

HIP

FAMILY
PLANNING
HIGH IMPACT
PRACTICES

HIP TAG 2015
June 30 – July 1, 2015

UNFPA

Orange Café
605 3rd Ave
New York, NY

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Technical Advisory Group Meeting Report

Day 1

Welcome

Gifty Addico, introduced Jagdish Upadhyay, Head of Reproductive Health Commodity Security and Family Planning at UNFPA. Mr. Upadhyay welcomed participants, thanked members of the technical advisory group for their work and reiterated the importance and the role the High Impact Practices (HIPs) play in strengthening country programs. He emphasized the importance of implementation and working at the country level.

Ms. Addico welcomed Maxine Eber as Chair for day. Shawn Malarcher provided an overview of the agenda.

Updates

Shawn Malarcher gave an update on progress since the 2014 TAG meeting. Over the last year, the HIP partnership has accomplished a great deal including addressing most of the recommendations from the 2014 TAG. Some important accomplishments included: establishing a process for updating current HIP briefs, developing a Theory of Change for each new service delivery HIP brief, and establishing improved methods and recommendations for standards of evidence on equity and sustainability.

Ms. Malarcher noted several recommendations for which little progress has been made including: development of a document that outlines the overarching principles of the HIP work, improving the transparency of the HIP process by making these processes public, clarifying the criteria for proven, promising, and emerging practices, and development of derivative products to improve dissemination and utilization of HIPs.

At the time of this meeting, all three briefs reviewed at the 2014 TAG had been approved for finalization. The Keeping Girls in School and Voucher briefs were published earlier and the Leadership and Management brief was in the final revision and copy editing stage.

Ms. Malarcher made several suggestions to improve the probability of completing all recommendations of the TAG, these are:

1. Recommendations should be clear and actionable, particularly revisions for the briefs.
2. All recommendations should be voiced and approved during TAG deliberations and should reflect general consensus.
3. Volunteers help move the process along during the year and we need individuals to agree to take leadership of the process.

A request was made for volunteers to work on the uncompleted recommendations from 2014. The group agreed that if sufficient volunteers were not identified, the uncomplete recommendations would be dropped from the recommendations.

Suzanne Reier reported on behalf of the IBP Task Team on HIP implementation. The purpose of the Task Team is to support dissemination and implementation of the HIPs. Ms. Reier gave illustrative examples of activities at the global and regional level to disseminate the HIPs including; supporting presentations at the FP2020 Focal Point Meeting, CORE Group Meeting, and the K4Health Knowledge Fair; development of a webinar series on HIPs; documentation and mapping of HIPs in Tanzania, Guatemala, and Mozambique; and presenting HIPs at IBP Regional Meeting Addis Ababa Ethiopia in June 2015.

Gifty Addico reviewed the main discussion points from the HIP Partners meeting. Highlights included; the partners found “significant limitations to the proposed approach for monitoring implementation of HIPs and suggested developing better methods for documenting how countries are using HIPs. The survey found that use of HIP materials among Partners was mixed. There is a need to make the materials available at the country level. There is a lot of interest in the HIP map, and there is a need to facilitate more participation in the map.” Presentation of the new proposed HIPs garnered much discussion. Participants were very concerned that the practices were too broad to be useful.

Brief Review: Adolescent Friendly Contraceptive Services (AFCS)

Jill Gay, first author of the brief, provided an overview of the brief development process, limitations, and remaining issues. Discussants Hashina Begum and Gael O’Sullivan opened the discussion with their observations and recommendations. The lack of evidence and experience with the proposed approach of mainstreaming adolescent friendly services versus the traditional stand along was a key point of contention. Another main concern of the group was how to categorize this “practice” within the HIP framework. The weak evidence-base suggested it fit at the “emerging” practice stage. However, as the authors recommended the components of adolescent friendly services be integrated into existing HIPs, such as mobile outreach, post abortion family planned, etc. AFCS did not meet the criteria of a “practice” by itself. After much consideration, the group agreed to categorize AFCS as a “HIP enhancement” similar to mHealth.

