



High Impact Practices

Technical Advisory Group

Meeting Report

June 12–14th, 2023

Hosted by IPPF, London

Report prepared by IPPF



Day 1. Monday, Jun 12, 2023

Chair for the day: Gamachis Shogo

Opening of Meeting – Welcome Remarks, Nathalie Kapp (IPPF)

Dr. Nathalie Kapp opened the meeting and thanked everyone for their participation. Chair for the day Gamachis Shogo then welcomed everyone to introduce themselves and shared an overview of the agenda.

HIPs Production and Dissemination (Ados May, presenting on behalf of the P&D team)

For the presentation, please see the PowerPoint presentation at the end of the report.

The website usage went up—more than 6,000 new users and 9,000 sessions; the duration of each visit is more than 1 minute which is the average for such websites.

The regional distribution for this year (FY23) saw more visitors from Africa (42% up from 35% in FY22). For the Americas: we have seen an increase in visitors, of about 10,000, from last year. One of the reasons for increased regional distribution is the availability of the briefs in different languages (i.e., French, Spanish, and Portuguese).

Within Africa, there is a shift in users from Eastern to Western Africa. More uptake has been seen among Francophone Africa and currently the highest is Nigeria.

The users by language: English has decreased from 72% in 2019 to 41% in 2023. The language which increased most significantly is French.

The website usage by country is similar between 2021–2022 and 2022–2023, except for India and Peru (whose rankings have shifted).

The type of device used: more people are accessing the website by mobile devices. Mobile phone use has increased over the last two years.

The acquisition overview (how people access the website): mostly through searching keywords, and through HIPs—only 22.5% accessed through direct links. The referral from social media is limited.

The most read HIP is the postabortion family planning brief, the second and third is the pharmacy brief in French and English.

Discussion

- One suggestion to increase access to the HIPs is to increase the distribution of the newsletter.

- Out of the most accessed 10 briefs (especially the SBCC briefs, partially due to the presence at the SBCC conference in Morocco) are ones in different languages. The experience of launching the briefs at events helps drive more traffic to the site.

Literature review for Task Sharing brief (Maria Carrasco and Elizabeth Larson)

For the presentation, please see the PowerPoint presentation at the end of the report.

At the last TAG meeting, three briefs were approved, of which two were for a refresh: task sharing, mobile outreach services, and a possible new brief on self-care. It was decided to add a step in the process whereby the literature is collectively reviewed to adjust quickly as new literature comes out, to decide on how to move forward, to collect guidance on the HIPs identified for the brief, and to gather any additional guidelines for the brief development.

At the January meeting it was decided there is a need to be clearer on the different types of briefs—whether a topic could change from a strategic planning guide (SPG) to an HIP product. The methodology was an open search on the published systematic reviews, grey literature (family planning, contraception, task sharing, and task shifting). The inclusion criteria were: conducted in LMICs, included multiple contraceptive methods, included FP-related programs and was written in English only.

Impact articles included are not only impact evaluations but also publications that include results on task sharing; the WHO recommendations on task sharing were used as guidance to categorize the literature. The benefits of task sharing from the literature are aligned with the WHO recommendations (details in presentation slides).

The specialization of lower-level cadres will promote quality: for example, when community health workers (CHWs) focus on delivering injectables that will promote better quality rather than doing multiple interventions.

Task sharing alone is not sufficient and it needs to be paired with other initiatives. Training needs to be context specific, including follow-up training, which will contribute to higher quality services. Lack of adequate training and funding affects the outcome of task sharing.

Discussion

- There is a lot of emphasis on CHWs in the brief and that may lead to duplication with the CHW HIP brief. However, when looking at the HIP brief for CHWs, it does not get into the details on the transition of their provision of methods.
- Should we have the brief and the SPG on the same topic? We could cancel the SPG or elevate it to a HIP. That would be a task sharing enhancement. What is the value added of making this brief as an enhancement? What difference does that make on the country level?
- We need to be aware of the context and what providers are permitted to practice in the country, which provides more reason to revisit the issue of the inclusion of one method evidence.

- There are discussions within WHO to change the term from task sharing/shifting and this is an evolving discussion. We need to see if there has been more evidence/literature to update the guidance on the WHO table on the cadres or service provision.
- We need to include other cadres beyond CHWs. CHWs had a lot of emphasis and other cadres also had a role in initiating methods (i.e., pharmacies and emergency contraception).
- We need to differentiate between terminology of task sharing and task shifting. Task sharing may be more acceptable in some contexts.
- The countries represented in the literature were in sub-Saharan Africa. There is a list of all the included literature and the countries. If there is literature from other contexts, please share it with the group.

Literature review for Mobile Outreach brief (Maria Carrasco and Elizabeth Larson)

For the presentation, please see the PowerPoint presentation at the end of the report.

Discussion

- How much have governments adopted mobile outreach services as part of their model compared to NGOs for sustainability? Look to include any government models or of partnership and also in humanitarian settings.
- We need to also include the operation/implementation research (i.e., from projects like WISH where country work took place across a 27-country portfolio, including humanitarian settings like South Sudan).
- We need to define sustainability in the context of outreach. Maybe to address that we can use the new evidence criteria.
- There are countries that are graduating from funding for services and now governments are doing the mobile service delivery and we can learn from their experiences.
- For some of the underutilized methods it makes sense to enhance its outreach (i.e., vasectomy where it makes sense to have it provided from mobile outreach. The evidence is from Canada).
- Is there evidence on continuity rate—what would be the optimal spacing/frequency of the outreach visit? Maybe we need more literature on the continuity and satisfaction of method use because of mobile outreach, as well as access to contraceptive removal services?
- The technical expert group are expected to take all this feedback and incorporate it.
- The issue of quality, counseling method choice, and quality of care should be integrated. There exists some operational evidence from WISH Lot 1 and Lot 2 projects on switching methods, counseling, quality of care, continuum of care, and demand generation that could be included.

Presentation on IPPF's new FP Strategy (Manuelle Hurwitz, IPPF Director, Member Association Development & Impact)

The strategy was produced after extensive research, consultations, roundtable discussions, and various engagements with stakeholders.

The strategy came at a time where there are many synergies and intersections of our work with issues such as humanitarian response (i.e., more than 10 million people in humanitarian settings reached by IPPF services), youth, digital health.

The strategy includes 4 pillars with 3 critical pathways each. For example, pillar one (center care on people) seeks to emphasize often neglected areas (i.e., fertility which many IPPF member associations [MAs] have been providing for many years), revitalizing the work on important issues (i.e., HIV biomedical prevention), and continuing the work on issues such as expanding contraceptive choice (rights-based approaches). Some areas will be scaled up in this strategy such as quality self-care (abortion, contraception, and HIV and STIs) as well as digital health initiatives (DHI).

The second pillar on moving the sexuality agenda includes the work of IPPF on political advocacy and expanding that to strengthen the work with communities and amplifying their voices. These communities are also expected to be reflected more in the work of IPPF.

That pillar also includes emphasis on shifting norms on issues such as comprehensive sexuality education (CSE), female genital mutilation (FGM), and the patriarchal norms.

Solidarity for change is the fourth pillar that includes both strategic partnerships and building social movements. For example, in Ukraine, our MA is both working in the country but also working with neighboring countries and the organizations in these countries where we amplify impact and reach. In that strategy we are emphasizing innovation and sharing knowledge and growing IPPF centers and funds through the centers of excellence that provide peer-to-peer support on issues such as social enterprise, CSE, FGM, and potentially one on DHI.

This pillar emphasizes the way we work as IPPF where we shift power and decolonize the way we work in the sector. To ensure this strategy embodies what IPPF stands for as a Federation—there is a charter of values where MAs sign up to and live up to. Growing the Federation doesn't only mean enrolling new members but recognizing and measuring our contribution to national service provision and modernizing the work of MAs with new models such as social enterprise.

The results framework includes IPPF's commitment that will be measured through a specific indicator. Some guidelines for these indicators include segmentation (not all indicators measured across all countries), detailed client level information where applicable, the use of impact studies on issues such as CSE quality, gender norms. Details here:

[Come Together: IPPF Strategy 2028 | IPPF](#)

Discussion

- In many countries, the IPPF MAs are considered an extension to government services (i.e., in Ethiopia).

