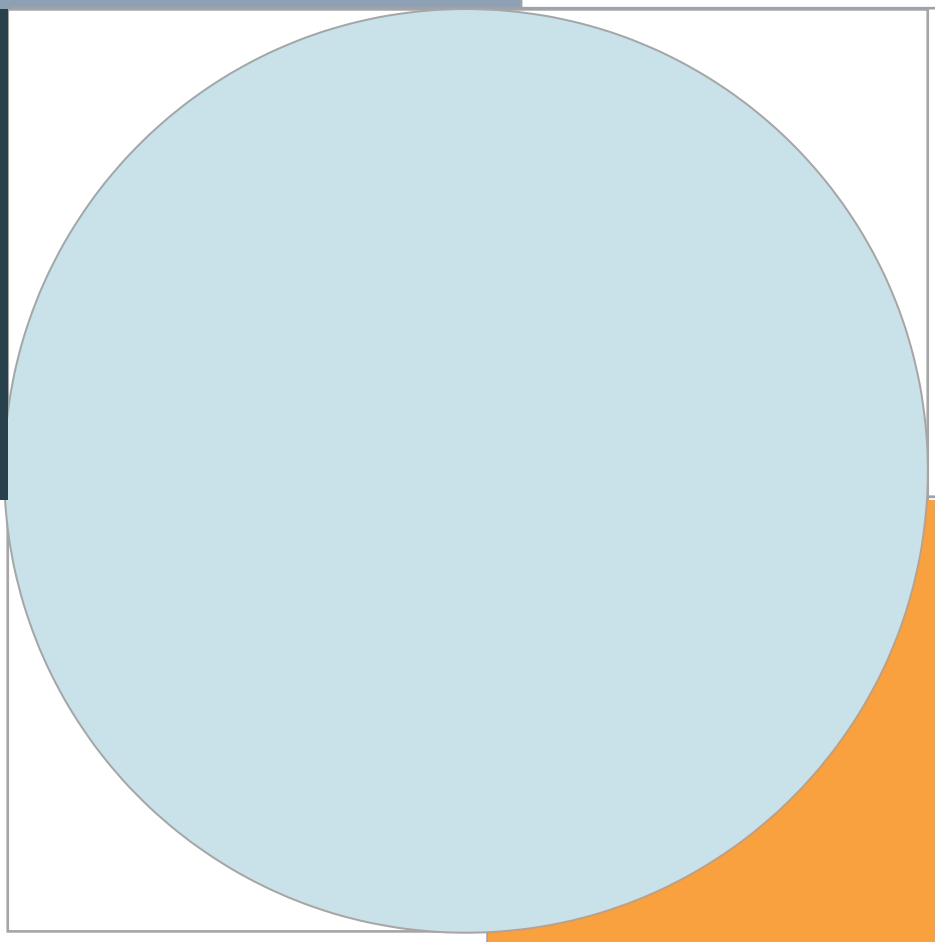
High Impact Practices (HIPs) in Family Planning (FP)

A qualitative assessment of quality and scale of implementation for three service delivery HIPs in Bangladesh and Tanzania



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High Impact Practices (HIPs) in Family Planning (FP)

A qualitative assessment of quality and scale of implementation for three service delivery HIPs in Bangladesh and Tanzania

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A final and important note of thanks goes to the project staff in Bangladesh and Tanzania. This includes both those from the leadership, management, and monitoring, evaluation, and learning (MEL) teams and the 156 men and women from the project teams and district units who agreed to be participants for the data collection activities for this assessment.

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Abbreviations

AUAFP	Accelerating Universal Access to Family Planning
AUHC	Advancing Universal Health Coverage
BA-LWZ	Boresha Afya Lake and Western Zones
BA-NCZ	Boresha Afya North and Central Zones
BA-SZ	Boresha Afya Southern Zone
C3HP	Comprehensive Client-Centered Health Program
CBSG	Capacity Building Services Group
CHW	community health worker
CREMES	Centre for Research Mentorship and Support
CSO	civil society organization
D4I	Data for Impact
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FP	family planning
FY	fiscal year
GoT	Government of Tanzania
HMIS	National health information system
HIP	high impact practice
IHE-IRB	Institute of Health Economics Institutional Review Board
IPPF	International Planned Parenthood Federation
IPPFP	immediate postpartum family planning
IR	intermediate results
IRB	Institutional Review Board
KII	key informant interview
MEL	monitoring, evaluation, and learning
MNCSP	MaMoni Maternal and Newborn Care Strengthening Project
MISHD	Marketing Innovations for Sustainable Health Development
MOH	Ministry of Health
MOSD	mobile outreach service delivery
NIMR	National Institute of Medical Research
PPFP	postpartum family planning

PRH	Population and Reproductive Health
R4S	Research for Scalable Solutions
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SHOPS	Sustaining Health Outcomes through the Private Sector
SMC	Social Marketing Company
TAG	technical advisory group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

High Impact Practices (HIPs) in family planning (FP) are a collection of evidence-based practices identified by global experts that have demonstrated impact on contraceptive uptake and other related outcomes in varied settings. This assessment focused on the extent that three HIPs are implemented and monitored across several United States Agency for International Development (USAID)-funded health service delivery projects in Bangladesh and Tanzania. The specific HIPs covered in this assessment relate to community health workers, mobile outreach service delivery, and immediate postpartum family planning. Prior to this assessment, no implementation standards for HIPs had been established beyond the HIP technical briefs. As such, HIP core components were developed for this assessment with core components referring to an established standard for implementation. Data collection included the administration of core component checklists to rank individual core component implementation using a scale of 1 (limited) to 4 (foundational) and key informant interviews. A total of 156 individuals (83 male and 73 female) participated in data collection. The results from the two data collection activities are, to an extent, the opposite. The self-assessed ranking through the core component checklists suggests that the projects are implementing the core components and thus, the HIPs. However, the interviews with the project staff and district FP experts point to challenges around implementing what is laid out in the core components. The results of this assessment indicate the need for USAID to further clarify how HIPs implementation is defined as part of laying the groundwork to establish a HIPs measurement framework.

Suggested citation

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Executive Summary

Background and Purpose

The High Impact Practices (HIPs) in family planning (FP) are a collection of evidence-based practices identified by global experts that have demonstrated impact on contraceptive uptake and other related outcomes in varied settings. The identification of these practices has facilitated evidence-based consensus efforts on what works in FP in four categories: (1) service delivery; (2) enabling environment; (3) social and behavior change; and (4) HIP enhancement. The HIPs initiative is led by six co-sponsor organizations, including the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the International Planned Parenthood Federation (IPPF), Family Planning 2030, and the Bill and Melinda Gates Foundation.[1]

Service delivery High Impact Practices (HIPs) selected for this assessment:

- Integrate trained, equipped, and supported community health workers (CHWs) into the health system.
- Support mobile outreach service delivery (MOSD) to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods.
- Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities.

Assessment focus areas:

- **Monitoring, evaluation, and learning (MEL)** and the extent that the project MEL system and other repositories capture and use input, process, output, and outcome indicators.
- **Scale of Implementation** and the extent that each HIP has reached the intended locations, including in ways that bear in mind gender and scale in equitable and representative ways.
- **Quality of Implementation** and the extent that established implementation standards are being followed, specifically that the needed resources, skills, policies, and quality assurance procedures are in place.

The HIPs co-sponsors are interested in better understanding the extent that FP projects implement and monitor HIPs. To this end, the USAID Office of Population and Reproductive Health (PRH) provided funding for an assessment of three service delivery HIPs with focus on implementation in multiple FP projects in Bangladesh and Tanzania.

Methods and Limitations

This assessment used a nonexperimental design and included data collection, review of project documents, and review of indicator data. The assessment was led by the Data for Impact (D4I) project in collaboration with the Capacity Building Services Group (CBSG) in Bangladesh and the Centre for Research Mentorship and Support (CREMES) in Tanzania.

Table ES-1 indicates the projects selected by the USAID Missions. The four projects in Tanzania came to an end in 2021 and the Mission identified three subsequent projects to be included in this study.

The protocol was reviewed by the ICF Institutional Review Board (IRB) and rated exempt in August 2021. Ethics approvals were received by the Institute of Health Economics Institutional Review Board (IHE-IRB) in Bangladesh in November 2021 and the National Institute of Medical Research (NIMR) in Tanzania in February 2022.

[1] For additional information about the HIPs, see: Homepage | HIPs

Table ES-1. Selected projects in Bangladesh and Tanzania for this assessment

Project	Implementing partner
Bangladesh	
Accelerating Universal Access to Family Planning (AUAFP)	Pathfinder
Advancing Universal Health Coverage (AUHC)	Chemonics
MaMoni Maternal and Newborn Care Strengthening Project (MNCSP)	Save the Children
Marketing Innovations for Sustainable Health Development (MISHD)	Social Marketing Company (SMC)
Tanzania (2016 – 2021)	
Boresha Afya Lake and Western Zones (BA-LWZ)	Jhpiego
Boresha Afya Southern Zone (BA-SZ)	Deloitte
Boresha Afya North and Central Zones (BA-NCZ)	Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
Sustaining Health Outcomes through the Private Sector (SHOPS Plus)	Abt Associates, Inc.
Tanzania (2021 – 2026)	
Comprehensive Client-Centered Health Program (C3HP)-Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)	Jhpiego
Afya Yangu Southern (C3HP HIV/TB)	Deloitte
Afya Yangu Northern (C3HP HIV/TB)	Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)

Data collection included the administration of core component checklists, based on preestablished core components via small group discussion sessions. Determining the core components was initiated by referring to the HIP briefs to develop a long list of possible core components.[2] Through literature review and consultation with subject matter experts, the list of core components was reduced and a final list of core components was established. The 20 HIPs core components are presented in Table ES-2.

With a set of core components established for each of the three service delivery HIPs, a checklist tool for each was developed. The key questions for the core component checklist were:

- Does the project implement [insert core component]?
- Are there indicators for the core component?
- What challenges and successes have you had in relation to the core component?

A ranking in relation to implementing the HIP was used: 1 (limited); 2 (emerging); 3 (advancing); and 4 (foundational), with an assessment made by both the project teams and the assessment team.

Data collection also included key informant interviews (KIIs) with project staff and district-level FP experts. Across the two countries, 43 KIIs were conducted (14 with project staff and 29 with FP experts at the district level).

This assessment used qualitative methods. As with most qualitative research, the assessment had limitations, such as the limited generalizability of the data and potential bias in responses from participants.

[2] The HIP briefs can be found here: High Impact Practice Briefs | HIPs (fphighimpactpractices.org)

Table ES-2. Core components for the three service delivery HIPs included in this assessment

Integrate trained, equipped, and supported community health workers (CHWs) into the health system	
1	Assures CHWs have necessary supplies and materials to fulfill their roles
2	Monitors, reports, and assesses data on CHW services and referrals provided
3	Monitors data on CHW logistics and commodities at both the health center and district level to avoid stockouts
4	Trains and assesses CHWs' abilities to provide services and behavior change messages
5	Provides regular and as-needed supportive supervision from health system to CHWs
6	Engages communities in recruiting and supporting CHWs
7	Formalizes the role of CHWs as part of the health system to recognize their services
Support mobile outreach service delivery (MOSD) to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods	
1	Ensures consideration of cultural, economic, and social factors and needs in relation to client base
2	Coordinates with community leaders as part of aligning staff to needs, raising awareness for the service, and communicating relevant details to potential clients
3	Ensures equipment and supplies are in place and used appropriately
4	Trains service providers in providing respectful care including counseling services and recognizing instances when a referral for additional care is appropriate
5	Procedures in place for discussing follow-up care and helping clients understand how to access follow-up care
6	Follows a plan for collecting and recording data and inputting information in relevant repositories to ensure follow-up
Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[3]	
1	Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences
2	Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients
3	Trains providers for IPPFP on counseling and service provision per local guidance
4	Engages health facility leadership and staff to promote the practice
5	Ensures staff availability for FP services and products prior to discharge
6	Assures that national service delivery guidelines are readily available and widely disseminated
7	Communicates the role of service providers as outlined in national service delivery guidelines

Results

The results are primarily presented in the aggregate, with selected country-specific focus.

Core Component Checklists (ranking and small group discussion)

- The rankings of 1 (limited) and 2 (emerging) were more commonly used by the assessment team and the ranks of 3 (advancing) and 4 (foundational) were more commonly used by the project teams to describe the level of HIP implementation.
- The largest difference was with the ranking of 4 (foundational). The project teams used this rank in 69 instances in comparison to 32 instances for the assessment team.
- That the project team rankings are higher than the assessment team rankings is helpful for considering the possible ways that projects might conflate a broad approach (i.e., CHW, MOSD, IPPFP) with the specificity of each core component.
- Key points during the small group discussion include: (1) projects do not necessarily have control over the extent that CHWs are integrated into the health system; (2) project MOSD

[3] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

provides a range of health and FP services, including, but not exclusively, the provision of contraceptives; and (3) projects tend to focus more on PPFP and not IPPFP, and in many instances, focus on IPPFP does not define immediate as within 48 hours.

Key Informant Interviews (project staff and district-level family planning experts)

- For Bangladesh, most key informants referenced that CHWs are commonly government employees as evidence of integration into the heath system whereas for Tanzania, most key informants referenced that CHWs are generally not employees of the government as evidence of lack of integration into the health system.
- The key informants described MOSD as providing health services and engaging in FP community awareness raising as opposed to providing contraceptives methods specifically.
- The key informants generally indicated that FP counseling begins during ANC visits and continues onsite at the facility following delivery and during PNC visits, which indicated the specificity of IPPFP is in some instances not understood.

Quality and Scale of Implementation

- The results from the core component ranking exercise potentially indicate that quality of implementation across the projects is relatively strong; however, many of the points raised during the core component small group discussion and KIIs appear to present a more complicated landscape where quality of implementation is more mixed.
- While national data systems and individual projects are collecting data related to the CHW, MOSD, and IPPFP HIP activities, HIP specific indicators are rarely collected. The key informants noted that the HIPs lack standard reporting tools and relatedly, national policies and guidelines tend to focus on FP in a broader sense and as such, without a foundation of indicators, gaining a sense of scale of implementation is challenging.

Conclusions and Recommendations

Across the numerous conclusions that can be drawn, two stand out as overarching. First, given variable levels of HIPs awareness, it is important to recognize that implementation of or presence of CHW, MOSD, or IPPFP expertise and activities does not necessarily equate to awareness and monitoring. Second, it appears that monitoring HIPs would not be possible with existing indicators; thus, an important question is how to increase integration of the implementation of HIPs while limiting additional work to monitor their implementation.

Table ES-3 provides a summary of the conclusions and recommendations. The table first focuses on the importance of continued advocacy for and the scale up of HIPs implementation, notably in relation to coordination efforts and actions internal to USAID. The remainder of the table focuses on conclusions and recommendations in relation to the three HIPs. These recommendations include suggestions for both USAID and projects implementing health service delivery projects with HIP-related activities and primarily are in relation to ensuring clarity and consistency in the language used to define HIPs.

Table ES-3. Overview of selected conclusions and recommendations

Continued Advocacy for and the scale up of HIPs implementation	
Conclusions	**Recommendations**
▪ The assessment findings suggest the need for caution in asserting that the CHW, MOSD, and IPPFP HIPs are being implemented and monitored by the projects. CHW, MOSD, and IPPFP work is being implemented and monitored, but that work, and the related indicators, generally are not sufficiently specific to the HIP definition and core components. ▪ The core components are aimed to be established standards for the HIPs; however, potentially they are not well aligned to projects that do not solely focus on FP. This disconnect may raise questions about the applicability of the core components for more broadly focused health service delivery projects.	▪ Awareness raising, advocacy, and scale-up efforts should continue to acknowledge that FP programming evidence and best practices exists outside of the work of the HIPs initiative. ▪ Continue to pursue coordination and collaboration around the HIPs between and among USAID headquarter-based operating units and Missions. ▪ Establish Mission-sponsored HIPs committees made up of representatives from the projects. ▪ Hold discussions within USAID and consider if the core component checklist used in this assessment could be further developed and promoted as a tool for USAID projects to use.
Implementation of the CHW HIP	
Conclusions	**Recommendations**
▪ Understanding and measuring the extent CHWs are integrated into the health system is complicated. ▪ Recruitment and retention of CHWs requires a delicate balance of honoring longevity, the views of community leaders, and promoting integration into the health system. ▪ The training, equipment, and support CHWs receive align with the comprehensive service delivery approach, which generally does not align with the specificity of the MOSD and IPPFP HIPs.	▪ Project teams should work to establish a definition of "integrated into the health system," including a means to measure whether integration is present. ▪ Conduct research to examine curriculum for CHW training and delineate what is different in providing HIP specific training.
Implementation of the MOSD HIP	
Conclusions	**Recommendations**
▪ Overlap across MOSD and broader focus on community engagement creates challenges in distinguishing if contraceptives are provided through MOSD. ▪ In site selection, cultural and socioeconomic factors are variably prioritized, with projects not always the decisionmaker. ▪ For the projects, successful MOSD does not necessarily need to include the provision of contraceptives; however, without the provision of contraceptives, it would be considered that the HIP is not being implemented.	▪ Project teams should work to improve the availability of service providers to provide permanent methods via MOSD and in turn, track MOSD service by service, including referrals and counseling. ▪ Establish a definition of mobile, including recognizing that often mobile outreach is not solely focused on providing contraceptives.
Implementation of IPPFP HIP	
Conclusions	**Recommendations**
▪ Several projects include the single indicator needed to monitor this HIP in their annual report; however, standardization of the wording is weak. ▪ Views are varied about providing FP counseling immediately (i.e., within 48 hours). ▪ Challenges around the provision of IPPFP revolve around limitations in terms of service providers with the needed skills and shortages of commodities, equipment, and space and privacy for providing the service	▪ Project teams should work to improve their understanding that, for the IPPFP HIP, the definition of immediate must be fixed at 48 hours. ▪ Consider if potential preferred focus on PPFP in Bangladesh and Tanzania is common in other countries and if so, clarify that the intent of the IPPFP HIP is to outline approaches for implementing IPPFP specifically.

Background on High Impact Practices (HIPs) in Family Planning

The High Impact Practices (HIPs) in family planning (FP) are a collection of evidence-based practices identified by global experts that have demonstrated impact on contraceptive uptake and other related outcomes in varied settings. The identification of these practices has facilitated evidence-based consensus efforts on what works in FP in four categories: (1) service delivery; (2) enabling environment; (3) social and behavior change; and (4) HIP enhancement. The HIPs initiative is led by six co-sponsor organizations including the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the International Planned Parenthood Federation (IPPF), Family Planning 2030, and the Bill and Melinda Gates Foundation.[4]

Assessment Purpose

The HIP co-sponsors were interested in better understanding the extent that projects implement and monitor HIPs. To this end, the USAID Office of Population and Reproductive Health (PRH) provided funding for an assessment of service delivery HIPs with a focus on multiple USAID-funded projects in Bangladesh and Tanzania. Three service delivery HIPs were selected for this assessment in consultation with the relevant USAID Mission staff and based on a review of FP and service delivery project activities, as follows:

- Integrate trained, equipped, and supported community health workers (CHWs) into the health system.
- Support mobile outreach service delivery (MOSD) to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods.
- Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities.[5]

The activity work plan is presented in Appendix 1. In summary, the purpose of the assessment is as follows:

- Document indicators being used by selected USAID-funded service delivery projects in Bangladesh and Tanzania that align to service delivery HIPs.
- Assess the scale of implementation for three service delivery HIPs within selected USAID-funded projects in Bangladesh and Tanzania, with scale defined in relation to coverage.
- Assess the quality of implementation for three service delivery HIPs within selected USAID-funded projects in Bangladesh and Tanzania, with quality defined in relation to following expected standards of implementation.

[4] For additional information about the HIPs, see: Homepage | HIPs

[5] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

- Use the findings to inform the development of a HIP measurement framework, including the establishment of core components for implementing HIPs.

Assessment Questions

This assessment does not focus on an individual USAID project or a portfolio of USAID projects. Instead, the assessment focuses on three service delivery HIPs and the extent they are being implemented and monitored by select USAID-funded projects in Bangladesh and Tanzania. The questions this assessment seeks to investigate can be grouped into the following focus areas.

- **Monitoring, Evaluation, and Learning (MEL)** and the extent that the MEL system and other repositories capture and use input, process, output, and outcome indicators.
- **Scale of Implementation** and the extent that each HIP has reached the intended locations, including in ways that bear in mind gender and scale in equitable and representative ways.
- **Quality of Implementation** and the extent that established implementation standards are being followed, and in particular that the needed resources, skills, policies, and quality assurance procedures are in place.

The assessment of three service delivery HIPs in Bangladesh and Tanzania (the "assessment" hereafter) was designed under the Data for Impact (D4I) Project. The assessment was led by D4I in collaboration with two partner organizations—Capacity Building Services Group (CBSG) in Bangladesh and the Centre for Research Mentorship and Support (CREMES) in Tanzania.

Collaboration with a Complementary Assessment

A complementary assessment of service delivery HIPs in Mozambique, Nepal, and Uganda—also funded by the USAID/PRH—is being implemented under the Research for Scalable Solutions (R4S) Project. The R4S team will also investigate MEL, scale of implementation, and quality of implementation as well as cost of implementation.

Two of the four service delivery HIPs covered by the R4S assessment overlap with the HIPs covered by the D4I assessment (specifically CHW and IPPFP). The two other service delivery HIPs that are part of the R4S assessment are as follows:

- Train and support drug shop and pharmacy staff to provide a wider variety of FP methods and information.
- Integrate family planning and immunization services: Offer FP information and services proactively to women in the extended postpartum period.

The D4I and R4S assessments have similar goals in relation to better understanding the extent that service delivery HIPs are implemented and monitored within projects. Both assessments are part of a longer-term effort to develop a HIP measurement framework, including the establishment of core components for implementing HIPs. As such and as requested by USAID, D4I and R4S have collaborated to facilitate complementary methodological approaches where feasible. In particular, the D4I and R4S teams worked together to similarly define scale of implementation and quality of implementation.

