourages the meeting sponsors to seek publication in a peer review journal for wider dissemination.
- To improve transparency and awareness of the HIP development and review process, the TAG will review 1.) the current guidance provided to authors and 2.) documentation of the HIP process. The group will advise on any changes to the process and additions/changes to the research domains outlined in the guidance in order to strengthen the overall process. These documents will be made available on the website.
- The TAG recommends that all new service delivery briefs include a "causal pathway" (exact terminology to be determined).
- The TAG values the current classification system of proven, promising, and emerging and encourages further deliberations on clarifying criteria for these categories.
- The TAG recommends all new briefs include descriptions of any specific population groups that are ***intended*** to be reached by specific service delivery HIPs and data on who is ***actually*** being served (descriptive).
- The TAG recommends the development of guidance on methodological suggestions for analytical approaches to assess the ability of specific service delivery HIPs to reach disadvantaged populations. This document will be used to inform future research and TAG deliberations.

- The TAG recommends a review of the “scale-up” box in the proven practice briefs to provide guidance on ways to strengthen text and incorporate considerations for sustainability.
- The TAG appreciated the thought piece on sustainability and requests the authors review and revise the guidance according to the TAG discussion so that the document can be made available on the web.
- The TAG found the guidance on the enabling environment briefs useful and recommends this document be made available to authors of new briefs, as appropriate.
- The TAG recommends development of derivative products to facilitate utilization and dissemination of the HIP briefs, such as one-page advocacy briefs.
- The TAG encourages more economic analysis including research on costing, cost/benefit, and cost effectiveness and efficiency.

Recommendations from brief review:

- Revise the Leadership and Management brief according to suggested revisions and submit for interim review.
- The TAG classified the evidence in the Voucher brief as an “emerging service delivery” HIP. They approved the brief after incorporating suggested revisions.
- The TAG found the Keeping Girls in School brief helpful and believe it will be a valuable contribution to the field. The group approved the brief after incorporating suggested revisions.

Annex A: Agenda

HIP | FAMILY PLANNING HIGH IMPACT PRACTICES

AGENDA

Technical Advisory Group Meeting

June 4 and 5, 2014
09:00 – 17:00

Population Council, New York
One Dag Hammarskjold Plaza,
9th floor
New York, NY

Objectives

- Review draft HIP briefs and make recommendations regarding the strength and consistency of the evidence and adherence to the HIP criteria.
- Identify key gaps in the evidence base.
- Develop recommendations for classifying service delivery HIPs as "proven" versus "promising" practices, determining if HIPs reach underserved population groups, and sustainability.
- Define the role/scope of the HIP brief for enabling environment HIPs.
- Review scope of review for identifying/describing HIPs for 2015.

Wednesday, June 4th : John Pile, Chair

08:30 – 09:00	**Arrival** *Continental Breakfast*

09:00 – 09:30	**Opening of Meeting**
	• Welcome Remarks by
	  • Nuriye Ortayli, UNFPA
	  • Shawn Malarcher, USAID
	  • Vicente Diaz, IPPF
	  • Suzanne Reier, WHO
	• Agenda Overview

09:30 – 10:00	**Updates** • IBP Task Team - Suzanne Reier, WHO • FP 2020 Country Engagement Working Group – Maggwa Baker, Bill and Melinda Gates Foundation • HIP Partner's Meeting – Shawn Malarcher, USAID

10:00 – 10:30	**Break**
10:30 – 12:30	**Standards of Evidence** • **Update from Croydon meeting** Panel – Ian Askew, Karen Hardee, Johannes VanDam • **Developing standards for "Proven" versus "Promising" HIPs** *Debrief on interim review of mobile outreach services brief* - Ian Askew, Jennifer Friedman, John Pile • **Developing standards for measuring access for underserved populations** Maxine Eber, Sara Stratton, Ian Askew • **Developing standards for measuring sustainability** Karen Hardee, Minki Chatterji, Suzanne Reier
12:30 – 13:30	**Lunch** provided
13:30 – 14:30	**Standards of Evidence Continued**
14:30 – 15:30	**What is the role of the HIP brief for enabling environment HIPs?** • Linda Cahaelen, Jay Gribble, and Erin Mielke
15:30 – 16:00	**Break**
16:00 – 17:00	**Review Leadership and Management Brief** • Nandita Thatte – author via video conference • Vincente Diaz and Victoria Jennings, discussants
17:00	**Closing**

Thursday, June 5th: Victoria Jennings, Chair

08:30 – 09:00	**Arrival** *Continental Breakfast*
09:00 – 09:30	**Review Recommendations from Day 1**

	• Comments and Reflections
09:30 – 10:30	**Review Voucher Brief** • Ben Bellows, authors via video conference Eugene Kongnyuy and Venkatraman Chandra-Mouli, discussants
10:30 – 11:00	**Break**
11:00 – 12:00	**Review Girls in School Brief** • Shefa Sikder and Shannon Taylor, authors via video conference • Kathleen Hill and Hashina Begum, discussants
12:00 – 12:30	**Refining HIPs for 2015** *Galvanize **commitment** to family planning through advocacy and policy* • Gifty Addico, discussant
12:30 – 13:30	**Lunch** provided
13:30 – 14:30	**Refining HIPs for 2015 – adolescents** • Contraceptive services – Elaine Menotti, discussant • Information and knowledge – Gwyn Hainsworth, discussant • Structural Interventions – Johannes Van Dam, discussant
	Break (as needed)
14:30 – 15:30	**Review Recommendations from Day 2 and 2015**
15:30 – 16:00	**Next Steps and Closing**

Annex B. List of Participants

List of Participants

Technical Advisory Group Meeting

June 4 and 5, 2014

09:00 – 17:00

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Annex C: Classifying Proven versus Promising Service Delivery Practices (use PDF)

High Impact Practices (HIPs) are grouped into two interrelated categories: (1) creating an enabling environment; and (2) high-impact practices in service delivery. Moreover, for service delivery practices, a HIP is categorized and recommended as a 'proven', 'promising' or 'emerging' practice according to the current definitions for these categories on the HIP website (see box).

Assigning a HIP to these categories is determined through a process in which the authors of the HIP brief consider the strength and consistency of the body of evidence that they reviewed, and then make a recommendation to the TAG, whose members then confirm or revise the recommendation. This session seeks to determine whether the current approach for determining how HIP recommendations are reached and communicated should and could be undertaken more rigorously.