- The strategy is progressive and already benefits from the HIP products (i.e., integration, emergency preparedness). There is potential for synergy with other organizations' work.
- The sexual health element: do you have indicators that measure sexual health and well-being? Sexual well-being is now included as part of IPPF's IPES package. MAs will be reporting on it as one of the indicators.
- Commodity security: websites on the various committees (i.e., UNFPA commodity supplies), we have been working closely with UNFPA (i.e., MAs accessing the commodities and also passing them on to the government). The new way of working around domestic financing doesn't incorporate support to civil society organization (CSOs) when the governments don't meet their commitments. Over the years, we had no increase in funding for contraceptives that doesn't cope with inflation and increase in demand.
- Sexual and gender-based violence (SGBV) is included in the IPPF IPES and that exists in MAs with varying capacity on the availability of services and referral pathways.

Preliminary findings from R4S self-care studies form a user perspective (Trinity Zan)

For the presentation, please see the PowerPoint presentation at the end of the report.

Discussion

- Anecdotally, people have heard the same feelings—people like going to facilities, they like the interaction with the provider—are there any other benefits to service provision? For example, self-care can be very beneficial for women, but women like going to the facility as a social event (should not forget this). Also, providers find facility visits very valuable since they can screen for other issues (GBV, cervical cancer). It's important to think about this, since while we are promoting self-care, we might be taking something important away from people.
- Not aware of any findings emphasizing those two points, but it might have come up in the qualitative study. However, these were not options that were included in the quantitative studies, but it still didn't come up in the quantitative survey.
- The term self-care is dependent upon who is using the term. When you talk about self-care, is it, "Do I know how to use a condom?" or is that awareness? One of the debates in South Asia is that self-care is seen as an anti-provider terminology. We need to be cautious about how we focus on self-care. There is tension, and it is leading to a lot of backlashes from providers. Self-care needs to be more inclusive. Also, we need to take the perspective of the consumer.
- Self-care does not mean not going to the health facility. The decision to go to the health facility itself is self-care. The fact that you know that you need to seek services means that you are practicing self-care. We went too far in the wrong direction with task sharing, and providers thought we were walking about cutting them out of the picture.
- What are the stages of self-care?

- Usage (support management of chosen method), access (access the methods) and awareness (ensure understanding of fertility and contraceptive options) (slide 3 of the PPT)
- Need to frame the discussion around empowerment.
 - Governments are interested in self-care because the health system does not have the capacity to meet the needs of the population.
 - Need to be careful as a community and make sure that we have the right definitions, and that self-care does not lead to less responsibility being taken by governments for health care.
- There have been many movements under the banner of empowerment and rights that have actually had cost savings objectives.
 - Even though the study did not find a connection to empowerment, it was cross-sectional, and more research is needed.
- Self-efficacy is part of this and is not always part of the self-care discussion. Self-efficacy is important from a behavioral perspective.
- University of California-San Francisco and a school in Uganda are longitudinally testing a measure for contraceptive agency. Results from the study will not be available for at least a year.
- Self-care is a way to strengthen the health system; it is not stand-alone.
- Another question people are asking: is self-care going to increase inequities in terms of who accesses what types of care? Are we going to broaden the gap?
- The purpose of self-care is to make sure that more people have access to new products and technologies. Sometimes when these new things come out, our providers and systems push back. How do we formulate the recommendations to keep the user focus and address systems issues?
- There are two perspectives: (1) How to engage providers so they know this is part of what they do, and it is not meant to be exclusionary; (2) There is an assumption that there is a shortage of healthcare workers in SSA; however, there is such a high number of trained medical professionals who have graduated and cannot get a job, or who have retired early.
- Empowerment is a conundrum because we don't know if people are choosing to use self-care or if they are being forced into it. Especially because people don't have a strong understanding of what self-care is. We need to keep the end user perspective in mind.

Literature review on self-care (Maria Carrasco and Elizabeth Larson)

For the presentation, please see the PowerPoint presentation at the end of the report.

Discussion

- The review followed the previous HIPs guidance of one-method studies and that resulted in eliminating 90% of the studies on the topic.

- The team used the WHO definition. It seems from the definition that self-care can mean different things. The idea that self-care isn't new and has been something women have been engaging with and that could be a response to health systems being overwhelmed but does not replace service delivery.
- These guidelines are aimed at empowering people and with different crises we will have to do self-care at some point in our lives.
- The team used the WHO classification of self-care interventions. The definitions and classifications are quite broad and how to distinguish it from other overlapping areas.
- Sub-categories included by WHO were self-management (the space with most literature), self-testing, self-awareness (overlaps with SBCC). The places where self-care exists are the same places (e.g., digital, physical service delivery, community).
- Insights from the WHO guidelines: they have 8 recommendations, 7 out of the 8 are on self-management of FP (i.e., self-injection).
- The available multi-method literature focuses on self-care for education purposes/self-awareness and comprehensive sexuality education. The one-method studies overwhelmingly focused on DMPA-SC.
- Borrowing from the HIV literature, the focus is on differentiated service delivery where the focus is on the client centeredness where the client accesses the treatment when they need it. Within that the link to the health provider is clear in that definition.
- Another area of literature is the vast literature of chronic and non-communicable diseases. Self-management in that sphere is more of a continuum that doesn't stop with accessing the service but in how people manage that health condition.

Self-care trailblazers' presentation on self-care in FP and its operationalization in self-care policies (Sara Onyango)

For the full presentation, please see the PowerPoint presentation at the end of the report.

Discussion

Q: We have discussed some resistance from providers toward self-care, what is the Self-Care Trailblazers Group (SCTG)'s experiences with this? A: SCTG has experienced some of this; the worries are the loss of work and the inability to ensure high-quality care. One approach is to work to build partnerships with providers. Working with providers to increase awareness and gain support and to bring providers on board.

Q: Will the dashboards be available? A: Yes, the data will be updated at the end of June. It will be uploaded to the website and available to all stakeholders.

Q: Regarding the policy to advocate for and mobilize support for self-care. What is the exact practice people are advocating for? A: Worked at two levels. The first is to work with countries to develop national guidelines. One of the main outcomes is that a country has national guidelines. The second area of work is to work with existing policies and make sure that the policies mention self-care.

Way forward with self-care brief (Gamachis Shogo and Maria Carrasco)

- One option is to consider a pause on this brief if we think an SPG is not the way forward.
- There is a concept that is expected to come from WHO, from the literature review; we don't have enough evidence currently to inform an enhancement.
- From all the presentations, the definitions are confusing, which is something to consider as well. What is the problem that this brief would be solving? We need to answer that question.
- There was a lot of evidence on self-injection that is DMPA-SC-centric, and it may not extrapolate to other areas of SRH self-care.
- On the one-method inclusion criteria, maybe that needs to be reassessed for this brief where we include the ones not only on self-injection but also EC (pills).
- Can we consider self-care within pandemic/emergency response? And in that case, it will focus on the availability of supplies/supplies ensured and not the availability of providers.
- Given that WHO and the trailblazer groups are going to publish a lot of products on this topic, does it make sense to publish at all?
- We may want to pause the topic for a year when more data are available; the issue is not the lack of evidence, but rather a lack of consensus on what self-care practice is.
- Given that there are so many self-care products, is there a need for a HIP? The TAG doesn't need to put out its own product; they can direct people toward the resources.

TAG meeting decisions – Day 1 (June 12, 2023)

Task sharing enhancement brief - TAG input.

- The Technical Expert Group (TEG) should ensure to use the most updated terminology to refer to task sharing. There are discussions within WHO to change the term from task sharing to more inclusive terminology.
- It is critical to make sure the SPG is well linked to WHO guidelines on task sharing.¹
- The group should take care to avoid significant overlap between the task sharing enhancement and the [CHW HIP brief](#).
- The brief should build on the existing [task sharing HIPs SPG](#)
- The TEG members should strive to add studies on telehealth and its role in task shifting and also include studies about task sharing with pharmacists (if available). Also, the countries currently represented in the literature review are primarily in sub-Saharan Africa. It will be important to try to include evidence from other regions.

¹ TAG member [Nandita Thatte \(thatten@who.int\)](mailto:thatten@who.int) can provide more information on WHO guidelines that are directly related to task sharing.

