HIP Technical Advisory Group (TAG) Meeting
November 28, 2016

UN Foundation – FP2020
1750 Pennsylvania Ave NW
Suite 300
Washington, DC 20006

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Welcome and Agenda Review

Beth Schlachter opened the HIP TAG Meeting on November 28, 2016, with welcoming remarks. She introduced Ellen Eiseman as the chair of the meeting. Ellen provided an introduction of names and organizations in attendance, and identified the brief authors present. Please see Annex A for the meeting agenda, Annex B for the list of participants, and Annex C for the presentation slides.

Review and Refine of TAG Processes

Key Outcomes of Interest

Shawn Malarcher reviewed the key outcomes of interest. No changes were made to these outcomes.

Guidance to Writers and Reviewers

Shawn Malarcher led the session on guidance to writers and reviewers. The following recommendations and decisions were made:

- The TAG agreed to add a Social and Behavior Change category.
- The decision-making process should be clearly articulated on the website.
- Some edits were suggested, such as changing "document of any type" and "use citations when possible". The TAG wants to reflect a rigorous standard that is also open to learning from a variety of sources. Karen Hardee will send Shawn specific recommendations for addressing these points.
- The Standards of Evidence/Practice work group will give further consideration to clarifying how evidence, including the quality, is judged in the HIP process (Michelle Weinberger, Minki Chatterji, Martyn Smith, Karen Hardee, Mario Festin, Gael O'Sullivan, Maggwa Baker, and Ritu Shroff). This group will develop a proposition that will be discussed at the June 2017 TAG meeting and will explore what do to about the "emerging practices" category and practices that do not meet HIP criteria, such as the economic empowerment summary.

Theory of Change

Ritu Shroff and Maggwa Baker led the Theory of Change (TOC) session. The following recommendations were made:

- It was agreed the TOC is helpful to the authors, reviewers, and consumers of the HIP briefs.
- TOC will not be included in Enabling Environment Briefs.
- The TAG would like a standard format that could be somewhat adjustable as needed.
- The TOC should be simple. Recent examples are at about the right level of complexity.
- There has been some discussion about assumptions and context, but this could be incorporated into other parts of the brief.
- Consider presenting the TOC in a way that shows variations in the level of evidence for specific components/relationships in the TOC (such as the relationship between the intervention and the outcome). Authors can address/discuss this in the text.
- Add citation(s) for the TOC that will provide readers with additional background, if desired. This could also be available on the website to increase understanding.
- A small group will work on developing guidance for authors on what should be included on the TOC in the briefs. In addition, this group will propose guidance for the TAG on how the TOC should be used for deliberations (Ritu Shroff, Paata Chikvaidze, Michelle Weinberger, and Maggwa Baker).
- It was agreed to update the two-page HIP list. Ados and Peggy will complete the first draft.

Review 2017 Briefs

Post-Partum Family Planning (New Brief)

Laura Raney (Jhpiego) is the author of the new Post-Partum Family Planning brief. The TAG reviewed the brief and provided the following recommendations:

- Saying there is a lack of training is insufficient, expand terminology to reflect the more complex needs of support
- Emphasize the "within 48 hours" focus of this practice; also, post-partum is too broad and the terminology used does not provide clarity
- Consider other barriers, such as male engagement and commodity stock-outs
- Align barriers and intermediate effects in the TOC
- Provide specificity on methods; emphasize those methods that can be provided in the first 48 hours after delivery
- Refer to contraception rather than contraceptives to ensure permanent methods are included; also, language should reflect the "offer" of methods

Since no studies were found that measure the impact of community-based provision of contraceptives within the first 48 hours of delivery and address the complexity of balancing a focus on community-level immediate post-delivery family planning, with the focus on moving women from delivering in the community to delivering in a facility, the TAG advised the author to focus the brief on facility-based provision. The brief should include discussion on the role of community-level work, such as supporting family planning counseling as part of community-based antenatal care.

Social Franchising (New Brief)

Gillian Eva (Marie Stopes International) is the author of the new Social Franchising brief. The TAG reviewed the brief and provided the following recommendations:

- Revise definition so that it includes some of the key features of social franchising (the current definition could include any network of providers)
- Revise the TOC to strengthen the causal chain, e.g., increased health insurance coverage is not a direct result of a social franchise
- Improvements in equity are difficult to prove; consider dropping for TOC unless sufficient evidence substantiates this claim
- Separate social franchising evidence that focuses solely on family planning from that with a broader mandate; keep the latter, as evidence from other areas can be valuable
- Focus on social franchising of private providers, as there is not much evidence for social franchising of public sector
- Clarify if the practice is social franchising of providers or of clinics, and whether the practice is focusing on a fractional model only
- Emphasize the importance of expanding choice for all methods
- Drop the phase "high priority health services" in the HIP definition, as it does not add additional information or meaning to the definition

mHealth (Update)

Trinity Zan (FHI 360) is the author updating the mHealth brief. The TAG provided the following recommendations:

- Clarify the term "point of care"

- Provision of family planning services and support for providers should be distinctly addressed
- Revise the TOC to reflect the format used in other briefs
- Workforce development is broader than training
- Drop financial incentives; vouchers are included in a different brief
- Use World Health Organization (WHO) building blocks provided a useful framework, if needed. It did not work as the basis for the TOC but could provide a framework for the overall structure of the brief. If used, all building blocks should be included.