Recommended revisions:

- Include a theory of change
- Recognise the need for youth segmentation and limited evidence on boys.
- *3rd para:* Remove sentence “The consensus of the group...”
- Add a sentence on the importance of the demand side; how are young people attracted to the services; how do they know where the services are? etc. and cross reference other briefs.
- Developed country evidence: Include sentence on evidence of impact from developed countries eg UNESCO review and note existing evidence is from developing countries. Include box on AFCS from developed countries.
- Table 1: present it as per table in the voucher brief. Include impact and scale of implementation data.
- Figure 1: Revise based on DHS data, select countries with high adolescents CPR & broad method mix.
- Add text on the challenge of communicating with young people and lack of knowledge about their body and reproduction generally. Add information on tips to address this challenge if possible
- Add the need to do a needs assessment to understand the preferences of young people and their sexuality.
- Pg 8, 2nd para: add to end of 2nd sentence “including LARCs”. Reference relevant statements from ACOG and MEC on LARCs safe for adolescents.
- Pg 8, 4th bullet: Include providers and religious leaders as part of the community.
- Reference the importance of HIV prevention for young people.

Updating current briefs

The updated brief on Community Health Workers was presented to the TAG. This brief was the first to go through the proposed process: literature search, review by endorsing organizations, and updating of language and key information. Discussant Erin Mielke provided a review of the current post abortion family planning brief. Ms. Mielke noted that the PAC Consortium recently updated its Compendium and there is likely some new evidence that could be incorporated into the brief. Discussant Elaine Menotti suggested that the mHealth brief would benefit from new evidence that is emerging on the subject. Ms. Menotti also noted the need to link this work with the mHealth forum. Discussant Minki Chatterji reviewed the Health Communication brief. Ms. Chatterji noted the complexity and breadth of this brief. Consideration is needed to how best to present this information to maximize implementation. Other specific suggestions included:

- The Community Health Worker brief needs additional work on the scale-up column and some revisions to the theory of change.
- The 3 remaining briefs will benefit from incorporating new evidence.

- Post Abortion Family Planning needs a theory of change and update reference to information, education, and communication.
- Authors of the mHealth brief should consider dividing into 2 briefs – client and provider/health systems side given explosion of initiatives in the mHealth arena.
- Health Communication also needs a theory of change and a framework to distinguish different communication channels. Include additional emphasis that normative change often takes more than communicating a simple message. Authors should also distil evidence on improved knowledge and behaviour change, specifically explore ways to revise the table to distinguish effects from IPC versus reflected dialogue versus other SBCC approaches.

Concept note review for 2016 HIP briefs

The TAG reviewed the 2 concept notes for the HIP briefs and provided the following comments for consideration.

Ellen Eiseman, served as discussant for the Community Engagement brief. Ms. Eiseman reiterated the importance of this brief. She noted that it will be a challenge to summarize this topic in the 8 page limit.

- The topic is likely to have broad appeal. Please pay particular attention to the level of language used and simplify for lower English reading levels and less jargon where possible.
- Clarify if the authors are distinguishing community mobilization and community engagement or are they equivalent?
- Make sure to draw on the review conducted by WHO.
- Consider drawing from tested models such as Save the Children and Care. Be clear on the role of attitude change versus behavior change.
- The following TAG members have agreed to give input and provide support as needed during the development phase – Alice, Gwyn, and Maggwa.

Alice Payne Merritt and John Pile reviewed the concept note on economic empowerment. The discussants raised concerns about the evidence-base on this topic and suggested the authors focus on some key practices rather than attempt to cover all potential mechanisms. As stated in the concept note the practice was difficult to understand.

- Reviewers found this to be a very broad topic. Authors may want to consider honing in on one practice such as micro-financing.
- Consider including a project conducted in Ethiopia by CARE and evaluated by ICRW (Towards Economic and Sexual Reproductive Health Outcomes for Adolescent Girls - TESFA) and UNFPA's Adolescent Girls Initiative.
- Currently the language and the theory of change is confusing. Authors will need to clarify.
- Review evidence from Outlook 2011 and PRB 2014. Also consider drawing on evidence from HIV. WHO and EVIDENCE have also done a relevant reviews.

- The group discussed cash transfers and found these are not relevant for the topic since the cash does not go directly to the girls. Usually goes to caregiver and therefore cannot economically empower them.
- Include evidence from Grameen Bank.
- The following TAG members have agreed to give input and provide support as needed during the development phase - Tamara.

Day 2

Sara Stratton took over as meeting Chair for day two.

The day began with a review and refinement of recommendations from Day 1. In addition to recommendations on the subjects review the TAG noted it would be helpful to establish clear expectations for the TAG and other groups working on the HIPs. These should be circulated broadly and available on the website. In addition, the TAG noted that the SEED framework needs to be revisited to ensure it meets the needs of the HIP work and reflects current thinking in program planning.