- For this brief, the TEG should use the updated HIP rule of including articles that only focus on one method as long as the totality of the literature includes various methods and ensures method choice.
- Recommendation to include this recent review as a reference:
<https://usaidmomentum.org/resource/larc-pm-task-sharing-desk-review>

Mobile outreach brief update

- The TAG noted that it would be helpful to include operations research data if available (such as data from the WISH project; TAG member Heidi Quinn could help find the data).
- It will be important to include evidence on the provision of mobile outreach services by government facilities (if any). It was noted that there are countries that are graduating from donor funding of mobile outreach services and now governments are doing the mobile service delivery. Are there lessons learned from these experiences?
- One of the issues with mobile outreach is the lack of reporting and/or reporting not captured in the national data. In the tips section, are there tips to be shared in terms of best practices on ensuring data capturing?
- Some of the articles in the literature review note that mobile outreach have a positive impact on CYPs. Please note that CYPs favor long-acting methods and that it may not be an effective indicator of uptake and ensuring choice.
- TAG members noted that mobile outreach may be particularly helpful in complementing the work of CHW who are distributing methods that don't require specialized skills to deliver (such as IUDs or vasectomy)
- The writing group should emphasize the role of community outreaches in ensuring method choice.

Self-care enhancement brief

- The TAG decided to pause the development of a self-care enhancement brief until more data/evidence is available. The SCTG noted that they are collecting data in countries where self-care has been included in local policies. Additionally, the research from a user perspective from R4S should be published in the next 6–12 months. For the January 2024 TAG meeting, TAG members helping to set the agenda will consider if self-care should be included or not.

Day 2

Chair for the day: Heidi Quinn

Welcome and Reflections from Day 1

Maria welcomed the group to Day 2 and acknowledged the great information and updates of Day 1.

Roles and responsibilities for today's session (Lynette Lowndes)

For the full presentation, please see the PowerPoint presentation at the end of the report.

Within the meeting the group engaged in group work as below, three key topics were posed to discuss during group work, and the replies and discussion from the groups have been combined for the purpose of this report.

1. TAG membership: guiding principles

- Specific skills required; optimum size; how to recruit diverse, skilled membership (what does diverse and skilled mean); add to, change, confirm the suggested draft principles.

2. Implementation of HIP practices “at scale”

- How do the HIP groups each contribute; are changes required to support implementation and scale up; do roles and responsibilities need to be adapted?

3. Strengthening internal processes and decision-making

- Review suggestions in the issues paper; suggest areas to refine or change; consider TEG role, recruitment and selection - is it clear?

Report out on group work.

1. TAG membership and role: guiding principles

- The membership and role of the TAG is a peer review body, insights into what kinds of products should be developed on the evidence, to identify how to move forward on concept notes for new briefs/products based on the evidence provided and criteria, expertise that includes field experience, research, policy, advocacy.
- The optimum size could be 2 TAG members + co-sponsors reps + 2 youth experts (max 25 people total) and could explore having youth researchers/implementers?
- Instead of term limits, propose 25% of TAG needs to turn over every 5 years; intake/outtake/criteria/qualifications/profile determined by TAG and balance experience, newness, etc.
- Inclusivity: need systems to support/fund TAG members (without budget) to attend in person, buddy system to support new members, ensure full participation from all TAG members, right now the bar for membership is too low with a need increased self-evaluation.
- Explicit list of roles and responsibilities of the TAG, cannot miss more than X meetings, need to participate in sub-groups, and other expectations of the TAG. If people don't meet these expectations, then their membership needs to be reevaluated.

2. Implementation of HIP practices “at scale”

- The current process includes sending out requests for people to submit proposals. However, most of the people who respond are a small group and may not represent the target audience of the HIPs.
- To succeed at implementation at scale, you need to be able to localize. How do we take advantage of some of the existing structures?
- What do we think is the role of the TAG in implementation? It was originally an evidence-review group and implementation was not part of the intent. Do we need to expand this role and make sure that implementation is also part of the TAG? Expanding the scope would require relooking at the structure of the TAG to make sure that the experts have the background they need (implementation and measurement experience).
- There is an assumption about the audience, and we need to be more intentional about who we define as the audience. They were originally USAID products for USAID missions; as this has expanded, we need to redefine the audience and be more intentional about how to support the expanded audience to implement.
- Measurement. To talk about implementation at scale you need to be able to measure implementation.
- If the role of the TAG expands, there will be a requirement for additional resources, and the co-sponsors need to make sure that the TAG has access to those resources. Do there need to be more salaried positions within the TAG?
- The framing can appear prescriptive (rolling out HIPs), top down. Needs to be a down-up process, the HIPs need to respond to the needs at the local levels-- if they aren't then they won't be scaled up.
- The TAG is more about producing high-quality resources that support implementation at the local level. Support implementation by improving access to evidence.
- An objective is to make sure that a HIP product is in the hands of implementers as they are developing programs—success should be measured through the use of HIPs in the development of programs, not the scale up of HIPs.
- There is a difference between co-sponsors and the TAG because co-sponsors want to see scale-up, but this is not the objective of the TAG.
- From the identification of the HIPs there needs to be involvement of people from all levels.
- Not the role of the TAG to scale up the HIPs; the TAG can support providing guidance on how to implement HIPs, the TAG can encourage documentation of scale-up to inform the evidence base, and the TAG can help identify if practices are scalable.
- There are other partners/networks that support implementation and scale-up like the co-sponsors and others (e.g., IBP Network, FP2030, IPPF, UNFPA, etc.).
- Explore more about how to link to other implementation products, guidelines, etc. within the HIPs. We could start with the website; it could contain more than just the HIPs materials.
- Consider another sub-group within the HIP initiative focused on implementation (perhaps a sub-group within the IBP network led by a HIP partner).

Strengthening internal processes and decision-making

- The way this is described is broad and passive; need to strengthen the language, need to make sure that the process is fit for purpose.
- The roles and the responsibilities of the co-sponsors and the TAG need to be separate. The co-sponsors should not be part of the TAG; however, each can be observers on the other group. This will allow to move past the different objectives of the two groups; co-sponsors can also help to ensure continuity.
- One of the responsibilities of the co-sponsor is to set aside funding for representation from the Global South. This is critical to shift the balance of representation and needs to happen over multiple years.
- Part of the co-sponsors responsibility includes approving HIP product, which seems to be the role of the TAG.
- HIPs secretariat: rotating the secretariat roll would represent quite a serious shift in how the TAG functions; need to be realistic about what this means, need to keep the ship moving in the right direction.
- Recruitment and selection process, there are different processes happening parallel for example, UNFPA = co-sponsor + 2 members and others are selected based on their areas of expertise.
- Need to be more explicit about the processes, need a list of key areas of expertise that we need on the TAG and then map people to that to see where the gaps are as currently there is a lot of overlap in expertise.
- Want to change representation over time to ensure broader representation.
- Need to have an explicit set of expectations and have people move off if they haven't met those expectations.
- The "light self-evaluation process" doesn't seem necessary or desirable.

Further Discussion

- What role does the TAG play regarding scale-up? Scale-up and implementation should happen at the local level.
- If one of the priorities of the HIPs initiative is scale-up and measuring scale-up, then one of the roles the TAG could play is measuring scale-up and implementation.
- There needs to be feedback from implementation—where is the progress? How big is the scale-up, what are the projects doing? How do we use this information to update the briefs?
- If the end goal is scale-up, then the way a person approaches the evidence review process is different than if the end is something else.
- Another way to think about scalability is whether the HIPs are performing in a way that contributes to scalability? Are they answering the questions that implementers are asking? Why are the top 10 HIPs being downloaded? Why aren't enabling environment HIPs being downloaded?
- The goal isn't to scale up all of the HIPs; part of the beauty of the HIPs is that they can be contextualized.
- Are we going to link the HIPs with the FP2030 commitments? Yes, working on this.