Because the two assessments fall under different projects, have different scopes of work, and have different budgets, some variation in approach is present. Notably, the R4S assessment includes a facility-based survey whereas the D4I assessment used qualitative methods to examine the implementation of three service delivery HIPs. Despite the variation in approach, the two assessments intend to be complementary.

Project Background

The USAID Missions in Bangladesh and Tanzania each identified four projects to participate in this assessment. None of the projects identified are dedicated solely to FP; instead, they take a comprehensive approach to health service delivery, including strong FP programming.

The four projects in Tanzania came to an end in 2021 and the Mission identified three subsequent projects to participate in the assessment. Table 1 indicates the projects in Bangladesh and Tanzania that were selected for this assessment. Descriptions of the projects in Bangladesh and Tanzania are provided in Appendix 2.

Table 1. Selected projects in Bangladesh and Tanzania for this assessment

Project	Implementing Partner
Bangladesh	
Accelerating Universal Access to Family Planning (AUAFP)	Pathfinder
Advancing Universal Health Coverage (AUHC)	Chemonics
MaMoni Maternal and Newborn Care Strengthening Project (MNCSP)	Save the Children
Marketing Innovations for Sustainable Health Development (MISHD)	Social Marketing Company (SMC)
Tanzania (2016 – 2021)	
Boresha Afya Lake and Western Zones (BA-LWZ)	Jhpiego
Boresha Afya Southern Zone (BA-SZ)	Deloitte
Boresha Afya North and Central Zones (BA-NCZ)	Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
Sustaining Health Outcomes through the Private Sector (SHOPS Plus)	Abt Associates, Inc.
Tanzania (2021 – 2026)	
Comprehensive Client-Centered Health Program (C3HP) - Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)	Jhpiego
Afya Yangu Southern (C3HP HIV/TB)	Deloitte
Afya Yangu Northern (C3HP HIV/TB)	Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)

Methods and Limitations

This assessment used a nonexperimental design and included multiple qualitative data collection methods. To the extent that indicator data from project documents and a national health information system (HIS) were available, these data have been reviewed and the findings are included in this report.

The protocol was reviewed by the ICF Institutional Review Board (IRB) and rated exempt in August 2021. Ethics approvals were received by the IRB of the Institute of Health Economics (IHE-IRB) in Bangladesh in November 2021 and the National Institute of Medical Research (NIMR) in Tanzania in February 2022.

Data collection focused on three service delivery HIPs and included the administration of core component checklists and key informant interviews (KIIs). A total of 156 individuals (83 male and 73 female) were data collection participants. Data collection was conducted between January 2022 to May 2022 in Bangladesh and between April 2022 to July 2022 in Tanzania. The bulk of the data collection was conducted virtually. Verbal informed consent was obtained from all participants.

Design of the Data Collection Tools

Data collection tools were developed for administering the core component checklists, and conducting KIIs. The data collection tools align to both the assessment focus areas and are grounded in the assertion that a HIP has core components.

Centrally, this assessment seeks to understand the extent that certain practices (i.e., the selected HIPs) follow established implementation standards (i.e., quality of implementation). For this assessment, the term core component is used synonymously with implementation standard. In addition, the core components reflect the need for criteria for the assessment.

Core components were developed specifically for this assessment and the R4S assessment. The process to determine core components was initiated by considering the HIP briefs, particularly the "how to" section to develop a long list of possible core components.[6] Through literature review and consultation with subject matter experts, the list of core components was reduced, and the final list of core components was established.

At the request of USAID, determining the core components was undertaken collaboratively by R4S and D4I. Determining core components for the CHW HIP and the IPPFP HIP was led by R4S as these HIPs are included in the R4S and D4I assessments. The core components for the MOSD HIP were determined by D4I as only D4I is focusing on this HIP.

The 20 core components are presented in Table 2.

[6] The HIP briefs can be found here: High Impact Practice Briefs | HIPs (fphighimpactpractices.org)

Table 2. Core components for the High Impact Practices (HIPs) included in this assessment

Integrate trained, equipped, and supported community health workers (CHWs) into the health system	
1	Assures CHWs have necessary supplies and materials to fulfill their roles
2	Monitors, reports, and assesses data on CHW services and referrals provided
3	Monitors data on CHW logistics and commodities at both the health center and district level to avoid stockouts
4	Trains and assesses CHWs' abilities to provide services and behavior change messages
5	Provides regular and as-needed supportive supervision from health system to CHWs
6	Engages communities in recruiting and supporting CHWs
7	Formalizes the role of CHWs as part of the health system to recognize their services
Support mobile outreach service delivery (MOSD) to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods	
1	Ensures consideration of cultural, economic, and social factors and needs in relation to client base
2	Coordinates with community leaders as part of aligning staff to needs, raising awareness for the service, and communicating relevant details to potential clients
3	Ensures equipment and supplies are in place and used appropriately
4	Trains service providers in providing respectful care including counseling services and recognizing instances when a referral for additional care is appropriate
5	Procedures in place for discussing follow-up care and helping clients understand how to access follow-up care
6	Follows a plan for collecting and recording data and inputting information in relevant repositories to ensure follow-up
Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[7]	
1	Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences
2	Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients
3	Trains providers for IPPFP on counseling and service provision per local guidance
4	Engages health facility leadership and staff to promote the practice
5	Ensures staff availability for FP services and products prior to discharge
6	Assures that national service delivery guidelines are readily available and widely disseminated
7	Communicates the role of service providers as outlined in national service delivery guidelines

The data collection tool for conducting the KIIs provided instructions for the interviewer, an informed consent procedure, and an interview guide. The approach was to use the interview guide as a way to facilitate a conversation, with the interviewers having the freedom to ask follow-up and probing questions. The interview guide questions were organized as noted below.

- Part 1: Goals and activities of programs in relation to HIP core components
- Part 2: Geographic reach of programs and what challenges have been encountered
- Part 3: Program implementation
- Part 4: Monitoring, Evaluation, and Learning (MEL)
- Part 5: HIP-Specific, Community Health Workers (CHW)
- Part 6: HIP-Specific, Mobile Outreach Service Delivery (MOSD)
- Part 7: HIP-Specific, Immediate Postpartum Family Planning (IPPFP)

[7] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Data Collection

Data collection was undertaken through the administration of the core component checklists and KIIs. Each data collection activity was undertaken by the CBSG team (Bangladesh) and the CREMES team (Tanzania), as follows:

- Bangladesh core component checklists (N = 10)
- Bangladesh KII (N = 16)
- Tanzania core component checklists (N = 9)
- Tanzania KII (N = 27)

Core component checklists were administered through facilitated small group discussion. Each project determined the size and make-up of the group. Generally, the participants were mid- to senior-level management, MEL, and technical staff.

The aim of the small group discussion was to understand if the core components are being implemented and monitored, and if not, why. The core component checklist tools for each HIP are presented in Appendix 3. The key questions were as follows:

- Does the project implement [insert core component]?
- Are there indicators for the core component?
- Probing questions around whether policies are in place to implement the core component and if there is readiness at the service delivery level to implement the core component.
- What challenges and successes have you had in relation to the core component?

Facilitation of the small group discussions centered on establishing consensus among the participants around if the core component is being implemented and monitored. The participants were asked to agree on a ranking for each core component, as noted in Table 3:

Table 3. Scale used for ranking implementation of each core component

1 **LIMITED**	2 **EMERGING**	3 **ADVANCING**	4 **FOUNDATIONAL**
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Following each session, the assessment team also assigned rankings for each core component. Using the same scale as the project team, the assessment team made their rankings based on what they heard in the small group discussion and in adherence to the scale.

Neither the ranking by the project team nor the assessment team should be viewed as a metric, for example, in the way a baseline indicator is viewed. Instead, the rankings—individually from

the project teams and the assessment team in comparison—contribute to the qualitative assessment of the extent that each core component is implemented and monitored.

Across the two countries, small group discussions were conducted virtually. Each small group discussion was primarily conducted in Bengla (Bangladesh) and Swahili (Tanzania), with some discussion in English. A summary of the small group discussion participants by project and sex is presented in Table 4.

Table 4. Summary of the participants for the small group discussions to administer the core component checklists, by project and by sex

HIP / Project		Number of Participants		
		M	F	Total
Integrated CHW HIP				
1	AUAFP	4	4	8
2	AUHC	3	4	7
3	MNSCP	3	3	6
4	MISHD*	4	6	10
5	C3HP-RMNCAH	1	2	3
6	Afya Yangu Southern	3	0	3
7	Afya Yangu Northern	3	0	3
MOSD for Contraceptives HIP				
8	AUAFP	2	5	7
9	AUHC	4	3	7
10	MNSCP	3	3	6
11	C3HP-RMNCAH	2	1	3
12	Afya Yangu Southern	3	1	4
13	Afya Yangu Northern	2	1	3
Immediate PPFP HIP				
14	AUAFP	3	4	7
15	AUHC	4	3	7
16	MNSCP	3	4	7
17	C3HP-RMNCAH	3	0	3
18	Afya Yangu Southern	3	2	5
19	Afya Yangu Northern	2	1	3
TOTALS		**55**	**47**	**102**

**MISD only implements the CHW HIP*

With permission from all participants, each small group discussion was recorded. Based on notes taken and review of the recording, summaries were developed and organized in excel spreadsheets. Analysis of the small group discussion data was in relation to themes, common responses, challenges, and successes.

Across the two countries, 43 KIIs were conducted (14 with project staff and 29 with FP experts at the district level). For the KII with project staff, the assessment team suggested inclusion of mid- to senior-level managers, MEL team members, or technical experts as well as primarily individuals who had not participated in the core component checklist exercise. Each project considered the suggestions of the assessment team, but ultimately determined the KII participants from their staff.

Because the district-level FP experts work with the projects, the projects assisted in selecting and contacting the district-level FP experts. The 16 KIIs in Bangladesh were conducted virtually and 22 of the 27 Tanzania KIIs were conducted in person.

The term district FP expert is broad. In Bangladesh, each of the eight district KII participants worked for the Ministry of Health and Family Welfare in the FP or maternal and child welfare offices. Their titles included medical officer, FP officer, and deputy director. In Tanzania, the 32 district KII participants included district reproductive and child health coordinators and managers, health management and information system focal persons, logistics officers, and CHW coordinators and supervisors. In addition, district KIIs were conducted with staff from district-based civil society organizations (CSOs) and CHWs.

In Bangladesh, the district KIIs were conducted in Brahman Baria, Faridpur, Madaripur, and Manikganj districts. In Tanzania, the district KIIs were conducted in Babati, Geita DC, and Kiteto districts. For both countries, the factors for district selection included project coverage, balance of urban and rural areas, and ensuring inclusion of hard-to-reach areas. Each KII was conducted in Bengla (Bangladesh) and Swahili (Tanzania). A summary of the number of KIIs and number of KII participants is presented in Table 5. The interview guides for the KIIs are presented in Appendix 4 and Appendix 5.

Table 5. Summary of the number of project- and district-level key informant interview participants

Level	Bangladesh				Tanzania				Total			
	# of KII	# of participants			# of KII	# of participants			# of KII	# of participants		
		M	F	Total		M	F	Total		M	F	Total
Project	8	2		8	6	3	3	6	14	5	9	14
District	8	5		8	21	15	17	32*	29	20	20	40
Total	16	7		16	27	18	20	38	43	25	29	54

**Three district KIIs included 4, 4, and 6 participants; therefore, the number of KII and number of participants is not the same*

All but one of the KIIs were recorded, with the permission of the participants. One district KII in Bangladesh was not recorded due to technical challenges. For Bangladesh, summary notes were developed based on the notes taken during each KII and review of the recording. For Tanzania, a transcript for each KII was prepared. The transcribers listened in Swahili and prepared the transcript in English. All summary notes and transcripts were entered into excel spreadsheets for further organization, with continued organization around the interview parts. Analysis of the KII focused on identifying themes, challenges, and successes.

Gender Integration

This assessment did not focus on the performance of a project or a portfolio of projects. Instead, the assessment focused on what indicators are being used to monitor three service delivery HIPs in Bangladesh and Tanzania and assessing the scale of implementation (geographic coverage) as well as the extent the HIPs are being implemented and monitored per established standards (quality of implementation). In this context, gender integration is different from a traditional project performance evaluation. For example, this assessment did not aim to examine the extent that the projects constructively and effectively apply a gender lens in their programming. It is not programming or specific interventions per se that has been the focus; rather, the focus was on how three service delivery HIPs are being implemented and monitored.

Gender integration for this assessment was undertaken by ensuring that the data collection tools incorporated questions around equity and representativeness broadly and gender specifically. An effort was made to have gender balance in terms of data collection and participants. For Bangladesh, the data collection and analysis team consisted of five males and two females. For Tanzania, the data collection and analysis team consisted of eight females and zero males. A total of 156 individuals were included in data collection activities (83 males and 73 females).

Limitations

This assessment used qualitative methods. As such, the assessment entails common limitations, such as the limited generalizability of the data and potential bias in responses from participants.

The focus of this assessment is complicated and nuanced. In particular, prior to this assessment, no implementation standards for HIPs had been established beyond the HIP technical briefs, and as such, HIP core components were developed for this assessment. Bearing this in mind, the results may be better seen as providing insights that can be discussed and applied as part of continued awareness raising around HIPs and establishing a measurement framework for HIPs.

The complexity and focus of this assessment necessitated gathering a large amount of information about the project activities and the MEL approaches, with the project staff also serving as participants in the data collection. The Missions as well as the projects in Bangladesh and Tanzania kindly responded to numerous requests for information with efficiency and understanding despite it not being a requirement for them to do so. Even so, the assessment team was asked to limit the number of requests made to the projects; therefore, it is a limitation of this assessment to not have had unconstrained access to the projects.

Results: Core Component Checklists

This section presents selected results around the core component checklists, including a focus on both the rankings—tallies and averages—and themes that emerged through the small group discussion. In some instances, the results are presented disaggregated between Bangladesh and Tanzania (introduced as “for Bangladesh” or “for Tanzania”); however, the results are primarily presented in the aggregate (introduced as “the projects” to refer to the projects in both Bangladesh and Tanzania). Looking at the results in these two ways aims to provide useful insights in relation to the longer-term goals of the HIPs co-sponsors; notably, to establish a HIPs measurement framework.

Ranking Exercise

Table 3 (presented in the methods and limitations section) presents the scale used for ranking implementation of each core component. The rankings are (1) limited, (2) emerging, (3) advancing, and (4) foundational.

The rankings should not be viewed as a metric, for example, in the way a baseline indicator is viewed. Instead, the rankings are one element of the approach taken in this assessment to qualitatively understand the extent that each core component is or is not being implemented and monitored. In all applicable instances, the average rankings across the project teams and the rankings of the assessment team are presented side-by-side.

As a starting point to presenting the results of the ranking exercise, Table 6 and Table 7 each provide a high-level overview of the rankings. The side-by-side comparison of the project teams and assessment team demonstrates that the project teams' rankings are consistently higher than the assessment team rankings. Such a variation is helpful for considering the possible ways that projects might conflate a broad approach (i.e., CHW, MOSD, IPPFP) with the specificity of each core component. Further, while it is commonplace for projects to have detailed MEL plans inclusive of many indicators that help to track activities, rankings in relation to core components represent a new and different way for projects to track their activities. With this new way of tracking, it is possible that the projects relied on ranking based on what they aspire to achieve.

Table 6 presents the average rankings for each HIP. The project teams' average rankings for each HIP are higher than the assessment teams' average rankings for each HIP. In only one instance is the average ranking below 3.0 (assessment team rank for the CHW HIP).

Table 6. Average rankings for each HIP

HIP	Average Ranking	
	Project Teams	Assessment Team
Integrated CHW	3.17	2.68
MOSD for contraceptives	3.45	3.03
Immediate PPFP	3.58	3.12

Table 7 conveys that the rankings of 3 and 4 are more common for the project teams. The largest difference is with the ranking of 4 (69 instances for the project teams in comparison to 32 instances for the assessment team). In addition, the project teams rarely gave themselves a ranking of 1 or 2 (18 instances in comparison to 109 instances of a rank of 3 or 4).

Table 7. Number of instances of each ranking

Rank	# of instances	
	Project Teams	Assessment Team
Rank of 1 (Limited)	4	10
Rank of 2 (Emerging)	14	22
Rank of 3 (Advancing)	40	63
Rank of 4 (Foundational)	69	32

Table 8 presents a tally of core components with rankings 1 or 2, with the number of instances from the project teams and assessment team side-by-side. For the CHW HIP, there are a total of 10 instances of a core component ranking of 1 or 2 from the project teams and 17 instances from the assessment team. For the MOSD HIP, there are a total of 5 instances of a core component ranking of 1 or 2 from the project teams and 9 instances from the assessment team. For the IPPFP HIP, there are a total of 3 instances of a core component ranking of 1 or 2 from the project teams and 6 instances from the assessment team.

Tallying and averaging rankings shows how project teams view the extent to which they are implementing and monitoring individual HIPs and which core components they may implement and monitor less. For example, as presented in Table 8, CHW core components 6 and 7 have the most rankings of 1 and 2. However, interpretation of these rankings needs to be cautious, particularly because the rankings are subjective.

Table 8. Instances where individual core components were given a ranking of 1 or 2

	Integrated CHW: Core components	Instances of 1 or 2 rankings	
		7 Project Teams	Assessment Team
1	Assures CHWs have necessary supplies and materials to fulfill their roles	1	3
2	Monitors, reports, and assesses data on CHW services and referrals provided	1	1
3	Monitors data on CHW logistics and commodities at both the health center and district level to avoid stockouts	1	1
4	Trains and assesses CHWs' abilities to provide services and behavior change messages	1	1
5	Provides regular and as-needed supportive supervision from health system to CHWs	1	1
6	Engages communities in recruiting and supporting CHWs	3	4
7	Formalizes the role of CHWs as part of the health system to recognize their services	2	6
Sub-Total		***10***	***17***
	MOSD for contraceptives: Core components	**Instances of 1 or 2 rankings**	
		6 Project Teams	**Assessment Team**
1	Ensures adequate attention to relevant cultural, economic, and social factors as well as the overall context and needs in relation to the intended client base	2	3
2	Coordinates with community leaders as part of aligning staff to the specific needs, establishing a plan to raise awareness for the service, and communicating the relevant details to potential clients	0	1
3	Ensures the necessary equipment and supplies are in place and used appropriately to provide family planning services as well as integrated services, including preparedness for any emergency needs	1	2
4	Trains service providers in providing respectful care including counselling services and recognizing instances when a referral for additional care is appropriate	1	1
5	Procedures in place for discussing the importance of follow-up care with their clients and helping clients understand how to access follow-up care	1	1
6	Follows a plan for collecting and recording relevant data and inputting that information into the relevant national, sub-national, and/or project repositories to ensure follow-up	0	1
Sub-Total		***5***	***9***
	Immediate PPFP: Core components	**Instances of 1 or 2 rankings**	
		6 Project Teams	**Assessment Team**
1	Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences	0	0
2	Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients	0	0
3	Trains providers for IPPFP on counseling and service provision per local guidance	1	0
4	Engages health facility leadership and staff to promote the practice	0	2
5	Ensures staff availability for FP services and products prior to discharge	1	2
6	Assures that national service delivery guidelines are readily available and widely disseminated	0	0
7	Communicates the role of service providers as outlined in national service delivery guidelines	1	2
Sub-Total		***3***	***6***
TOTAL		***18***	***32***

Small Group Discussion

Integrated Community Health Worker (CHW) High Impact Practice (HIP)

The project and assessment team core component rankings for the CHW HIP are presented in Table 9. For Bangladesh, core component 3 has the highest average ranking across the project and assessment teams (3.75 and 3.50 respectively). For Tanzania, core component 4 has the highest average ranking across the project and assessment teams (4.00 and 3.67 respectively). The lowest average ranking across the project and assessment teams in Bangladesh is for core component 6 (2.25 and 1.75 respectively). The lowest average ranking across the project teams in Tanzania is for core component 1, 2, 3, and 7 (3.00) while the lowest ranking for the assessment team in Tanzania is for core component 7 (1.67).

Table 9. Project and assessment team core component rankings on a scale of 1 to 4 for the community health worker (CHW) High Impact Practice (HIP), Bangladesh and Tanzania

Core components		Bangladesh		Tanzania	
		4 Project Teams	Assessment Team	3 Project Teams	Assessment Team
1	Assures CHWs have necessary supplies and materials to fulfill their roles	3.50	2.75	3.00	2.33
2	Monitors, reports, and assesses data on CHW services and referrals provided	3.25	2.75	3.00	3.33
3	Monitors data on CHW logistics and commodities at both the health center and district level to avoid stockouts	3.75	3.50	3.00	2.33
4	Trains and assesses CHWs' abilities to provide services and behavior change messages	2.75	2.75	4.00	3.67
5	Provides regular and as-needed supportive supervision from health system to CHWs	3.00	2.75	3.33	3.33
6	Engages communities in recruiting and supporting CHWs	2.25	1.75	3.67	2.33
7	Formalizes the role of CHWs as part of the health system to recognize their services	2.75	2.25	3.00	1.67
AVERAGE ACROSS ALL CORE COMPONENTS		***3.04***	***2.64***	***3.29***	***2.71***

The project team rankings for each core component were the culmination of a small group discussion among project staff facilitated by the assessment team. The discussion made apparent some of the barriers to a ranking of 4 and provided insights about what indicators the projects see as relevant to the HIP (see Box 1).