The objectives of this session are to:

- Review the rationale and process for classifying HIP recommendations according to
- different categories of certainty;
- Consider other approaches, or "evidence frameworks", that are used when summarizing
- and categorizing bodies of evidence for practice recommendations;
- Determine whether the existing process and categories are appropriate for HIP recommendations; and if not, what modifications might be considered.

Recommendations for introducing and widely using a health care practice based on evidence reviews have often focused largely on their impact, effectiveness and safety – historically, evidence-based practice recommendations in health care were used for medical interventions, for which these are the primary criteria for implementation. However, other factors are

Current Definitions

Proven practices in service delivery are those where sufficient evidence exists to recommend widespread implementation, provided that there is careful monitoring of coverage, quality, and cost, and that operations research helps understand how to improve implementation.

Promising practices in service delivery are those where good evidence exists that these interventions can lead to impact; more information is needed to fully document implementation experience and impact. These interventions should be promoted widely, provided that they are implemented within the context of research and are being carefully evaluated both in terms of impact and process.

Emerging practices in service delivery are those in which some initial experiences with developing interventions exist, but there is a need for more intense intervention development and research.

important to consider when recommending an FP service delivery practice , including understanding how and why an intervention works, determining whether an intervention is acceptable, appropriate and affordable for different populations, forecasting the resources needed to sustain and scale-up effective interventions, among others. Additionally, the quality of the evidence – usually defined in terms of the type of research design used – has been the predominant domain used when deciding which evidence to include in reviews, especially for evidence of effectiveness. However, many other domains are considered by decision-makers when bodies of evidence are being reviewed, beyond the quality of evidence included. A number of 'evidence frameworks' have been developed for systematically reviewing evidence using multiple domains beyond the quality of the evidence in order to inform decisions about the evidence for recommending a service delivery practice; these include[1]: Strength of evidence;

Magnitude of benefits vs. harm; Consideration of context (i.e. generalizability); Implementation procedures; Feasibility; Costs; Sustainability; Other health and social benefits; among others. Whether the HIP TAG should adapt or adopt such a framework for the practice recommendations in HIP briefs is the focus of this session; considerations include the benefits and costs of being as systematic and rigorous as possible, as well as the challenges and advantages of establishing transparent procedures for reaching decisions regarding the classification of practice recommendations. As recommended by participants at a recent Consultation on Developing Standards for Identifying Evidence Based Practices in Reproductive Health:

> *"A systematic, transparent and replicable process, guided by an explicit evidence framework, should be followed when developing practice recommendations from a body of evidence. The evidence framework should incorporate those domains that are of specific interest to particular decision-makers; different evidence frameworks may be appropriate for summarizing evidence to inform different types of decisions."*

Examples of such frameworks include (see attachment):

- US Community Preventive Services Task Force
- DFID's "How to" assess the strength of evidence
- Steady, Ready, Go! (LSHTM and WHO)
- DECIDE (WHO)
- Donabedian's RE-AIM framework

Each framework then "grades" or categorizes the body of evidence into a summary rating which is analogous to the HIP ratings of proven, promising, or emerging. However, as documented by Luoto et al2, the choice of framework can influence the category rating for specific interventions; it is essential, therefore, to consider the types of domains that are included in a framework, the categories or grades used to rate the evidence, and to identify those domains and categories/grades that would be most desirable for determining HIP recommendations.

If the TAG decides to move ahead with the evidence framework approach, one option would be to first identify those domains that the TAG feels are most relevant for the HIP recommendations, and to then develop a set of guiding questions based on these domains that authors can use to determine whether a practice is proven, promising or emerging. Such questions could include:

1. Is there sufficient evidence (consider how long has the practice has been being implemented, the diversity of context in which it's been implemented and which may moderate its effectiveness, number of studies, direction of effect) to reasonably expect full implementation of this practice would lead to substantial (consider the magnitude of effect) improvements in a health behavior (e.g. effective contraceptive use) and/or health outcome (e.g. fertility)?
2. Does implementation of the practice hold the potential for harm? If so, what is the magnitude of that harm?
3. Does the practice reduce inequities in access to FP services, and if so, among which populations?
4. Is there evidence that the practice can be implemented "at scale" (i.e. expanded beyond effective implementation at small-scale in a pilot setting to impact large numbers), and is sustainable as a routine practice? SEE READY, STEADY, GO

Questions for Discussion:

- Should we adopt a more rigorous process and framework for summarizing evidence and
- determining practice classification for the HIP briefs?
- Can a framework be applied without diverting the goals of the HIP initiatives to ensure that program managers on the ground have timely access to information on effective family planning interventions?

Annex D: Reaching the Underserved

Reaching the Underserved: Guidance for Evaluating Evidence for Inclusion in HIP Briefs
Sara Stratton, Ian Askew, Maxine Eber

Introduction of the issue

As contraceptive use and interest in improving access increases, as a community we want to ensure that FP programs are reaching as many individuals as possible. Knowing the challenges of many populations to access services, projects/organizations and donors frequently prioritize reaching "the underserved", using limited resources to focus on those who otherwise would not have access to services, products, or information.

A review of current (as of May 2014) and upcoming HIP briefs found that eight describe approaches that have as one of their outcomes increasing access among "underserved populations". These include existing HIPs on Community Health Workers, Drug Shops and Pharmacies, Financing Commodities and Services, mHealth, Supply Chain Management, Social Marketing, Mobile Services, and the HIP on Vouchers, which is currently under review (see Annex I).

As the HIP TAG, we need standards for determining whether interventions are really reaching the underserved. However, there is no standard definition of "underserved", or agreement on what evidence is needed to demonstrate that a program is reaching the underserved.

There are a number of reasons why an individual may be underserved, and a successful HIP should address the health system barriers that need to be overcome. For example, health workers may be unavailable to provide the service thereby limiting access overall, or a client may determine that the opportunity and/or financial costs of traveling to and waiting to be obtain a service is too high. In addition, there may be other supply-side factors that compromise access including stock outs, malfunctioning equipment, no water/electricity, etc.

While it is important to consider these health system barriers, for the purpose of this discussion we will focus more narrowly to seek agreement on:

A working definition of "underserved";

The evidence needed to demonstrate that services are reaching and being used by an underserved population.