- Something that came up in January was to have a TAG chair. This person could be the liaison with the co-sponsors; it is a higher level of commitment and responsibility.
- Right now, there isn't a lot of clarity on who the secretariat is; there is a lot of responsibility on an individual person—we need to reevaluate how the secretariat is formulated.
- The secretariat of the TAG should be independent of the co-sponsors; this will allow all donors to sponsor the secretariat.
- The experience of moving IBP and placing it in WHO has helped to make IBP more functional.
- USAID has been serving as an informal secretariat, but they recognize the need to pass on this position (funding, fit for purpose, things have evolved and changed). The question is where does this role fit? How do we make sure things move forward on the technical side?
- Representation from the country programs, co-sponsors should identify people who are working at the country level to participate, need to make clear guidance on how to do this.
- The co-sponsors shouldn't have a greater number of representatives on the TAG, but they are well positioned to identify TAG members.
- Youth observers: how to ensure that their engagement is meaningful, why do we have to go for observers, why can't we tailor the recruitment to have young scientists active in the group? FP2030 has diversified and brought in young people so they can participate and benefit from being mentored by the experts so they can grow.
- Need for a dramatic shift in the make-up of the TAG, in their background, and where they come from. If all co-sponsors have 2 members, then that is going to skew the make-up of the TAG. Because of where people work/are based, the lines between where people work and where they are from are quite blurry. For example, is a person who is from the Global South who works in the U.S. representing the views of the Global South or the U.S.?
- Global North vs. Global South: need to be more explicit and have more guidelines, need to think more about diversity—who is responding to calls for new HIPs topics. Should HIPs downloads be coming from the U.S., or should they be coming from the Global South?
- One of the main reasons the HIPS products are so big is because USAID mandates their implementation via their RFPs. What would changing the secretariat mean for RFPs?
- When we go back and look for a strategy for these HIPs, one doesn't really exist. The intentionality of DEI needs to be tied with a budget. If this is an important initiative, then it needs to have funding to support participation.
- Still caught in the narrow space of family planning—the world is moving toward SRH. People who are here with particular expertise can also suggest people for membership, are probably more connected than the co-sponsors.

SPG guidance (Maria Carrasco)

For the full presentation, please see the PowerPoint presentation at the end of the report.

Strategic Planning Guides

- Main purpose is to lead program implementers and planners to meet a specific objective.
- The documents are about helping to lead people toward a decision; they are not looking at evidence.
- Currently have a 3-page document that outlines what an SPG is for the writing groups.
- On the HIPs website there is also guidance on the SPGs.

High Impact Practices

- Different than SPGs.
- The TAG does not review SPGs.
- HIPs have at least 2 members who participate in writing documents, but this isn't the case for SPGs.
- Guidance on HIP development is posted on the website.

Discussion

Question: Should we add a step for TAG review?

- If the TAG should review the SPG draft, it needs to be earlier in the process; perhaps include a TAG member in the expert group so that the TAG is able to address the potential issues that come up.
- If the TAG is responsible for the SPGs, then the TAG would need to review the SPGs; a sub-group who have the right expertise could also be a solution.
- SPGs are difficult to develop so we should ensure that they are necessary and filling a gap.

Conclusion: The TAG should review but can be a small group.

Question: Who works on the SPG? Is there any guidance on who should be engaged?

Currently, it is the group that submitted the concept note with additional support from the co-sponsors.

- The request for inclusion and external participation needs to be more than just a request—one approach might be an application process to be included in the writing process.
- This is another issue with inclusivity; whoever works on the SPG is also going to require resources. There are people in the Global South who might want to engage but won't be able to because they don't have the resources.
- We could use a targeted approach for who should be in the review process, like a peer review process for a journal review.
- When groups submit their concept note, they should outline the steps they will adopt to ensure a participatory process of development.

Conclusion: The group that submitted the concept note should also suggest additional participants outside of their group and a TAG member should be on the writing group.

HIP criteria tool (Karen Hardee, Michelle Weinberger, Maria Carrasco, Saad Abdulmumin)

For the full presentation, please see the PowerPoint presentation at the end of the report.

Presentation of the analysis for the HIPs evidence scale and the group's suggestions

- The group took all the service delivery and SBC briefs and analyzed whether the subject met the HIP evidence scale, including 6 service delivery briefs and 5 SBC briefs.
- HIP evidence scale, different levels of evidence based on study design and available data. RCTs vs. HMIS vs. etc.
- HIPs briefs aren't based on systematic reviews and proven vs. promising isn't only based on the impact section.
- The TAG retains the ability to make the determination, and this is not based on a rigid criteria.
- Exceptions to the rule
 - PFP: Proven practice, based on 5 positive studies that include routine data.
 - Social Norms: Proven practice, based on 12 qualitative studies.
- Proposed tips for determining proven/promising designation for HIPs using the 5 HIP criteria.
- If we applied the updated criteria to the analyzed briefs, some of the briefs may not meet the criteria of proven without an additional explanation of why they are considered proven.
- Questions: Are suggestions for proven/promising fit for purpose? What outcome is used for proven/promising? Inconsistent mention of the HIP criteria in the briefs—should the criteria be addressed in the brief?

Discussion

- Need to improve documentation for decision-making around whether something is proven vs. promising. This includes updating the summary of the HIPs criteria table with decisions that were made during the TAG meeting.
- Should we include sustainability and scalability in the HIP at the time of review? The practices haven't always been around for a long time, or you can't know whether it is possible based on the available evidence (not a lot of papers address this evidence).
- How is the literature review done for the HIP? The tendency is that people look for papers with positive results. But maybe there are also an equal number of papers that didn't demonstrate impact.
- What is the definition of affordability? Even if there isn't information on affordability, the writers should reference it in the briefs.
- Who will be using the tool? An external researcher (likely a consultant or a research intern) will be contracted by the co-sponsors to use the tool with updated promising HIP

briefs or new briefs. This is what the TAG uses to determine whether something is proven or promising (service delivery and SBC).

- Vote to approve the updated tool.

The Challenge Initiative (TCI) (Kojo Kokko, Kim Martin, Jessica Mirano)

For the full presentation, please see the PowerPoint presentation at the end of the report.

Overview of The Challenge Initiative

TCI was launched in 2016 with a “business unusual” approach to implementing high-impact interventions throughout 6 geographics. The high-impact interventions were proven as effective during the Urban Reproductive Health Initiative (URHI).

TCI does not implement; it supports local governments to implement and scale what worked under URHI. At Phase 1, TCI scaled up to 118 cities. At Phase 2, TCI next gen, scaled to 172 local governments (including the 118 cities)

Discussion

- The two examples that were shared, in one the long-acting reversible contraceptives (LARCs) increase more than the short-acting methods, but in the other city, both increase (no preference for one over the other). Do you know why this might be happening since the packages aren't supposed to be preferring one type of method over the other?
 - What TCI wants to focus on with the graphs is that after graduation people continue to uptake contraception.
 - Need to further investigate to better understand what is going on.
 - Most important takeaway is that the HIPs are being sustained.
 - Would be concerned if there was a massive drop in the LARCs.
 - In India, part of the objective was to improve both increase short-acting and long-acting methods.
- Can you talk about the process of adaptation and how much the Hubs needed to adapt based on the initial guidance they received?
 - Adaptation is very important to the TCI model; bi-directional learning from the governments to TCI and then back down.
 - Hub-specific adaptations within the HIPs that are on TCI University.
 - In the mapping, TCI went through the core components for each Hub by each HIP.
 - Importance of context in which TCI works. Mindful of the way that a particular practice is implemented is based on the context while making sure that there is fidelity to the original practice. Based on what the Hub is doing on the ground.

Whatever is adapted doesn't happen at the beginning of programming—begin by implementing and things are adapted over time?

- How do you simplify HIPs to make them easier and faster at scale?
 - Each hub has its own toolkit where each of the interventions are codified. They include step-by-step guidance with tools for the government. Templates, checklists, etc. Also have job aids that are even more simplified (2-page fact sheets) and that are used in the coaching. When people are coached on how to implement the HIPs, they are also learning from them on how to effectively implement and adapt the practices.
- What is the longer-term scaling vision? Do you expect these cities to partner with new cities? How do you recruit new cities? How do cities know about TCI? What role do graduate cities have in providing support to the new cities?
 - TCI are marketers, and from the onset TCI markets what they have to offer. Market through different platforms to the cities. Cities hear about TCI from regional or country meetings. Now, from this push, and from cities learning about what cities have achieved, TCI has more cities asking to join the initiative than they have the capacity to take. When you graduate from TCI, you don't go away; you're part of a network. There is a south-to-south collaboration. Also, even though TCI is focused in urban areas in Nigeria, the focus is at the state level, so they can translate the learnings to other areas that are not under TCI (try to track this type of diffusion). In India, point of contact is at the state and the district level—this also enables diffusion.
- Do you have any documentation that the TAG group can rely on as the TAG updates the HIPs? Can the TAG continue to learn from the implementation of HIPs via TCI?
 - TCI is an iterative process. The learning shows that there might be tweaks that work better for one location than the other. TCI should systematize a way for people to learn from TCI. One example of how TCI measures its learning is the Most Significant Change approach.
- How do the cities go about selecting the HIPs? Do they choose the HIPs or does TCI facilitate a process of prioritization?
 - The interface where we discuss the HIPs occurs at the beginning of engagement during the process of program design. This comes after the detailed gap analysis and landscaping. The government then has a basket of interventions from which they can choose. Cannot support all of the interventions, so the government needs to prioritize.

