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

Review and Refine of TAG Processes
Key Outcomes of Interest
Shawn Malarcher reviewed the key outcomes of interest. No changes were made to these outcomes.

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

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

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

- It was agreed the TOC is helpful to the authors, reviewers, and consumers of the HIP briefs.
- TOC will not be included in Enabling Environment Briefs.
- The TAG would like a standard format that could be somewhat adjustable as needed.
- The TOC should be simple. Recent examples are at about the right level of complexity.
- There has been some discussion about assumptions and context, but this could be incorporated into other parts of the brief.
- Consider presenting the TOC in a way that shows variations in the level of evidence for specific components/relationships in the TOC (such as the relationship between the intervention and the outcome). Authors can address/discuss this in the text.
- Add citation(s) for the TOC that will provide readers with additional background, if desired. This could also be available on the website to increase understanding.
- A small group will work on developing guidance for authors on what should be included on the TOC in the briefs. In addition, this group will propose guidance for the TAG on how the TOC should be used for deliberations (Ritu Shroff, Paata Chikvaidze, Michelle Weinberger, and Maggwa Baker).
- It was agreed to update the two-page HIP list. Ados and Peggy will complete the first draft.
Review 2017 Briefs

Post-Partum Family Planning (New Brief)

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

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

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

Social Franchising (New Brief)

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

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

mHealth (Update)

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

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

Health Communication (Update)
Joan Kraft (USAID) is the author updating the Health Communication brief. The TAG provided the following recommendations:
• Draw on evidence from HIV where appropriate
• Emphasize the importance of audience segmentation; look at the Community Engagement brief, can we add something on segmentation in the TIPs section?
• Include information on dose (repeat messaging)
• Include text box referencing digital health media

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

<table>
<thead>
<tr>
<th>Source</th>
<th>TAG Discussant Guidance</th>
<th>HIP List</th>
<th>HIP Video</th>
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<tbody>
<tr>
<td>The breadth and quality of evidence</td>
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<td></td>
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<tr>
<td>Demonstration and magnitude of impact on contraceptive use and continuation.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Potential public health impact.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential application in a wide range of settings.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Consistency of result</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Replicability</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Scalability</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sustainability</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Proven, Promising, Emerging; Enhancements

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

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

- **Emerging:** Although emerging HIPs have a strong theoretical basis, they have limited evidence to assess impact. Therefore, emerging HIPs should be implemented within the context of research or an impact evaluation. For a complete list of emerging practices, see the HIPs website.

- An “enhancement” is a practice that can be implemented in conjunction with HIPs to further intensify the impact of the HIPs.

**Next Steps and Wrap-Up**

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

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

### HIPs Technical Advisory Group Meeting

**November 28th, 2016**  
**10:00 – 17:15**

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

### Monday, November 28, 2016

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

Hashina Begum
UNFPA
hashina@unfpa.org

Rati Bishnoi
FP2020
rbishnoi@familyplanning2020.org

Vicky Boydell
IPPF
VBoydell@ippf.org

Minki Chatterji
Abt Associates
minki_chatterji@abtassoc.com

Margaret D'Adamo
USAID
mdadamo@usaid.gov

Ellen Eiseman
Chemonics
eeiseman@chemonics.com

Mario Festin
WHO
festinma@who.int

Sarah Fox
Options
s.fox@options.co.uk

Jennie Greaney
UNFPA
greaney@unfpa.org

Jay Gribble
Palladium
Jay.Gribble@thepalladiumgroup.com

Karen Hardee
Population Council
khardee@popcouncil.org

Roy Jacobstein
IntraHealth
rjacobstein@intrahealth.org

Victoria Jennings
IRH
jenningv@georgetown.edu

Baker Maggwa
USAID
bmaggwa@usaid.gov

Shawn Malarcher
USAID
smalarcher@usaid.gov

Ados May
IBP Initiative Secretariat
ados.may@phi.org

Alice Payne Merritt
CCP
alicepayne.merritt@jhu.edu

Erin Mielke
USAID
emielke@usaid.gov

Gael O'Sullivan
Abt Associates
Gael_Osullivan@abtassoc.com

John M. Pile
UNFPA
pile@unfpa.org

Heidi Quinn
IPPF
hquinn@ippf.org
Ritu Shroff  
Gates Foundation  
Ritu.Shroff@gatesfoundation.org