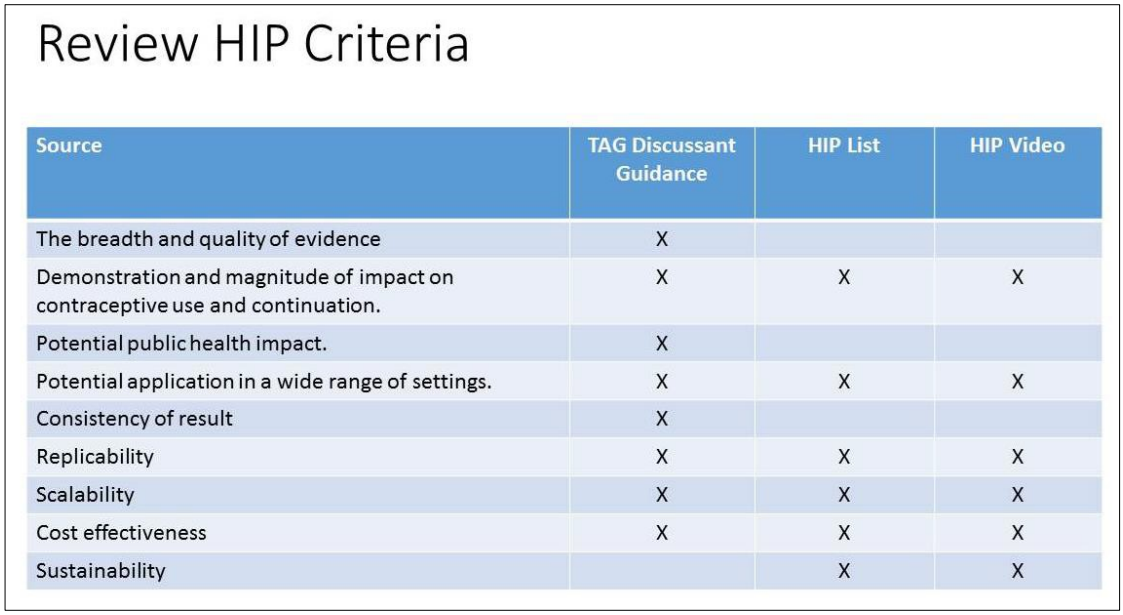
Health Communication (Update)

Joan Kraft (USAID) is the author updating the Health Communication brief. The TAG provided the following recommendations:

- Draw on evidence from HIV where appropriate
- Emphasize the importance of audience segmentation; look at the Community Engagement brief, can we add something on segmentation in the TIPs section?
- Include information on dose (repeat messaging)
- Include text box referencing digital health media

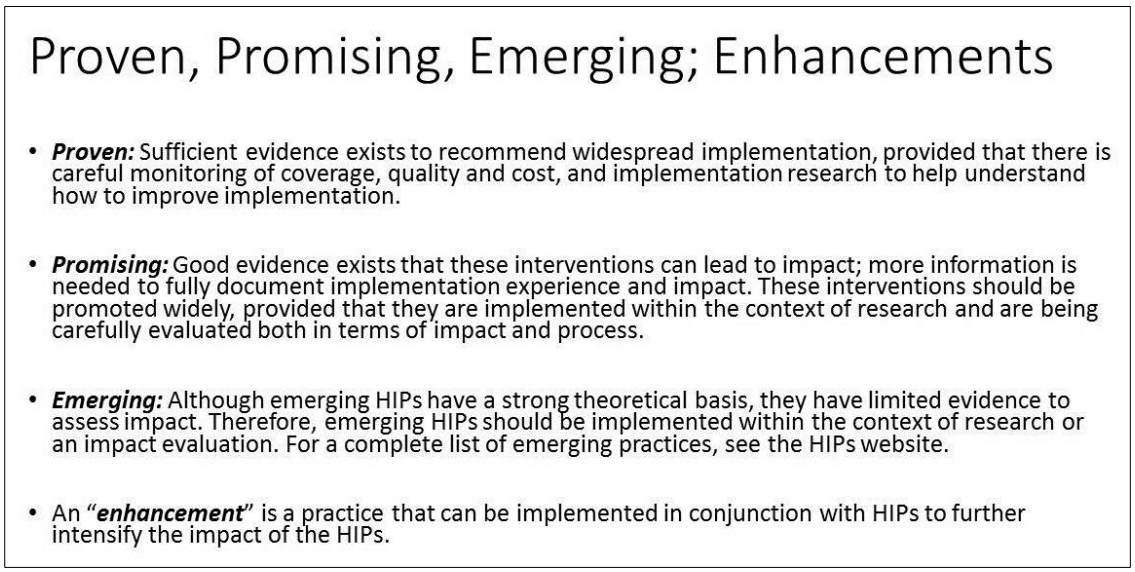
HIP Classification (Proven, Promising, Emerging)

Shawn Malarcher led the discussion about the definitions, in order to get input from the TAG about whether or not to keep the category of "Emerging" and to figure out how to be more specific about how we determine "Proven" vs. "Promising." There was extensive discussion with support for both eliminating the category and for keeping it. It was agreed that the Evidence/Standards of Practice work group would address this issue and develop a proposition for the TAG. The presentation slides are provided as a reference.



Review HIP Criteria

Source	TAG Discussant Guidance	HIP List	HIP Video
The breadth and quality of evidence	X		
Demonstration and magnitude of impact on contraceptive use and continuation.	X	X	X
Potential public health impact.	X		
Potential application in a wide range of settings.	X	X	X
Consistency of result	X		
Replicability	X	X	X
Scalability	X	X	X
Cost effectiveness	X	X	X
Sustainability		X	X



Next Steps and Wrap-Up

Ellen Eiseman and Shawn Malarcher led the closing session by starting with the question, "Did we accomplish what we said we would do?" Ellen restated the objectives of the day and Shawn indicated that the decisions and recommendations made during the meeting would be sent out for review in about a week. They reiterated the work groups/teams formed to follow up on recommendations and decisions, including the Theory of Change work group, the Standards of Evidence/Practice work group, and the team that will revise the HIP list. Thanks were given to those who presented during the day—recognizing their work and efforts—and to FP2020 for hosting the meeting.

The next HIP TAG meeting is planned for June at WHO in Geneva. The final dates for the two-day meeting have not yet been confirmed. Because some will be in attending the Special Programme on Human Reproduction, Policy Coordination Committee meeting on June 22–23, 2017, consideration is being given to holding the meeting June 20–21, 2017. Mario Festin will confirm if those dates work.