- ***Core component 1:*** The projects indicated there are national guidelines; but ambiguities exist in terms of defining necessary supplies for CHWs. For example, it was mentioned that CHWs often feel they need a bicycle; however, that may not be seen as necessary by others in comparison to other supplies. Further, the projects mentioned that they often act as a third-party coordinator to help facilitate CHWs receiving supplies but have limited control over availability of supplies. It was noted that tracking supply distribution to CHWs would benefit from computer-based supply chain management systems; however, projects do not always have the needed resources and instead rely on manual and more informal systems, such as WhatsApp groups.

- ***Core component 2:*** Several projects reported having strong systems to monitor, report, and assess data on CHW services, but not referrals. Relatedly, national guidelines focus on the provision of FP services overall and not FP services specifically for CHWs. For Tanzania, it was noted that routine reporting on CHWs has prompted the government to take the role of CHWs more seriously and continue to establish standards.
- ***Core component 3:*** The projects that support both services and commodities discussed the importance of avoiding stockouts. For Tanzania, it was noted that some projects only support CHW services. For Bangladesh, one project follows a push sales method which is needs-based whereas another project keeps a stockpile in reserve. To move from recording data manually would require CHWs to have the skill to enter data in tablets and this is not always feasible.

Box 1. Indicators mentioned during administration of CHW core component checklist

- # of methods provided to clients by CHWs
- Contraceptive prevalence rate (CPR) by method
- Total fertility rate
- # of clients contacted with messages through interpersonal communication
- Couple years of protection
- # of clients served by CHWs
- # of commodities provided to clients
- # of CHWs trained / untrained
- # of CHW that engage with project
- # of service providers trained
- # of supervision visits conducted by staff
- # trained in mentorship or supportive supervision
- # of community leaders engaged
- # of community leaders involved in project

- ***Core component 4:*** The projects indicated they provide training for CHWs per national guidelines; however, projects often rely on CHWs previously trained by another project. For Tanzania, it was reported that the trainers and supervisors are sometimes from the MOH. In this context and without CHWs integrated into the health system, a disconnect is present that sometimes creates complications in that the MOH-provided trainers and supervisors often only assess capacity and performance informally.
- ***Core component 5:*** The approach to supervision was often described as supportive, routine, and coaching oriented. Some challenges in providing supervision mentioned include weak mobile networks, limited internet access, and mobility of the CHWs. The projects gave mixed responses about the existence of and adherence to national guidelines. It was noted that the number of supervisory observation visits is generally not tracked as an indicator.
- ***Core component 6:*** In some instances, the projects indicated they onboard CHWs from past projects rather than recruit new ones. Further, it was noted that recruiting from the community is not the same as involving the communities in the recruitment process. Several projects indicated that involving community leaders in recruitment often becomes political and potentially results in preference for under-qualified CHWs. The projects consistently mentioned they follow protocols for community engagement; however, community engagement protocols are not necessarily always outlined in national guidelines.
- ***Core component 7:*** For Bangladesh, it was noted that formalization reveals inconsistencies regarding whether CHWs receive a salary and whether the salary is from the government. For Tanzania, the projects noted that often the government scrambles to retain CHWs when projects end, and therefore, the projects do not view formalization as their responsibility.

Mobile Outreach Service Delivery (MOSD) High Impact Practice (HIP)

The project and assessment team core component rankings for the MOSD HIP are presented in Table 10. For Bangladesh, core components 2, 5, and 6 have the highest average rankings across the project and assessment teams (3.33 and 3.00 respectively). For Tanzania, core components 3, 4, and 6 have the highest average ranking across the project teams (4.00) and core component 6 has the highest average ranking from the assessment team (4.00). The lowest average ranking across the project and assessment teams in Bangladesh is for core component 1 (2.33 and 1.67 respectively). The lowest average ranking across the project teams in Tanzania is for core component 1, 2, and 5 (3.67) while the lowest ranking for the assessment team in Tanzania is for core component 1 (3.00).

Table 10. Project and assessment team core component rankings on a scale of 1 to 4 for the mobile outreach service delivery (MOSD) High Impact Practice (HIP), Bangladesh and Tanzania

Core components		Bangladesh		Tanzania	
		3 Project Teams	Assessment Team	3 Project Teams	Assessment Team
1	Ensures consideration of cultural, economic, and social factors and needs in relation to client base	2.33	1.67	3.67	3.00
2	Coordinates with community leaders as part of aligning staff to needs, raising awareness for the service, and communicating relevant details to potential clients	3.33	3.00	3.67	3.33
3	Ensures equipment and supplies are in place and used appropriately	3.00	2.33	4.00	3.33
4	Trains service providers in providing respectful care including counselling services and recognizing instances when a referral for additional care is appropriate	3.00	2.67	4.00	3.33
5	Procedures in place for discussing follow-up care and helping clients understand how to access follow-up care	3.33	3.00	3.67	3.67
6	Follows a plan for collecting and recording data and inputting information in relevant repositories to ensure follow-up	3.33	3.00	4.00	4.00
AVERAGE ACROSS ALL CORE COMPONENTS		***3.05***	***2.61***	***3.84***	***3.44***

The project team ranks for each core component were the culmination of a small group discussion among project staff facilitated by the assessment team. The discussion made apparent some of the barriers to a ranking of 4 and provided insights about what indicators the projects see as relevant to the HIP (see Box 2).

- ***Core component 1:*** It was noted by the projects that national guidelines exist, but they generally do not cover location selection; however, projects do undertake community engagement and sensitization. For Bangladesh, it was reported that the locations for MOSD sites often were inherited from earlier projects, and the priority of past projects was to put the MOSD sites in central locations and evenly dispersed geographically. Relatedly, the government of Bangladesh does not implement programs for ethnic and vulnerable people that the projects feel would be challenging to establish a MOSD site with ethnicity and vulnerability as the main criteria for location selection. For Tanzania, the projects emphasized the importance of considering negative and positive cultural, economic, and social factors.

- ***Core component 2:*** Coordination with community leaders was described as an important yet challenging endeavor because sometimes community leaders do not agree with national FP policies. As a result, project work includes advocacy as well. Routine meetings were mentioned as key to understanding community context; however, indicators that record the number of meetings have limited utility as they do not capture the effectiveness of the meetings.
- ***Core component 3:*** Generally, the projects indicated they try to keep extra MOSD supplies on hand while also having procedures for reallocating from one location to another as needed. There are still instances where the equipment and supplies are insufficient for the number of clients. The projects noted that MOSD largely is not well set up to handle emergency needs unless there is a facility nearby. For Tanzania, the projects described that outreach teams coordinate across multiple government levels and offices and ultimately, questions around equipment and supplies hinge on the budget that has been allocated.
- ***Core component 4:*** The projects undertake training needs assessment work and align the training to national programs as feasible. Consistently, the projects noted that training is more focused on health and FP services broadly as opposed to FP services specifically at MOSD sites. Often, MOSD team members would have been trained already in FP services because they provide FP services at a facility; therefore, any additional preparatory work is more oriented to MOSD in general. For Tanzania, it was described that following orientation there is considerable on-the-job training and mentorship undertaken.
- ***Core component 5:*** For Bangladesh, the projects indicated that procedures for follow-up care are an important aspect of national guidelines. Some of the challenges noted include reliance on manual registers and follow-up cards, which are potentially not as effective as a computerized system. In addition, manual systems rely on cell phone communications between service providers and clients and cell phone service is sometimes limited. Similarly, for Tanzania, the value of cell phones was noted, but also concern was expressed in that reliance on cell phones potentially increases the need for local a service provider to be present for any MOSD service to help ensure the client knows who to follow up with. Further, the projects indicated that the follow-up care procedures for MOSD are linked to those for the facility.
- ***Core component 6:*** There were mixed responses from the projects about whether data entry occurs at the MOSD site or once back at the aligned facility. In either scenario, MOSD data collection is generally manual and begins by completing a form. The projects referenced the importance of recording data in government registries but expressed frustration around shortages of laptops as well as internet connectivity issues.

Box 2. Indicators mentioned during administration of MOSD core component checklist

# of caregivers meeting health management

# of committee management meetings held

# of service delivery point stockout

# of service providers trained

# of persons trained

# of participants trained on counseling

# of participants trained on family planning, including referrals

# of follow-up clients for specific FP service

# of methods uptakes

Couple years protection

Immediate Postpartum Family Planning (IPPFP) High Impact Practice (HIP)

The project and assessment team core component rankings for the IPPFP HIP are presented in Table 11. For Bangladesh, core components 1 and 6 have the highest average ranking across the project teams (3.67) while core component 1 has the highest average ranking across the assessment team (3.67). For Tanzania, core components 1, 2, 3, and 7 have the highest average rankings across the project teams (4.00) while core component 2 has the highest average ranking from the assessment team (4.00). The lowest average ranking across the project teams in Bangladesh is for core components 4, 5, and 7 (3.00) while the lowest average ranking from the assessment team is for core component 5 (2.33). The lowest average ranking across the project teams in Tanzania is for core component 4, 5, and 6 (3.67) while the lowest ranking for the assessment team in Tanzania is for core component 4 (2.67).

Table 11. Project and assessment team core component rankings on a scale of 1 to 4 for the immediate postpartum family planning (IPPFP) High Impact Practice (HIP), Bangladesh and Tanzania

Core Components		Bangladesh		Tanzania	
		3 Project Teams	Assessment Team	3 Project Teams	Assessment Team
1	Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences	3.67	3.67	4.00	3.33
2	Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients	3.33	3.00	4.00	4.00
3	Trains providers for IPPFP on counseling and service provision per local guidance	3.33	3.33	4.00	3.67
4	Engages health facility leadership and staff to promote practice	3.00	2.67	3.67	2.67
5	Ensures staff availability for FP services and products prior to discharge	3.00	2.33	3.67	3.00
6	Assures that national service delivery guidelines are readily available and widely disseminated	3.67	3.00	3.67	3.67
7	Communicates the role of service providers as outlined in national service delivery guidelines	3.00	2.33	4.00	3.00
AVERAGE ACROSS ALL CORE COMPONENTS		***3.29***	***2.90***	***3.86***	***3.33***

The project team ranks for each core component were the culmination of a small group discussion among project staff facilitated by the assessment team. The discussion made apparent some of the barriers to a ranking of 4 and provided insights about what indicators the projects see as relevant to the HIP (see Box 3).

- ***Core component 1:*** The projects described the use of registers, reporting procedures, and computerized supply chain management systems as key to ensuring availability. The challenges mentioned related to the need to take additional actions through more informal means, such as supervisory visits via WhatsApp group discussion, to ensure availability.

- ***Core component 2:*** Several projects expressed that tracking counseling, offering, and uptake of methods is not a single endeavor, and that the weakest area is counseling. While counseling is provided, the projects noted they face challenges to assess the quality and impact of the counseling.
- ***Core component 3:*** The projects provided mixed responses about whether training is IPPFP specific and the extent that training around counseling is provided. For Bangladesh, the importance of couple counseling was noted as was the reality that projects cannot control if private sector clinics provide IPPFP. For Tanzania, it was noted that training has helped service providers see the value of IPPFP yet challenges still exist as providers are sometimes uncomfortable providing FP counseling within the first 48 hours after a woman has given birth.
- ***Core component 4:*** The projects reported that they engage health facility leaders; however, facility staff turnover and the need to navigate multiple levels of leadership create challenges.
- ***Core component 5:*** Consistently the projects noted that the goal is to have staff available for FP services 24 hours per day, 7 days a week, and that they coordinate with the facility management. For some of the specialized services, the facilities are not able to have back up staff if the regular staff are absent. More broadly, staff shortages sometimes mean that staff based in labor wards who are well-versed in IPPFP are reallocated to other units.
- ***Core component 6:*** The projects reported that providing national service delivery guidelines is relatively straightforward. Often the projects provide supplemental materials as well, which they report helps to improve services. The challenges mentioned included the facilities losing the documents and deviating from the guidelines due to lack of supervision.
- ***Core component 7:*** It was noted by the projects that service provider roles are conveyed through job descriptions and other informational materials. For Bangladesh, one challenge was having to ensure that what the project communicates to a facility human resources department is accurately disseminated. Similarly, for Tanzania the projects noted that often they must provide additional explanation to help service providers understand their job responsibilities in the context of the overall national guidelines.

Box 3. Indicators mentioned during administration of IPPFP core component checklist

- # of facility having IPPFP commodity available
- # of facility that meet PPFP criteria
- # of women receiving IPPFP services
- % of women receiving PPFP service from public health facilities
- # of counseling and offerings
- # service received and uptakes by method
- # of PPFP service during ANC
- # of women that get pregnant
- # of deliveries at facility or community
- # of women counseled during PNC visit
- # of postpartum mothers receiving counseling
- Proportion of mothers receiving IPPFP services in the labor ward
- # of deliveries and # of women receiving family methods after delivery
- # of people trained
- # of increased services after training
- # of service providers trained on IPPFP
- # of training or trainers
- # of types of providers
- Proportion of postpartum mothers that adopt family planning methods
- # of facility that mee WHO readiness criteria for family planning
- # of facilities that receive family planning manual

Results: Key Informant Interviews (KIIs)

Across the two countries, 43 KIIs were conducted (14 with project staff and 29 with FP experts at the district level). The results in this section—organized by the seven interview guide parts—are primarily presented in the aggregate with selected distinctions between Bangladesh and Tanzania and project staff and FP experts at the district level.

Part 1: Goals and Activities

Consistently the key informants indicated that their approach to FP services is interconnected to maternal and child health, sexual and reproductive health, and even health services in general. Best practices revolved around, for example, but not limited to, providing client-focused services, ensuring service providers have access to training, aligning to government approaches and national guidelines, communicating, and working with the communities and community leaders, and other provision and supervision of quality health care service activities.

The responses from the key informants also varied and serve as a good reminder that the term "FP programming" is broad. For example, key informants described FP programming in relation to the clinical setting, diagnostic services, awareness raising, and health products or commodities and ensuring awareness of and access to these products. These focus areas, and others, logically can be part of "FP programming." However, their diversity creates challenges for the aims of this assessment and broader interest in globally standardized FP indicators. The crux of the challenge is the HIPs, the core components, and this assessment are highly specific and "FP programming" is broad, context specific, and topically multi-faceted.

Each key informant interview began with the question "how familiar are you with high impact practices or HIPs?" Responses to this question were post-coded, with the results presented in Table 12. This post-coded data suggests familiarity with the HIPs was not common across the key informants. However, "not familiar" responses from the key informants were often followed by recognition that they learned about the HIPs initiative through this assessment and that projects and country programs likely implement what is laid out in the CHW, MOSD, and IPPFP HIPs.

Table 12. Level of familiarity with High Impact Practices (HIPs), post coded responses from key informants

	Bangladesh	Tanzania
Very familiar	2	3
Somewhat familiar	1	5
Not familiar	13	8
Unclear	0	11

Part 2: Geographic Reach

Responses from the key informants about geographic reach were divergent, particularly between project-level key informants and district-level key informants. The variety can partly be attributed to the reality that each project has a unique scope of work. Further, projects are not necessarily mandated to reach all areas and all population groups in the country; however, country programs that the district key informants are involved in have such mandates.

The project key informants noted several nuances about geographic reach, representativeness, and the related challenges they face, as follows:

- Project geographic reach is often based on the needs and context of different areas and therefore, the services and approaches are not necessarily always the same for each area.
- Ensuring coverage for hard-to-reach areas is challenging, particularly in terms of travel and related logistics.
- Ensuring coverage for vulnerable sub-populations, such as ethnic minorities, pastoralists, adolescents, persons with disabilities, and others requires CHWs, MOSD teams, and facility staff to have specialized knowledge and training for working with specific sub-populations, which is not always of interest and/or possible.
- In some instances, projects are following government direction and do not necessarily control decision making around geographic coverage and representativeness; however, projects also try to fill gaps in terms of areas where government programs face challenges.
- Certain program design choices, particularly who is allowed in the room during service provision, can lead to men being excluded from project activities.
- In instances where the projects only target government hospitals, coverage of private clinics and hospitals is not within the project's control, and IPPFP services often are not provided at private clinics and hospitals.

Most of the project and district key informants emphasized that, despite limitations to having complete geographic coverage and full representativeness, the level of awareness, interest in, and uptake of FP services is improving.

Part 3: Program Implementation

Generally, the key informant responses mirror the core component checklist exercise in noting both successes and challenges. To an extent, it appears that the key informants offered more details in describing the challenges and complexities, which is possibly because the key informants were not asked to determine a ranking for each core component. The overarching challenges and complexities reported by the key informants include:

- ***Human and Financial Resources:*** The key informants consistently noted that often facilities do not have the needed human resources to implement all aspects of CHW, MOSD, and IPPFP programs. Efforts to work with the available human resources are often complicated given routine reallocations to try to counterbalance staff shortages and staff burn out. Some challenges with financial resources were noted, particularly inconsistent or limited access to vehicles.
- ***Skills:*** As consistently noted by the key informants, providing training is a high priority and systems are in place for the provision of training. However, training alone is not necessarily enough to ensure and maintain the needed level of skill and expertise. For Bangladesh, it was noted that long-standing CHW and facility staff sometimes lack motivation to take refresher training. Relatedly, for Tanzania, it was noted that the movement of service providers from

facility to facility creates high demand for refresher training. In both countries, the key informants expressed that skill gaps can generally be addressed through training, but regular supportive supervision and mentorship are also essential.

- ***Policy:*** The responses from key informants highlight the nuances of project-government relationships. In particular, the project key informants mentioned the prominence of national policies and guidelines relating to FP and service provision and the importance of aligning to them while district key informants noted the important role of projects to help improve government programs. In describing this relationship, the key informants often noted that the objectives and approaches of projects do not necessarily always align with national policies and guidelines notably in relation to targeted focus on ethnic minorities and vulnerable sub-populations.
- ***Quality Assurance Procedures:*** Commonly the key informants indicated that quality assurance procedures must be grounded in routine monitoring, supportive supervision, mentoring, and data verification while also incorporating platforms for client feedback (i.e., suggestion boxes, satisfaction surveys, dialogue) and processes for integrating the feedback as applicable. The main challenges with quality assurance procedures mentioned by the key informants were lack of human resources, hesitancy from community and religious leaders to prioritize the FP activities of the project, and broad concern that quality assurance procedures are the focus of the projects more than they are the focus of the facility.

Part 4: Monitoring, Evaluation, and Learning (MEL)

Discussion of MEL was varied among the key informants because of the specificities across the seven projects and their working relationships with the government and government facilities. However, one dynamic the key informants consistently noted is that the HIPs do not have standard reporting tools and relatedly, national policies and guidelines tend to focus on FP in a broader sense and not in terms of individual components of discrete HIPs. As such, MEL around HIPs was described as additional MEL work that is done to respond to donor requirements.

The key informants for Bangladesh noted that retaining qualified MEL staff on the project can be challenging, particularly in the context of the number of facilities from which data are being collected and monitored. Relatedly, with staffing challenges and the realities of COVID-19, field visits for data verification have been limited, which potentially impacts the quality of the data.

The key informants also reported challenges since FP-related MEL frameworks prioritize quantitative measures and a business-model approach to document targets and achievements. It was noted that this style of prioritization sometimes overlooks what works well, what does not, and why, as well as specific success stories.

The key informants for Tanzania emphasized that both the project activities and the MEL system are aligned to the priorities of and indicators from the MOH. To this end, the project MEL data is contained within an HMIS, and the projects play an important role in strengthening data quality capacity and data use through training and mentorship.

The MEL related challenges noted by the key informants centered on data quality. In particular, the key informants indicated that many of the data quality assessment procedures and tools are not fully under the purview of the project; rather, they are folded into government guidelines. It was also noted that delays in uploading data into an HMIS sometimes cause discrepancies when the data are pulled at different times.

Box 4 presents the indicators mentioned during the Tanzania district key informant interviews. One indicator-related challenge reported by the key informants included difficulties with tracking the number of personnel trained over time; notably that the indicators generally do not allow for knowing if the recipients of the training retain their positions as service providers.

Box 4. Indicators mentioned during the Tanzania district key informant interviews

Related to Integrated CHW HIP

# of clients counseled and received FP services (condoms/pills) from CHW

# of commodities given to CHWs

# of women mobilized by CHWs to receive FP services at facility

Related to MOSD for Contraceptives HIP

# of clients that received FP methods during outreach

# of new clients (have used a FP method before)

# of clients that are new FP users

# of clients that have come for method removal

Related to Immediate PPFP HIP

# of women that gave birth and adopted a FP method immediately after giving birth (labor ward or postpartum)

% of women that adopt FP methods postpartum against total deliveries

# of commodities in the labor ward

# of women who have been counseled for PPFP

Part 5: HIP-Specific, Integrated Community Health Workers (CHW)

The key informants offered a range of perspectives about the extent that CHWs are integrated into the health system. Most key informants included an assertion that it is not necessarily realistic to think of integrating CHWs into the health system as the responsibility of a donor-funded project. For Bangladesh, most key informants referenced that CHWs are commonly government employees as evidence of integration into the health system. At the other end of the spectrum, for Tanzania, most key informants referenced that CHWs are generally not employees of the government as evidence of lack of integration into the health system.

Across both countries, comments from the key informants highlighted that who employs CHWs is not the only determinant of integration into the health system. Other examples of evidence of integration into the health system noted by the key informants included the ways that CHWs are recognized across different levels of the government and among facility staff, the considerable amount of data CHWs collect (which they either enter directly into the national system or share for someone else to enter in the national system), the involvement of community leaders in selecting CHWs, instances of CHWs reporting directly to facility staff or receiving supplies directly from facilities, and efforts to provide CHWs with supportive supervision.