Defining "Underserved"

Before discussing how to measure whether an approach is successful at reaching an underserved population, we must first define what constitutes "underserved." In the case of family planning, one could argue that we must look beyond use of family planning, or percentage of need met by an FP program, within the whole population, to define whether or not a particular individual or sub-population has been served, that is whether they have been able to access and use an FP service.

In terms of defining underserved, one approach would be to consider a particular population group as being underserved if it has a lower prevalence of FP use, a higher unmet need, or lower proportion of demand satisfied, than the national or regional average. However, this rather simplistic definition would result in 50% of the population always being defined as underserved.

More commonly, and in alignment with a rights-based approach that seeks to ensure equity in investments and programming for FP, an underserved population can be defined by a national government, donor or service delivery organization as underserved if certain socio-demographic or other characteristics determine whether or not the individuals within that population cannot be served by an FP program. With the understanding that these characteristics vary greatly depending on context, initial brainstorming among the TAG subgroup yielded the following characteristics for discussion:

- Wealth quintile
- Poverty grading
- Location and physical access to services and transport (e.g. rural, or slums)
- Knowledge (of service and source)
- Age (e.g. youth)
- Gender
- Ethnicity
- Education
- Marriage status
- Parity
- Socially marginalized (e.g. sex workers, PLWHA, day laborers, young girls in servitude, women in seclusion).

These characteristics may be defined individually. Or they can be aggregated to define specific populations that are underserved because of a combination of characteristics rather than a single characteristic. For example, while a married woman may not be underserved, a young married woman is likely to be underserved; most urban woman are not underserved, but urban slum dwellers usually are, etc.

How do we assess whether we are reaching the underserved?

Once the underserved group is defined, what evidence do we need to assess whether an intervention is reaching this group, thereby reducing their being "underserved"? And how does this evidence allow us to categorize an intervention as *Emerging, Promising,* or *Proven?*

The commonest approach to determining whether a program is reaching the underserved is to measure the prevalence of FP use among the population defined as underserved, and to then benchmark this value against the "not-underserved" population. For example, the commonest definition uses the characteristic of wealth (as measured by DHS), and usually the "underserved" are those in the bottom 1 or 2 quintiles because it is assumed that their lack of wealth can inhibit access to services. Benchmarking may be a comparison of the FP prevalence

rate (or unmet need, or satisfied demand, etc.) against the national average FP prevalence, or against the FP prevalence of those in the top 1 or 2 wealth quintiles.

A second common definition is those defined as "poor" or "poorest" according to a poverty index, which is usually an aggregation of indicators that, taken together, measure a socially and economically agreed upon indication of poverty. Again, benchmarking would compare FP prevalence among those categorized at different levels of poverty on this index.

Poverty grading tools are sometimes used to screen for eligibility to benefit from or be "served by" a program – such tools have been commonly used in voucher and similar programs. With this approach, in principle, 100% of the population served by the program should be "underserved" because only the underserved can receive the services; assessments of the proportion of beneficiaries who are classified as poor can indicate the efficiency of the screening tool and program in reaching its desired beneficiaries.

The concentration index is favored by economists but hard to understand. As stated by Chakraborty et al: the concentration index uses one summary value to capture the magnitude of socioeconomic inequality in a health outcome. The concentration index ranges from -1 to +1, based on a Lorenz concentration curve that orders the population by SES on the x-axis and plots the cumulative percentage of a health outcome on the y-axis. With zero signifying perfect equality, a negative value represents the health outcome's concentration among the poor; a positive value denotes concentration among the wealthy. As the concentration index moves further away from zero, either positively or negatively, there is greater inequity in the health outcome. The concentration index offers advantages as a metric of health equity because it is statistically comparable across time periods and geographic regions.

Thus a concentration index can measure whether FP use is greater among the poor or non-poor and the degree of inequity between them.

Similar assessment principles, of benchmarking/comparing a measure (e.g. FP prevalence) between two or more populations defined as "underserved" and "not-underserved" could be applied to populations defined according to the other characteristics mentioned above, e.g. comparing urban with rural, young with old, etc.

Once the measurement and comparison principles have been determined, the next challenge is interpretation of the findings. Such measures and comparisons enable programs to confirm (or deny) that their programs are reaching the underserved if the FP prevalence (or other measure) improves within the underserved group after introduction of the program, either over time or (preferably) when compared with the not-underserved group over time (which indicates reduced inequity).

Some examples for discussion:

- In Country *X,* 35% of women in the highest 2 wealth quintiles are using contraception, compared with just 5% in the lowest 2. 50% of clients obtaining FP through a given intervention are from the lower 2 quintiles.
- In Country *Y*, during voucher follow up surveys using the multi-dimensional poverty index (MPI) it was found in 2012 that 85% of voucher clients in 2012 were considered multi-

dimensionally poor. This compares to the 2012 exit interview finding (also using MPI) that 26% of social franchisee FP clients overall (including voucher clients) were multi-dimensionally poor, suggesting that vouchers are successfully targeting a poorer population group than the general social franchise clientele.

- In Country Z, unmet need for family planning among youth is 35%. In region Q, following a 3-year targeted youth intervention, unmet need among this group was 20%.

- Questions for discussion:

- Are there other determinants of access (i.e. of being served) that we have not included and should?
- For such determinants, are there existing interventions that purport to improve access for these population groups?
- Should the TAG agree on a set definition of what the "underserved" is for the HIPs?
- What measure(s) and comparisons are acceptable to the TAG to evaluate whether an intervention/project/organization is reaching the underserved?
- Should HIP briefs include a section on the evidence used to measure access for underserved and/or should this issue be addressed on the website?