Appendix A: Agenda

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

AGENDA

HIPs Technical Advisory Group Meeting

November 28th, 2016
10:00 – 17:15

United Nations Foundation
FP2020
1750 Pennsylvania Avenue
Suite 300
Washington, DC

Objectives

- To refine HIP TAG decision-making processes
- Provide interim feedback on 2017 briefs

Monday, November 28, 2016

	Breakfast
10:00 – 10:15	**Welcome and agenda review** Beth Schlachter, FP2020 Ellen Eiseman, Chemonics (Chair)
10:15 – 12:30	**Review and refine TAG processes** Key outcomes of interest Guidance to writers and reviewers Theory of Change (Vicky, Ritu, Roy, and Maggwa)
12:30 – 13:30	**Lunch**
13:30 – 15:30	**Review 2017 Briefs** ***PPFP (New brief)*** *Laura Raney, Jhpiego* ***Social Franchising (New brief)*** *Gillian Eva, MSI* ***mHealth (update)*** *Trinity Zan, FHI 360* ***Health Communication (update)*** *Joan Kraft, USAID*
15:30 – 16:00	**Break**
16:00 – 17:00	**HIP Classification** (Proven, Promising, Emerging)
17:00 – 17:15	**Next Steps and Wrap Up** Ellen Eiseman, Chemonics (Chair)

USAID FROM THE AMERICAN PEOPLE · UNFPA · World Health Organization · IPPF · FP 2020

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Appendix C: Guidance for Developing an Evidence Brief

Purpose

HIP briefs are intended to facilitate the use of evidence to inform program investments in developing country contexts. They provide an unbiased synthesis of the evidence and experience on implementing HIPs to date, identify priority research gaps or limitations to the evidence base, and test tools related to the specific HIP of interest.

Audience

The primary audience for the briefs are individuals managing family planning programs or investments in developing countries. The briefs are not intended to include the level of detail needed for implementing programs; however, they are a valuable overview for those tasked with advocating, designing, and overseeing family planning funding.

Length and Layout

Total length of a brief should be no more than eight pages, including graphics.

- 1 inch margins all around
- 16 pt titles
- 14 pt headings
- 11 pt body text, with 9 pt references
- Single spaced text, with double spaces between paragraphs

Evidence

The briefs are intended to translate a wide variety of evidence and experiential learning. Where possible, quantitative data will provide support for the rationale and evidence of impact. Qualitative data can be used to support and strengthen these arguments. Experiential knowledge can be incorporated into the brief in the implementation section. Statements of effect of relationships should be supported by documentation of any type.

When presenting evidence, use citations when possible. Standardize results across settings. Original analysis can also be used. Include systematic reviews when possible.

Language

Briefs should be written in plain language. Avoid using jargon whenever possible, as even words like “integration”, “quality”, and “engagement” can be interpreted in a variety of ways. It is preferable to focus on observable inputs and outcomes that can be measured and reported.

Do not reference branded models or tools; instead, describe the intervention in common terms. Organizations should not be referenced in the text, however they should be cited. Use countries or locations to refer to studies or specific interventions. Specific branded tools can be referenced in the “Tools” section, where appropriate.

Content

The structure and content of the briefs will vary somewhat depending on the type of HIP (enabling environment, service delivery, or social and behavior change) and the level of evidence (proven, promising, or emerging). However, all briefs should follow the following structure:

Title

The focus of the practice (e.g., community health workers, postabortion care), what the practice is intended to accomplish (e.g., bringing family planning services to where people live and work, strengthening the family planning component of postabortion care)

What is the proven (promising/emerging) high impact practice in family planning?

Simple statement with referencing the intervention.

Background

This section orients the reader to the content, and is similar across briefs (one page max.)

Why is this practice important?

This section provides the rationale or context for the practice. What problems can this practice address? The rationale should be specific to the practice rather than to family planning more generally. Use quantitative data when possible to demonstrate the magnitude of the problem. Consider using graphics.

This section includes a theoretical framework that describes the mechanism of action and key expected outcome of the practice.

What is the impact?

This section focuses on the HIP criteria:

- Breadth and quality of evidence
    - The TAG recognizes that the HIP briefs do not allow for discussion of study design or details on quality of evidence. However, the writing team should consider these aspects when summarizing the evidence base.
- Demonstration and magnitude of impact on contraceptive use and continuation, and potential public health impact
- Potential application in a wide range of settings
- Consistency of result
- Replicability
- Scalability
- Cost-effectiveness

For practices with a limited evidence base, authors should propose the priority research agenda and/or gaps in knowledge specific to the HIP criteria. Consider using graphics.

How to do it: Tips from the implementation experience

This section allows authors to synthesize experiential and tacit knowledge. What lessons have been learned from implementation? Consider the following:

- What did not work? Do not make the same mistake.
- What gender issues should be addressed?
- Should adaptations be made for special populations, such as youth, rural, and poor?
- How sustainable is the intervention, e.g., provider motivation, task sharing?
- Do supply chain issues exist and how should they be addressed?

Tools

Link to a small number of tools. This is not intended to be comprehensive, so the authors and contributors may need to review and prioritize the tools. A short description should be included with the link.

Process for **I**dentifying **T**opics for **N**ew **E**vidence **B**riefs

Anyone is welcome to undertake the development of an evidence brief. Each year at the HIP Partners meeting participants are invited to propose new topics. Those proposing new topics should be willing to support the complete development of the evidence brief, which generally takes 15 months from approval to printing.