HIP products table (Erin Mielke, Karen Hardee, Michelle Weinberger)

For the full presentation, please see the PowerPoint presentation at the end of the report.

- Updates occurred via discussion and feedback from TAG members, inserted links to guidance where relevant, reformatted, inserted dates.
- Some pending questions.

- Reading across the products and seeing “standard of evidence does not apply” raises a question for the group. We do use evidence for SPGs, for example, as noted. Is there another term that might convey that evidence is used and vary according to thinking from a country-based perspective?
- HIP briefs, should we mention that HIP briefs are purposefully not contraceptive method specific, confirm wording of Definition and Purpose and for standard of evidence, and add link to the criteria tool?

Discussion

- Change the name of “White Papers” to “Discussion Papers.”
- What are the differences between the various adolescent resources? Adolescent-Responsive Contraceptive Services: Enhancement that outlines how to effectively provide services to adolescents/youth. Adolescent SPG: covers what do you need to think about to program work toward adolescents. Meaningful engagement of adolescents SPG: Health systems, how do you work with youth to address everything health that adolescents deserve to be a part of (designing, implementing, planning, monitoring).
- Is the page limit on SPGs too short? Can you cover a strategic issue with the page limit?
- How do we get feedback from the users to inform some of these decisions?
- Maybe we should have thematic landing pages that include the different products and what they are? The roadmap conversation will touch on this topic.
- A lot of the briefs have sections on adolescents—maybe a search engine will be better utilized to share this information.

TAG meeting - Day 2 (June 13, 2023)

Roles and responsibilities

- TAG members agreed on the TAG continuing to serve a technical role for the HIPs Partnership, providing a neutral review of the evidence and making decisions related to the content of the HIPs knowledge products.
- TAG members agreed that the work on implementation and scale-up of HIPs should not be a main function of the TAG so that the group can keep a neutral perspective on the various HIPs. The TAG could provide input on HIP measurement from a technical perspective.
- TAG members agreed that TAG membership should include a mechanism for rotation of members and also highlighted the need for continuity to ensure new members learn from others.
- TAG members recommended that the TAG should elect a TAG chair who should serve on a rotating basis. The TAG chair would have an observer role in the co-sponsors group.

SPG guidance

- The TAG agreed that the SPG development process should be updated to be more similar to the HIP brief development process.
 - A TAG sub-group should review a draft SPG before the SPG is approved for posting on the HIPs website.
- A sub-group was formed to work on developing a draft SPG guidance document to be shared for TAG finalization at the next TAG meeting. The sub-group members are Maria Carrasco, Jay Gribble, Karen Hardee, Monica Kerrigan, and Saad Abdulmumin.
- Some of the updates to the current process put forth are as follows:
 - The TAG should recommend/provide ideas on the groups/stakeholders to engage in the SPG development process.
 - The SPG application should include names of the organizations that will be convened to develop the SPG.
 - Ideally, a small group will develop the SPG and build in the process consultation with a larger group of stakeholders.

HIP criteria tool

- The TAG approved the updated HIP criteria tool.
- The TAG approved the proposal for tips for determining proven vs. promising (see table below).
- The TAG makes the determination of whether an SBC or service delivery practice is promising or proven using the HIP criteria tool for guidance. Decisions should be documented for transparency.
- The TAG recommended that affordability is kept as part of the criteria but that it is not used to decide if an SBC or service delivery practice is promising or proven since there are rarely any articles/evidence available on affordability.

Tips for determining proven/promising designation for HIPs using the 5 HIP criteria		
(1)	(2)	(3)
HIP Criteria	Proven	Promising
Impact	At least 4 studies with positive evidence at level I, II, or IIIa on the HIP Evidence Scale (with at least 3 studies with statistically significant results), with explanation for exceptions	At least one study at levels I, II, and IIIa and/or at least 4 studies at levels IIIb, IV, or V in only 1 country or region, with explanation for exceptions
Applicability, reliability, generalizability	At least 4 countries across more than one region	Fewer than 4 countries or evidence from only one region

Scalability	Broad evidence of implementation at reasonable scale (for the HIP)	Evidence from pilots and/or small-scale implementation
Affordability	Not included in determining proven/promising designation given paucity of evidence on costs. Authors of HIP briefs encouraged to include existing evidence of affordability.	
Sustainability	Not included in determining proven/promising designation. Authors of HIP briefs encouraged to review the sustainability checklist in the White Paper and to include evidence of sustainability.	

HIP products table

- The TAG approved the HIP product table (included as an Annex to the TAG meeting report). The table should be inserted in the guidance to develop a HIP brief.
- One change to finalize the table is to change the name “white papers” to “discussion papers.”

Day 3

Chair for the day: Rodolfo Gómez Ponce de León

Reflections from Day 2

- Would it be strategic to have someone from the TCI on the TAG? Very helpful to learn from the implementation and the experience of the project.
- Lynette’s report discussed a strategic plan; it would be helpful for the TAG to have a copy.
- The two finalized items (products table and evidence work) were great progress since they have been delayed.

HIP updates (Maria Carrasco)

- Update on the HIP knowledge products.
- Working on the SPG on better access and inclusion of person with disabilities in family planning programming. There will be a webinar coming up shortly—please disseminate.
- Inclusion of faith actors in family planning programming will be forthcoming in the next 3 months.

Discussion point 1: Writing groups for new briefs, 120 experts submitted their names to be in the writing groups for mobile outreach (update), task sharing (enhancement), self-care, community health workers.

- If the self-care brief is on hold, we might want to revisit the CHW brief if we have capacity as it was published in 2014 and there have been many advances,. For example, there was a big CHW/PHC conference in March 2023. Will form the group and then see how far we will get—there will be a lot of pre-work that needs to be done.
- Update on TAG members down on the brief writing groups.
- Mobile Outreach: Heidi Quinn and Erin Mielke.
- Task Sharing: Sara Stratton and Nandita Thatte.
- CHW: selected from Chris Galavotti, Gamachis Shogo, and Saad Abdulmumin.
- We have the resources to support 2 youth writers.
- People to help select the final group members—the groups needed to be decided by June 16, 2023.

Discussion point 2: Call for concept notes.

- The current cadence is 3 briefs/enhancements per year—will review the concept notes at the next TAG meeting.
- What is expected?
- People submit a 1-page concept note.
- Rolling application process; however, it is currently closed. Will open the link ASAP.
- Do we want to add to the call that we are looking for X, Y, Z to fill gaps?
- Specific topics/areas where we are looking for more information.
- An issue with this is that people will view it as this is what we want—it will make the pool less diverse (people usually look at the wording and then respond to that).
- The problem is not that we don't receive a wide number of submissions from a large pool, rather that we consider the ones that are submitted in "global health speak," i.e., that are written in a certain way, using specific terminology. We should revisit this—people have good ideas that may not be articulated in a specific way.
- Is there any effort to support those who are interested but whose concepts do not meet a specific threshold (e.g., a webinar). If there is already a diverse group of people who are submitting concepts but are disadvantaged because they cannot meet the threshold, the TAG needs to figure out how to support them.
- There needs to be some kind of criteria because you need someone who understands and champions the topic; we can't take an unlimited number of topics.

Further discussion points

- Literature reviews: should we open up the literature review to non-English? Tap into WHO resources, Gates resources?
- At what point in time do we have the users' interest? Who is identifying the gap? This be a top-down process, with limited people at the table saying, "this is important," but the question is, "important to who?"
- The TAG is changing, and we haven't really moved many products forward. Do we want to take another pause? TAG has so many products. Nervous to keep asking and developing briefs if we aren't able to invest in implementation and use.