Annex E-HIP Briefs related to Increasing Access among Underserved Groups

Community Health Workers: Bringing family planning services to where people live and work

- Community Health Workers can provide family planning services to rural underserved populations.
    - Example: In Guatemala, a study of injectible use in Community based programs found that women who used Community Health Workers were more likely to be indigenous (83%).
    - Example: In Uganda and Ethiopia, clients of CHWs were more likely to be single (16% and 12%, respectively) than clients at clinics (9% and 8%, respectively). (Malarcher et al., 2011; Prata et al., 2011).
        - Malarcher S, Meirik O, Lebetkin E, Shah I, Spieler J, Stanback J. 2011. Provision of DMPA by community health workers: what the evidence shows. Contraception 2011 Jun;83(6):495-503.
        - Prata N, Gessesew A, Cartwright A, Fraser A. Provision of injectable contraceptives in Ethiopia through community-based reproductive health agents. Bull World Health Organ 2011;89:556–564. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150764/pdf/BLT.11.086710.pdf

Financing Commodities and Services: Essential for meeting family planning needs

- Social safety net programs, like insurance, can reach underserved groups with family planning services at low-or no- cost.
    - Example: The Integrated Health Insurance program in Peru offers primary health care for millions of the country's most vulnerable populations.
        - Menotti E, Sharma S, Subiria G. Increasing access to family planning among the poor in Peru: building on and strengthening financing mechanisms for the poor. Washington, DC: USAID | Health Policy Initiative, Task Order 1; 2008. Available from: http://www.healthpolicyinitiative.com/Publications/Documents/505_1_Final_Paper_IA4_acc.pdf
    - Social insurance programs in Argentina (Plan Nacer) and Brazil also provide family planning counseling and services, improving access to sexual and reproductive health services among the poor (Eichler et al., 2010).
        - Eichler R, Seligman B, Beith A, Wright J. Performance-based incentives: ensuring voluntarism in family planning initiatives. Bethesda, MD: Abt Associates, Health Systems 20/20 project; 2010. Available from: http://www.healthsystems2020.org/content/resource/detail/2686/

mHealth: Mobile technology to strengthen family planning programs

- mHealth programs can reach underserved populations and strengthen family planning programming
- Mobile technologies offer innovative opportunities to reach populations underserved by family planning programs, particularly men and younger people
    - L'Engle KL, Vahdat HL, Ndakidemi E, Lasway C, Zan T. Evaluating feasibility, reach and potential impact of a text message family planning information service in Tanzania. Contraception 2013 Feb ;87(2) :251-256.

Mobile Outreach Services: Expanding access to a full range of modern contraceptives

- Mobile outreach services reach new and underserved populations by bringing health services closer to the client. Mobile outreach services often reach clients who are new to family planning.
    - Example: 41% of mobile outreach clients in sub-Saharan Africa, 36% in South Asia and the Middle East, 47% in Pacific Asia, and 23% in Latin America were new to FP.
        - Hayes G, Fry K, Weinberger M. Global impact report 2012: reaching the under-served. London: Marie Stopes International; 2013. Available from: http://www.mariestopes.org/sites/default/files/Global-Impact-Report-2012-Reaching-the-Under-served.pdf
    - Example: A study in Zimbabwe showed that mobile outreach services can have a large effect on use of contraceptives. It was found that exposure to mobile outreach services had the same effect on current and ever contraceptive use as having a general hospital in the area.
        - Thomas D, Maluccio J. Fertility, contraceptive choice, and public policy in Zimbabwe. The World Bank Economic Review 1996;10(1):189-222. Available from: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/05/14/000333037_20130514125827/Rendered/PDF/771130JRN0WBER0Box0377291B00PUBLIC0.pdf
- Along with other service delivery channels, mobile outreach offers an effective way to reach the poor.
    - Example: In 2012, in sub-Saharan Africa, 42% of mobile outreach clients of one (NGO) lived on less than US$1.25 per day, compared with 17% and 13% of clients of static clinics and social franchises, respectively
        - Hayes G, Fry K, Weinberger M. Global impact report 2012: reaching the under-served. London: Marie Stopes International; 2013. Available from: http://www.mariestopes.org/sites/default/files/Global-Impact-Report-2012-Reaching-the-Under-served.pdf

- Example: A study in Zimbabwe found that mobile family planning units had their greatest impact among the poor as they seem to serve women with little education
    - Thomas D, Maluccio J. Fertility, contraceptive choice, and public policy in Zimbabwe. The World Bank Economic Review 1996;10(1):189-222. Available from: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/05/14/000333037_20130514125827/Rendered/PDF/771130JRN0WBER0Box0377291B00PUBLIC0.pdf

- "Mobile outreach services serve communities with limited access to clinical providers and supplies. Geographic distribution of human resources for health, along with availability of medical commodities and supplies, determines which health services will be available as well as the quantity and quality of such services. Populations residing in rural areas, urban slums, and marginalized communities experience either geographic or economic barriers to qualified health workers, which contribute to large inequities in health outcomes and use of health services. The World Health Report 2006 identified 57 countries facing critical shortages in health personnel (WHO, 2006). In addition to deploying trained clinical providers, mobile outreach service delivery models ensure a reliable supply of contraceptive commodities, medical supplies, and equipment needed to deliver a full range of family planning options."
    - World Health Organization (WHO). The World Health Report 2006: working together for health. Geneva: WHO; 2006. Available from: http://www.who.int/whr/2006/en/
- In Tunisia, mobile units were found to play a large role in increasing geographic coverage of family planning services, especially in rural areas.
    - Coeytaux F, Donaldson D, Aloui T, Kilani T, Fourati H. An evaluation of the cost-effectiveness of mobile family planning services in Tunisia. Studies in Family Planning 1989;20(3):158-169.

Drug Shops and Pharmacies: Sources for family planning commodities and information

- As Drug shops are often more common than pharmacies, they can remove barriers to family planning access in underserved areas specifically by reducing the clients travel time to/from the shop.
- Clients often prefer Drug Shops as they are closer, have flexible working hours and are more responsive to the clients need as compared to providers in the public sphere.
    - Okonkwo AD, Okonkwo UP. Patent medicine vendors, community pharmacists and STI management in Abuja, Nigeria. African Health Sciences 2010;10(3).
    - Van der Geest S. Self-care and the informal sale of drugs in south Cameroon. Soc Sci Med 1987;25:293-305.
- Drug shops and pharmacies are preferred by some marginalized or underserved populations, including males and youth.