Brief Review: Galvanizing Commitment

Jay Gribble, the first author provided an overview of the brief development process, limitations, and remaining issues. Discussant Roy Jacobstein opened the discussion with observations and recommendations.

Recommended revisions:

- Reference the importance of global movements, such as FP 2020, ICPD, and London Summit in the background section.
- Global Health Program example from Contraceptive Security.
- Include examples of partnerships with the private sector as examples of commitment.
- Include older examples of commitments, such as other examples from Asia and LAC to balance those listed from Africa, if possible.
- Include monitoring as an example of accountability.
- Figure of policy and mCPR needs additional explanation.
- Link to relevant HIP briefs, such as the policy brief.
- Distinction between the levels of commitment, information on funding flows and National Health Accounts needs more nuance.
- Commitment is focused on national government level. Add reference to commitment from regional and/or district level as well as others such as local organization and private sector.
- Explicitly link to sustainability.
- Recognize the volatility commitment, such as the example of Guatemala.
- Add additional detail on *how* in the Tips section.

Developing standards of evidence

Sustainability

Karen Hardee, Minki Chatterji, and Suzanne Reier have been work on a concept note on this issue for the past two years. The note was circulated to TAG members prior to the meeting. The TAG appreciated the work of this team and suggested making the document public after addressing the following issues:

- Document should acknowledge changing health systems and the evolving needs of beneficiaries. Not all programs are needed for extended periods of time.
- Include an introduction that clearly states the intended audience and purpose of the document.
- Recognise the private sector in the context of a total market approach and its role in sustainable development
- Clarify terminology - sustainability and scale-up. Use terms consistently.
- Add a discussion on financial sustainability.

Measuring access for underserved populations

Maxine Eber, Sara Stratton, and Ian Askew have been work on a concept note on this issue for the past two years. The note was circulated to TAG members prior to the meeting. Dr. Askew made a presentation identifying the complexities of this issue. The TAG appreciated the work of this team and suggested making the document public after addressing the following issues:

- Include an introduction that clearly states the intended audience and purpose of the document.
- Incorporate a checklist of questions, like the sustainability brief

Decision-making tool

Nuriye Ortayli gave an update on progress in developing a decision-making tool. A small group of TAG members and other interested parties met in the spring to discuss and deliberate how to develop such a tool and what it would look like.

- Linking the HIP process and CIP tools would be helpful for countries.
- HC3 has relevant tools to consider as part of this process. (*Alice to share links.*)
- Consider adding scale as a key decision point and what level of scale is appropriate.
- Consider acknowledging these decisions are also made at the sub-national as well as the national level.

Implementation Research

Erin Mielke gave a presentation on a case study of how HIPs are implemented in Tanzania. Ms. Mielke's analysis found that many of the HIPs were being supported in Tanzania. However, implementation of any one HIP usually covered less than a quarter of the population. Ms. Mielke also noted significant implementation challenges faced by these programs. Suzanne Reier followed with a presentation on documentation of HIP by WAHO.

K4Health study for improving dissemination/utilization efforts. John Pile provided a review of the concept note. Dr. Pile noted that the concept note was brief and did not include study instruments so it was difficult to give details comments. Specific feedback included:

- The study will provide useful information to inform the HIP work.
- Consider expanding the timeline so that additional information can be gathered during the International Conference on Family Planning in November.
- On-line surveys may be difficult for key informants to access due to internet limitations. Consider a hybrid approach such as an on-line survey complemented by a hard-copy questionnaire administered by the country office.
- TAG members agreed to help identify respondents in collaboration with UNFPA, WHO and USAID. Members requested a standard message to send to potential respondents.

The TAG was provided with a protocol developed in support of the World Bank. The specific aim of the protocol was to standardize data collection for implementation research specific to issues of scale-up. Victoria Jennings reviewed the protocol. The group discussed the merits and limitations of the protocol. After much discussion, the group decided that it would be too much to take on this work at this time. The TAG preferred to focus on the recommendations and current priorities.

Suggestions for TAG 2016

The group found the seating arrangement did not facilitate discussion among TAG members making it difficult to see and hear participants. Organizers prefer to have the meeting earlier in the year and are exploring dates in late April or early May of 2016.

Recommendations:

- Explore options to implement a continual survey of published literature on finalized HIPs to support the update process.
- 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 development of derivative products to facilitate utilization and dissemination of the HIP briefs, such as one-page advocacy briefs.