- Good opportunity to figure out how people are using the products and who is using the process. This will create general guideposts for future HIP development.
- The TAG might need to take a pause, but not recommended because it doesn't seem like the TAG has identified all of the high-impact practices. There still is a lot that needs to be addressed through the research process.
- A strong message for many years (but not so much now) was that people were overwhelmed with the vast number of resources, and the goal of the HIPs was to have a short list of the best of the best practices. If this is still a goal, then the TAG needs to limit itself, and/or retire things that are no longer the top 10. The TAG needs to be explicit in its goal—does it still want a short list?
- Maybe the TAG can build on what FP2030 is discussing at their Regional Hub meetings; they are bringing together key stakeholders who are expressing their needs. The TAG can listen to this. Are there reports coming from these meetings that the TAG can build off? This could support evidence if the TAG to continue to look at updating old briefs and/or retiring briefs.
- In West Africa, there are several projects that are generating great data (Inspire project)—the Southern voices are getting stronger, and the resources are getting stronger, and we need to look at that.
- For transparency, the TAG should share the scoring sheet that is being used to approve the concept notes. As it not always obvious to the submitters, they are going to miss the mark.
- For the SPGs, is the juice worth the squeeze, there are other resources that are available for the majority of the SPG topics—why don't we just make a 2-pager pointing to those?
- The current studies in implementation and scale-up do not address the questions that we are asking on impact nor looking at practice and scale-up gaps. The studies are coming from implementing partners who are not going through a gap-identifying process.
- As the TAG continues to discuss this, in addition to looking at HIPs, the TAG should also evaluate the practices that are not bringing significant value to better identify where to put resources.
- Data on the use and implementation of briefs—a lot of this exists. Gates Foundation qualitative assessment of the utility of SPGs and briefs, interviewed people from about 30 countries and this provides a lot of information. Implementation and Scale-Up Study - qualitative study on the implementation and scale-up of HIPs globally. Peru Study - how people are using HIPs in Peru.
- The current process has been set up to be highly participatory and remove barriers to access; the HIPs are not intended to be top down, they are a summary of the evidence.
- Old briefs, how to go about retiring practices that may no longer be as important to emphasize, need to come back to this question. Propose sub-group to brainstorm ideas on how to improve engagement.
- Task: Group that would continue the discussion about how to better engage the field and brainstorm ways about how to do that (e.g., reports from FP2030, OPCU, etc.). And then see if the TAG can come up with things they think they could try to do. Question: How to better engage the field so that we can better understand what their needs are, so that

when the TAG is creating the HIPs, the HIPs are responding to the needs proposed by TAG members; Magwa Baker, Monica Kerrigan, Nandita Thatte, Rodolfo Ponce de Leon.

- Propose sub-group to determine the criteria for the TAG to review existing HIPs with the goal of evaluating continued relevance to be able to retire them? TAG members: Barbara Seligman, Sara Stratton, Maria Carrasco.
- Decision, pause until the next meeting. (Need to make sure that the next meeting has a concrete agenda so that there is a strong justification for the next meeting.)

Revisit literature review process for HIPs and any updates needed in the “Guidance for Developing a HIP Brief” (Maria Carrasco)

- A highlight of the HIPs brief development guidance is:
 - anyone can submit a concept note;
 - the TAG is a neutral platform where experts are making decisions around what becomes a HIP;
 - anyone can apply to be in the writing groups, the process is simple (should take around 20 minutes to apply) and the brief goes through a public and a TAG review.
- Proposed change and agreed: Updating the graphic to include the TEG selection on the graphic. One issue is that people need jobs to be able to participate; we need to try to figure out how to find fund to support people in the writing group.
- Literature reviews: when should the TAG look at the literature review? Brief updates would be helpful to see the literature reviews beforehand to be able to identify gaps and things that the TAG wants to see explored in the literature, share after the TAG looks at the literature and before it is updated based on feedback from the TAG.
- Can the TEG do the literature review? The challenge being able to go to the right sources to pull the literature and the TEG does need to read the review before continuing writing the paper. Also, the literature review performed by one person is considerable work; it would be advisable to find resources to contract someone to do the literature review.
- The guidance on one-method articles currently reads: exclude studies that only focus on ONE contraceptive method, and we think it should change to change to: “Articles focusing on only ONE contraceptive method should be tagged as ‘one method’ and should only be included when,
 - There are a number of one-method articles that provide an overview of the landscape.
 - The totality of the evidence should not focus on one method, but the individual articles can.”

- Even if most articles focus on one method, they may provide a lot of insight; we could consider putting a comment on the landing page explaining the exclusion criteria and that the brief will be updated to include more data.

[HIP Development | HIPs \(fphighimpactpractices.org\)](https://fphighimpactpractices.org)

[HIP Products | HIPs \(fphighimpactpractices.org\)](https://fphighimpactpractices.org)

HIP User Roadmap (Erin Mielke, Laura Raney, Maggwa Baker, Maria Carrasco, Michelle Weinberger, Sara Stratton)

What is the issue? In 2022 the HIPs User Survey showed people want: (1) guidance on how to prioritize among the HIPs, (2) detailed guidance on how to implement the HIPs, and (3) guidance and tools to measure HIPs implementation.

HIP briefs were developed to promote high-impact practices in family planning programs, but the audience is broad and expects more detailed information and guidance and many other resources exist that do not need to be reinvented.

A good example of a roadmap comes from the Momentum Project and Global Research project and shows a set of tools that fit together that help program planners adopt innovative solutions within their family planning programs. It is a roadmap which illustrates starting at different points in time to show where to start based on where you are.

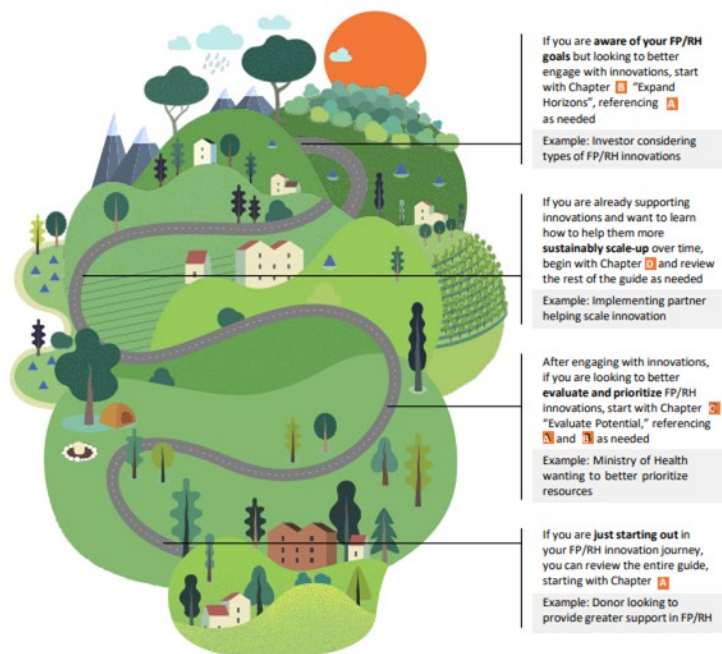
HIPs are a range of tools and interventions for FP programs; not everyone needs to apply everything, but how do you know where to look and sort through the range of materials offered by the HIPs website?

To date, the group have reviewed what HIPs are and are not, discussed who the primary audience is, brainstormed examples or categories of external resources the HIPs website can link to, examined what the steps would be along a user's journey with the HIPs, and listed which products are relevant for each of the stages of family planning programs (early, mid, and late). Next steps are to get TAG input on the main steps and resources for the 3 stages, review any glaring omissions, propose any additions for later stage, work with Momentum Country and Global Leadership team to develop the visual of the user's roadmap, and incorporate the HIP TAG's earlier table showing HIPs by outcomes and the Track 20 visual of the S-curve and program maturity level.

Different journeys for different users

Depending on where you and your organization are on the journey of supporting FP/RH innovations, you can start at different points in this guide. While this guide provides a flow, it is also designed to be modular and users can use various elements of the guide as is helpful for them. Supporting FP/RH innovations is an ongoing journey that this guide can help support.

Regardless of where you are in this journey, you can review the separate scale-up lessons and case studies to understand key insights and experiences.