- Males: Men and boys find Drug Shops convenient who may be less willing to travel for services
    - Okonkwo AD, Okonkwo UP. Patent medicine vendors, community pharmacists and STI management in Abuja, Nigeria. African Health Sciences 2010;10(3).
- Youth: "Studies from Zambia, El Salvador, the United States, and the United Kingdom have shown that youth are more comfortable obtaining contraceptives from pharmacies than from clinics, which they consider more intimidating and judgmental"
    - Ahmed Y, Ketata M, Skibiak J. Emergency Contraception in Zambia: Setting a New Agenda for Research and Action. Nairobi: Population Council; 1998.
    - Bullock J. Raising awareness of emergency contraception. Community Nurse 1997;3(7):28-9.
    - Sucato GS, Gardner JS, Koepsell TD. Adolescents' use of emergency contraception provided by Washington State pharmacists. Journal of Pediatric and Adolescent Gynecology 2001;14(4):163-169

Supply Chain Management: Investing in contraceptive security and strengthening health systems

- Strengthen supply chains to the last mile. Community-based distribution (CBD) offers the potential to significantly increase access to and use of family planning services, particularly by underserved groups. Although these programs often have established mechanisms to train and supervise CBD workers, they usually devote limited resources to SCM. CBD programs have inherent characteristics that require unique supply chain considerations, including the distributor's educational level, volunteer or part-time status, and access to resupply.

Social Marketing: Leveraging the private sector to improve contraceptive access, choice, and use

- "Social marketing helps reduce geographic and socio-economic disparities in family planning use."
    - Example: "Analyses of DHS data have shown that even among the poorest people in the poorest countries, significant numbers of women obtain their contraceptive method from a private-sector source. Much of this access through private-sector outlets has been made possible by social marketing programs."
        - Private Sector Partnerships-One Project (PSP-One). State of the private health sector wall chart. Washington, DC: USAID/PSP-One; 2005.
- Social marketing helps reach underserved young people. Adolescents generally prefer to obtain contraceptive methods from private-sector sources, which tend to provide more anonymity than public-sector sources

    - Meekers D, Ahmed G, Molatlhegi MT. Understanding constraints to adolescent condom procurement: the case of urban Botswana. AIDS Care 2001;13(3):297-302.

- Through subsidization, social marketing reduces the true market cost of these services to improve accessibility for the young and poor.
    - Example: "In Bangladesh, the majority of young married women use socially marketed contraceptives sold by a local NGO and obtained through pharmacy outlets."
        - Karim A, Sarley D, Hudgins AA. Bangladesh: Family planning market segmentation—update of the 2003 analysis. Arlington, VA: USAID | DELIVER PROJECT; 2007.
- Social marketing programs help to sustain family planning gains.
    - Example: In Morocco, using the manufacturer's model, a USAID project entered into a partnership with the pharmaceutical companies Wyeth and Schering to lower the price of two low-dose oral contraceptive brands in return for a time-limited communications campaign. USAID worked with these manufacturers to establish a "Return-to-Project Fund" so that promotional activities could be sustained after the graduation of USAID support. Results from the DHS show that after the social marketing program started, there was a substantial increase in the proportion of women in the three poorest wealth quintiles using oral contraceptives (Agha et al., 2005), so much so that the gap between rich and poor in oral contraceptive use was reduced to a few percentage points post-graduation in 2003.
        - Agha S, Do M, Armand F. When donor support ends: the fate of social marketing products and the markets they help create. Soc Mar Q 2005;12(2):28-42.

Vouchers: Addressing inequities in access to contraceptive services: What is the "promising" high-impact practice in family planning service delivery? (Unpublished: currently under review)

- Vouchers may serve as a way toward social health insurance schemes as they can help governments develop their capacity to purchase health services and to target subsidies to underserved populations (Sandiford et al., 2005).
        - Sandiford, P., Gorter, A., Salvetto, M., & Rojas, Z. (2005). A guide to competitive vouchers in health (pp. 1–118). Washington DC.
    - Example: In Uganda, the government is building on its experience of overseeing a VMA-led safe delivery and FP voucher program to provide national coverage. Voucher programs also establish the concept of pre-payment for voucher users and post-service reimbursement for providers, paving the way for health insurance programs.
- Vouchers can target resources to underserved populations. Nearly all voucher programs use some form of beneficiary identification to channel resources to an underserved group as an attempt to address large inequities in access. The most commonly used mechanisms are poverty assessment tools in the form of a questionnaire, a pre-existing poverty

identification system such as those used in India (the “below poverty line” -BPL - card) or Cambodia (the Poor ID Card) or geographical targeting of areas identified as poor.

  - Gwatkin, D. R. (2000). The current state of knowledge about targeting health programs to reach the poor (pp. 1–25). Washington, D.C.
  - Hanson, K., Worrall, E., & Wiseman, V. (2006). Targeting services towards the poor: a review of targeting mechanisms and their effectiveness. In A. Mills, S. Bennett, & L. Gilson (Eds.), Health, economic development and household poverty: from understanding to action (pp. 1–23). London: Routledge.

- Vouchers may increase access to contraceptive services among the poor and adolescents. Family planning vouchers have shown results in reaching members of disenfranchised communities who often do not receive the most basic services. Two recent systematic reviews of voucher programs concluded that these programs can be designed to effectively target resources to specific populations (N. M. Bellows et al., 2011; Brody et al., 2013).

  - Bellows, N. M., Bellows, B. W., & Warren, C. (2011). The use of vouchers for reproductive health services in developing countries: systematic review. Tropical Medicine & International Health, 16(1), 84–96. doi:10.1111/j.1365-3156.2010.02667.x
  - Brody, C. M., Bellows, N., Campbell, M., & Potts, M. (2013). The impact of vouchers on the use and quality of health care in developing countries: A systematic review. Global public health, (February), 26. doi:10.1080/17441692.2012.759254

- Example: A voucher program in rural India led to an increase in mCPR among women living below the poverty line from 33% to 43% (IFPS, 2012).
- Example: In Nicaragua, adolescents who received vouchers were three times more likely to use sexual and reproductive health centers, twice as likely to use modern contraception, and 2.5 times more likely to report condom use at last sexual contact compared to adolescents who did not receive vouchers (Meuwissen et al., 2005).

Annex F. Sustainability

Note to the TAG on Sustainability and the HIPs

Karen Hardee, The Evidence Project, Suzanne Reier, IBP; and Minki Chatterji, SHOPS

May 19, 2014

1. Background and Purpose

As the number of HIP briefs on service delivery, technology and the enabling environment increases and activities to implement them grow, the question of sustainability of the HIPs has arisen. Some questions include: How is sustainability addressed in current HIP briefs? What is the definition of sustainability for the HIPs? Is sustainability the same across all HIPs? Does the HIP have to remain in its same form to be considered sustained? How much can the HIPs change over? How long do they have to last?