Martyn Smith  
FP2020  
msmith@familyplanning2020.org

Sara Stratton  
Palladium  
Sara.Stratton@thepalladiumgroup.com

Michelle Wienberger  
Avenir Health  
MWeinberger@avenirhealth.org
Appendix C: Guidance for Developing an Evidence Brief

Purpose

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

Audience

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

Length and Layout

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

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

Evidence

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

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

Language

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

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

Content

The structure and content of the briefs will vary somewhat depending on the type of HIP (enabling environment, service delivery, or social and behavior change) and the level of evidence (proven, promising, or emerging). However, all briefs should follow the following structure:
Title
The focus of the practice (e.g., community health workers, postabortion care), what the practice is intended to accomplish (e.g., bringing family planning services to where people live and work, strengthening the family planning component of postabortion care)

What is the proven (promising/emerging) high impact practice in family planning?
Simple statement with referencing the intervention.

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

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

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

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

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

How to do it: Tips from the implementation experience
This section allows authors to synthesize experiential and tacit knowledge. What lessons have been learned from implementation? Consider the following:
• What did not work? Do not make the same mistake.
• What gender issues should be addressed?
• Should adaptations be made for special populations, such as youth, rural, and poor?
• How sustainable is the intervention, e.g., provider motivation, task sharing?
• Do supply chain issues exist and how should they be addressed?

Tools
Link to a small number of tools. This is not intended to be comprehensive, so the authors and contributors may need to review and prioritize the tools. A short description should be included with the link.
Process for Identifying Topics for New Evidence Briefs

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

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

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

**HIP Brief Development**

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

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

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

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

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

**Step 6:** After comments from the TAG are incorporated, K4Health provides copy editing and layout for the briefs. Final versions are available in hard copy and through the K4Health website.
Appendix D: Guidance for HIP Brief Discussants

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

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

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

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

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

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

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

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

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

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

   **Promising:** Good evidence exists that these interventions can lead to impact; more information is needed to fully document implementation experience and impact. These interventions should be promoted widely, provided that they are being carefully evaluated both in terms of impact and process.
Emerging: Some initial experiences with developing interventions exist, but there is a need for more intense intervention development and research.

3. What additional evidence, if any is needed?

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

High-Impact Practices Technical Advisory Group Meeting

Washington, D.C.
Nov. 28, 2016

FP2020 MOMENTUM AT THE MIDPOINT
TOPLINE PROGRESS 2015-2016

AS OF JULY 2016
AT THE MIDPOINT OF FP2020

MORE THAN
300 MILLION
WORKERS & GIRLS
ARE USING MODERN
CONTRACEPTION
69 FP2020 FOCUS
COUNTRIES

30.2 MILLION
ADDITIONAL
CONTRACEPTIVE
USERS

AS A RESULT OF MODERN
CONTRACEPTIVE USE
FROM JULY 2015-JULY 2016:

82 MILLION
UNUNEDERED PREGNANCIES
WERE PREVENTED

25 MILLION
UNNEEDED ABORTIONS
WERE AVOIDED

124,000
INFANTS WERE SAVED

IN 2015, DONOR
GOVERNMENTS PROVIDED:

US$1.3 BILLION
IN BILATERAL FUNDS FOR
FAMILY PLANNING

Progress at the Midpoint

FIVE CROSS-CUTTING INITIATIVES

DRIVING COUNTRY-LEVEL SUPPORT

PROMOTING DATA USE & PERFORMANCE MANAGEMENT

SHARPENING THE FOCUS ON GLOBAL ADVOCACY, RIGHTS & YOUTH

FACILITATING DISSEMINATION OF KNOWLEDGE & EVIDENCE
**CONVENING DONOR AND COUNTRY FOCAL POINTS**

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

**NEW FAMILY PLANNING HIGH IMPACT PRACTICES ADVISOR**

New position underscores growing collaboration with HIPs/USAID:
- Developing overarching strategy to promote and disseminate HIPs (integrated with FP2020 country action plans)
- Identify new areas of collaboration around HIPs
- Coordinating with WHO/IBP a comms and dissemination strategy to inform and engage the broader family planning community
- Identify and engage new stakeholders
Re-thinking Theories of Change in High Impact Practice Briefs

HIP TAG MEETING
NOVEMBER 2016

What we want to discuss

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

REFRESHER!

What is a Theory of Change?

"I think you should be more explicit there in step two."
**Why do we need a TOC?**

**Developing a TOC: 6 critical steps**

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

**What evidence supports a TOC?**

There are four important assumptions in any TOC:

(a) assertions about the connections between long term, intermediate and early outcomes on the map;
(b) substantiation for the claim that all of the important preconditions for success have been identified; and
(c) justifications supporting the links between program activities and the outcomes they are expected to produce;
(d) the contextual factors that will support or hinder progress toward the realization of outcomes in the pathway of change.

Any evidence that backs these assumptions can strengthen the TOC—how reliably and predictably we can expect the “theory” to work in practice.

**ToCs in past HIPs**
Examples from elsewhere
Discussion

Our proposition:

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

Questions?

1. Should we have a TOC in our HIPs?
2. What components should it include?
3. How should we develop some guidance on the ToC(s)?
## Immediate Postpartum Family Planning (PPFP):

Counseling and provision of a contraceptive method within the first 48 hours after childbirth at facility or in the community

---

### Table: Beneficial impact of PPFP

<table>
<thead>
<tr>
<th>Country</th>
<th>Counseled and received contraceptive method prior to discharge from facility</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Pre: 12% (180/1497) Post: 95% (1672/1863)</td>
<td>Tawfik et al., 2014</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>55% (849/1437)</td>
<td>Cordero et al., 1996</td>
</tr>
<tr>
<td>Egypt</td>
<td>Control 12% (12/100) Intervention 47% (47/100)</td>
<td>Soliman 1999</td>
</tr>
<tr>
<td>Guatemala</td>
<td>31% (67/218,656)</td>
<td>Kestler et al., 2011</td>
</tr>
<tr>
<td>Honduras</td>
<td>Pre: 10% (47/474) Post: 33% (188/571)</td>
<td>Medina et al., 2001</td>
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<td>Honduras</td>
<td>Pre: 30% Post: 9%</td>
<td>Medina et al., 1998</td>
</tr>
<tr>
<td>Honduras</td>
<td>Pre: 47% Post: 47%</td>
<td>Vernon et al., 1993</td>
</tr>
</tbody>
</table>