While the CHW HIP centers on integration into the health system, the HIP also advocates focus on ensuring CHWs receive training on FP service provision; have access to information, supplies, and equipment; and receive supportive supervision. The perspectives of the key informants in these areas are as follows:

- ***Training:*** The key informants described training as largely oriented toward health service provision broadly as opposed to specific HIPs. For example, it was often noted that training focuses on counseling and PPFP counseling and not IPPFP. The project key informants tended to express more confidence in the level of training among CHWs in comparison to the district key informants. The latter set of key informants held the view that CHWs need refresher training more frequently.
- ***Access to Information, Supplies, and Equipment:*** The key informants for Bangladesh emphasized that communications and information sharing with and among CHWs is strong, particularly through routine meetings and cell phone conversations as needed. It was noted that CHWs in Bangladesh often receive enough supplies for 15 days and have procedures in place to obtain additional supplies as needed. The key informants in Tanzania similarly emphasized that CHWs coordinate with facilities and with each other. It was noted that supplies are considered to be owned by the Tanzanian government and facilities maintain a ledger to track the supplies issued to CHWs; however, it was also noted that CHWs in Tanzania generally only provide information to clients and do not give out specific contraceptive methods.
- ***Supportive Supervision*:** Generally, the key informants described supportive supervision of CHWs as occurring routinely. It was noted that virtual check-ins and field visits from a supervisor focus on the number of clients, location of clients, challenges, documentation of activities, and submission of reports. The key informants noted that the use of coaching and mentoring techniques is important to help ensure that supervision is not overly weighted toward oversight and accountability alone without consideration of skill building and professional development.

Part 6: HIP-Specific, Mobile Outreach Service Delivery (MOSD)

The responses from the key informants make apparent similarities and differences in MOSD approaches. The variation is not surprising. Globally, MOSD has a broad aim of increasing access to health services; however, what is classified as mobile as well as proximity to a facility is often country specific. Consistently, the key informants described MOSD in terms of providing FP services and engaging in FP community awareness raising and sensitization broadly as opposed to providing contraceptives methods only. Similarly, it was noted that formal training around MOSD for contraceptives generally does not exist. The key informants indicated they follow national guidelines on FP service provision training, which include MOSD. They also noted that any training around providing contraceptives via MOSD tends to be more on the job and focused on logistics and that service providers rely on community engagement activities to facilitate understanding of community need as well as cultural, economic, and social factors.

While the MOSD HIP centers on the provision of contraceptives, the HIP is also grounded in ensuring thoughtfulness in how MOSD sites are determined, the availability of multiple contraceptive methods, and that systems for referrals and follow-up care are in place. The perspectives of the key informants in these areas are as follows:

- ***Site Selection:*** The key informants described a nuanced set of factors that inform the process to select MOSD sites. For Bangladesh, it was emphasized that they try to prioritize areas with less access and consider population density but must also factor in the needs and wishes of the community, particularly women. The responses about consideration of cultural and socioeconomic factors were mixed; it was emphasized that ultimately client needs are prioritized. For Tanzania, the key informants noted that MOSD is undertaken in connection with the overall community sensitization campaigns and advocacy for FP. Further, it was noted that CHWs play an important role in aligning MOSD with community context and specific cultural and socioeconomic factors.
- ***Availability of Contraceptives:*** The key informants for Bangladesh indicated that stock monitoring is done at the central level; a logbook and register are used to document the disbursement of contraceptives and other supplies to MOSD sites. Some of the challenges noted include restrictions as a USAID-funded project, unavailability of drugs, receiving damaged supplies, and the need to refer clients to a facility for long-term methods. Similarly, the key informants for Tanzania noted that sometimes service providers are not able to provide MOSD clients with long-acting methods either because the methods are unavailable or there is not a service provider at the MOSD site with the needed skills.
- ***Referrals and Follow-up Care*:** Generally, the key informants described referral and follow-up care procedures and systems at MOSD sites as informal. For example, it was noted that in some instances a referral slip is given to a client; in others, service providers escort clients from the MOSD site to the facility or follow up by phone. In addition, the key informants indicated that often referrals are given based on knowledge of the schedule of procedures to be given at the facility.

Part 7: HIP-Specific, Immediate Postpartum Family Planning (IPPFP)

The key informants emphasized that FP counseling is an essential part of their approach; however, they generally indicated that FP counseling begins during ANC visits and continues onsite at the facility following delivery and during PNC visits. Relatedly, it was consistently noted that many women are not delivering at a facility; therefore, FP counseling following delivery is often a challenge.

The comments from the key informants make apparent that the specificity of IPPFP is in some instances not understood by project staff and service providers and in other instances, a challenge to implement. In particular, there was inconsistent understanding that "immediate" is defined as within 48 hours. Some of the systemic challenges around implementing IPPFP include:

- Varied levels of staff awareness and availability to provide IPPFP as well as a lack of commodities and equipment for IPPFP services

- Limitations to the number of trained staff to provide counseling and services for long-acting methods, leading to potential prioritization of short-term methods
- Limited number of service providers with IPPFP skills assigned to labor wards; however, efforts are made to not rotate service providers with IPPFP skills out of the labor ward
- Lack of space and privacy for IPPFP
- Absence of IPPFP at private clinics
- Inclusion of IPPFP at district-level facilities, but not at sub-district level facilities
- Varied levels of confidence among service providers in IPPFP
- Need for increased advocacy to facility managers to promote IPPFP

Some of the challenges around implementing IPPFP in relation to client attitudes, beliefs, and practices include:

- Hesitancies to make FP-related decisions in the immediate postpartum timeframe
- Misperception from clients and their families that women cannot get pregnant while breastfeeding and therefore feeling that IPPFP is not needed
- Religious beliefs that do not allow for FP counseling or services
- Influence from husbands and mothers-in-law to not receive FP counseling or services

Results: Assessment Focus Areas

The previous section presented selected results organized by data collection activity. This section is organized by assessment focus areas. In addition, this section combines results and discussion, looks across all data collection activities as applicable, and draws on national HIS data. The focus continues to be on the three service delivery HIPs selected for this assessment.

Monitoring, Evaluation, and Learning (MEL)

The planning and design for this assessment revealed that while the projects have strong MEL systems, they are not set up specifically to monitor HIPs. Certain indicators align to the HIPs in general, but often the indicator definitions do not align fully to the specificity of the HIPs and their core components. The discussions during the core component checklist exercise and the KIIs further indicate this disconnect. While the assessment might have had an original goal to look at HIPs implementation with existing project indicators, designing and carrying out the assessment proved to be an unachievable goal. The projects have results frameworks and report on numerous indicators as part of their quarterly and annual reporting; however, with any MEL system, there is a limit to what can be included (i.e., objectives, results, intermediate results, indicators, etc.). As such, this assessment brings to light the important question of whether it is feasible to ask projects to expand their results frameworks, lists of indicators, and overall MEL systems to also report on HIPs. Some potential feasibility challenges relate to project type and core component specificity, as follows:

- ***Project Type:*** One potential challenge around expanding a project MEL system relates to whether a project is dedicated to FP versus a comprehensive health service delivery project with FP programming. The projects for this assessment are the latter. A comprehensive approach potentially does not lend itself well to the extent that the HIPs and their core components carry a singular focus on FP.
- ***Core Component Specificity:*** A second potential challenge around including HIP-specific indicators in a project MEL system relates to how compatible the core components are to having indicators given the specificity of the core components.

These types of feasibility challenges are further illuminated in Table 13, Table 14, and Table 15. For each HIP, the tables present 66 existing project indicators as aligned to the 20 core components. There are two sources for the indicators: 22 are indicators that one or more project reported during the indicator mapping exercise undertaken as part of the assessment design and 24 are indicators the assessment team identified in the fiscal year (FY) 20 annual reports from the projects.

There are indicators that align to six core components, including three for the CHW HIP, zero for the MOSD HIP, and three for the IPPFP HIP. Certainly, it is likely the projects have additional indicators that the assessment team missed or were not made aware of; however, the three tables also seem indicative of the ways that core components tend to be conceptual statements relating to a series of activities and processes. Further analysis of the three tables is presented following the third table.

Table 13. Aligning indicators to core components, community health worker (CHW) High Impact Practice (HIP)

Individual core components and relevant indicators	Soure	# of projects reporting indicator		Core component rankings*	
		BG	TZ	BG	TZ
Assures CHWs have necessary supplies and materials to fulfill their roles				**3.5**	**3.00**
None					
Monitors, reports, and assesses data on CHW services and referrals provided				**3.25**	**3.00**
# of USG assisted CHW providing FP information, referrals, and/or services during the year	SRIM	4	2		
# of USG assisted CHWs providing FP information, referrals, and services	FY20AR		1		
% of clients referred by CHWs who received the services needed	FY20AR		1		
% of UH & FWCs providing 24/7 normal delivery services	FY20AR	1			
Monitors data on CHW logistics and commodities at both the health center and district level to avoid stockouts				**3.75**	**3.00**
None					
Trains and assesses CHWs' abilities to provide services and behavior change messages				**2.75**	**4.00**
# of CHWs trained using integrated MNCH curriculum	FY20AR		1		
# of GSPs are trained on injectables under project	FY20AR	1			
# of PCHP trained on injectables under project	FY20AR	1			
# of PSP's assistants are trained on counseling, infection prevention and record keeping for LARC services	FY20AR	1			
# of BSPs trained with the new curriculum (referrals for LAPM and TB, injectables, FP counseling, MCH, ARI and nutrition)	FY20AR	1			
# of service providers trained on use of at least one modern communication technology for adolescents and youth with support of USG funding	SRIM	1			
# of service providers trained with support of USG funding	SRIM	1	1		
# of service providers who obtained FP certification with support of USG funding	FY20AR	1			
# of persons trained in MNC by type and level with project support	FY20AR	1			
# of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations	FY20AR	1			
# of staff trained in FP (pill, condoms, injectable, LARC, PM), delivery, ANC, ENC, Sick childcare, child health, nutrition, NCD & RH IPP, waste management within last 24 months	FY20AR	1			
# of trainers who received training in FP teaching with support of USG funding	SRIM	1			
% of trainers assessed to perform up to the internationally accepted standards for FP service delivery and training on FP service delivery with support of USG funding	FY20AR	1			
# of training curricula developed or updated with support of USG funding	SRIM	1			
Provides regular and as-needed supportive supervision from health system to CHWs				**3.00**	**3.33**
# of CHWs supported to provide community-based services to HIV, FP, and/or TB clients	SRIM		1		
# of personnel trained in mentorship and/or supportive supervision with the support of USG funding	FY20AR	1			
Engages communities in recruiting and supporting CHWs				**2.25**	**3.67**
None					
Formalizes the role of CHWs as part of the health system to recognize their services				**2.75**	**3.00**
None					

**Core component ranks included here are the average rank across the project teams*
SRIM = Self-reported by project as part of indicator mapping exercise undertaken during the design of the assessment
FY20AR = Assessment team identified indicator from FY20 annual report

Table 14. Aligning indicators to core components, mobile outreach and service delivery (MOSD) High Impact Practice (HIP)

Individual core components and relevant indicators	Sourc	# of projects reporting indicator		Core component rankings*	
		BG	TZ	BG	TZ
Ensures consideration of cultural, economic, and social factors and needs in relation to client base				**2.33**	**3.67**
None					
Coordinates with community leaders as part of aligning staff to needs, raising awareness for the service, and communicating relevant details to potential clients				**3.33**	**3.67**
None					
Ensures equipment and supplies are in place and used appropriately				**3.00**	**4.00**
None					
Trains service providers in providing respectful care including counselling services and recognizing instances when a referral for additional care is appropriate				**3.00**	**4.00**
None					
Procedures in place for discussing follow-up care and helping clients understand how to access follow-up care				**3.33**	**3.67**
None					
Follows a plan for collecting and recording data and inputting information in relevant repositories to ensure follow-up				**3.33**	**4.00**
None					
Other – Indicators do not align to a core component					
# of clients accepting FP methods through outreach	SRIM		2		
# of counseling visits for FP/RH as a result of USG assistance	SRIM	1			
# of facilities conducting regular integrated outreach services (HIV, HIV/TB, FP/MCH)	SRIM		1		
# of people reached with project -supported services through community-based outreach disaggregated by type of services	SRIM		1		
# of USG supported service delivery points providing short acting and long acting and permanent methods (LA/PM)	SRIM	1			
# of clients receiving FP services from a PEPFAR-supported service delivery point	FY20AR		1		
# of facilities conducting regular integrated outreach services (HIV, HIV/TB, FP/MCH	FY20AR		1		
% of the women receiving quality ANC 4+ visits [4] for the last pregnancy	FY20AR	1			
% of USG-assisted service delivery sites providing family planning (FP) counseling and/or services	FY20AR	1			
CYPs for short acting modern methods (Pills, Condoms, Injectable, ECP) provided by SH clinics	FY20AR	1			

**Core component ranks included here are the average rank across the project teams*
SRIM = Self-reported by project as part of indicator mapping exercise undertaken during the design of the assessment
FY20AR = Assessment team identified indicator from FY20 annual report

Table 15. Aligning indicators to core components, immediate postpartum family planning (IPPFP) High Impact Practice (HIP)

Individual core components and relevant indicators	Soure	# of projects reporting indicator		Core component rankings*	
		BG	TZ	BG	TZ
Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences				**3.67**	**4.00**
# of outlets and health facilities offering project supported brands, products, services	SRIM		1		
# of priority health services delivered with project support	SRIM		1		
# of targeted priority products dispensed to clients with project support	SRIM		1		
Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients				**3.33**	**4.00**
# of USG-assisted facilities that IPPFP (i.e., <48 hours postpartum)	SRIM		1		
% of LOP-planned-for-USG-assistance facilities providing immediate postpartum FP services in MNCH settings	FY20AR		1		
# / % of women receiving modern method IPPFP (i.e., <48 hours postpartum)	SRIM		2		
# / % of women provided with IPPFP among facility-delivered women	FY20AR		1		
# of women delivered in SH clinics who received IUD as PPFP within 48 hours or 4-6 weeks after discharge	FY20AR	1			
# of facilities that provide PPFP services with support of USG funding	SRIM	1			
# of facilities that provide post-partum family planning and post-abortion care-FP services with support of USG funding	FY20AR	1			
% of USG-assisted service delivery sites providing family planning counselling and/or services	FY20AR	1			
# of new PPFP acceptors in USG-assisted facilities	SRIM	1			
# of service contacts of postpartum women delivered in SH clinics who left with any modern contraceptive methods	SRIM	1			
% of women initiating modern method of FP in the PPFP	SRIM	1			
Trains providers for IPPFP on counseling and service provision per local guidance				**3.33**	**4.00**
# of people trained in PPFP	SRIM		1		
# of private providers trained in priority clinical areas with project support	SRIM		1		
Engages health facility leadership and staff to promote practice				**3.00**	**3.67**
None					
Ensures staff availability for FP services and products prior to discharge				**3.00**	**3.67**
None					
Assures that national service delivery guidelines are readily available and widely disseminated				**3.67**	**3.67**
None					
Communicates the role of service providers as outlined in national service delivery guidelines				**3.00**	**4.00**
None					

**Core component ranks included here are the average rank across the project teams*
SRIM = Self-reported by project as part of indicator mapping exercise undertaken during the design of the assessment
FY20AR = Assessment team identified indicator from FY20 annual report

Table 13, Table 14, and Table 15 include the core component rankings from the project teams. Bearing in mind the definition for a ranking of 4—the core component has always been and is being implemented fully, with indicators to track—it is noteworthy to consider the following:

- In Table 13 and for CHW core component 4 (trains and assesses CHWs' abilities to provide services and behavior change messages), the projects in Tanzania ranked themselves at 4, yet only two indicators were reported that align to the core component (number of CHWs trained using integrated MNCH curriculum and number of service providers trained with support of USG funding).
- In Table 13 and for CHW core component 6 (engages communities in recruiting and supporting CHWs), the average ranking across the Bangladesh projects is the lowest core component rank (2.25) and no indicators were reported that align to the core component. The average ranking for core component 4 (trains and assesses CHWs' abilities to provide services and behavior change messages) across the Bangladesh projects is the second lowest ranking at 2.75, yet there were 13 indicators reported that align to the core component.
- In Table 14 and under the MOSD HIP none of the ten indicators reported from the projects align to any of the six core components.
- In Table 14 and under the MOSD HIP there are three core components where all three projects in Tanzania ranked themselves at 4, yet no indicators were reported that align to the core components. The three core components are (1) ensures equipment and supplies are in place and used appropriately; (2) trains service providers in providing respectful care including counseling services and recognizing instances when a referral for additional care is appropriate, and (3) follows a plan for collecting and recording data and inputting information in repositories to ensure follow up.
- In Table 15 and for IPPFP core component 7 (communicates the role of service providers as outlined in national service delivery guidelines) all three projects in Tanzania ranked themselves a 4, yet no indicators were reported that align to the core component.
- In Table 15 and under the IPPFP HIP there are three core components where all three projects in Tanzania ranked themselves at 4. The three core components are: (1) ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences; (2) monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients; and (3) trains providers for IPPFP on counseling and service provision per local guidance). All 16 indicators reported by the projects in Bangladesh and Tanzania align to these three core components.

In highlighting these points, the purpose is not to critically examine if the ranking and number of indicators match. Instead, the purpose is to both note the possible disconnect between the core components and the indicators and consider that the projects feel confident about implementing the broad activities denoted in the HIPs but are not necessarily considering their indicators as HIP specific indicators.

Scale of Implementation

For this assessment, scale of implementation is defined as the extent that each HIP has reached the intended populations, including in ways that bear in mind gender and scale in equitable and representative ways. To attempt to assess scale for each HIP, data from program reports, HMIS sources, and available population projections were used. Limited subnational data were available and used to assess scale at the most relevant geographic level.

Bangladesh

Integrated Community Health Worker (CHW) High Impact Practice (HIP)

For the CHW HIP, numbers of CHWs providing FP information, services and referrals were provided for two projects (MNCSP and AUAFP) in FY20 and FY21 at the project level.[8] These projects served districts in Chittagong, Dhaka, Khulna, Mymensingh and Sylhet and while they were supporting over 11,000 CHWs in the provision of FP services in FY21, there were less than 4 CHWs providing these services for every 10,000 women of reproductive age estimated to live in these divisions (Figure 1). Additionally, AUHC reported supporting a further 1145 CHWs providing FP information, services and referrals working in 54 out of 64 districts. Unfortunately, no project provided details about the geographical or urban/rural coverage of the CHWs they supported and in the absence of a comprehensive national CHW reporting system, it is not possible to have details beyond CHW activities reported by the programs. If the project supported CHWs are the only CHWs providing FP counseling, services, and referrals, this indicates substantial room for scale up.

Figure 1. Number of CHWs providing FP information, services, or referrals for every 10,000 women of reproductive age and percent of districts in Bangladesh served by these CHWs

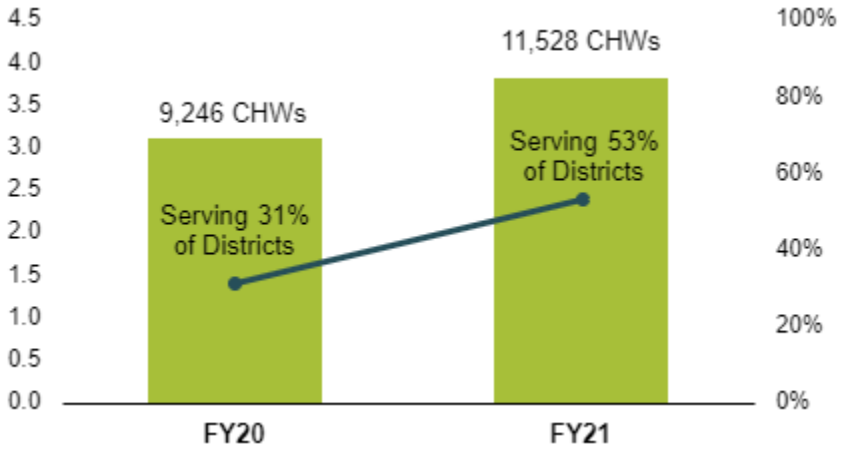

Figure 1 Source: AUAFP and MNCSP annual program reports

[8] Population estimates for women age 15-49 were obtained from United Nations World Population Prospects 2022 Revision (World Population Prospects - Population Division - United Nations) for data by sex and age and subnational population by sex from the Bangladesh Bureau of Statistics shared by the United Nations Office for the Coordination of Humanitarian Affairs Regional Office for Asia and the Pacific (Bangladesh - Subnational Population Statistics - Humanitarian Data Exchange (humdata.org)).

Mobile Outreach Service Delivery (MOSD) for Contraceptives High Impact Practice (HIP)

For the MOSD HIP, no projects reported on FP distribution via outreach services separately and mobile outreach indicators are not included in the HMIS FP data. AUAFP partners with the Family Planning Association of Bangladesh, who provide services via 75 mobile clinics and 1,260 Reproductive Health Promoters in five districts, but they do not provide data on any MOSD being done. Reporting related to outreach services were largely focused on training and oversight and did not include data on service provision through outreach nor details on the training and oversight done.

Immediate Postpartum Family Planning (IPPFP) High Impact Practice (HIP)

For the IPPFP HIP, neither projects nor the national HMIS capture IPPFP, though they collect data on women accepting FP within the postpartum period. Examining these data, many women are accepting PPFP, indicating potential demand for IPPFP services. Unfortunately, data are insufficient for determining how soon after delivery FP services were received.

For the provision of FP services immediately postpartum, women would need to deliver at a facility with someone trained to deliver IPPFP. However, in Bangladesh while births in a facility or with a skilled attendant are increasing, less than 50 percent of deliveries were in a facility or with a skilled attendant from 2018–2021 according to HMIS data (Figure 2). Since more than half of births occurred without a skilled attendant, it is unlikely that many of the clients receiving PPFP did so within the first 48 hours post-partum.