All members wishing to write about a topic are invited to submit a short concept note to the HIP TAG for consideration. Concept notes should include: the HIP statement (what is the practice?), a brief description of the evidence base, and the author responsible for brief development. The TAG can approve no more than two topics each year for development. ***Approval by the TAG to develop an evidence brief does not mean the practice is a HIP. That determination is made once the brief is fully developed and reviewed by the TAG.***

Once a HIP is identified for the development of an evidence brief, it should follow a process similar to the one described below. Adaptations of this process may be required and are at the discretion of the co-conveners (USAID, UNFPA, WHO, IPPF, and FP2020).

HIP Brief Development

Step 1: Identify a group to facilitate the development of the brief. This usually includes one or more of the following: a technical expert or champion, an implementation partner, and a HIP coordinator to facilitate the review process and ensure consistency across materials being developed.

Step 2: Identify a primary author. It is helpful to have one person develop a first draft, which is then reviewed by a larger group, usually four or five individuals. The author should understand the research and present information in an clear unbiased manner. Avoid research that disregards information or represents a biased point of view. The author should be well respected in the field. The organizing group should identify any additional individuals or organizations that will participate in early stages of the brief development.

Step 3: Once a first draft is developed, it is distributed to HIP partner organizations. This group should include representatives from outside family planning, if appropriate, and technical experts in the field.

Step 4: Once the larger group has incorporated comments, the brief is sent for third-party fact checking and any lingering issues are addressed.

Step 5: The brief is ready for review by the TAG. This usually takes place in the context of a TAG meeting. The TAG makes recommendations regarding the inclusion of the HIP on the HIP list, reviews any substantial adjustments or changes to the wording of the HIP, and provides guidance on the strength of the evidence base. The TAG also reviews and revises the research agenda proposed in the brief.

Step 6: After comments from the TAG are incorporated, K4Health provides copy editing and layout for the briefs. Final versions are available in hard copy and through the K4Health website.

Appendix D: Guidance for HIP Brief Discussants

Two TAG members serve as the discussant for each HIP brief. All TAG members are expected to have read and reviewed each brief prior to the meeting. The role of the discussants is to open discussion and to help identify any critical issues for the group to discuss.

Each discussant will have three minutes to reflect on the HIP brief. Comments should be concise to allow for group discussion. In reviewing the HIP brief, the TAG is asked to consider the following:

- Breadth and quality of evidence
    - Study design is not discussed in detail within the briefs. All references are available in DropBox for more detailed review.
- Demonstration and magnitude of impact on contraceptive use and continuation, and potential public health impact
- Potential application in a wide range of settings
- Consistency of result
- Replicability
- Scalability
- Cost effectiveness

The discussant may reflect on any relevant issues or observations from their review. At the end of this period, the TAG is asked to make recommendations on the following:

1. **Does the evidence as reflected in the brief meet the HIP criteria?**

    *The **enabling environment** HIPs are identified based on expert opinion and demonstrate correlation with improved health behaviors and/or outcomes. These outcomes include improvements in unintended pregnancy, fertility, or one of the primary proximate determinants of fertility—increased modern contraceptive use, delay of marriage, birth spacing, and breastfeeding.*

    *HIPs in **service delivery** are identified based on demonstration and magnitude of **impact** on service utilization, including contraceptive use and continuation; and potential application in a wide range of settings. Consideration is also given to the evidence on **replicability, scalability, sustainability, and cost-effectiveness.***

    *Briefs can also be classified as an **"enhancement".** An example of this is the mHealth brief, which is not a stand-alone practice, but rather a technology that could be added to a practice for additional impact or cost-effectiveness.*

2. **Categorize service delivery practices based on the strength and consistency of the evidence base (*Proven*, *Promising, Emerging*).**

    Proven: Sufficient evidence exists to recommend widespread implementation, provided that there is careful monitoring of coverage, quality and cost, and operations research to help understand how to improve implementation.

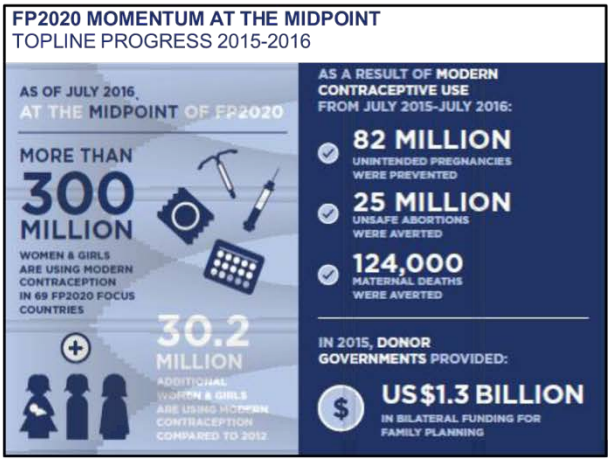
    Promising: Good evidence exists that these interventions can lead to impact; more information is needed to fully document implementation experience and impact. These interventions should be promoted widely, provided that they are being carefully evaluated both in terms of impact and process.

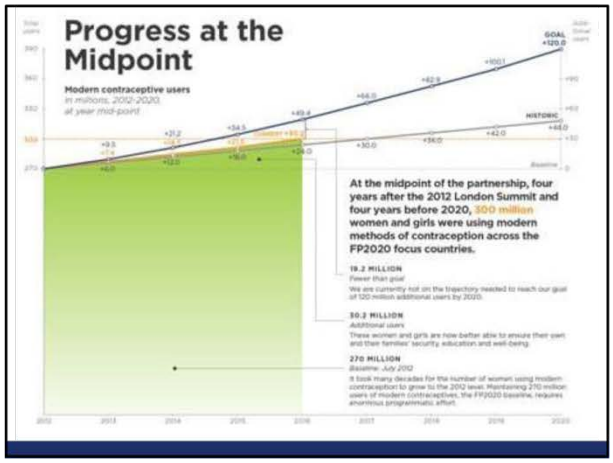
Emerging: Some initial experiences with developing interventions exist, but there is a need for more intense intervention development and research.