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### Key Points

- **High-Impact Practice Enhancement**
  - Incorporate post-partum FP service delivery elements into existing pregnancy and childbirth services at facility and community levels.
- **Service Delivery Changes**
  - National guidelines are updated.
  - ANC staff are trained to counsel on FP methods.
  - Maternity staff are trained to counsel and provide FP methods.
- **Benefits for Post-Partum Women**
  - Increased awareness of contraceptive options in postpartum.
  - Increased uptake of FP on the day of birth.
  - Reduction in unintended postpartum pregnancy.
- **Outcomes**
  - Improved CPR
  - Increased maternal and child health and nutrition.
<table>
<thead>
<tr>
<th>Country</th>
<th>Counseled and received a contraceptive method prior to discharge from facility</th>
<th>Reference</th>
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<tr>
<td>Honduras</td>
<td>25%</td>
<td>Lopez-Canales et al., 1992</td>
</tr>
<tr>
<td>Honduras</td>
<td>Control 54% (162/300)</td>
<td>de Chavez et al., 1987</td>
</tr>
<tr>
<td>Mexico</td>
<td>49% (505/1025)</td>
<td>Romero-Gutierrez et al., 2003</td>
</tr>
<tr>
<td>Nigeria</td>
<td>41% (300/728)</td>
<td>Eluwa et al., 2016</td>
</tr>
<tr>
<td>Peru</td>
<td>Semester 1 66% (732/1106)</td>
<td>Forrest et al., 1993</td>
</tr>
<tr>
<td>Peru</td>
<td>Semester 2 89% (1218/1375)</td>
<td></td>
</tr>
<tr>
<td>Russia</td>
<td>Pre 0% (6/94)</td>
<td>Stephenson et al., 1998</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Post 65% (65/100)</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>Control 6% (18/279)</td>
<td>Dhont et al., 2009</td>
</tr>
<tr>
<td>Rwanda</td>
<td>Intervention 38% (66/175)</td>
<td></td>
</tr>
</tbody>
</table>
High impact practices (HIP) in family planning

Social franchising

Clarification of the practice:
Organize health clinics into quality assured networks to increase access to FP and other high priority health services.

Theory of change

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Intervention</th>
<th>Service delivery change</th>
<th>Benefits</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited quality of providers trained in delivery of quality FP methods, especially LARC</td>
<td>SF organizes health clinics into quality assured networks to increase access to FP and other high priority health services</td>
<td>More providers able to deliver broad range of quality FP methods, including LARC</td>
<td>Improved access, scale and use of FP services, especially LARCs</td>
<td>A higher capacity private sector</td>
</tr>
<tr>
<td>Limited awareness and demand for FP methods</td>
<td>SF organizes health clinics into quality assured networks to increase access to FP and other high priority health services</td>
<td>More consumers receive FP information and franchising enhanced marketing</td>
<td>Improved awareness and demand for FP services, especially LARCs</td>
<td>Rise in CPR</td>
</tr>
<tr>
<td>Insufficient private providers, and poor regulation and awareness of scale in the private sector</td>
<td>More providers participating in health insurance schemes</td>
<td>Greater regulation of private providers</td>
<td>More equitable health outcomes</td>
<td>Higher quality health services</td>
</tr>
</tbody>
</table>

Evidence brief:
Impact on contraceptive access and use

- Franchising increases client volumes including client volumes for FP (Agha et al. 2003, Huntington et al. 2012, Qureshi 2010; Starveding et al. 2015, Stephenson et al. 2004; Ngo et al. 2010)
- Franchising may improve CPR in intervention catchment areas (Azmat et al. 2013 shows rise in CPR, Hennek & Clements 2005 shows no change)
- Franchising improves quality of services (Bishai et al. 2008; Agha et al. 2007; Hennek & Clements 2005; Plautz et al. 2003)
Evidence brief: Can social franchising be scaled?

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

Evidence brief: Evidence from implementers: scale

Evidence brief: Gaps in the evidence

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

Thank you
HIGH IMPACT PRACTICE DEFINITION

Digital Health for Family Planning: Health Systems Strengthening

Digital applications (including mHealth, eHealth, and Information Communication Technology) which support the delivery of family planning commodities, services, systems-level information, and counseling.¹