Figure 2. Number of births in a facility or with a skilled attendant, Bangladesh, 2019–2020

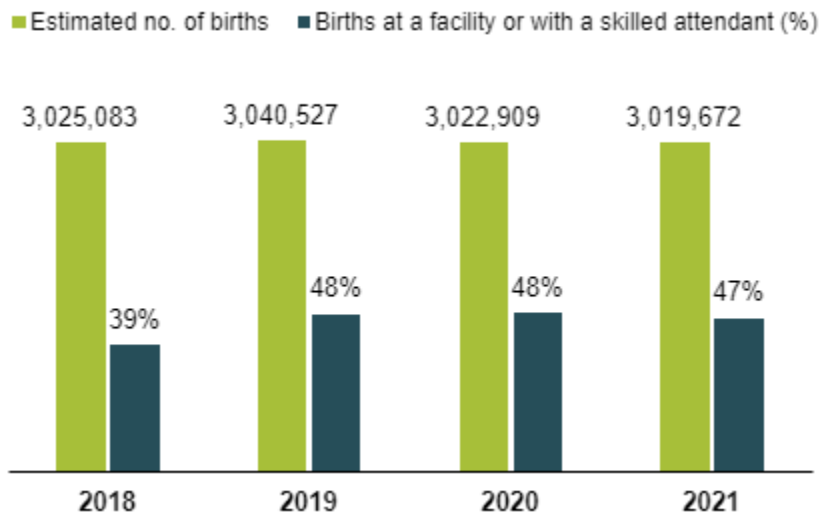

Figure 2 Source: Bangladesh Directorate General of Family Planning Management Information System Service Statistics (dgfpmis.org)

The MNCSP project reported the acceptors of modern FP methods in the postpartum period as a proportion of all estimated births in the coverage area and found only 19 percent accepted in FY20 and 24 percent accepted in FY20 (Figure 3 shows details by districts served). This indicates a substantial potential unmet need for PPFP.

Figure 3. (a) Percent of women accepting PPFP out of estimated deliveries by year and selected districts; and (b) Percent of women accepting PPFP who accepted PPIUCD by year and district

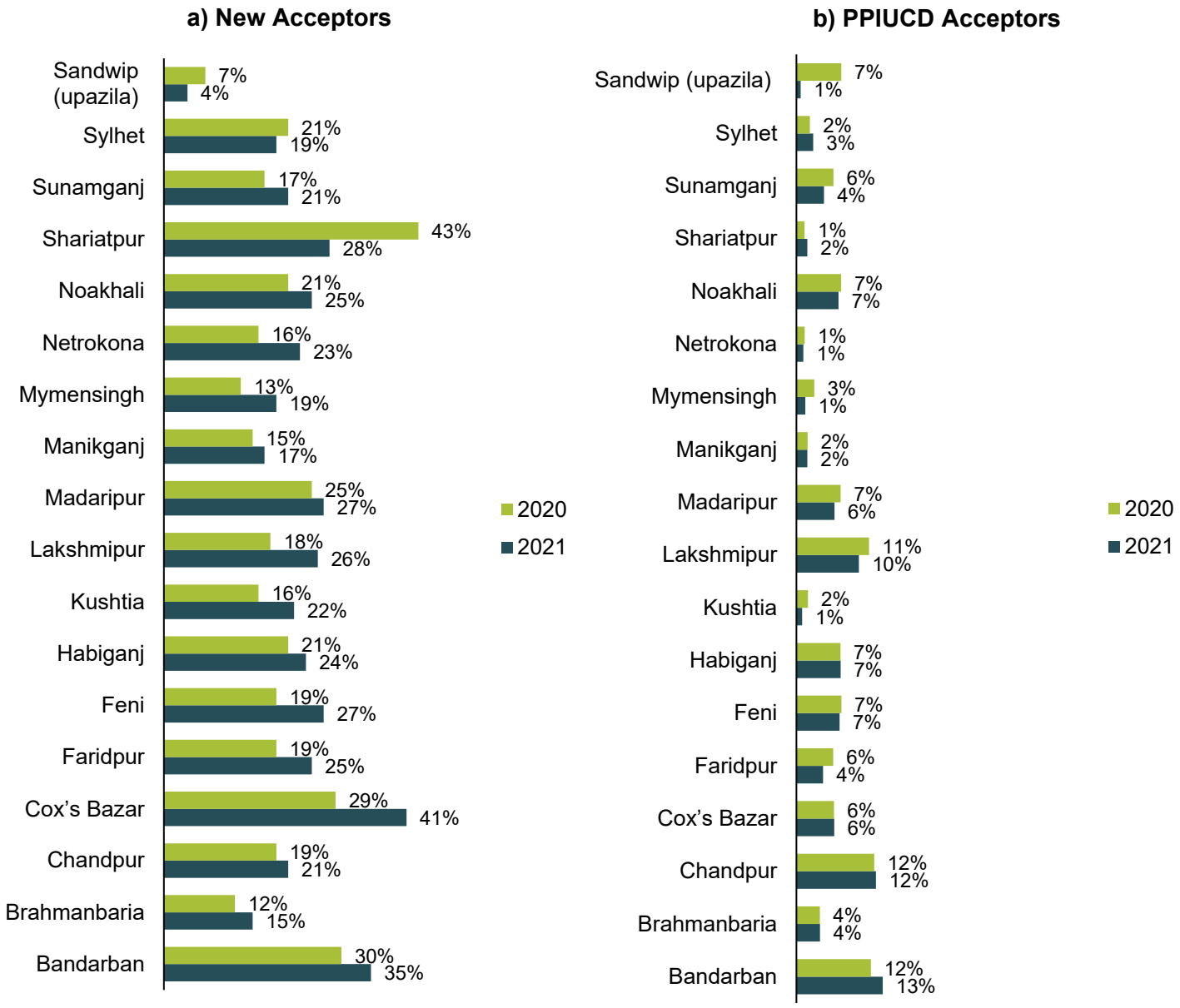

Figure 3 Source: DHIS-2; DGFP MIS report (www.dgfpmis.org/ss), presented in MNCSP Year 4 Progress Report

Tanzania

Integrated Community Health Worker (CHW) High Impact Practice (HIP)

For the CHW HIP, two projects (BA-LWZ and BA-NCZ) reported on the number of supported CHWs providing FP information, services, and referrals, and both projects were supporting around 1,000 or more as of FY20. When compared to the estimated population of women of reproductive age in the project zones, while scale has increased over the project span, it is still relatively low (Figure 4). This indicates less than one project-supported CHW providing FP is serving every 1,000 women, suggesting substantial room for scale-up of this HIP in Tanzania.[9]

Figure 4. Number of CHWs providing information, services, or referrals for every 1,000 women of reproductive age

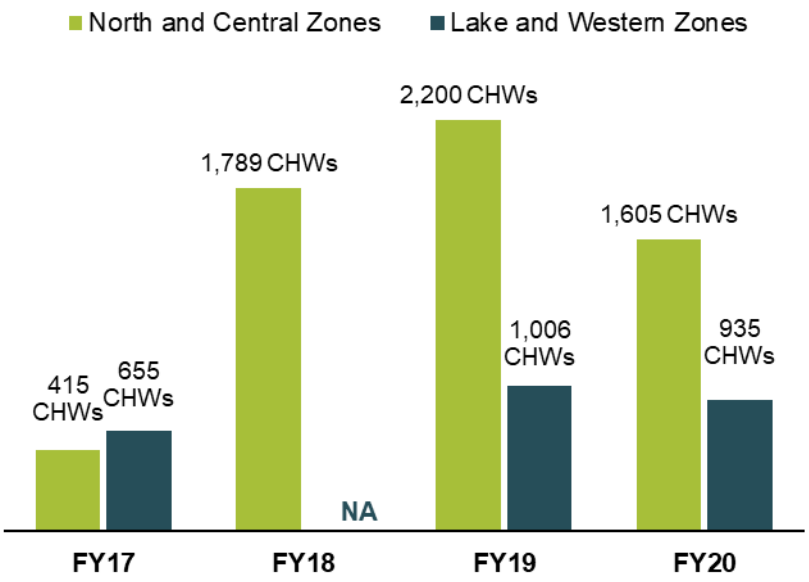

Figure 4 Source: BA-LWZ and BA-NCZ annual program reports

Mobile Outreach Service Delivery (MOSD) for Contraceptives High Impact Practice (HIP)

For the MOSD HIP, BA-LWZ, BA-NCZ, and BA-SZ provided data on FP clients reached through outreach activities, though each provided varying levels of details about the outreach services, methods selected and geographic area. Including clients reached via outreach as defined by the project, they reflect a small proportion of total clients accepting a modern method of FP as reported by the projects. Data from FY18, FY19 and FY20 indicated an increase in outreach's contribution to the overall FP projects from FY18 to FY19, dropping slightly in FY20 (Figure 5). Programs did not report groups served through mobile outreach beyond indicating that these efforts targeted "hard-to-reach" populations, in many cases focusing on geographically remote populations. It should be noted that COVID-19 disrupted outreach services for some projects in

[9] Population data for women age 15-49 by subnational area for Tanzania obtained from the US Census Bureau subnational population projections for Tanzania (Subnational Population by Sex, Age, and Geographic Area (census.gov)).

2020. Relative to the overall FP programming, the scale of outreach- or mobile-based FP remains small.

Figure 5. Family planning clients (acceptors), total and outreach, from project reports, all projects

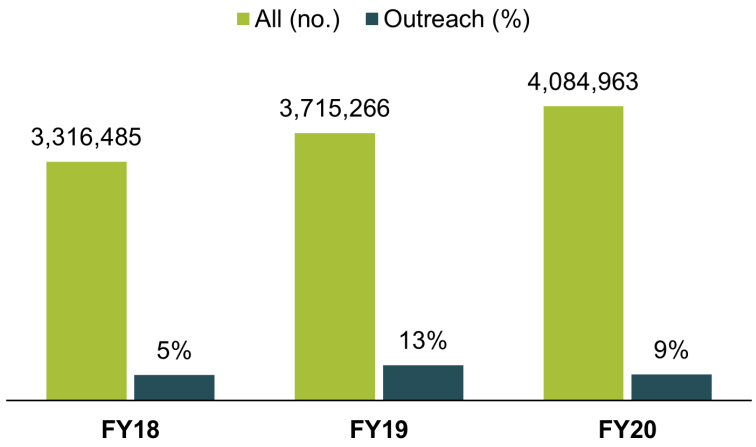

Figure 5 Source: BA-SZ, BA-NCZ, and BA-LWZ annual program reports

Tanzania HMIS provides the number of clients who receive implants or IUCDs via outreach services by subnational area, and both BA-NCZ and BA-LWZ provide data in their reports about the methods distributed through outreach services, allowing for assessment of programs' contributions to all clients in the zones where they are working. BA-NCZ supported outreach was providing implants and IUCDs to 57 percent of the clients receiving those methods via outreach in Northern and Central Zones by Quarter 2 of FY2020, shown in Figure 6. This proportion increased substantially, from 20 percent in Q1FY18. While these figures saw fluctuation quarter to quarter, by the first half of FY20, both the overall number of clients served, and those served by BA-NCZ, had increased substantially.

Figure 6. Uptake of IUCDs and implants through outreach in Northern and Central Zones

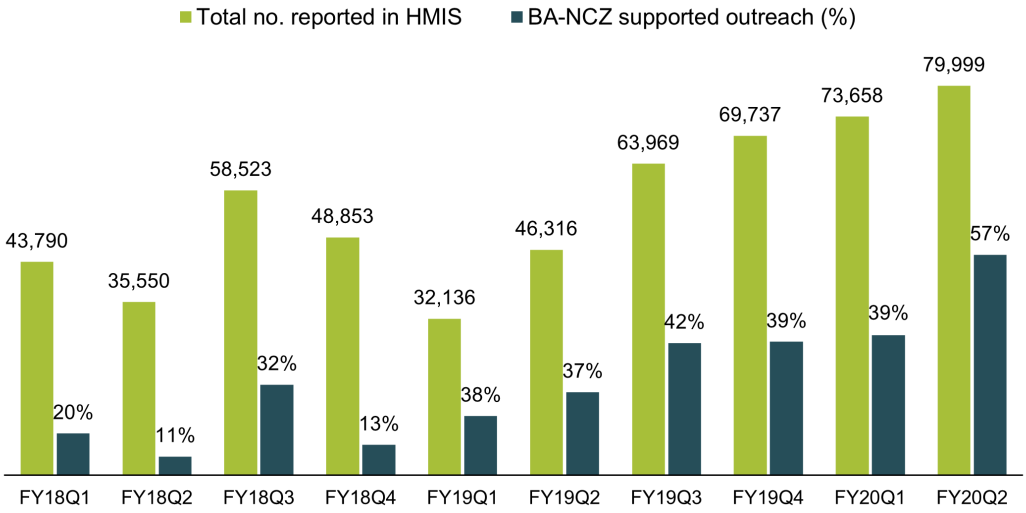

Figure 6 Source: BA-NCZ annual program reports and Tanzania National Health Portal (Tanzania National Health Portal (moh.go.tz))

The number of clients obtaining implants and IUCDs in Lake and Western Zones (Figure 7) increased steadily from FY17 through FY20 and the proportion served by BA-LWZ increased through FY19, reaching 47 percent, though sharply declined in FY20 both in absolute number and as a proportion of all clients reached with these methods via outreach in the two zones.

Figure 7. Uptake of IUCDs and implants through outreach in Lake and Western Zones

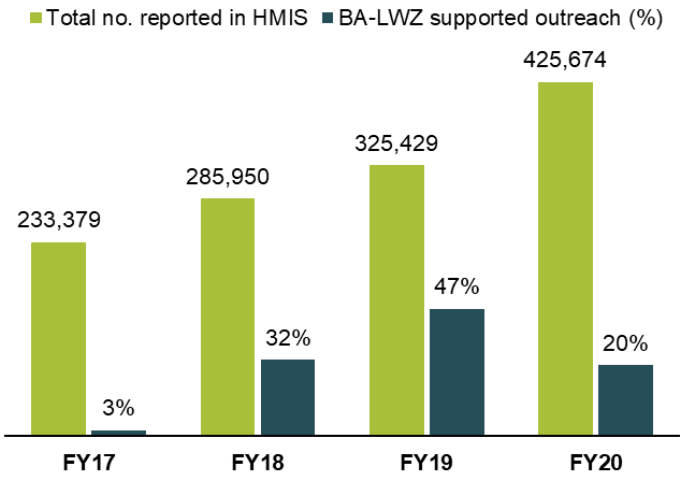

Figure 7 Source: BA-LWZ annual program reports and Tanzania National Health Portal

Immediate Postpartum Family Planning (IPPFP) High Impact Practice (HIP)

For the IPPFP HIP, despite HMIS reporting high rates of births at facilities, over 50 percent in all regions in 2022, or with a skilled birth attendant, above 80 percent in April to June 2022, the rates of uptake of IPPFP remains very low. For the period July to December 2020, HMIS reports 63,060 clients accepting PPFP compared to an estimated 1,131,150 births in that period (6%). Figure 8 compares data from the projects providing IPPFP in Tanzania to estimated births and shows that while uptake of IPPFP increased over the period, scale is quite low.

Figure 8. Clients receiving immediate postpartum family planning (IPPFP) as a proportion of estimated live births, Tanzania FY17–FY20

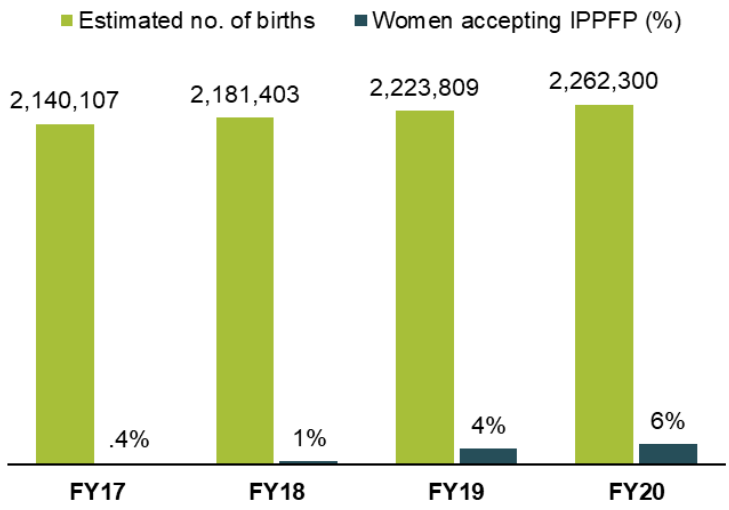

Figure 8 Source: BA-SZ, BA-NCZ, and BA-LWZ annual program reports and Tanzania National Health Portal

Subnational estimates of births were not available for assessing relative coverage in the project service areas, but program reports provided IPPFP uptake as a proportion of facility deliveries for some periods and are presented in Figure 9. Overall, uptake of IPPFP remains low, though it has increased over the project period.

Figure 9. Clients receiving immediate postpartum family planning (IPPFP) as a proportion of facility deliveries by project, FY17–FY20

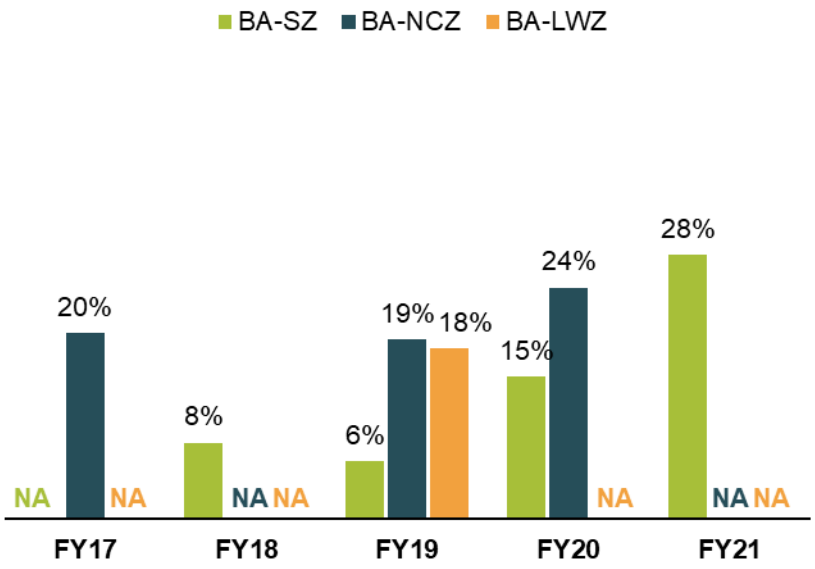

Figure 9 Source: BA-SZ, BA-NCZ, and BA-LWZ annual program reports

Quality of Implementation

The results from the ranking exercise potentially indicate that quality of implementation across the projects in each country is relatively strong. The higher rankings of 3 and 4 are common from both the project teams and the assessment team. However, many of the points raised by the participants during the core component checklist exercise and KIIs present a more complicated landscape. In particular, the specificity of the HIP definitions and the core components at times do not align with the programming of the projects. Relatedly, many of the challenges the participants described potentially indicate that quality of implementation is more mixed.

All projects selected for this assessment implement programming around CHWs, and all but one implements programming around MOSD and IPPFP. However, implementation of this programming does not automatically mean the HIPs are being implemented nor is it required for the projects to implement and monitor these three service delivery HIPs. This distinction in play—implementing a HIP but not calling it a HIP—is subtle, but important. The projects appear to not implement to the level of specificity outlined in the HIP definitions, in particular:

- Projects prioritize providing training for their CHWs and have systems in place to help ensure CHWs have the needed equipment; however, the projects do not necessarily have control over the extent that CHWs are *integrated* into the health system.
- Projects tend to approach MOSD comprehensively and aim to provide a broad range of FP services (and even broader health services in some instances), including, but not exclusively, provision of *contraceptives*.
- Projects tend to focus more on PPFP and not IPPFP, and in many instances, focus on IPPFP does not define "*immediate*" as within 48 hours.

Central to the reflection is recognition that the foundational aspect for the CHW, MOSD, and IPPFP HIPs (integrate, contraceptives, and immediate) is not being implemented. Thus, while other elements of the HIP are being implemented, without the foundational aspect being implemented, quality of implementation is low regardless of the rankings from the core component checklist exercise.

This assessment has sought balance; specifically balance between a strict lens (HIP implementation is firmly a yes-no question) and a more flexible lens (the term "HIP" might not be used, and implementation might be partial, but that counts as implementation). With the latter, the assessment has tried to uncover insights around if the lack of or limited implementation is because of challenges, as opposed to disagreement with the suggested approach outlined in the HIP. Generally, the data suggests that the projects face challenges that impede their abilities to implement the CHW and MOSD HIPs to their fullest. With the IPPFP HIP, the data suggest something different: that there is not universal agreement that pursuing PPFP counseling immediately (defined as within 48 hours) is always the best approach.

Assessing quality of implementation has included the HIP definitions, core components, and associated specificities as well as the extent that the needed resources, skills, policies, and quality assurance procedures are in place. Results from the data collection have yielded a mixed

bag in each of these areas. In particular, the resources, skills, policies, and quality assurance procedures in place tend to align to FP broadly, not HIPs. Table 16 presents selected challenges in relation to the extent that the needed resources, skills, policies, and quality assurance procedures are in place.