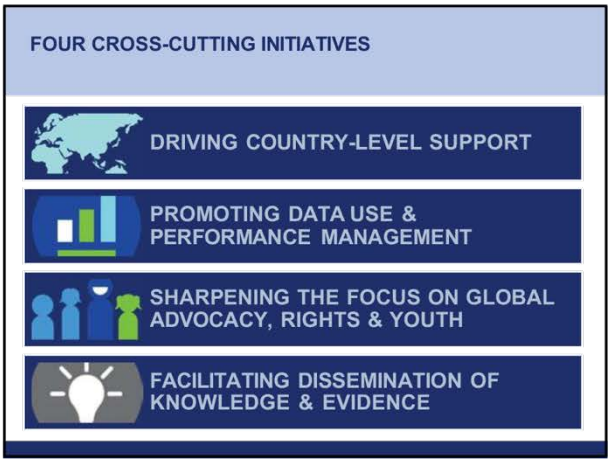
3. What additional evidence, if any is needed?

When developing the brief, contributors are asked to reflect on this question and develop a research agenda, if appropriate. This is included toward the end of each brief. The agenda should focus on evidence that addresses key gaps related to the HIP criteria. The research questions should be clear as to what type of evidence is needed, and the TAG is asked to give specific guidance on appropriate counterfactuals where possible.

Appendix E: Presentation Slides







CONVENING DONOR AND COUNTRY FOCAL POINTS

Common priorities have surfaced across countries and regions:

- Building high-level political support for family planning in-country
- Expanding data use
- Mapping resource mobilization
- Scaling up LARCs
- Improving supply chain and delivery systems
- Investing in demand-side efforts and social and behavior change communications
- Increasing private sector involvement

NEW FAMILY PLANNING
HIGH IMPACT PRACTICES ADVISOR

New position underscores growing collaboration with HIPs/ USAID:

- Developing overarching strategy to promote and disseminate HIPs (integrated with FP2020 country action plans)
- Identify new areas of collaboration around HIPs
- Coordinating with WHO/ IBP a comms and dissemination strategy to inform and engage the broader family planning community
- Identify and engage new stakeholders

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info@familyplanning2020.org

Core Partners

Re-thinking Theories of Change in High Impact Practice Briefs

HIP TAG MEETING

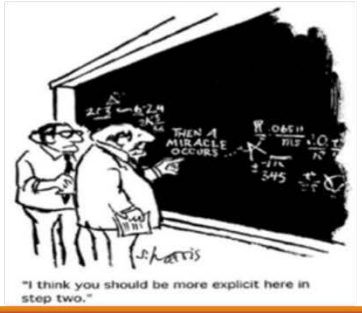
NOVEMBER 2016

What we want to discuss

- Align on the purpose of the ToC
- Clarify how the TAG intends to use the ToC for whether a practice becomes a HIP and then classifying practices
- Discuss and agree on guidance on developing a ToC for the HIPs
- Align on what components we want included, and why, in our ToC guidance going forward, including any additions or changes to the current approach

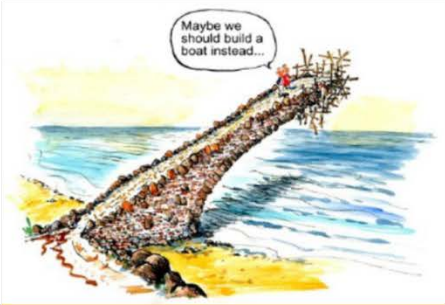
REFRESHER!

What is a Theory of Change?



"I think you should be more explicit here in step two."

Why do we need a TOC?



Developing a TOC: 6 critical steps

1. Identify long-term goals
2. Map backwards and connect the preconditions or requirements necessary to achieve that goal and explaining why these preconditions are necessary and sufficient: ***Evidence!***
3. Identify your basic assumptions about the context: ***Evidence!***
4. Identify the interventions that your initiative will perform to create your desired change: ***Evidence!***
5. Develop indicators to measure your outcomes to assess the performance of your initiative
6. Write a narrative to explain the logic of your initiative

What evidence supports a TOC?

There are four important assumptions in any TOC:

(a) assertions about the connections between long term, intermediate and early outcomes on the map;

(b) substantiation for the claim that all of the important preconditions for success have been identified; and

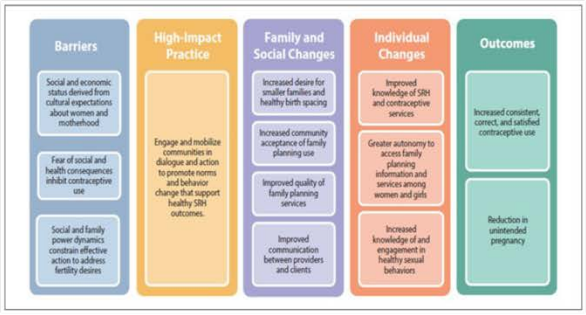
(c) justifications supporting the links between program activities and the outcomes they are expected to produce

(d) the contextual factors that will support or hinder progress toward the realization of outcomes in the pathway of change

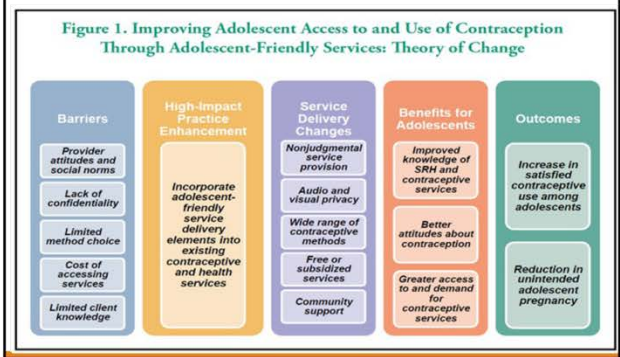
Any evidence that backs these assumptions can strengthen the ToC—how reliably and predictably we can expect the "theory" to work in practice!