Results

<table>
<thead>
<tr>
<th>Project</th>
<th>Country</th>
<th>Digital Health Application</th>
<th>Results</th>
</tr>
</thead>
</table>
| CTSTOC, JFR | Malawi | Supply Management | Reporting rates average 80% in all districts, compared to 40% in baselines, with some districts reaching 90%.
| AHRM | Bangladesh | Supply Management | At the facility level, stock-out rates for implants went from 8% in 2010 to 1% in 2014. |
| BHS, The Nigerian Urban Reproductive Health Initiative | Nigeria | Monitors development and performance support | Improves health outcomes and improve service delivery and management. |
| CHS, The Centre for Health Services, Antioch | India | Monitors development and performance support | ICF features of the mobile tool helped promote permanent methods of contraception: 24% in the intervention versus 16% in the control. |
| MHRMNS, Capacity Plus | Senegal | Monitors development and performance support | Increases in knowledge of contraception side effects, which remained high 18 months after the end of training without any further reinforcement. |
| Maternal, MNG | Nigeria | Service Delivery and Support | In year one, the system received 30,000 messages; 11,000 messages related to mother cares. |
| HEDPH for Community Based Family Planning Services, Kothyper | Tanzania | Service Delivery and Support | A 52% increase in the number of pregnant women who attended antenatal clinics. |
| Mobile App, JFR 360 | Tanzania | Service Delivery and Support | Obtains quicker service and better quality of information, increased method choice, and improved confidentiality and trust with clients. |
| Partnering for Health: Wellness Center for Human Services | Benin | Service Delivery and Support | 240 clients received FP counseling via mobile app, 225 had at least one visit at the clinic. |
LIMITATIONS AND FUTURE DIRECTIONS

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

Definition, Theory of Change and Results (Draft)

Joan Merte Kraft
Angela Brangston
Keigo Honpitone
Shawn Malarcher
Nov 28, 2016

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

Theory of Change (TOC)

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>HIGH IMPACT PRACTICE</th>
<th>SOCIAL CHANGES</th>
<th>INDIVIDUAL CHANGES</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge &amp; skills</td>
<td>Use Mass Media Channels</td>
<td>Increase Awareness, Knowledge &amp; Skills</td>
<td>More supportive family environment</td>
<td>Increased uptake of contraception</td>
</tr>
<tr>
<td>Negative Attitudes &amp; Opinions</td>
<td>Emotional Appeal</td>
<td>Increase use of contraception</td>
<td>Improved access, behavior, use</td>
<td>Increased correct and consistent use of contraception</td>
</tr>
<tr>
<td>Lack of self-efficacy</td>
<td>Social Marketing</td>
<td>More contraceptive choices</td>
<td>Reduction in Unwanted Pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

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

Of the 20 interventions

- 5 interventions EXCLUDED because evaluation not rigorous
  - Pre- and post-test only, bi-variate analysis does not control for self-selection

- 5 interventions statistically non-significant effects on FP use, with some statistically significant effects on some individual outcomes in TOC

- 7 interventions mixed effects on FP use, with some statistically significant effects on some individual outcomes in TOC

- 3 interventions statistically significant effects on FP use, with statistically significant effects on some individual outcomes in TOC

Questions??

Recommendations??

Thank you!

Joan Marie Kraft, Gender Advisor
USAID/GH/PRH/PEC
jkraft@usaid.gov
**Review HIP Criteria**

<table>
<thead>
<tr>
<th>Source</th>
<th>NCC/SOP/Other Guidance</th>
<th>HIP List</th>
<th>HIP/Video</th>
</tr>
</thead>
<tbody>
<tr>
<td>The breadth and quality of evidence</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Demonstration and magnitude of impact of intervention in a wide range of settings</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Potential public health impact</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Consistency of result</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Replicability</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Stability</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cost-effectiveness</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Testability</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Proven, Promising, Emerging, Enhancements**

- **Proven**: Sufficient evidence exists to recommend widespread implementation, provided that there is sound monitoring of leverage, quality, and consistency, and implementation research to help understand how to improve implementation.

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

- **Emerging**: Although emerging HIPs have a strong conceptual basis, they have limited evidence to assess impact. Therefore, emerging HIPs should be implemented within the context of research or evaluation to assess and improve their feasibility. For a complete list of emerging practice, see the HIP website.

- "Enhancement" is a practice that can be implemented in conjunction with HIPs to further intensify the impact of the HIP.