Table 16. Challenges in relation to resources, skills, policies, and quality assurance procedures for three service delivery High Impact Practices (HIPs)

Integrated CHW	MOSD for contraceptives	Immediate PPFP
Challenges to having the resources in place to implement the HIP		
– Inconsistencies around whether CHWs are paid or volunteers – Variation in compensation across different donors – High expectation for volunteers, many of whom have been volunteering for years	– Coordination across facilities, commodity suppliers (including government, private sector, project) and responding to different levels of demand across multiple locations – Availability of MOSD-specific staff	– Shortages of the needed human resources working in labor wards – Inconsistent availability of commodities during the immediate postpartum period – Lack of private space for counselling during the immediate postpartum period
Challenges with individuals having the needed skills to implement the HIP		
– Refresher training is not always routine – Lack of skill and willingness among CHWs to enter data using tablets – CHWs with past project experience potentially viewed as already trained	– Service providers often lack skill to provide long-term methods – Ability to consider context specific cultural and socioeconomic factors is nuanced and based on experience	– Counseling in general often noted as area where skill improvements needed – Greater interest, to an extent, in PPFP and some hesitation about IPPFP – Not implemented in private facilities
Challenges with national policies to guide implementation of the HIP		
– Weak guidance around recruitment, rely on longstanding presence of CHWs – HIP is dependent on presence of a policy to integrate CHWs into the health system, which generally do not exist	– Policies relate to MOSD broadly, not contraceptive provision specifically – Lack of clarity about selecting sites based on reaching certain populations – Pressure from community leaders	– Policies relate to FP counselling broadly, not IPPFP specifically – If resistance to FP counselling is strong, policies may not be enough to change views based on religion and family role
Challenges to having quality assurance procedures in place to implement the HIP		
– Mobility of CHWs is needed daily whereas supervision is monthly or quarterly – Importance of factoring in level of formal education of CHWs and what services they can and cannot provide	– Geared toward service provision overall and not MOSD specifically – Risk that the quality of MOSD services are lower in an effort or prioritize speed – Time lags in communication with facility, including data entry at MOSD sites	– MEL focused more on occurrence of FP counseling and less focused on quality – Weak systems for providing mentorship specific to FP counselling – With high levels of on-the-job-training, the criteria to define quality shift

Conclusions and Recommendations

This assessment sought to better understand the extent that projects implement and monitor HIPs. In particular, the focus has been through the lens of multiple USAID-funded projects in Bangladesh and Tanzania, three service delivery HIPs, project indicators, and quality and scale of implementation, as noted in Table 17.

Table 17. Overview of what the assessment sought to understand and the lens that was used

Projects	Service delivery high impact practices (HIPs)	Assessment focus areas
▪ AUAFP ▪ AUHC ▪ MNCSP ▪ MISHD ▪ C3HP ▪ Afya Yangu Southern ▪ Afya Yangu Northern	▪ Integrate trained, equipped, and supported community health workers (CHWs) into the health system ▪ Support mobile outreach service delivery (MOSD) to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods ▪ Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities	▪ **Monitoring, Evaluation, and Learning (MEL):** extent projects capture and use input, process, output, and outcome indicators ▪ **Scale of Implementation:** extent each HIP reaches intended locations, including in gender sensitive and equitable ways ▪ **Quality of Implementation:** extent established implementation standards are followed, with resources, skills, policies, and quality assurance procedures in place

The purpose of this assessment has not been to evaluate individual USAID projects or a portfolio of USAID projects; therefore, correspondingly, the conclusions and recommendations also do not focus on individual projects or a portfolio of projects. The projects served as a lens through which to consider broader questions about the extent that three service delivery HIPs are implemented and monitored within country-based projects.

The conclusions and recommendations do not lay out how projects should implement CHW, MOSD, and IPPFP programming; rather, the goal is to provide high level conclusions about the nuances, challenges, and context that shape the extent that the CHW, MOSD, and IPPFP HIPs are implemented and monitored. The conclusions and recommendations are organized topically and by the three HIPs. The topically organized conclusions and recommendations aim to provide actionable steps USAID can take to continue to advocate for the implementation and monitoring of HIPs. The HIP-related conclusions and recommendations provide actionable steps for both USAID and, to an extent, the projects.

Mixed Level of HIPs Awareness among Project Staff

- Many project staff are aware of the HIPs and the HIPs initiative. Indeed, the data suggest that some staff members have been involved in writing and/or reviewing HIPs briefs. The data also suggest that many project staff are not aware of the HIPs and the HIPs initiative.
- Implementation of CHW, MOSD, and IPPFP activities does not necessarily equate to awareness of these HIPs and the HIPs initiative overall.
- Presence of CHW, MOSD, and IPPFP experts on a project does not necessarily equate to awareness of these HIPs and the HIPs initiative overall.

Recommendations

- Awareness raising efforts for the HIPs initiative should continue to recognize and acknowledge that the HIPs initiative is not a singular or definitive space in relation to international FP programming.
- Establish a HIPs implementation case competition similar to the collaboration, learning, and adaptation case competition and the recently launched HSS case competition. A case competition would provide increased opportunity for USAID Missions and their projects to reflect on their programming accomplishments and areas of overlap with what the HIPs initiative is advocating.
- Establish ways for projects to contribute to the HIPs initiative website. Possible ideas include:
  - A forum for projects to share their knowledge and evidence products, including a process through which the HIPs initiative would verify the soundness of the submissions
  - Establish an additional element in the HIPs structure called field-based implementers (in addition to co-sponsors, partners, technical advisory group, products and dissemination team, and technical experts group)
  - Continue to host webinars and consider expanding the framing to move beyond celebration of finished products and convene a webinar series under a theme; something to the effect of insights from the field

Unclear Incentives and Pathways to Implement and Monitor HIPs

- Designing and implementing this assessment made apparent that there is some ambiguity about what counts as implementing a HIP.
- Project design in Bangladesh and Tanzania was Mission led, with the MEL framework also subject to Mission input and approval. To advocate for inclusion of HIPs implementation and monitoring among USAID-funded projects necessitates internal coordination to provide Missions with guidance on increasing the integration of HIPs into the design and implementation of relevant projects.
- This assessment served as a HIPs awareness raising activity, with many participants indicating that the core component checklist exercise led to important reflection on how activities are being implemented and monitored. Feeling as though participation in the assessment was valuable will not necessarily prompt a shift to more directly implement a HIP. For USAID-funded projects the question remains: How can increased integration of HIPs be effectively incentivized while limiting the amount of additional work that would be required?

Recommendations

- Continue to pursue coordination and collaboration within USAID, particularly between headquarter operating units and Missions. Relatedly, continue to strategize how six HIPs co-sponsors—each of which are large institutions with structural constraints—can be both unified and cognizant of possible ways to establish institution-specific objectives to pursue.
- Establish Mission-sponsored HIPs committees made up of representatives from the projects. Often Missions establish a regular meetings series for all Chief's of Party or Project Directors to promote coordination and learning. A HIPs committee would follow the same logic.
- Hold discussion and consider if the core component checklist used in this assessment could be further developed and promoted as a tool for USAID-projects to use.

Co-existing Measurement Frameworks

- A conscious decision was made to not use the term "evaluation" given that this assessment did not evaluate the performance of a project or portfolio of projects. What this assessment brings to light is the possibility of an expectation that a project would need to be evaluated on performance and assessed for HIPs implementation, thus essentially creating two co-existing measurement frameworks.
- The establishment of the HIP core components served as a constructive way to have a framework for this assessment at this moment in time. The future of the core components after this assessment, is an open question, with pros and cons in terms of either continuing with them or rethinking the foundation of a measurement framework.

Recommendations

- Establish an additional element in the HIPs structure called MEL (in addition to co-sponsors, partners, technical advisory group, products and dissemination team, and technical experts). Alternatively, within one of the existing elements establish a scope of work and a team to work on MEL.
- Take a collective a step back and consider what this assessment uncovered and how this new information can inform the development of a measurement framework.

HIPs Implementation and Monitoring Broadly

- The data suggest the need for caution in asserting that the CHW, MOSD, and IPPFP HIPs are being implemented and monitored by the projects that participated in this assessment. As approaches or activities, CHW, MOSD, and IPPFP work is being implemented and monitored, but that work, and the related indicators, generally are not sufficiently specific to the HIP definition and core components.
- The core components are established standards for the HIPs, but not necessarily established standards aligned to projects not solely focused on FP. This disconnect raises questions about the relevance of the core components for service delivery projects taking a comprehensive approach, including consideration of what the core components would be if the projects were to write them, or even be consulted.
- It appears unlikely that the projects can monitor HIPs with existing indicators. Whether or not it is feasible for a project to add indicators to monitor HIPs implementation is a decision individual projects would have to make.

Recommendations

- Consideration should be given around the possibility that implementing and monitoring HIPs as specifically defined will not necessarily be a high priority for USAID-funded projects unless USAID Missions shift how FP projects are designed.
- Reflect on how the core components were created and consider the pros and cons around a HIPs measurement framework that is likely to be external and essentially divergent from the existing MEL frameworks for many USAID-funded FP projects.

Integrated CHW HIP

- CHWs play a prominent role across the projects in Bangladesh and Tanzania; however, understanding and measuring the extent CHWs are integrated into the health system is complicated. Indicators to track CHW training, supervision, and supplies are common across the projects, but they do not enable a determination around integration into the health system.
- The projects seek to provide training, supervision, and supplies for CHWs; however, being successful in these areas is sometimes challenging for reasons not completely within the control of the projects. Notably, how CHWs are recruited and retained requires a delicate balance of honoring longevity and commitment, the needs and wishes of community leaders, and promoting transition toward greater integration into the health system.
- The training, equipment, and support services CHWs provide aligns to the comprehensive service delivery approach, which generally does not align to the specificity of the MOSD and IPPFP HIPs.

Recommendations

- Conduct further research that examines curriculum for CHW training and delineate what might be different in providing HIP specific training.
- Improvement from the projects appears to be needed to establish a definition of integrated into the health system, including a means to measure whether integration is present.

MOSD for Contraceptives HIP

- Project programming around MOSD and broader focus on community engagement appear intertwined to an extent. In certain ways, this is logical; however, being intertwined creates some challenges in terms of distinguishing between outreach, awareness raising, sensitization, and specific service provision.
- While every indication is that the projects take a thoughtful approach in selecting MOSD sites, the approaches are not always solely prioritizing cultural and socioeconomic factors and, in some instances, cultural and socioeconomic factors are not considered.
- If the MOSD team is not able to provide contraceptives (i.e., because the method is not available or there is not a provider with the needed skills available), that is not necessarily considered unsuccessful MOSD if other services are provided whereas, per the MOSD HIP definition, not providing contraceptives would be considered unsuccessful MOSD.

Recommendations

- Establish a definition of mobile for the HIP, including recognizing that often MOSD is not solely focused on providing contraceptives given health service delivery projects provide a wide range service via MOSD; therefore, factor in that the title of the HIP might be misleading.
- Improvement from projects appears to be needed in terms of availability of service providers to provide permanent methods via MOSD and in turn, tracking MOSD service by service, including referrals and counselling.

Immediate PPFP HIP

- Unlike the CHW and MOSD HIPs, understanding if the IPPFP HIP is being implemented and monitored can be determined largely by a single question and a single indicator. Several of the projects include the needed indicator in their annual report.
- PPFP and FP counseling in general are certainly widely supported, but there appears to be some differing views about the strategy of providing counseling immediately, with "immediately" defined as within 48 hours.
- Challenges around the provision of IPPFP include limitations in terms of service providers with the needed skills and shortages of commodities, equipment, and space and privacy for providing the service.

Recommendations

- Consider if the potential preferred focus on PPFP in Bangladesh and Tanzania is common in other countries and if so, reconcile the extent that the intent of the HIP is specifically IPPFP.
- Improvement from the projects appears to be needed to better understand that for the IPPFP HIP, the definition of immediate must be fixed at 48 hours.

Concluding Statement and Next Steps

The results of this assessment have largely yielded more questions than answers. The uncertainties are not surprising given this assessment was exploratory in the context of USAID's interest in further understanding and defining what it means to implement and monitor HIPs at both an individual project level and in the broader global context. The findings from the two data collection activities are, to an extent, the opposite. The self-assessed rankings through the core component checklist exercise suggests that quality of implementation is strong given that the project teams predominantly gave themselves rankings of 3 and 4. However, the interviews with the project staff and district-level FP experts point to challenges around implementing what is laid out in the core components.

As anticipated, the results of this assessment suggest the need for further discussion about the development of a HIPs measurement framework. One overarching question is definitional and the need to further establish what counts as implementing a HIP. Other related and more specific questions are as follows:

- At this time, it does not seem that USAID-funded projects have the mandate and resources to measure HIPs implementation.
- Core components could be the measurement framework or included in a multi-part measurement framework. Either way, the use of core components is grounded in implementation science and awareness raising on this approach may be required.
- The core components are not necessarily conducive to all indicator types.
- Indicator type potentially shapes what it is about HIPs implementation that is being measured.

Table 18, Table 19, and Table 20 further illustrate the need for discussion in these areas.

Table 18. Core components categorized by indicator type, community health worker (CHW) High Impact Practice (HIP)

Core components		Type	Illustrative list of possible aligned indicators
1	Assures CHWs have necessary supplies and materials to fulfill their roles	Input	# of CHWs equipped with necessary supplies and materials to fulfil their roles
2	Monitors, reports, and assesses data on CHW services and referrals provided	Output	# of FP counseling sessions by CHWs # of FP referrals made by CHWs
3	Monitors data on CHW logistics and commodities at health center and district level to avoid stockouts	Outcome	# of CHWs that experienced stockout
4	Trains and assesses CHWs' abilities to provide services and behavior change messages	Output	# of CHWs trained on FP service delivery # of CHWs trained to provide FP behavior change messages
5	Provides regular and as-needed supportive supervision from health system to CHWs	Input	# of CHWs that received supportive supervision from the respective facility
6	Engages communities in recruiting and supporting CHWs	Output	# of community leaders involved in recruiting CHWs # of community leaders involved in supporting CHWs
7	Formalizes the role of CHWs as part of the health system to recognize their services	Outcome	# of CHWs provided with competitive compensation

Table 19. Core components categorized by indicator type, mobile outreach service delivery (MOSD) High Impact Practice (HIP)

Core components		Type	Illustrative list of possible aligned indicators
1	Ensures consideration of cultural, economic, and social factors and needs in relation to client base	Input	# of MOSD points selected considering cultural, economic, and social factors # of MOSD points selected considering specific community needs
2	Coordinates with community leaders as part of aligning staff to needs, raising awareness for the service, and communicating relevant details to potential clients	Input	# of community meetings held to plan for MOSD # of announcements to advertise MOSD
3	Ensures equipment and supplies are in place and used appropriately	Output	# of MOSD procedural documents to help ensure equipment and supplies are in place # of MOSD procedural documents to help ensure equipment and supplies are used appropriately
4	Trains service providers in providing respectful care including counselling services and recognizing instances when a referral for additional care is appropriate	Input	# of service providers trained on MOSD # of MOSD service providers trained on counseling # of referrals made during MOSD
5	Procedures in place for discussing follow-up care and helping clients understand how to access follow-up care	Output	# of MOSD with procedures around follow-up care # of MOSD with procedures around helping clients to access follow-up care
6	Follows a plan for collecting and recording data and inputting information in repositories to ensure follow-up	Output	# of MOSD with data collection plan

Table 20. Core components categorized by indicator type, immediate postpartum family planning (IPPFP) High Impact Practice (HIP)

Core components		Type	Illustrative list of possible aligned indicators
1	Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences	Output	# of facilities ensuring availability of supplies and equipment
2	Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients	Output	# of IPPFP counseling sessions # of instances of uptake of FP methods as a result of IPPFP
3	Trains providers for IPPFP on counseling and service provision per local guidance	Input	# of providers trained on IPPFP counseling # of providers trained on IPPFP service delivery # of facilities ensuring availability of trained staff to provide IPPFP counselling # of facilities ensuring availability of trained staff to provide IPPFP services
4	Engages health facility leadership and staff to promote the practice	Output	# of facilities with leaders that promote IPPFP
5	Ensures staff availability for FP services and products prior to discharge	Input	# of facilities ensuring staff availability for FP services and products prior to discharge
6	Assures that national service delivery guidelines are readily available and widely disseminated	Input	# of facilities ensuring availability of national FP policy guidelines
7	Communicates the role of service providers as outlined in national service delivery guidelines	Output	# of facilities that posted IPPFP and role of service providers at a public, visible place

Appendix 1. Activity Work Plan

Work Plan

D4I-PRH-013: Evaluation of High Impact Practices

Activity Lead: TBD

USAID Primary Backstop: Amani Selim, Maria Carrasco

Needs Statement

A technical advisory group (TAG) consisting of USAID, UNFPA, WHO, IPPF, and Family Planning 2030 identified and vetted 21 evidence-based high impact practices (HIPs) for "what works best" in FP. The TAG has requested information on the degree to which the HIPs are being implemented at the country level and if/how HIP implementation is measured, to inform the development of an assessment framework. This activity will respond to this need by evaluating the extent to which select HIPs are being implemented in two countries.

Work Plan

HIPs are a set of identified and vetted evidence-based practices for "what works best" in FP that include practices at the enabling environment level, service delivery level, and social and behavior change level. Twenty-one HIP briefs include assessments of the evidence as well as strategic planning guides, and in a few cases, measurement indicators.

D4I will assess the extent to which select HIPS are being implemented in two countries. In collaboration with USAID technical advisors, D4I will identify a set of HIPs to include in the assessment, select two countries to include in the analysis, and determine the final activity deliverables. The two countries will be selected from among PRH-priority countries and will include one country with a large portfolio of FP activities and one country with a mid-size portfolio.

D4I will develop an evaluation plan to assess the extent to which selected HIPs are being implemented in the two countries. The assessment will emphasize the use of routine data and will examine the following:

- The degree to which the HIPs are being tracked
- The degree to which HIP information is needed/used for decision making
- The indicators being used to track HIP implementation
- Measurement recommendations, including assessment of feasibility
- Experiences that can be shared with other countries

D4I will liaise with the HIP TAG as needed to complete this work. Following the assessment, D4I will disseminate the findings to the HIP TAG through a formal report, presentation, or another deliverable.

Assumptions

This activity assumes cooperation and collaboration with USAID-funded bi-laterals, as these are the mechanisms that implement the HIPs, and with country missions. Additionally, the current COVID-19 pandemic may restrict travel and data collection efforts at certain points during the activity. If travel is prohibited, we will explore alternative means of collaboration and participation with partners.

Benchmarks

Benchmark	Expected Completion*
HIPs selected for assessment	May 2020
Countries selected for analysis	June 2020
Evaluation plan drafted	August 2020
Data collection for assessment completed	February 2021
Communication materials on results of evaluation (report, presentation(s), and/others) drafted	March 2021

**These dates assume a work plan start date of April 1, 2020. If delays in work plan approval or the receipt of funding delay the start date, these dates will be automatically adjusted to account for the delay.*

Deliverables

Deliverable	Expected Completion*
Final evaluation plan	September 2020
Final communication materials on results (report, presentation(s), and/or others)	April 2021

**These dates assume a work plan start date of April 1, 2020. If delays in work plan approval or the receipt of funding delay the start date, these dates will be automatically adjusted to account for the delay.*

This evaluation will inform the development of a framework to assess HIP implementation in other countries, to guide HIP measurement recommendations, and to strengthen the promotion of practices deemed to be the "best bet" for improving FP and PRH programs.

Annual Performance Targets

The objective of the D4I award is to increase capacity for rigorous evaluation. To that end, the Project has three intermediate results (IRs). The work performed under this work plan is expected to contribute to project indicators under two of the project IRs as follows:

- IR 4.1: Strong evidence needed for program and policy decision making generated through the appropriate use of available data sources and generation of new data via innovative, rigorous, and efficient methods, approaches, and tools.
    - Assessments/evaluations completed

- IR 4.3. The use of evaluation data for global health programs and policies facilitated and enhanced through compelling, user-friendly, and actionable organization, visualization, and communication.
    - Data visualization and/or communication products/resources developed and shared with stakeholders
    - Data used to inform program and/or policies

Appendix 2. Project Descriptions

Accelerating Universal Access to Family Planning (AUAFP) / Shukhi Jibon

The Accelerating Universal Access to Family Planning project—known as Shukhi Jibon—focuses on accelerating family planning uptake by strengthening the Ministry of Health and Family Welfare in Bangladesh. Shukhi Jibon supports FP providers through increased skills and training; strengthens quality FP service delivery and works with communities to address norms related to FP. The project relies on strong collaboration and coordination among the associated government departments, and in supporting the Medical Education and Family Welfare Division to revise the FP operational plans, the project has a functional relationship with government stakeholders primarily at the national level.

Implementing Partner: Pathfinder International

Source: Annual reports shared by the project (FY 19, FY20, FY21)

Project Website: Pathfinder International

Advancing Universal Health Coverage (AUHC)

The Advancing Universal Health Coverage (AUHC) project supports transforming the NGO clinics of the Smiling Sun Network into a centrally managed, sustainable private social enterprise called the Surjer Hashi Network. AUHC aims to improve healthcare quality, equitable access, and coverage in Bangladesh through this new model of service delivery. At the strategic level, the project activities complement government health services particularly in reproductive health services—both in rural and urban areas. The project currently oversees 134 static clinics across 63 districts and has earmarked geographical areas to work. The project reports FP activities and supply and stock of FP commodities at the district level while at the national level, the project maintains a relationship with the Directorate General of Health.

Implementing Partner: Chemonics

Source: Annual reports shared by the project (FY 19, FY20, FY21)

Project Website: Improving Health and Human Capital in Bangladesh - Chemonics International

MaMoni Maternal and Newborn Care Strengthening Project (MNCSP)

The MaMoni Maternal and Newborn Care Strengthening project employs collaborative learning and adaptation to scale up proven interventions and approaches that strengthen maternal, newborn, and child health services in Bangladesh. This 5-year project incorporates global technical leadership approaches to improve capacity and program reach. The project provides direct benefits to district and upazila health management and public sector facilities, including medical colleges, district hospitals, mother and child welfare centers, UHCs, and union level health facilities. The project works through and for the government system and therefore, they maintain a supportive relationship with government stakeholders at the national and subnational levels.

Implementing Partner: Save the Children

Source: Annual reports shared by the project (FY 19, FY20, FY21)

Project Website: Mamoni - Home Page

Marketing Innovations for Sustainable Health Development (MISHD)

The Marketing Innovations for Sustainable Health Development (MISHD) project increases access to and demand for essential health products and services using social marketing tools and concepts. This 5-year project includes an integrated social marketing program to provide a comprehensive range of products and services in Bangladesh.