ToCs in past HIPs

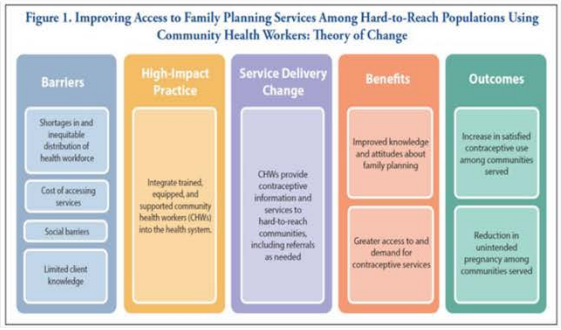
Community Group Engagement Brief



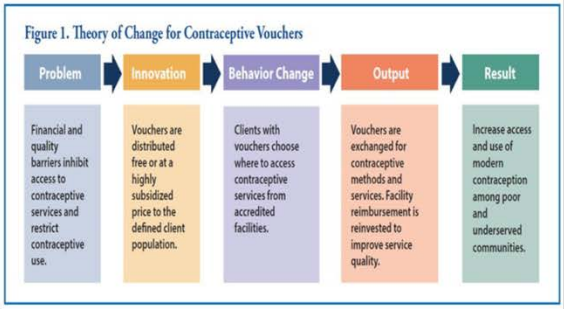
Adolescent- Friendly Contraceptive Services Brief



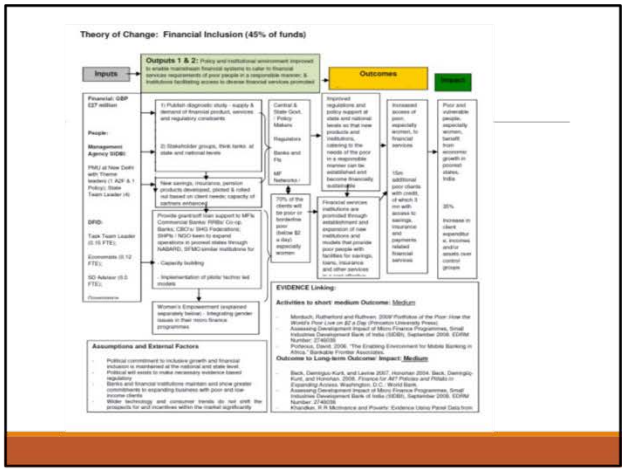
Brief on Community Health Workers: Bringing Family Planning Services to where People Live and work

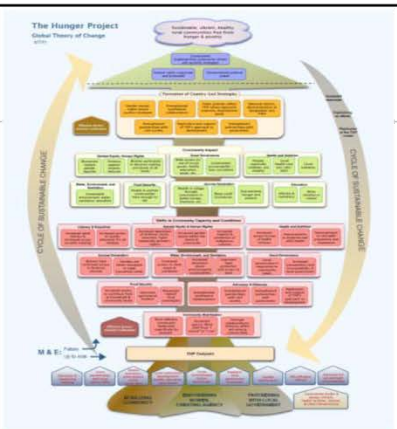


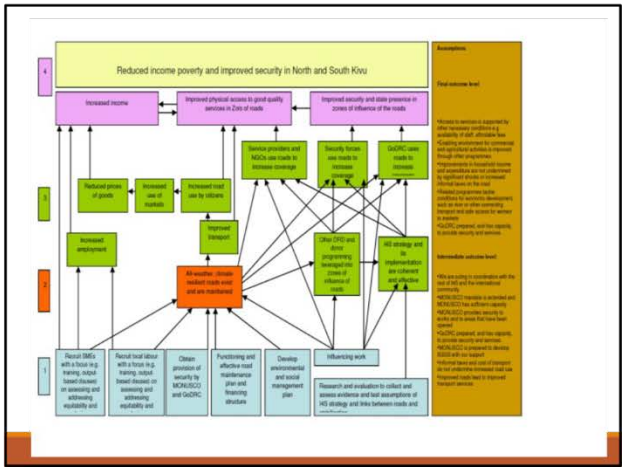
Brief on Vouchers: Addressing Inequities in Access to Contraceptive Services

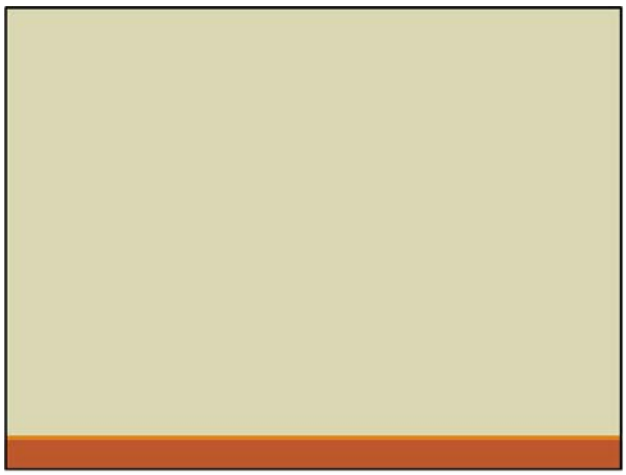


Examples from elsewhere









Discussion

Our proposition:

- We should have a theory of change in our HIPs to show how the practice we are proposing contributes to the outcomes we care about.
- This theory of change can have some unproven and proven assumptions about why and how the practice leads to the outcome—but both need to be explicit
- The assumptions that are proven should be backed by evidence, and the ones that are not should be identified as research priorities
- The less proof we have around our assumptions of change, the less certain we are that the practice is proven to have a desired effect.

Questions?

1. Should we have a TOC in our HIPs?
2. What components should it include?
3. How should we develop some guidance on the ToCs?