The purpose of this note is to:

- Review the literature on sustainability in family planning programming including definitions of sustainability measures and methods used to make the claim of sustainability
- Review what has been included on sustainability in the existing service delivery HIPS
- Consider which measures of sustainability should be discussed within the service delivery HIPs in order to be well prepared for eventual sustainability.
- Propose some guidance to the TAG on how the HIP initiative might address sustainability, including in new HIP briefs

2. What is meant by a sustainable family planning practice?

The literature on sustainability of family planning programs, much of which comes from the 1990s, ranges from sustainability of programs, organizations and practices. Much of the literature addresses removal of external (usually donor) funding. For example, USAID's Office of Sustainable Development, Bureau for Africa's (1999: 1) defined sustainability as "the ability of host country entities (community, public and/or private) to assume responsibility for programs and/or outcomes without adversely affecting the ability to maintain or continue program objectives or outcomes." Writing about program sustainability in Egypt, Khalifa et al. (2001) define Program Sustainability as, "The national family planning program and its public, private and NGO institutions can provide current and potential clients with the information and services necessary to obtain the benefits of quality family planning on a continuous basis without external aid."

Writing about sustainability of nongovernmental organizations (NGOs), Ashford and Haws (1992) said that improving quality of services, expanding coverage and increasing program sustainability should not be considered incompatible goals. SHOPs uses the ProCap Index (http://www.procapindex.org/), to assess sustainability of organizations along three dimensions: 1) financial sustainability, 2) programmatic sustainability, and 3) organizational sustainability. Shah et al. (2011) describe sustainability as a "three-legged stool" wherein the pillars of a successful program are: 1) Quality, 2) cost control, and 3) access.

The frameworks developed for sustainability have some common elements:

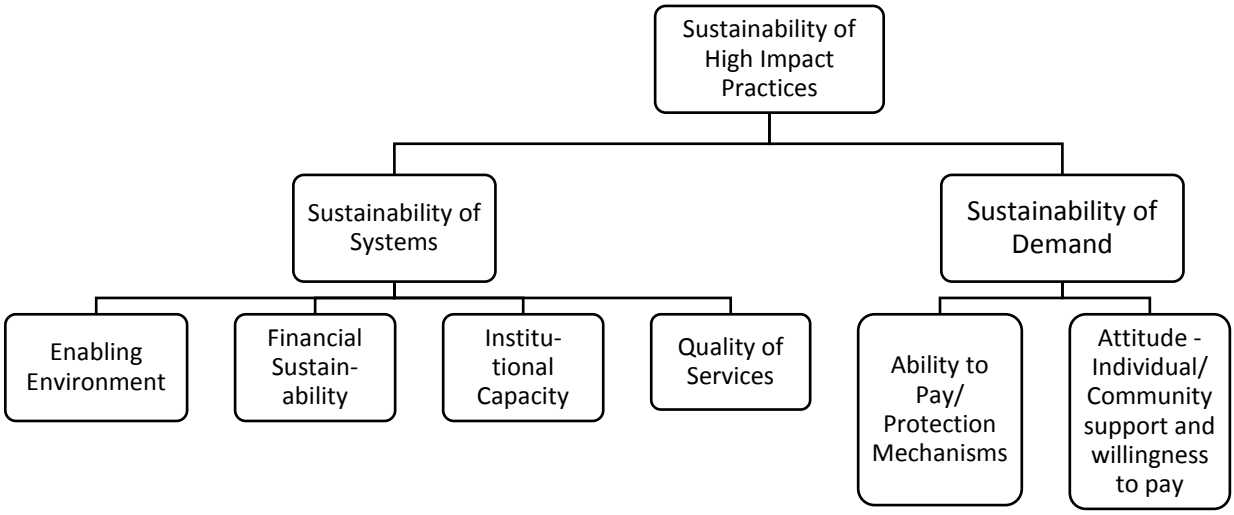
- A strong enabling environment: including laws, policies and regulations that promote sustainability.
- Financial sustainability with local resources, including income generation where appropriate.
- Institutional/organizational/programmatic sustainability, including capacity to implement the program and improvements in efficiency.
- Demand sustainability – the service is recognized as necessary, there is willingness to pay and mechanisms for reaching those who cannot pay, and there is community support.

Some of the frameworks also include cross cutting issues which should remain through to the stage of sustainability:

- Provision of quality services
- Equity

The components of sustainability are illustrated in Figure 1.

Figure 1. Considerations for the Sustainability for High Impact Practices



Source: Adapted from USAID, 1999.

3. What evidence is available on sustainability in the current HIP Briefs?

This review included 5 service delivery HIPs, 1 new technology HIP and 3 enabling environment HIPs posted on the HIP website as of May 15, 2014. Among these, 6 HIP briefs reviewed include some form of the term sustainable, but how sustainability is approached in the briefs is not consistent, nor is the concept addressed in all briefs or discussed clearly where it is used. The text on sustainability included in the current HIP briefs is found in Annex 1.

In summary, some comments found in the HIP briefs concerning sustainability include issues such as:

- Sustainability as cost: mhealth
- Focus on cost at the expense of equity or other considerations: CHW
- Failure to address quality of care and social barriers to FP issues: CHW
- Unsustainable workload of providers: FP and Immunization
- How HIP helps to sustain family planning: Policy, PAC and Social Marketing
- Need to plan for sustainability: Social Marketing and mhealth

4. What are key criteria when planning for sustainability of service delivery HIPs?

Based on the framework of components for sustainability of HIPs, specific criteria that should be considered for all HIPs (as relevant given the differences in the HIPs) could be developed. The new HIP briefs could address relevant components of sustainability.

5. What role do the enabling environment HIPs play in ensuring sustainability of Service Delivery HIPs?

The enabling environment is a component of sustainability. The service delivery HIPs need to think about planning for sustainability. The Environment HIPs are elements of what needs to take place in that planning (policy, finance, communication, etc).

6. Questions for consideration by the TAG

- Is this framework of components of sustainability, or some modified version, useful for considering sustainability of HIPs?