- Update and circulate the Terms of Reference for the TAG. Once reviewed and finalized by the joint sponsors publish them on the website and distribute to TAG members.
- The joint sponsors will develop a process for identifying new HIPs. The proposed scheme will be shared with the TAG and endorsing agencies for comment prior to the next HIP Partner's meeting and finalized at the HIP Partner's meeting.
- Review the HIP categorization and the SEED framework to ensure both reflect current thinking in programming and respond to current and future HIP development. (Volunteers – Karen Hardee, Tamara, Alice, Sarah Fox, Elaine Menotti, Minki, and Shawn)
- Once revised, the sustainability and reaching the underserved documents should be made available on the website and to TAG members directly.
- The TAG acknowledges the importance of learning from the implementation experience. However, given other priorities of the group the TAG recommends taking no further action on developing or supporting implementation case studies at this time. The group will continue to learn from work supported through the IBP HIP task team and others.

Brief Recommendations 2015:

- The TAG concluded that the ***Adolescent Friendly Contraceptive Services*** brief will be a valuable contribution to the field and approved it to be finalized after incorporating the suggested revisions. The final brief will be published as a supportive document similar to the mHealth brief.
- The TAG concluded that the ***Galvanizing Commitment*** brief will be a valuable contribution to the field and approved it to be finalized after incorporating the suggested revisions. The final brief will be published as an Enabling Environment brief.

Annex A: Agenda



AAGENDA

Technical Advisory Group Meeting

June 30 and July 1, 2015

09:00 – 17:00

Orange Cafe, UNFPA, New York

605 Third Avenue
5th floor

Objectives

- Review draft HIP briefs and make recommendations regarding the strength and consistency of the evidence and adherence to the HIP criteria.
- Continue to refine HIP process and identify priority activities.
- Refine HIPs for 2016.

Tuesday, June 30th : Maxine Eber, Chair

08:30 – 09:00	Arrival <i>Continental Breakfast</i>
09:00 – 10:30	Opening of Meeting Welcome Remarks, UNFPA Updates Progress on HIP TAG recommendations from 2014, Shawn Malarcher IBP Task Team, Suzanne Reier Partner’s Meeting, Gifty Addico
10:30 – 11:00	Break
11:00 – 12:00	Review Adolescent Friendly Services Brief Authors – Jill Gay, Karen Hardee, and Gwyn Hainsworth Discussant – Hashina Begum and Gael O’Sullivan
12:00 – 13:00	Lunch <i>provided</i>
13:00 – 14:00	Review Galvanizing Commitment Brief

	<p>Authors – Jay Gribble, et al.</p> <p>Discussants – Roy Jacobstein and Sivananthi Thanenthiran</p>
14:00 – 15:00	<p>Refine Practices for 2016</p> <p>Community Engagement – Discussant, Ellen Eiseman and James Kiarie</p> <p>Economic Empowerment – Discussant, Kabir Ahmed and Alice Payne Merritt</p>
15:00 – 15:30	Break
15:30 – 17:00	<p>Updating old briefs</p> <p>Community Health Workers</p> <p>Post abortion FP - Discussant, Sukanta Santer</p> <p>mHealth – Discussant, Elaine Menotti</p> <p>Health Communication – Discussant, Minki Chatterji</p>
17:00	Closing

Wednesday, July 1st: Sara Stratton, Chair

08:30 – 09:00	Arrival <i>Continental Breakfast</i>
09:00 – 10:00	Review Recommendations from Day 1 Comments and Reflections
10:00 – 11:00	Updating old briefs con't Community Health Workers Post abortion FP - Discussant, Sukanta Santer mHealth – Discussant, Elaine Menotti Health Communication – Discussant, Minki Chatterji
11:00 – 11:30	Break
11:30 – 12:30	Developing standards for measuring sustainability Karen Hardee, Minki Chatterji, Suzanne Reier Developing standards for measuring access for underserved populations Maxine Eber, Sara Stratton, Ian Askew
12:30 – 13:30	Lunch <i>provided</i>
13:30 – 14:30	Updates on Decision-making tool Nuriye Ortalyi and Maggwa Baker

	Break (as needed)
14:30 – 16:30	Implementation Research Tanzania case study, Erin Mielke WAHO documentation, Suzanne Reier K4Health study for improving dissemination/utilization efforts – discussant, John Pile Case study protocol World Bank – discussant, Victoria Jennings
16:30 – 16:45	Next Steps and Closing



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Annex C: 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?

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 injectable 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).