Implementing Partner: Social Marketing Company

Source: Annual reports shared by the project (FY 19, FY20, FY21)

Project Website: SMC | MISHD (smc-bd.org)

Boresha Afya Lake and Western Zones (BA-LWZ)

The Boresha Afya Lake and Western Zones project sought to increase access to high-quality, comprehensive, and integrated health services including reproductive, malaria, maternal, newborn, child, and adolescent care. The project worked closely with the various departments of the government, including the National Malaria Control Program and the Reproductive and Child Health Section of the ministry of health as well as the President's Office, Regional Administration and Local Government, Regional and Council Health Management Teams. Relevant government staff were offered technical support and involved in supporting implementation of the various project activities, including through joint supportive supervisions and feedback forums.

Implementing Partner: Jhiego

Source: Annual reports shared by the project (FY17, FY18, FY 19, FY20)

Project Website: Tanzania - Jhpiego

Boresha Afya Southern Zone (BA-SZ)

The Boresha Afya Southern Zone project sought to support the Government of Tanzania (GoT) in increasing access to high-quality, comprehensive, and integrated health services including reproductive, malaria, maternal, newborn, child, and adolescent care. The project worked with GoT Ministries, Departments and Agencies such as the Ministry of Health, Community Development, Gender, Elderly and Children and the President's Office, Regional Administration and Local Government through participation in the Technical Work Groups, stakeholders' meetings, developing, reviewing, and dissemination of policies, strategies, and guidelines to health facilities and the community.

Implementing Partner: Deloitte

Source: Annual reports shared by the project (FY17, FY18, FY 19, FY20)

Project Website: USAID Boresha Afya – Southern Zone (deloitte.com)

Boresha Afya North and Central Zones (BA-NCZ)

The Boresha Afya North and Central Zones project followed a strategic partnership that offered technical expertise and evidence-based TA approaches for integrated HIV, TB, FP, and reproductive health, and health systems strengthening. The project was the pioneer in developing and implementing the "*district approach*" in Tanzania, a model currently utilized across several countries to enhance local ownership, financial accountability, and coordination of donor-supported activities. The model involves working hand in hand with Regional and Council Health Management Teams to develop joint work plans, which are financed via subawards.

Implementing Partner: Elizabeth Glaser Pediatric AIDS Foundation

Source: Annual reports shared by the project (FY17, FY18, FY 19, FY20)

Project Website: Boresha Afya Project - EGPAF (pedaids.org)

Sustaining Health Outcomes through the Private Sector (SHOPS Plus)

Through mission field support, the Sustaining Health Outcomes through Private Sector partnered with the private and public sector to increase the capacity of the private sector to provide priority health products and services. SHOPS Plus aimed to improve and sustain global health outcomes through public-private engagement. The project worked with the GoT agencies responsible for establishing policies impacting the private health sector, health financing, and programmatic decisions in Tanzania (including the Reproductive and Child Health Section and National AIDS Control Program), to build support for total market approach principles.

Implementing Partner: Abt, Associates

Source: Quarterly reports shared by the project (Fy 17, FY18, FY 19, FY20)

Project Website: Tanzania | Sustaining Health Outcomes through the Private Sector (SHOPS) Plus (shopsplusproject.org)

Comprehensive Client-Centered Health Program (C3HP) - Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

The Comprehensive Client-Centered Health program supports the governments of Tanzania and Zanzibar to increase demand for and access to quality integrated RMNCAH services, particularly among women of reproductive age, youth, and children. The project utilizes a client-centered approach to improve access to quality, client-centered RMNCAH services in both health facilities and the surrounding communities, and the ability of individuals to practice positive health-seeing and self-care behaviors.

Implementing Partner: Jhpiego

Source: USAID Afya Yangu RMNCAH Factsheet | Tanzania | Fact Sheet | U.S. Agency for International Development

Project Website: Tanzania - Jhpiego

Comprehensive Client-Centered Health Program (C3HP) – HIV/TB (Afya Yangu Southern)

The Comprehensive Client-Centered Health program—known as Afya Yangu Southern—works to increase the demand for and use of quality integrated HIV and TB services in Iringa, Lindi, Morogoro, Mtwara, Njombe, and Ruvuma regions by improving access to quality services in both facilities and the surrounding communities, promoting positive health seeking behaviors among Tanzania's population, and enhancing the overall policy environment for HIV & TB service delivery. The program's comprehensive approach includes the integration of FP and gender services, including continued support to ensure there is an enabling and conducive environment for FP services provision at care and treatment centers.

Implementing Partner: Deloitte

Source: Quarterly reports shared by the project (FY 22 Q1, FY22 Q2)

Project Website: USAID Afya Yangu Southern Program (deloitte.com)

Comprehensive Client-Centered Health Program (C3HP) – HIV/TB (Afya Yangu Northern)

The Comprehensive Client-Centered Health program-known as Afya Yangu Northern—is designed around client-centered approaches to address gaps in HIV, TB, and FP service delivery, while continuously building and transferring the capacity of local stakeholders for sustainable and country-led ownership. The project will focus intensely on direct service delivery across all regions in early project years, ensuring that gaps to epidemic control are identified, and tailored solutions are designed to meet the needs of vulnerable populations. The program's comprehensive approach includes the integration of FP services, particularly a continuation of those implemented under the Boresha Afya project, such as interventions to improve FP uptake through post-partum family planning (PPFP), FP/HIV onsite coaching and mentorship sessions, FP special service days, FP/immunization integrated activities, and integrated FP community outreach.

Implementing Partner: Elizabeth Glaser Pediatric AIDS Foundation

Source: Quarterly reports shared by the project (FY 22 Q1, FY22 Q2)

Project Website: Tanzania Country Profile - EGPAF (pedaids.org)

Appendix 3. Core Component Checklist Tools

Appendix 3A. CHW Core Component Checklist Tool

Integrate trained, equipped, and supported community health workers (CHWs) into the health system

Date of the small group meeting

Assessment team (name, role)

Small group participants (name, title)

Country

Project

Core Components for the HIP

1. Assures CHWs have necessary supplies and materials to fulfill their roles
2. Monitors, reports, and assesses data on CHW services and referrals provided
3. Monitors data on CHW logistics and commodities at both the health center and district level to avoid stockouts
4. Trains and assesses CHWs' abilities to provide services and behavior change messages
5. Provides regular and as-needed supportive supervision from health system to CHWs
6. Engages communities in recruiting and supporting CHWs
7. Formalizes the role of CHWs as part of the health system to recognize their services

Core Component Ranks

1	2	3	4
LIMITED	**EMERGING**	**ADVANCING**	**FOUNDATIONAL**
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Instructions for the Small Group Session

1. The purpose and approach for completing the checklist will have been explained ahead of time, and they will have received the core components and the ranks for reference.
2. At least two people will work together to conduct the assessment (for example, one person to ask the questions and facilitate discussion and a second person to take notes)
3. With permission of the small group, the meeting will be recorded to enable verification and enhancement of the notes.
4. The small group is likely to be 3–6 people comprised of project staff with technical expertise in relation to the HIP, with the possible inclusion of an M&E focused staff member.
5. For each component, begin with a yes-no question: Does your team [insert core component]?
6. If yes or partially yes, ask follow-up questions about how implementation of the core component is monitored. Are there specific indicators? Is the monitoring through quarterly reports and presented more in textual form? Is there another way that implementation of the core component is monitored?
7. If not, ask follow-up questions about why the team does not implement the core component. Was it implemented in the past and something changed? Does the project believe the core component is not necessary? Is implementing the core component not feasible?
8. Ask the probing questions, and possibly other probing questions based on how the discussion unfolds.
9. Ask what specific successes and challenges have been experienced.
10. Use the space provided for notes, or if preferred, use a computer or separate pages for notes. Be sure to label any separate notes per the information noted at the top of this page.
11. Once the discussion is completed for the core component, ask the group to select a rank: 1, 2, 3, 4. Work to encourage the group to agree on a rank; however, if agreement is not possible note the multiple ranks.
12. When working with the group on the rank, be sure to convey that the rank is not binding in any way. The rank does not function like a baseline indicator or any type of metric. Instead, the rank is a way for the evaluation team (and in turn USAID) to better understand various challenges and successes across family planning projects, and gain insight into how indicators could be better standardized across projects.

What to do after the Small Group Session

13. After the meeting, review the notes and establish what rank you as the assessment team would give in terms of the extent the project is implementing the core component. Your rank might be the same and might be different from the small group. Either way is ok, and remember, the rank is not a binding metric that the project is accountable to track.
14. Follow the protocols that will be established in terms of saving the audio recording, organizing the notes, contributing to the analysis of the session, and alerting the larger evaluation team of any challenges of follow up that is needed.

INFORMED CONSENT

Read this statement and document the responses

Hello. My name is_____. I am part of a team from the Data for Impact (D4I) project.

We are undertaking a study to better understand how a sample of USAID projects in Bangladesh and Tanzania are implementing high impact practices (HIPs) in family planning. Our study is funded by USAID.

In this small group discussion, we would like to discuss how [insert project name] implements its activities relating to community health workers, mobile outreach services, and immediate postpartum family planning [as applicable]. We will also be asking a few questions about how activities on the project are monitored.

Everything you say will be kept confidential and remain anonymous. In our report, we will not link any comments made to specific individuals or specific projects.

We are grateful for your time. Our hope is that the findings from our study will help USAID and its implementing partners continue to have strong programming in health and family in [insert country name] and in other parts of the world.

I am happy to answer any questions (allow time for questions and answer them)

During our discussion my colleague [insert name] will be taking notes. In addition, with your permission we would like to record this meeting. The recording will only be used to help ensure that we have good notes. No one outside of our study team will have access to the recording. After the completion of data collection, we will delete the recording.

Do you give your consent to be part of this recorded small group discussion?

Participant Name					
1			YES		NO
2			YES		NO
3			YES		NO
4			YES		NO
5			YES		NO
6			YES		NO

Thank you so much for taking the time for this discussion.

Let's go ahead and get started.

Start the recording

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (supplies, materials)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
1 [Does the project] assure CHWs have the necessary supplies and materials to fulfill their roles?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *To what extent is a national norms or procedures document that describes how CHWs will be re/supplied used?*
- *To what extent do CHWs have appropriate methods (the ones they can offer) and counseling materials on-hand?*
- *Are there ever disagreements between the project staff and CHWs regarding what supplies and materials are needed?*
- *What is the process by which CHWs request supplies and materials, and how they held accountable for the supplies and materials they use to fulfill their roles?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component	
Rank =		Rank =	
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (services, referrals)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
2 [Does the project] monitor, report, and assess data on CHW services and referrals provided?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Does the CHW and/or associated health facility regularly document relevant indicators through registers or other means?*
- *Are the indicators aligned with the activities and approaches defined as a HIP?*
- *Are the indicators disaggregated by specific services? And specific referrals?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component	
Rank =		Rank =	
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (avoiding stockouts)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
3 [Does the project] monitor data on CHW logistics and commodities at both the health center and district level to avoid stockouts?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Does the CHW and/or associated health facility regularly document relevant indicators through registers or other means?*
- *Are the indicators disaggregated by specific logistics? And specific commodities?*
- *Are there plans and procedures in place if there is a stockout?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component	
Rank =		Rank =	
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (training)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
4 [Does the project] train and assess CHWs' abilities to provide services and behavior change messages?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *To what extent is a national training curriculum used and does it include appropriate services and messages for CHWs?*
- *Are CHWs who provide family planning services screening mothers for unmet need for family planning?*
- *Are CHWs who provide family planning services providing behavior change messages?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (supervision)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
5 [Does the project] provide regular and as-needed supportive supervision from health system to CHWs?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *To what extent are national norms or procedures used in establishing a plan for supervision visits?*
- *At what interval do supervisory visits occur?*
- *Do CHWs have contact information of supervisors?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (engagements)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
6 [Does the project] engage communities in recruiting and supporting CHWs?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Describe the procedures for managing authorities to seek feedback from communities on CHW recruitment and support*
- *Are CHWs are recruited from local communities?*
- *What procedures are followed to monitor if CHWs have good rapport with local communities?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Integrate trained, equipped, and supported community health workers (CHWs) into the health system				
Core Component (HS integration)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
7 [Does the project] formalize the role of CHWs as part of the health system to recognize their services?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *To what extent does the managing authority use/refer to a national norms or procedures document as part of how CHWs are formalized into the health system?*
- *Do CHWs see their role as formalized in the health system?*
- *Do CHWs receive financial and/or non-financial incentives for their work?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Appendix 3B. MOSD Core Component Checklist Tool

Support mobile outreach service delivery (MOSD) to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods

Date of the small group meeting

Assessment team (name, role)

Small group participants (name, title)

Country

Project

Core Components for the HIP

1. Ensures adequate attention to relevant cultural, economic, and social factors as well as the overall context and needs in relation to the intended client base.
2. Coordinates with community leaders as part of aligning staff to the specific needs, establishing a plan to raise awareness for the service, and communicating the relevant details to potential clients.
3. Ensures the necessary equipment and supplies are in place and used appropriately to provide family planning services as well as integrated services, including preparedness for any emergency needs.
4. Trains service providers in providing respectful care including counselling services and recognizing instances when a referral for additional care is appropriate.
5. Procedures in place for discussing the importance of follow-up care with their clients and helping clients understand how to access follow-up care.
6. Follows a plan for collecting and recording relevant data and inputting that information into the relevant national, sub-national, and/or project repositories to ensure follow-up.

Core Component Ranks

1	2	3	4
LIMITED	**EMERGING**	**ADVANCING**	**FOUNDATIONAL**
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Instructions for the Small Group Session

1. The purpose and approach for completing the checklist will have been explained ahead of time, and they will have received the core components and the ranks for reference.
2. At least two people will work together to conduct the assessment (for example, one person to ask the questions and facilitate discussion and a second person to take notes)
3. With permission of the small group, the meeting will be recorded to enable verification and enhancement of the notes.
4. The small group is likely to be 3–6 people comprised of project staff with technical expertise in relation to the HIP, with the possible inclusion of an M&E focused staff member.
5. For each component, begin with a yes-no question: Does your team [insert core component]?
6. If yes or partially yes, ask follow-up questions about how implementation of the core component is monitored. Are there specific indicators? Is the monitoring through quarterly reports and presented more in textual form? Is there another way that implementation of the core component is monitored?
7. If no, ask follow-up questions about why the team does not implement the core component. Was it implemented in the past and something changed? Does the project believe the core component is not necessary? Is implementing the core component not feasible?
8. Ask the probing questions, and possibly other probing questions based on how the discussion unfolds.
9. Ask what specific successes and challenges have been experienced.
10. Use the space provided for notes, or if preferred, use a computer or separate pages for notes. Be sure to label any separate notes per the information noted at the top of this page.
11. Once the discussion is completed for the core component, ask the group to select a rank: 1, 2, 3, 4. Work to encourage the group to agree on a rank; however, if agreement is not possible note the multiple ranks.
12. When working with the group on the rank, be sure to convey that the rank is not binding in any way. The rank does not function like a baseline indicator or any type of metric. Instead, the rank is a way for the evaluation team (and in turn USAID) to better understand various challenges and successes across family planning projects, and gain insight into how indicators could be better standardized across projects.

What to do after the Small Group Session

13. After the meeting, review the notes and establish what rank you as the assessment team would give in terms of the extent the project is implementing the core component. Your rank might be the same and might be different from the small group. Either way is ok, and remember, the rank is not a binding metric that the project is accountable to track.
14. Follow the protocols that will be established in terms of saving the audio recording, organizing the notes, contributing to the analysis of the session, and alerting the larger evaluation team of any challenges of follow up that is needed.

INFORMED CONSENT

Read this statement and document the responses

Hello. My name is_____. I am part of a team from the Data for Impact (D4I) project.

We are undertaking a study to better understand how a sample of USAID projects in Bangladesh and Tanzania are implementing high impact practices (HIPs) in family planning. Our study is funded by USAID.

In this small group discussion, we would like to discuss how [insert project name] implements its activities relating to community health workers, mobile outreach services, and immediate postpartum family planning [as applicable]. We will also be asking a few questions about how activities on the project are monitored.

Everything you say will be kept confidential and remain anonymous. In our report, we will not link any comments made to specific individuals or specific projects.

We are grateful for your time. Our hope is that the findings from our study will help USAID and its implementing partners continue to have strong programming in health and family in [insert country name] and in other parts of the world.

I am happy to answer any questions (allow time for questions and answer them)

During our discussion my colleague [insert name] will be taking notes. In addition, with your permission we would like to record this meeting. The recording will only be used to help ensure that we have good notes. No one outside of our study team will have access to the recording. After the completion of data collection, we will delete the recording.

Do you give your consent to be part of this recorded small group discussion?

Participant Name					
1			YES		NO
2			YES		NO
3			YES		NO
4			YES		NO
5			YES		NO
6			YES		NO

Thank you so much for taking the time for this discussion.

Let's go ahead and get started.

Start the recording.

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods				
Core Component (context)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
1 [Does the project] ensure consideration of cultural, economic, and social factors and needs in relation to client base?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Does the project follow national guidelines or standards in designing and determining locations for mobile outreach services?*
- *Is data being collected that helps to assess if contextual factors create barriers for clients to access mobile outreach services?*
- *Do health facilities have the needed resources to manage both service delivery at the facility and mobile service delivery?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods				
Core Component (engage community)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
2 [Does the project] coordinate with community leaders as part of aligning staff to the specific needs, establishing a plan to raise awareness for the service, and communicating the relevant details to potential clients?				
Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.* ▪ *What approaches are used to engage the community and who is involved in this effort?* ▪ *What information is collected as part of establishing community and client needs and to what extent are existing health facilities involved in this effort?*				
Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions				
Ask about successes, challenges, how challenges are addressed, and summarize here				
Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component		
Rank =		Rank =		
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*	

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods				
Core Component (equipment, supplies)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
3 [Does the project] ensure the necessary equipment and supplies are in place and used appropriately to provide family planning services as well as integrated services, including preparedness for any emergency needs?				
Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.* ▪ *What management and supervisory systems are in place to track the work of the mobile outreach team?* ▪ *How are referrals tracked by the mobile outreach team and coordinated with facility-based staff?* ▪ *What planning and staffing is incorporated to ensure a mobile outreach team can handle emergency needs?*				
Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions				
Ask about successes, challenges, how challenges are addressed, and summarize here				
Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component		
Rank =		Rank =		
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*	

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods				
Core Component (training)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
4 [Does the project] train service providers in providing respectful care including counselling services and recognizing instances when a referral for additional care is appropriate?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *What oversight and client feedback mechanisms are in place to track satisfaction with the services provided?*
- *Do standard of care expectations for mobile services align to the same standards for facility-based care?*
- *What types of trainings are mobile services staff required to take and what is the frequency with which they take trainings?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods				
Core Component (follow-up care)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
5 [Does the project] have procedures in place for discussing the importance of follow up care with their clients and helping clients understand how to access follow-up care?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *How common is it that mobile outreach clients need follow-up care?*
- *Are most clients open to the idea of seeking follow up care?*
- *What process does the mobile outreach team follow to determine the need for follow-up care and then in turn, track if the client seeks follow-up care?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods				
Core Component (data)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
6 [Does the project] follow a plan for collecting and recording relevant data and inputting that information into the relevant national, sub-national, and/or project repositories to ensure follow-up?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Do mobile outreach teams record data while in their mobile location, or do they wait until they return to the home base?*
- *Are data collected by the mobile outreach team that do not get entered in a national, sub-national, or project repository? If so, what data?*
- *Who uses the data that mobile outreach teams collect, and is the data sufficient and helpful in drawing lessons and making programming adjustments?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

Appendix 3C. IPPFP Core Component Checklist Tool

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[10]

Date of the small group meeting
Assessment team (role)
Small group participants (name, title)

Country
Project

Core Components for the HIP

1. Ensures consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences
2. Monitors, reports, and assesses on counseling, offering, and uptake of methods for postpartum clients
3. Trains providers for IPPFP on counseling and service provision per local guidance
4. Engages health facility leadership and staff to promote the practice
5. Ensures staff availability for FP services and products prior to discharge
6. Assures that national service delivery guidelines are readily available and widely disseminated
7. Communicates the role of service providers as outlined in national service delivery guidelines

Core Component Ranks

1 LIMITED	2 EMERGING	3 ADVANCING	4 FOUNDATIONAL
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

[10] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Instructions for the Small Group Session

1. The purpose and approach for completing the checklist will have been explained ahead of time, and they will have received the core components and the ranks for reference.
2. At least two people will work together to conduct the assessment (for example, one person to ask the questions and facilitate discussion and a second person to take notes)
3. With permission of the small group, the meeting will be recorded to enable verification and enhancement of the notes.
4. The small group is likely to be 3–6 people comprised of project staff with technical expertise in relation to the HIP, with the possible inclusion of an M&E focused staff member.
5. For each component, begin with a yes-no question: Does your team [insert core component]?
6. If yes or partially yes, ask follow-up questions about how implementation of the core component is monitored. Are there specific indicators? Is the monitoring through quarterly reports and presented more in textual form? Is there another way that implementation of the core component is monitored?
7. If no, ask follow-up questions about why the team does not implement the core component. Was it implemented in the past and something changed? Does the project believe the core component is not necessary? Is implementing the core component not feasible?
8. Ask the probing questions, and possibly other probing questions based on how the discussion unfolds.
9. Ask what specific successes and challenges have been experienced.
10. Use the space provided for notes, or if preferred, use a computer or separate pages for notes. Be sure to label any separate notes per the information noted at the top of this page.
11. Once the discussion is completed for the core component, ask the group to select a rank: 1, 2, 3, 4. Work to encourage the group to agree on a rank; however, if agreement is not possible note the multiple ranks.
12. When working with the group on the rank, be sure to convey that the rank is not binding in any way. The rank does not function like a baseline indicator or any type of metric. Instead, the rank is a way for the evaluation team (and in turn USAID) to better understand various challenges and successes across family planning projects, and gain insight into how indicators could be better standardized across projects.