- Are there other dimensions of sustainability that need to be considered – for example, sustainability by when[1] and sustainability for how long? Does sustainability mean "last forever" or last as long as the practice is needed?[2]

- What evidence is acceptable to the TAG to show that a HIP has the potential to be sustainable?
- Does the HIP Initiative need a tool/checklist on sustainability for authors writing new briefs to consider to make the information about sustainability in the briefs more

[1] Sustainable by when? Looking at some literature on the question of sustainability or sustainable development, the indicators or expectations are that the programs factor in these issues but not that they are already accomplished. So for instance, that if we're looking at community programme for injectables, that it may still have quite a bit of donor funding, but that sustainable criteria such as policies being in place for community agents to give injections, the community worker becoming a cadre that is recognized by the government, etc. are being initiated. We can still say it is a high impact practice, but it needs these particular elements to ensure eventual sustainability.

[2] Sustainable for how long? For instance, is the goal of a community health worker programme to exist forever? Or just until it is no longer needed? For example, the Morocco VDMS programme is no longer in existence because it is no longer needed. This might also be the case with mobile clinics (a new HIP).

consistent or are the HIPs different enough that there are not common elements of sustainability?

- Should the HIP website have a section (or document) that addresses sustainability generally? This could go into more detail than each HIP brief in describing the components of sustainability.

Annex F: What the Current HIP Briefs say on Sustainability

Service Delivery HIP

- **Community Health Workers**

  Factors Contributing to Failure of CHW Programs

  - Misconception that CHW programs are simple and self-sustaining
  - Preoccupation with a single commodity or service resulting in failure to develop a comprehensive service system
  - Lack of broad political support
  - Focus on sustainability and cost recovery which may be incompatible given the objective of reaching poor and remote communities
  - Failure to address quality-of-care requirements and social barriers to Family Planning use
  - Responsibility of galvanizing and mobilizing communities rests solely with CHWs

  Source: Adapted from Philips et al., 1999 and WHO 2007

- **Drug Shops and Pharmacies**

  Nothing about sustainability

- **Family Planning and Immunization Integration**

  Factors That Inhibit Successful Integration

  - Weak referral systems and follow-up
  - Lack of supportive supervision
  - Unsustainable workloads for providers
  - Staff turnover and shortages
  - Inadequate provider knowledge or skills
  - Commodity stock-outs
  - Lack of collaboration between vertical programs or funders

  Source: Adapted from USAID's FP-MNCH-NUTRITION Integration Technical Consultation, Conference Report.

- **Postabortion Care**

  Postabortion family planning improves sustainability and institutionalization of postabortion family planning counseling and services over time. In Peru and Turkey, studies show that institutions that have strengthened the family planning component of PAC have sustained or improved family planning counseling and services well after technical assistance ended (Benson and Huapaya, 2002; Senlet et al., 2001). In Peru, over 80% of postabortion clients received a method prior to leaving the facility three years after the initial technical assistance ended.

  Source: Benson J, Huapaya V. Sustainability of postabortion care in Peru. New York: Population Council; 2002 May. 45 p.

- **Social Marketing**

Social marketing programs help to sustain family planning gains. In Morocco, using the manufacturer's model, a USAID project entered into a partnership with the pharmaceutical companies. Whyeth and Schering in the 1990s to lower the price of two low-dose oral contraceptive brands in return for a time-limited communications campaign. USAID also worked with these manufacturers to establish a "Return-to-Project Fund" so that promotional activities could be sustained after the graduation of USAID support. Results from the DHS show that after the social marketing program started, there was a substantial increase in the proportion of women in the three poorest wealth quintiles using oral contraceptives (Agha et al., 2005), so much so that the gap between rich and poor in oral contraceptive use was reduced to a few percentage points post-graduation in 2003. Moreover, increases in contraceptive use were sustained after USAID graduated its promotional support (Agha and Do, 2008).

Source: Agha S, Do M, Armand F. When donor support ends: the fate of social marketing products and the markets they help create. Soc Mar Q 2005;12(2):28-42.

Source: Agha S, Do M. Does an expansion in private sector contraceptive supply increase inequality in modern contraceptive use? Health Policy Plan 2008;23(6):465-475.

There are three main social marketing models: the NGO model, the manufacturer's model, and hybrid models. The type of model to use depends on health impact and sustainability goals (more detail available in the brief, but the manufacturer's model and the hybrid model are more sustainable).

Plan for sustainability at the beginning. Multi-year funding is needed to build a sustainable market for contraceptive products. Short-term donor funds can result in subsidized products being pulled from the market or significant price increases.

Source: *Summary of Sustainability Strategies for Social Marketing Programs*. Provides a quick reference guide to the sustainability strategies discussed in greater detail in Moving Toward Sustainability: Transition Strategies for Social Marketing Programs http://shopsproject.org/sites/default/files/resources/4071_file_Strategies.pdf

New Technology HIP

- **mHealth**

  SUSTAINABILITY: Consider the accessibility of resources for the long-term operation of the project.

  Quantifying upfront costs, scale-up costs, and potential cost savings is critical for securing government and private sector investments in mHealth. Nurturing local capacity to develop and maintain mHealth tools will ensure long-term operation. Open source mHealth systems, which promote shared data standards and freedom to modify system functionality, are also viewed as potential future drivers of mHealth's scalability and sustainability. A report commissioned by the mHealth Alliance (Vital Wave, 2013) uses a value-chain analysis framework to evaluate five current mHealth financial models and suggests that sustainable models are contingent on a deep understanding of ecosystem players, market dynamics, and incentives that are specific to each.

Considerations

- What will mobile network operators and/or the telecommunications industry have to gain from working with you? Can your strategy evolve with changes in the industry?
- Is your tool adaptable to rapid or significant technological and economic changes?
- What are the ongoing costs to operate, secure, maintain, and scale the technology?
- Does the project use cost-effective technologies, or open-source systems?
- Does the project have a plan for building local capacity to maintain and develop state-of-the-art solutions?

Enabling Environment HIPs

- **Policy: Building the foundation for systems, services, and supplies**
  Policy plays a critical role in scaling up and sustaining health interventions. Scaling up evidence-based innovations requires integrating new practices into health programs and services, including addressing the policy dimensions of scaling up. Without attention to the policies that underlie health systems and services, the scale up of promising pilot projects is not likely to succeed.
- **Health Communication: Enabling voluntary and informed decision-making**

  No reference to sustainability
- **Financing**

  For programs to have the contraceptive supplies that respond to clients' needs, they must mobilize adequate financial support to sustain current and future demand for family planning and to offset the cost of more expensive contraceptives (usually long-acting reversible or permanent methods) for individuals who cannot afford the full cost.

  No specific reference to sustainability although financing is clearly linked with sustainability.