Empowering FP/RH Innovations for Scale 6

Discussion

- We have looked at how HIPs and WHO products overlap, and we could include other examples of the experience of the FP Goals application process.
- UNFPA is rolling out an "Acceleration Plan" that includes 130 different family planning interventions. Users come to this via Track20 looking at their country context and then use the list of interventions to determine the one that is the highest value based on the context. The HIPs are linked to this, and it would be interesting to see how the tools can be integrated.
- Need to make sure that the resource is as simple as possible, so people can tack it onto the wall.
- We can crowd-source resources via the relevant networks; the goal is to cross-link rather than rewrite.
- We could also link resources to adaptive management and quality of care and to connect the indicators in the briefs to the available resources.
- Add to the late stage a feedback mechanism so if programmers are doing implementation work and are using the HIPs, how could they give feedback to help in revisions (implementation stories).

HIPs website image audit (added session, audit)

The HIPS website has undergone a photo image audit drawing on the use of imagery in global health article (from The Lancet).

The process involved a review of current images and a redefinition of intention so that we can recommission appropriate images.

We will create SOP for the HIPs P&D Team to ensure diverse photos that are a positive and true representation of the countries of implementation.

Recap of the day and recommendations (Maria Carrasco)

- Maria will share TAG's recommendations for comment over email.
- There will be a report coming out—please comment on the draft.
- Date for the next meeting will be the week of January 8, 2024.
- Potential location: Kenya.

Closing (Heidi Quinn)

Heidi closed the meeting, thanking everyone for their participation and their openness to discussion and for traveling to London and taking time out of their busy schedules.

TAG meeting: Day 3 (June 14, 2023)

Decisions on forthcoming HIP products

- The TAG agreed to explore moving forward with the CHW brief update since the self-care brief was put on hold.
- The TAG members below volunteered to be POCs for the forthcoming HIP products:
 - CHW: Gamachis and Saad
 - Mobile outreaches: Heidi and Erin
 - Task sharing: Sara and Nandita
- Jay and Rodolfo volunteered to help to identify experts for the technical expert groups through the established selection process.
- The TAG decided not to open the call for concept notes. The TAG agreed that instead of reviewing concept notes at the next TAG meeting, a sub-group should present on (1) how to best engage stakeholders at country level to better understand their needs; (2) developing a criteria to retire HIP briefs. The sub-group members are Maggwa, Rodolfo, Nandita, and Monica.

Updates to the "Guidance for Developing a HIP Brief"

- The TAG agreed to update the graphic showing the HIP brief process by adding the TEG selection as a step.



- The TAG determined that once a concept note is approved or once a brief is voted for updating, it would be important for the TAG to discuss the literature reviews before the TEGs start their writing process. This is particularly important for new briefs, and it was also deemed helpful for brief updates. By discussing the literature reviews for brief updates, the TAG can provide input on any literature that may be missing and also provide general guidance to the writing groups. By discussing the literature reviews of briefs or enhancements for which the concept note was approved, the TAG can determine if the existing evidence or literature appears to be sufficient to warrant the writing of a HIP brief or enhancement.
 - TAG members highlighted that it is critical for co-sponsor organizations to ensure resources are available to conduct the literature reviews, which are a critical piece in developing HIPs briefs and enhancements.
- The TAG agreed that the rule excluding studies that only focus on one contraceptive method needs to be updated. Articles focusing on only one method should be noted as only covering one method in the literature review and they could be included in a brief or in an enhancement if, and only if, the totality of the articles focusing on one method provides a picture of offering method choice. Maggwa and Maria will develop language to this effect.
- The TAG agreed that hyperlinks to the new HIP criteria tool and the HIPs product table should be added to the HIP brief development guide.

Attending TAG Members	
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Annex A Agenda

Agenda

Hybrid Technical Advisory Group Meeting

Objectives

- Review literature reviews for briefs being updated/developed this calendar year and provide input to writing teams
- Discuss HIP evidence-related processes and update as needed

Monday, June 12: Gamachis Shogo

09:00 am – 5:00 pm London | 4:00 am - 12 pm New York| 10:00 am - 6:00 pm Geneva|11 am - 7:00 pm Nairobi |1:30 pm - 9:30 pm New Delhi - Find time in other time zones [here](#)



Time (London)	Agenda Item	Reference materials
09:00 – 09:30	Sign-in to meeting in person and online at 09.30 am	
09:30 - 09:45	Opening of Meeting – Welcome Remarks IPPF Nathalie Kapp / Heidi Quinn	

09:45 – 10:15	<p>HIPs Production and Dissemination</p> <p>Ados May</p>	
10:15 – 11:15	<p>Literature review for Task Sharing brief (present literature, discussion)</p> <p>Maria Carrasco and Elizabeth Larson</p>	Google Presentation
11:15 - 11:30	Break	
11:30 - 12:30	<p>Literature review for Mobile Outreach (present literature, discussion)</p>	Google Presentation
12:30 - 1:00	<p>Presentation on IPPF’s new FP Strategy</p> <p>Manuelle Hurwitz IPPF Director, Member Association Development & Impact</p>	
1:00 - 2:00	Lunch	
2:00 - 2:30	<p>Present preliminary findings from R4S self-care studies from a user perspective</p> <p>Trinity Zan</p>	
2:30 - 3:00	<p>Questions, answers, reflections on self-care from user perspective</p> <p>Gamachis Shogo and Trinity Zan</p>	
3:00 - 3:30	<p>Literature review on Self-Care</p> <p>Maria Carrasco and Elizabeth Larson</p>	Google Presentation

3:30 - 4:00	Self-care trailblazers presentation on self-care in FP and its operationalization in self-care policies Person TBD	
4:00 -4:50	Way forward with self-care brief -What is the HIP? -What are the guidelines and key considerations for the writing team? -Should we move forward now or pause? Maria Carrasco	
4:50 - 5:00	Recap of the day and recommendations Maria Carrasco	

Potential discussants: Salma Anas, Caroline Kabiru, Gamachis Shogo, Saad Abdulmumin, Erin Mielke, Medha Sharma, Roy Jacobstein, Baker Maggwa

Tuesday, June 13, 2023: Heidi Quinn, Chair

08:30 am – 4:30 pm London | 3:30 am - 11:30 am New York| 9:30 am - 5:30 pm Geneva|10:30 am - 6:30 pm Nairobi |1:00 pm - 9:00 pm New Delhi - Find time in other time zones [here](#)

Time (London)	Agenda Item	Reference materials
08:30 – 09:00	Sign-in to meeting	

Wednesday, June 14, Dr Rodolfo Gomez, Chair

08:30 am – 12:30 pm London | 3:30 am - 7:30 am New York| 9:30 am - 1:30 pm Geneva|10:30 am - 2:30 pm Nairobi |1:00 pm - 5:00 pm New Delhi - Find time in other time zones [here](#)

Time (London)	Agenda Item	Reference materials
08:30 – 09:00	Sign-in to meeting	
09:00 – 09:10	Welcome and Reflections from Day 2 TBD	
9:10 - 9:30	HIP Updates Maria Carrasco	
09:30 – 10:30	Final version of the HIP evidence scale and orientation to the TAG on how they would fill out the section/information that they need to complete Karen, Michelle, Maria, Saad	
10:30 – 11:30	<u>HIP User Roadmap</u> Erin, Michelle, Sara, Maggwa	
11:30 – 12:00	Recap of the day and recommendations Maria	
12:00 - 12:30	Final reflections and closing Heidi Quinn	

Annex B PowerPoint Presentations

HIP Production & Dissemination



HIP Production & Dissemination (P&D)

June 12th, 2023

Ados May, WHO/IBP Network

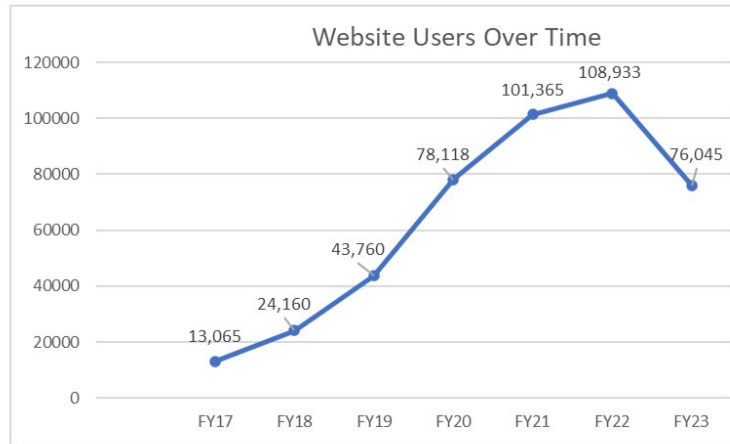


Agenda

- Website Usership
- Top 10 HIP Products
- HIP Webinars
- Twitter Engagement
- HIP Newsletter
- HIPs in Peer-Reviewed Literature