USAID FROM THE AMERICAN PEOPLE | Maternal and Child Survival Program

Immediate Postpartum Family Planning High Impact Practices Brief

Laura Raney

HIPs Technical Advisory Group Meeting
November 28, 2016

Definition

Immediate Postpartum Family Planning (PPFP):
Counseling and provision of a contraceptive method within the first 48 hours after childbirth at facility or in the community

Counsel all pregnant women and women presenting for childbirth and offer contraception prior to discharge from a facility: Theory of Change

Barriers	High-Impact Practice Enhancement	Service Delivery Changes	Benefits for Post-Partum Women	Outcomes
Health staff lack training Provision of methods limited to FP unit Limited client knowledge HMIS indicators do not track day of birth PPFP	Incorporate post-partum FP service delivery elements into existing pregnancy and childbirth services at facility and community levels	National guidelines are updated. ANC staff are trained to counsel on FP methods Maternity staff are trained to counsel and provide FP methods Contraceptives are available on the maternity ward with instruments and registers Community actors are oriented on PPFP	Improved awareness of contraceptive options in postpartum Increased uptake of PPFP on the day of birth Reduction in unintended postpartum pregnancy	Increased CPR Improved maternal and child health and nutrition

Country	Counseled and received a contraceptive method prior to discharge from facility	Reference
Afghanistan	Pre 12% (180/1497) Post 95% (1672/1863)	Tawfik et al., 2014
Dominican Republic	59% (849/1437)	Cordero et al., 1996
Egypt	Control 12% (12/100) Intervention 47% (47/100)	Soliman 1999
Guatemala	31% (67,783/218,656)	Kestler et al., 2011
Honduras	Pre 10% (47/474) Post 33% (188/571)	Medina et al., 2001
Honduras	30%	Medina et al., 1998
Honduras	Pre 9% Post 47%	Vernon et al., 1993

Country	Counseled and received a contraceptive method prior to discharge from facility	Reference
Honduras	25%	Lopez-Canales et al., 1992
Honduras	Control 54% (162/300) Intervention 68% (20/30)	de Chavez et al., 1987
Mexico	49% (505/1025)	Romero-Gutierrez et al., 2003
Nigeria	41% (300/728)	Eluwa et al., 2016
Peru	Semester 1 66% (732/1106) Semester 2 89% (1218/1375)	Foreit et al., 1993
Russia	Pre 0% (0/94) Post 65% (65/100)	Stephenson et al., 1998
Rwanda	Control 6% (10/179) Intervention 38% (66/175)	Dhont et al., 2009

High impact practices (HIP) in family planning

Social franchising

Gillian Eva
Technical Advisor SIFPO2
Marie Stopes International

Clarification of the practice:

Organize health clinics into quality assured networks to increase access to FP and other high priority health services.

Theory of change

Barriers	Intervention	Service delivery change	Benefits	Outcome
Limited supply of providers trained to deliver full range of quality FP methods, especially LARCs	SF organizes health clinics into quality assured networks to increase access to FP and other high priority health services	More providers able to deliver broad range of quality FP methods, including LARC	Improved access, scale and use of FP services, especially LARCs	A higher capacity private sector
Limited awareness and demand for FP methods		More consumers receive FP information and franchise brand marketing	Improved awareness and demand for FP services, especially LARCs	Rise in CPR
Isolation of private providers, and poor regulation and economies of scale in the private sector		More providers participating in health insurance schemes Greater regulation of private providers	Well-functioning strategic purchasing mechanisms	More equitable health outcomes Higher quality health services

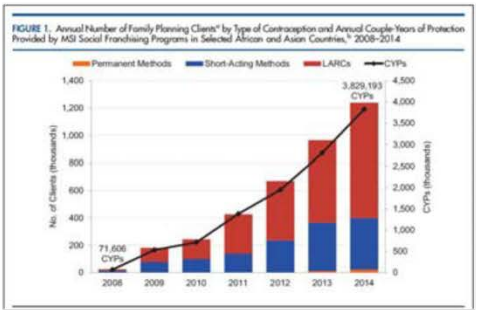
Evidence brief:
Impact on contraceptive access and use

- **Franchising increases client volumes including client volumes for FP** (Agha et al 2003; Huntington et al 2012; Qureshi 2010; Sieverding et al 2015; Stephenson et al 2004; Ngo et al 2010)
- **Franchising improves utilization of FP services, including of LARC methods** (Decker & Montagu 2007; Hennick & Clements 2005; Plautz et al 2003; Chakraborty et al 2016; Azmat et al 2013; Ngo et al 2010; Agha et al 2008; White & Corker 2016)
- **Franchising may improve CPR in intervention catchment areas** (Azmat et al 2013 shows rise in CPR. Hennick & Clements 2005 shows no change)
- **Franchising improves quality of services** (Bishai et al 2008; Agha et al 2007; Hennick & Clements 2005; Plautz et al 2003)

Evidence brief:
Can social franchising be scaled?

- **Franchising can be scaled to deliver FP, including scaling delivery of voluntary LARC methods** (Thurston et al 2015; Munroe et al 2015; White & Corker 2016)
- **Franchising may be cost effective** (Shah et al 2011. Studies looking at cost per client for non-FP franchised services: Bishai et al 2008; Bishai et al 2015)

Evidence brief:
Evidence from implementers: scale



Evidence brief:
Gaps in the evidence

- **Equity of access and health outcomes** – more evidence is needed including how SF can be linked with equity focused initiatives such as vouchers and health insurance
- **Sustainability** – more evidence is needed for both sustainability of franchise networks and of franchising's impact
- **Strategic purchasing mechanisms** – there are documented programmatic examples of success, but no published research

Thank you

November 2016

HIP ENHANCEMENT: DIGITAL HEALTH FOR FAMILY PLANNING SYSTEMS STRENGTHENING

TRINITY ZAN, TECHNICAL ADVISOR
NICOLE IPPOLITI, TECHNICAL OFFICER

fhi360

HIGH IMPACT PRACTICE DEFINITION

Digital Health for Family Planning: Health Systems Strengthening

Digital applications (including mHealth, eHealth, and Information Communication Technology) which support the delivery of family planning commodities, services, systems-level information, and counselling.[i]