What to do after the Small Group Session

13. After the meeting, review the notes and establish what rank you as the assessment team would give in terms of the extent the project is implementing the core component. Your rank might be the same and might be different from the small group. Either way is ok, and remember, the rank is not a binding metric that the project is accountable to track.
14. Follow the protocols that will be established in terms of saving the audio recording, organizing the notes, contributing to the analysis of the session, and alerting the larger evaluation team of any challenges of follow up that is needed.

INFORMED CONSENT

Read this statement and document the responses

Hello. My name is_____. I am part of a team from the Data for Impact (D4I) project.

We are undertaking a study to better understand how a sample of USAID projects in Bangladesh and Tanzania are implementing high impact practices (HIPs) in family planning. Our study is funded by USAID.

In this small group discussion, we would like to discuss how [insert project name] implements its activities relating to community health workers, mobile outreach services, and immediate postpartum family planning [as applicable]. We will also be asking a few questions about how activities on the project are monitored.

Everything you say will be kept confidential and remain anonymous. In our report, we will not link any comments made to specific individuals or specific projects.

We are grateful for your time. Our hope is that the findings from our study will help USAID and its implementing partners continue to have strong programming in health and family in [insert country name] and in other parts of the world.

I am happy to answer any questions (allow time for questions and answer them)

During our discussion my colleague [insert name] will be taking notes. In addition, with your permission we would like to record this meeting. The recording will only be used to help ensure that we have good notes. No one outside of our study team will have access to the recording. After the completion of data collection, we will delete the recording.

Do you give your consent to be part of this recorded small group discussion?

Participant Name					
1			YES		NO
2			YES		NO
3			YES		NO
4			YES		NO
5			YES		NO
6			YES		NO

Thank you so much for taking the time for this discussion.

Let's go ahead and get started.

Start the recording

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[11]				
Core Component (supplies, equipment)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
1 [Does the project] ensure consistent availability of essential supplies, equipment (i.e., medical instruments), and methods appropriate per local demand and preferences?				
Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.* ▪ *Is there a monitoring report (via HMIS or other database) of supplies, equipment, and methods and who accesses and uses this report? How frequently and for what purpose?* ▪ *Are facilities are appropriately equipped with supplies, equipment, and methods to meet local demands for family planning?* ▪ *Are there systems in place to understand what local demand and preferences are and act accordingly?*				
Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions				
Ask about successes, challenges, how challenges are addressed, and summarize here				
Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component		
Rank =		Rank =		
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*	

[11] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[12]				
Core Component (uptake of methods)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
2 [Does the project] monitor, report, and assess on counseling, offering, and uptake of methods for postpartum clients?				
Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.* ▪ *Is there a monitoring report (via HMIS or other database) of relevant indicators and who accesses and uses the report? How frequently and for what purpose?* ▪ *Are facilities regularly documenting relevant indicators through registers or other means?* ▪ *To what extent are indicators aligned to the specific activity and approach defined as the HIP?*				
Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions				
Ask about successes, challenges, how challenges are addressed, and summarize here				
Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component		
Rank =		Rank =		
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*	

[12] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[13]				
Core Component (counseling, service)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
3 [Does the project] train providers for IPPFP on counseling and service provision per local guidance?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Does facility management use and refer to a national training curriculum for IPPFP counseling and service provision?*
- *How motivated are providers to seek training opportunities around IPPFP counseling and service provision?*
- *What is the process for providers to screen postpartum mothers for unmet need for family planning?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component	After the meeting, review the notes and rank the extent the project is implementing the core component
Rank =	Rank =

1 Limited	2 Emerging	3 Advancing	4 Foundational
The core component is being implemented partially and/or in limited ways.	*Plans are in place to implement and monitor the core component.*	*The core component has always been and is being implemented fully, but there are no indicators to track.*	*The core component has always been and is being implemented fully, with indicators to track.*

[13] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[14]				
Core Component (engage facility)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
4 [Does the project] engage health facility leadership and staff to promote the practice?				
Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.* ▪ *How commonly do health facility managers use and refer to national procedures on how to promote IPPFP and at what interval?* ▪ *To what extent does health facility leadership promote IPPFP at their health facility?* ▪ *Do health facility managers and leaders have data available to promote IPPFP and understand how to effectively use the data?*				
Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions				
Ask about successes, challenges, how challenges are addressed, and summarize here				
Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component		
Rank =		Rank =		
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*	

[14] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[15]				
Core Component (staff availability)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
5 [Does the project] ensure staff availability for FP services and products prior to discharge?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Do the managers at facilities use and refer to procedures outlining provider time and capacity? And are the procedures part of a national-level policy?*
- *Are providers consistently available to provide family planning services and counseling to postpartum mothers?*
- *What do health facility managers do when they face staff availability challenges?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component	
Rank =		Rank =	
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*

[15] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[16]				
Core Component (guidelines)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
6 [Does the project] assure that national service delivery guidelines are readily available and widely disseminated?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Does health facility management use and refer to a procedures document on how IPPFP is implemented at facilities? And is the document a national-level policy or guidance document?*
- *To what extent are providers able and ready to screen postpartum mothers for unmet need for family planning?*
- *What are the specific national service delivery guidelines that are used at health facilities?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component	
Rank =		Rank =	
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*

[16] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Immediate postpartum family planning (IPPFP): Offer contraceptive counseling and services as part of care provided during childbirth at health facilities[17]				
Core Component (role of providers)	**Yes Partially No**	**HOW IS THE CORE COMPONENT MONITORED?**		
		Indicator	**Report (textually)**	**Other (specify)**
7 [Does the project] communicate the role of service providers as outlined in national service delivery guidelines?				

Possible Probing Questions: *These questions are to help understand if policies are in place to implement the core component and if at the service delivery level there is readiness to implement the core component.*

- *Do health facility managers use and refer to a procedures document outlining specific roles of providers in implementing IPPFP? Does the document align to national level policy?*
- *Are the different roles of providers relating to IPPFP clear among providers and health facility management?*
- *What procedures do health facility managers follow if there is confusion about the different roles of providers?*

Use this space for notes about the yes-partially-no discussion, monitoring, and probing questions

Ask about successes, challenges, how challenges are addressed, and summarize here

Ask the small group how they would rank the extent the project is implementing the core component		After the meeting, review the notes and rank the extent the project is implementing the core component	
Rank =		Rank =	
1 Limited *The core component is being implemented partially and/or in limited ways.*	2 Emerging *Plans are in place to implement and monitor the core component.*	3 Advancing *The core component has always been and is being implemented fully, but there are no indicators to track.*	4 Foundational *The core component has always been and is being implemented fully, with indicators to track.*

[17] After the protocol and data collection tools for this assessment were developed, the HIPs initiative revised the definition for the immediate postpartum family planning (IPPFP) HIP, as follows: Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility. In this report, the previous definition is presented because this is the definition that was used across all data collection activities.

Appendix 4. Project KII Interview Guide

Date of interview

Interview team (name, role)

Person being interviewed (name, title)

Country

Project

Instructions

1. The purpose of this interview will have been explained ahead of time to the individual. However, the first step of any interview is to be polite and build rapport. It is still important to begin the interview with a thoughtful introduction and acknowledgement of appreciation that the interviewee is taking the time out for the interview.
2. Follow the informed consent procedures. Be sure to allow time for the interview participant to ask any questions.
3. It will be known ahead of time which of the three HIPs the interviewee can speak to, or if they can speak to multiple HIPs.
4. If feasible, two people will work together to conduct the interview. For example, one person to ask the questions and facilitate discussion and a second person to take notes. If a second person is not available, the person conducting the interview will be responsible for producing notes from the interview.
5. With permission of the interview participant, the interview will be recorded to enable verification and enhancement of the notes.
6. It is ok to ask the questions in your own words, and, in some cases, you will want to ask follow-up questions based on the responses. It is not possible to anticipate what follow-up questions should be asked; therefore, it is important to listen to the interview participant.
7. Work to have a conversation with the person being interviewed; you are the facilitator and direction of that conversation. If the interviewee gives yes/no or very short response, probe and ask more questions.
8. Given the importance of appropriate introductions and depending on the number of HIPs the interviewee can speak to, plan for 1.5 hours for the interview.

INFORMED CONSENT (Project Staff)

Read this statement and document the responses

Hello. My name is_____. I am part of a team from the Data for Impact (D4I) project.

We are undertaking a study to better understand how a sample of USAID projects in Bangladesh and Tanzania are implementing high impact practices (HIPs) in family planning. Our study is funded by USAID.

In this interview, I would like to ask you some questions about how [insert project name] implements activities relating to community health workers, mobile outreach services, and immediate postpartum family planning [as applicable]. I will also be asking a few questions about how activities on the project are monitored.

Everything you say will be kept confidential and remain anonymous. In our report, we will not link any comments made to specific individuals or specific projects.

We are grateful for your time. Our hope is that the findings from our study will help USAID and its implementing partners continue to have strong programming in health and family in [insert country name] and in other parts of the world.

I am happy to answer any questions (allow time for questions and answer them)

Do you give your consent to be interviewed?

☐ YES ☐ NO

During this interview my colleague [insert name] will be taking notes. In addition, with your permission we would like to record this interview. The recording will only be used to help ensure that we have good notes. No one outside of our study team will have access to the recording. After the completion of data collection, we will delete the recording.

Is it ok if we record this interview?

☐ YES ☐ NO

Thank you so much for taking the time to speak with me.

Let's go ahead and get started.

Start the recording

INTERVIEW QUESTIONS (Project Staff)

To be finalized based on findings from the survey and core component checklists

PART 1 – PART 4 likely for all interview participants

PART 5 – PART 7 depending on the pre-determined expertise of interview participant

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PART 1: Goals and activities of the project in relation to HIP core components

1. What are the specific service delivery activities of the project? What are the family planning activities?
2. Across the project, what best practices do you follow with service delivery and family planning activities?
3. Can you tell me about how familiar you are with High Impact Practices or HIPs? To what extent are HIPs followed in the work of [insert project name]?

PART 2: Geographic reach of the project and what challenges have been encountered

4. Has the service delivery and family planning work reached the intended locations? Why or why not?
5. To what extent do you feel the project provides services in representative ways? For example, who receives the services of the project and who does not?
6. Are the procedures for providing the services working well, and could lessons be applied to services in other locations?

PART 3: Project implementation (resources, skills, policy, quality assurance procedures)

7. Are the resources needed to implement family planning services available across the relevant government, health system and citizen actors and are they being accessed consistently?
8. For those involved in service provision, what are the strengths and weaknesses around level expertise? What options are there to enhance skills and learn new skills?
9. In terms of the government policy relating to service delivery and family planning, do the policies align with the approach the project is taking? Are the policies working in relation to different sub-populations, particularly vulnerable populations (e.g., women, persons with disabilities, ethnic minorities)?
10. Are individuals providing services and the institutions they represent being monitored through established quality assurance procedures? By whom? In what ways are citizens able to weigh in? Are lessons learned being applied?

PART 4: Monitoring, Evaluation, and Learning (MEL)

11. Can you describe the strengths and weaknesses of the project's MEL system? In particular, does the system help you assess if activities are implemented in accordance with best practices and based on evidence?
12. Do you feel like data collected through the MEL work is used to improve implementation? What are some specific examples?

PART 5: HIP-Specific, Community Health Workers (*If applicable)*

13. How are CHWs who support family planning services integrated into the health system? Including, for example, in relation to referrals, supervision, and information systems? What strategies and technologies are used to link CHWs with the health system?
14. What training is provided for CHWs who support family planning services?
15. Are there systems in place to ensure CHWs have access to information, supplies, and colleagues?
16. To what extent is the support structure for CHWs grounded in participatory, inclusive, and incentive-based ways of working? Can you give some examples?

PART 6: HIP-Specific, Mobile Outreach Services (*If applicable)*

17. With the mobile outreach services work, can you describe the process to pick a site and assign staff for the work? For example, how does the project factor in various cultural and socio-economic factors?
18. How does the project work at the community level to raise awareness about their mobile outreach services? What is the community outreach strategy?
19. How does the project ensure that staff are trained for providing mobile outreach services? And have the needed equipment and supplies?
20. What are the procedures to help mobile outreach services staff provide referrals? How do staff help clients understand the importance of follow-up care? How do the staff introduce to clients the option of seeking counseling?

PART 7: HIP-Specific, Immediate Postpartum Family Planning (*If applicable)*

20. At the facility level, do immediate PPFP strategies exist for providers? Can you describe how providers offer this service? Are providers always available to provide this service? Are supplies adequate?
21. Does the project engage health facility leadership to promote the importance of immediate PPFP? How? Can you describe if health facility leadership agrees or disagrees with the importance of immediate PPFP?
22. What are the main challenges in working with postpartum clients? Are there national service delivery guidelines that help to address these challenges?
23. What types of training does the project have available for service providers around immediate PPFP?

CONCLUDING QUESTIONS (for all interviewees)

24. Overall, what is your view of the project's approach in providing family planning services? What are some of the strengths? And weaknesses?
25. Are there any questions you would like to ask me? Or any other details about the project that you would like to discuss?

Appendix 5. District KII Interview Guide

Date of interview

Interview team (name, role)

Person being interviewed (name, title)

Country

Project

Instructions

1. The purpose of this interview will have been explained ahead of time to the individual. However, the first step of any interview is to be polite and build rapport. It is still important to begin the interview with a thoughtful introduction and acknowledgement of appreciation that the interviewee is taking the time out for the interview.
2. Follow the informed consent procedures. Be sure to allow time for the interview participant to ask any questions.
3. It will be known ahead of time which of the three HIPs the interviewee can speak to, or if they can speak to multiple HIPs.
4. If feasible, two people will work together to conduct the interview. For example, one person to ask the questions and facilitate discussion and a second person to take notes. If a second person is not available, the person conducting the interview will be responsible for producing notes from the interview.
5. With permission of the interview participant, the interview will be recorded to enable verification and enhancement of the notes.
6. It is ok to ask the questions in your own words, and, in some cases, you will want to ask follow-up questions based on the responses. It is not possible to anticipate what follow-up questions should be asked; therefore, it is important to listen to the interview participant.
7. Work to have a conversation with the person being interviewed; you are the facilitator and direction of that conversation. If the interviewee gives yes/no or very short response, probe and ask more questions.
8. Given the importance of appropriate introductions and depending on the number of HIPs the interviewee can speak to, plan for 1.5 hours for the interview.

INFORMED CONSENT (District Facility Staff)

Read this statement and document the responses

Hello. My name is_____. I am part of a team from the Data for Impact (D4I) project.

We are undertaking a study to better understand how a sample of USAID projects in Bangladesh and Tanzania are implementing high impact practices (HIPs) in family planning. Our study is funded by USAID.

In this interview, I would like to ask you some questions about family planning services at [insert district facility name]. The specific topics include community health workers, mobile outreach services, and immediate postpartum family planning. I will also be asking a few questions about the HMIS and how this work is monitored.

Everything you say will be kept confidential and remain anonymous. In our report, we will not link any comments made to specific individuals or specific projects.

We are grateful for your time. Our hope is that the findings from our study will help USAID, its implementing partners, and the government of [insert country name] continue to have strong programming in health and family in [insert country name] and in other parts of the world.

I am happy to answer any questions (allow time for questions and answer them)

Do you give your consent to be interviewed?

☐ YES ☐ NO

During this interview my colleague [insert name] will be taking notes. In addition, with your permission we would like to record this interview. The recording will only be used to help ensure that we have good notes. No one outside of our study team will have access to the recording. After the completion of data collection, we will delete the recording.

Is it ok if we record this interview?

☐ YES ☐ NO

Thank you so much for taking the time to speak with me.

Let's go ahead and get started.

Start the recording

INTERVIEW QUESTIONS (District Facility Staff)

To be finalized based on findings from the survey and core component

T 1 – PART 4 likely for all interview participants

T 5 – PART 7 depending on the pre-determined expertise of interview participant

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PART 1: Goals and activities of programs in relation to HIP core components

1. What do you see as the most important family planning and service delivery activities that should be undertaken in [insert name of country]? What are the keys for them to be successful?
2. Can you tell me about how familiar you are with High Impact Practices or HIPs? To what extent are HIPs followed across family planning work in [insert name of country]?
3. To what extent do you feel [insert district facility name] follows the HIPs and/or other internationally recognized best practices? Please explain your response

PART 2: Geographic reach of programs and what challenges have been encountered

4. For your facility, does the service delivery and family planning work reach the intended locations? Why or why not?
5. To what extent do you feel the family planning services are provided in representative ways? For example, who receives the services and who does not? And why is this the case?

PART 3: Program implementation (resources, skills, policy, quality assurance procedures)

6. Are the resources needed to implement family planning services available at your facility? Are they being accessed consistently?
7. Do government policies align with the approach that donor-funded projects are taking? Are the policies working in relation to different sub-populations, particularly vulnerable populations (e.g., women, persons with disabilities, ethnic minorities)?
8. Does your facility have quality assurance procedures in place? How does the process work? In what ways are citizens able to weigh in? Are lessons learned being applied?

PART 4: Monitoring, Evaluation, and Learning (MEL)

9. Can you describe the strengths and weaknesses of the national HMIS? In particular, does the system help understand if activities are implemented in accordance with best practices and based on evidence?
10. Do all district facilities track the same family planning indicators? Please explain.
11. What are some of the main indicators that should be standardized?
12. What could be gained by having more standardized indicators? What are the risks of having standardized indicators across different projects?

PART 5: HIP-Specific, Community Health Workers *If applicable*

13. To what extent are CHWs integrated into the health system? Including, for example, in relation to referrals, supervision, and information systems? What strategies and technologies are used to link CHWs with the health system?
14. Is there adequate training in your district for CHWs? Why or why not?
15. To what extent is the CHW model grounded in incentive-based ways of working? Can you give some examples? How has this worked?

PART 6: HIP-Specific, Mobile Outreach Services *If applicable*

16. With mobile outreach services, how are various cultural and socio-economic factors considered?
17. How are communities made aware of mobile outreach services? What is the community outreach strategy at your facility?
18. How are your staff trained to provide mobile outreach services? Do they face challenges with having the needed equipment and supplies? Please give examples.
19. Do you feel that mobile outreach services staff have systems in place to provide referrals? How do staff help clients understand the importance of follow-up care? How do the staff introduce to clients the option of seeking counseling?

PART 7: HIP-Specific, Immediate Postpartum Family Planning *If applicable*

20. At the facility level, do immediate PPFP strategies exist for providers? Are providers always available to provide this service? Are supplies adequate?
21. Does your facility believe in the importance of immediate PPFP? Why or why not?
22. What are the main challenges in working with postpartum clients? Are there national service delivery guidelines that help to address these challenges?
23. What types of training are available for your service providers around immediate PPFP?

CONCLUDING QUESTIONS (for all interviewees)

24. Overall, across government programs and district facilities, what is your view of the approaches for providing family planning services? What are some of the strengths? And weaknesses?
25. Are there any questions you would like to ask me? Or any other details about the family planning projects in [insert country name] that you would like to discuss?

Thank you for your time!

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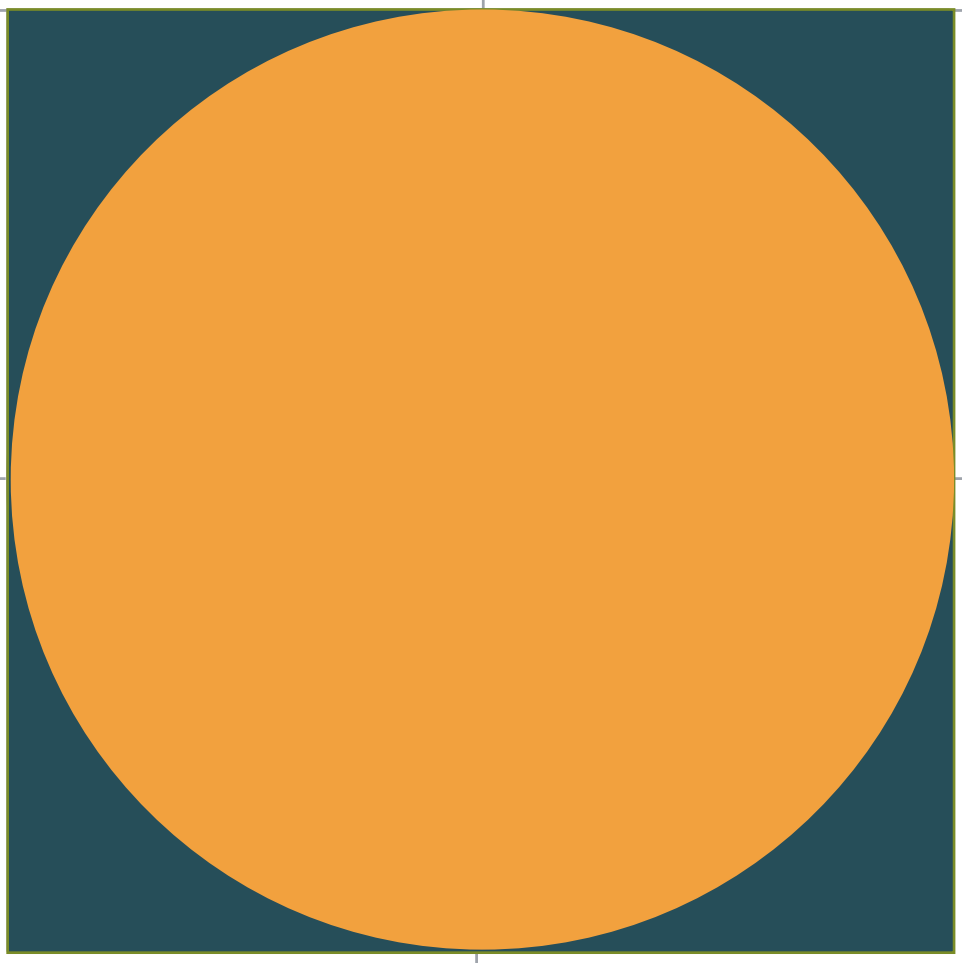

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