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Annex G. Enabling Environment

Guidance for HIP Briefs Addressing the Enabling Environment

Introductory remarks: The HIP briefs are intended to give useful information (to generalists) to guide and maximize investments in family planning programs. According to the Supply-Enabling Environment-Demand (SEED) model, the enabling environment encompasses "a range of interlinked sociocultural, economic, and policy factors [which] influence both the functioning and sustainability of health services, as well as social norms and practices related to health, including FP." The enabling environment HIP briefs differ from the service delivery ones in that each brief describes one element of the enabling environment and a set of practices to move that element further along a continuum to create a more supportive environment.

Below is guidance for each section of the Enabling Environment HIP Brief.

What is the high-impact practice in family planning for creating an enabling environment?

- Name the *element* of the enabling environment
- Name the practice or *set of key practices* to move this element further along the continuum toward a more supportive environment.
- Mention *what this practice enables* in relation to family planning. For example:
    - health communication enables "people to make voluntary and informed health care decisions"
    - financing supports "family planning services and supplies at the national and local levels"
    - supportive policies "…ensure that family planning has a prominent place on the national agenda and that adequate financial resources are allocated" while "operational policies support systems for delivering services."
    - Supply chain management enables women and men to "choose, obtain and use the contraceptive methods they want throughout their reproductive life."
    - Note: Some briefs mention what about FP is enabled in this section, while others include this point in the following background section.

Background

- Describe the subcomponents of this element of the enabling environment. This may be in the form of a framework or conceptual model, such as the Logistics Model in the Supply Chain brief or the Socio-Ecological Framework for Health Communication in the Health Communication brief.
- Describe the element is in terms of how the element is enabled at different levels (e.g., national and sub-national, health facility, individual; or according to each of the 6 WHO health systems building blocks)

- Mention the focus of this brief and (if applicable) specific things related to this element the brief does not address (e.g., the financing brief focuses on funds for contraceptive commodities and supplies, but not on broader health service provision)
- The last paragraph in this section should refer to this enabling environment practice as one of several HIPs and link to information about the others.

Why is this practice important?

- Describe what makes this practice important to reaching FP/RH goals.
    - Financing..."Substantial resources are needed to meet the growing demand for contraception."
    - Policy…
        - "Often, barriers to accessing high-quality health services have their roots in non-existent, inadequate, or conflicting policies."
        - "Policy plays a critical role in scaling up and sustaining health interventions."
        - Clear, up-to-date clinical guidelines maximize safe access to servies."
    - Supply Chain Management…"Supply chain improvements enhance quality of care and support choice of methods by reducing stockouts of contraceptives and related equipment."

What is the impact?

- Describe any proven impacts or correlations that have been reported in the literature or by project reports. This is where evidence is presented. In-country examples may be powerful here, presenting possible framework and relevance to family planning programming and goals.
    - Financing…"Greater resources for achieving contraceptive security contribute to improved access to contraceptive services and supplies."
        - In Peru, efforts to incorporate family planning into the conditional cash transfer (CCT) program resulted in a 67% increase in the number of women receiving family planning information.
    - Policy…"National policies direct program implementation."
        - More recently, Ethiopia, Malawi and Rwanda experienced dramatic increase in contraceptive use…These achievements were underpinned by significant political commitment and policy changes in each country.
    - Supply Chain Management…"Analysis of family planning logistics data from 11 countries shows that countries with high-functioning public-sector logistics

systems have higher product availability and higher use of modern contraceptives."

- A recent analysis of data from DHS and SPA surveys from Kenya, Rwanda, Tanzania and Uganda found that regional family planning supply and service environment factors are significantly associated with contraceptive use.

How to do it: Approaches to …

- The content of this section of the brief varies depending on the HIP. Some briefs include a set of sequential activities that should be undertaken; in other cases, the HIP topic is a broad set of activities and examples that are not necessarily linked. Typically, the "how to do it" section includes country examples of each step in the approach. The following examples illustrate the different approaches taken in explaining "how to do it"
    - Supply chain management HIP focuses on seven concrete sequential steps that are helpful to achieving the goal of a developing an effective supply chain: Have an LMIS, conduct quantification exercises, support more flexible procurement; explore public-private partnerships and outsourcing—among others.
    - Health communication HIP also lays out a step-by-step approach to developing and implementing a strategy—develop a systematic approach; base program design and evaluation on theory of change; plan for research, monitoring, and evaluation; address cultural, social, and gender issues; segment audience. While the steps are not necessarily sequential, each step needs to be carried out to develop and implement a successful health communication strategy.
    - Policy HIP offers a much less sequential approach. Because policy is such a broad topic and includes legal/regulatory, programmatic guidance, and operational issues to keep programs moving, it is difficult to lay out specific steps that can be followed to carry out policy change. Steps include promotion of strong governance and participatory processes; understand the policy process and involve the actors; identify policy barriers and opportunities; among others.
    - Finance HIP follows a much less structured approach because there is no set model for increasing funding for FP programs. In addition to drawing on a range of experiences, the HIP also provides several examples of guidance that can be useful to a person/group undertaking efforts to increase funding—directing coordinated and advocacy efforts to policymakers; include FP/RH in development strategies; be realistic about what is achievable.
- Some briefs include an additional text box in this section. Health communication mentions innovations and emerging trends in health communication; Policy includes a

list of indicators related to policy reform (legal and regulatory, contraceptive security, operational policies); Financing includes relevant experiences from achieving success and overcoming challenges.

Tools and Resources

- This section includes a few examples of different types of tools—some provide a focused explanation or a high-level view of the HIP area; some are far more specific, linking to an actual tool. In general, the more focused HIPs include specific tools and resources; the broader HIP briefs include tools and resources that address specific examples aspects of the practice, but generally don't touch on the breadth of examples included in the HIP.
    - Supply chain HIP includes a brief that explains supply chain, a software program; a tool on forecasting commodities, and a short report on supply chain integration
    - Health communication HIP offers different types of tools—a link to the Communications Initiative website (a community of practice/information sharing site); a guide for developing a health communication strategy; and links to resource depositories on behavior change communication;
    - Policy HIP includes links to a range of tools, including a toolkit to assess/monitor policy implementation, guidance on developing costed implementation plans, a guide for conducting social audits/social accountability activities, and a report on operational policies.
        - Financing HIP links to the policy HIP brief and a brief that explains costed implementation plans.