[i]Adapted from: Labrique AB, et al.. mHealth innovations as health system strengthening tools: 12 common applications and a visual framework. Global Health: Science and Practice. 2013

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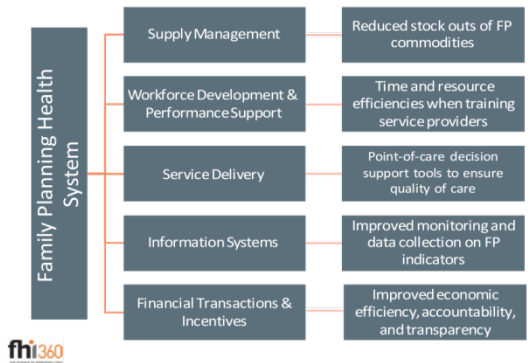
THEORY OF CHANGE



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Results

Project	Country	Digital Health Application	Results
CSTOCK, JSI	Malawi	Supply Management	Reporting rates average above 80% in all districts, compared to 43% at baseline, with some districts reaching 100%.
eLMIS	Bangladesh	Supply Management	At the facility level, stock-out rates for implanon went from 69% in 2009 to 1.0% in 2014.
iDEA, The Nigerian Urban Reproductive Health Initiative	Nigeria	Workforce development and performance support	Video role play emphasized to midwives their tendency to exhibit negative bias towards clients.
ICT Continuum of Care Services (CCS), CARE	India	Workforce development and performance support	ICT features of the mobile tool helped promote permanent methods of contraception: 24% in the intervention relative to 18% in the control.
mLEARNING, CapacityPlus	Senegal	Workforce development and performance support	Increase in knowledge of contraceptive side effects, which remained high 10 months after the end of training without any further reinforcement.
Marietxt, MSI	Uganda	Service Delivery and Support	In year one, the system received 29,984 messages; 17,765 messages reported voucher sales.
mHEALTH for Community-Based Family Planning Services, Pathfinder	Tanzania	Service Delivery and Support	A 522% increase in # of monthly registrations via mobile as compared to paper-based. A 15-fold increase in the number of follow-up visits
Mobile Job Aid, FHI 360	Tanzania	Service Delivery and Support	CHWs reported timelier care; better quality of information; increased method choice; and improved confidentiality and trust with clients.
Texting for Maternal Wellbeing, Center for Human Services	Benin	Service Delivery and Support	264 clients received FP counseling via mobile app; 225 had an FP session; 68 adopted an FP method.

LIMITATIONS AND FUTURE DIRECTIONS

- Comparison of digital health innovations to non-digital
  - Cost savings
  - Resource and time efficiencies
- Cost of digital health applications
- Operations research and impact evaluations of digital health interventions which support family planning service delivery

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Mass Media for Social and Behavior Change

Definition, Theory of Change and Results (Draft)

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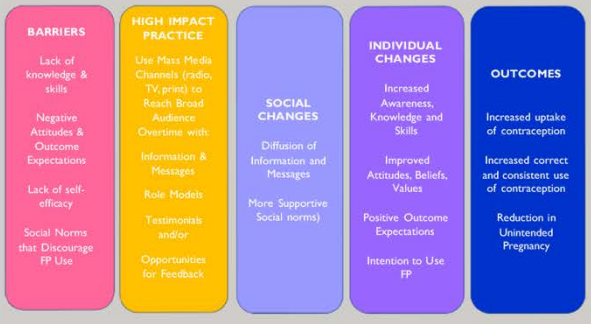
Nov 28, 2016

HIP Defined

- Use Mass Media Channels (radio, TV, print) to address barriers to family planning at multiple levels (individual, couple, community, social) multiple and encourage discussion about social norms and adoption of family planning methods within the community.

Theory of Change (TOC)



Preliminary Results

- 20 interventions
  - 19 interventions implemented in 1 country in 1990s/very early 2000s
    - 1 intervention implemented in 4 countries (Urban Reproductive Health Initiative)
  - Mix of drama/soap opera, multiple "spots", weekly non-drama program via radio or TV
  - All interventions had other components (e.g., logo, poster, cue cards for provider, leaflet, community events)
- Target women and/or men of reproductive age
  - 1 intervention had provider component (Radio Communication Project)
- Most papers mentioned theory or intermediate variables addressed
- Most

Preliminary Results (continued)

Of the 20 interventions

- 5 interventions EXCLUDED because evaluation not rigorous
  - Pre- and post-test only, bi-variate analysis does not control for self-section
- 5 interventions: **statistically non-significant effects on FP use**, with some statistically significant effects on some individual outcomes in TOC
- 7 interventions: **mixed effects on FP use,** with some statistically significant effects on some individual outcomes in TOC
- 3 interventions: **statistically significant effects on FP use,** with statistically significant effects on some individual outcomes in TOC

QUESTIONS??

RECOMMENDATIONS??

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Thank you!

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Review HIP Criteria

Source	TAG Discussant Guidance	HIP List	HIP Video
The breadth and quality of evidence	X		
Demonstration and magnitude of impact on contraceptive use and continuation.	X	X	X
Potential public health impact.	X		
Potential application in a wide range of settings.	X	X	X
Consistency of result	X		
Replicability	X	X	X
Scalability	X	X	X
Cost effectiveness	X	X	X
Sustainability		X	X

Proven, Promising, Emerging; Enhancements

- ***Proven:*** Sufficient evidence exists to recommend widespread implementation, provided that there is careful monitoring of coverage, quality and cost, and implementation research to help understand how to improve implementation.
- ***Promising:*** 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:*** Although emerging HIPs have a strong theoretical basis, they have limited evidence to assess impact. Therefore, emerging HIPs should be implemented within the context of research or an impact evaluation. For a complete list of emerging practices, see the HIPs website.
- An "***enhancement***" is a practice that can be implemented in conjunction with HIPs to further intensify the impact of the HIPs.