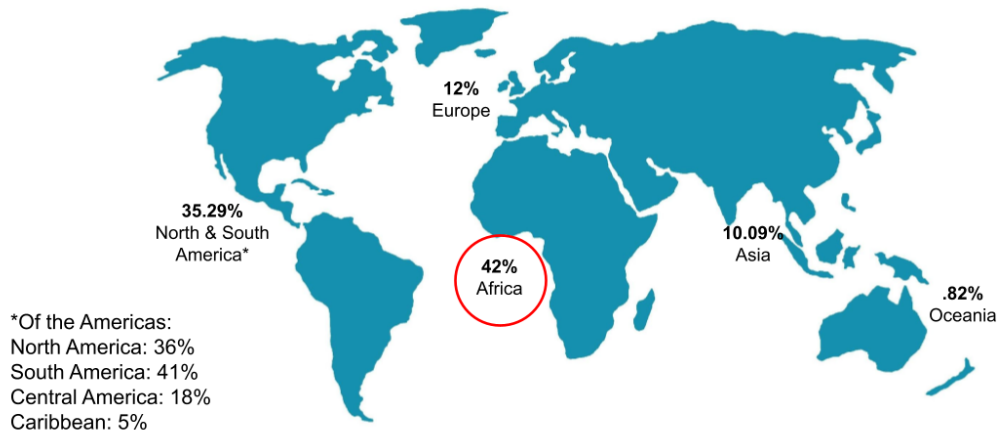
Website Users FY2018 – FY2023



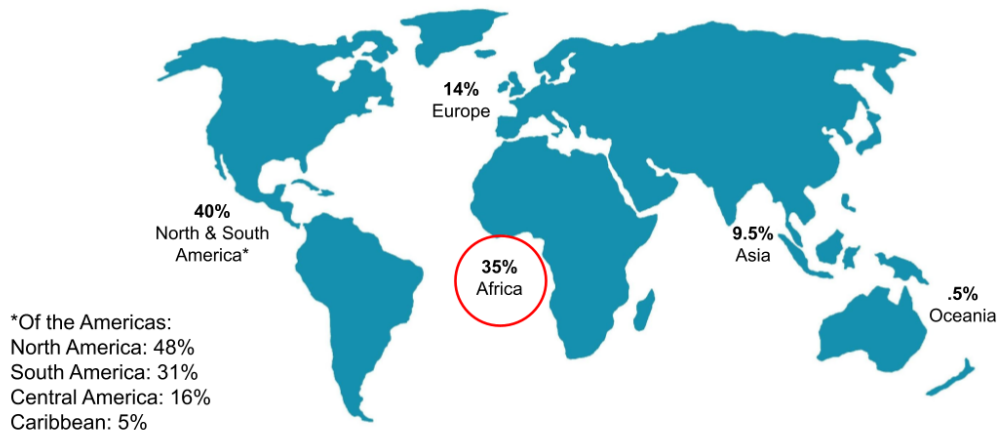
Analytics

FY23	
Users	75, 967
Sessions	97,013
Pageviews	132,941
Avg session duration	1 min 24 sec

Website Users by Region FY23



Website Users by Region FY22



Website Users by in the Americas FY23



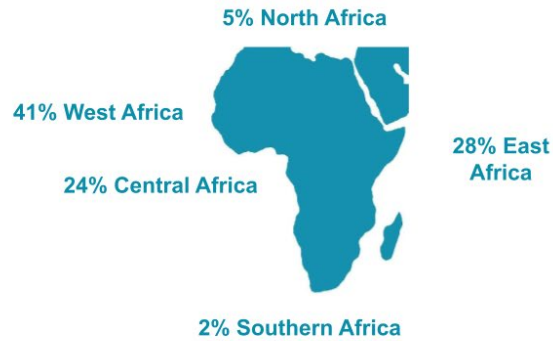
Website Users by in the Americas FY22



Website Users in Africa FY23

Countries with highest
number of users:

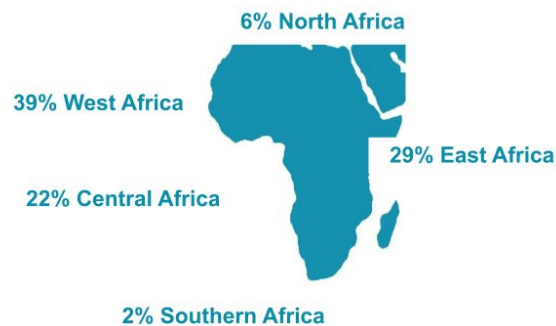
Nigeria (2,740)
Cameroon (2,655)



Website Users in Africa FY22

Countries with highest
number of users:

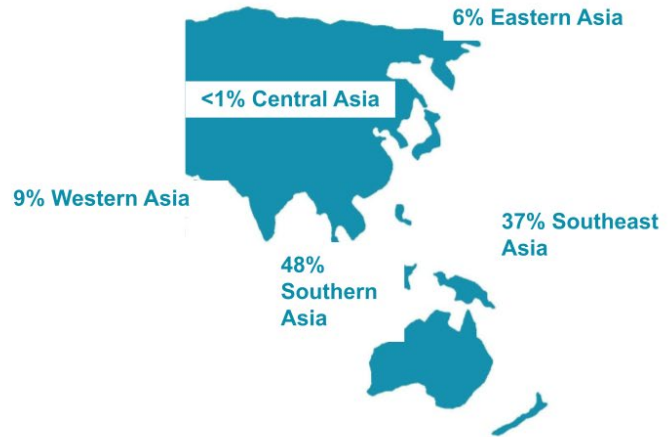
Nigeria (3,878)
Mozambique (3,469)



Website Users in Asia FY23

Countries with highest
number of users:

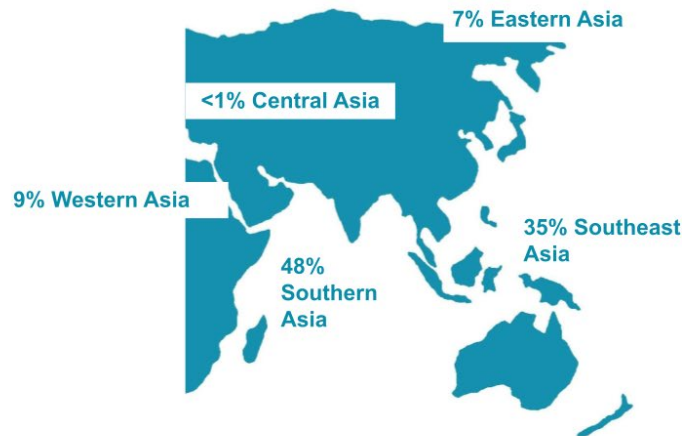
India (2,225)
Philippines (1,790)



Website Users in Asia FY22

Countries with highest
population of users:

India (3,145)
Philippines (2,575)



Website Users by Language

Language	FY19	FY20	FY21	FY22	FY23
English	72%	63%	47%	42%	41%
Spanish	14%	24%	17%	15%	19%
French	13%	12%	18%	25%	30%
Portuguese	1%	2%	4%	5%	6%

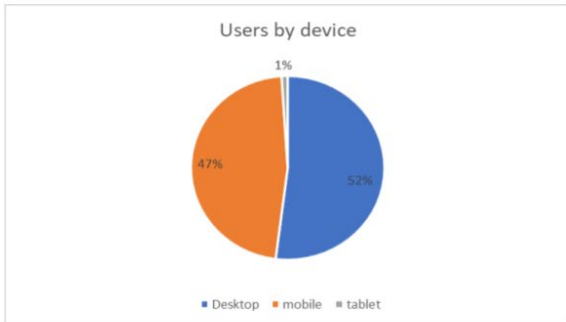
Website Users – Top 10 Countries June 2022-June 2023 June 2021-June 2022

Country	Number of Users
1. US	13,074 (12%)
2. France	7,048 (6%)
3. Colombia	6,629 (6%)
4. Mexico	4,327 (4%)
5. Nigeria	4,217 (4%)
6. Cameroon	3,937 (3%)
7. Peru	3,731 (3%)
8. DRC	3,703 (3%)
9. India	3,345 (3%)
10. Mozambique	3,235 (2.9%)

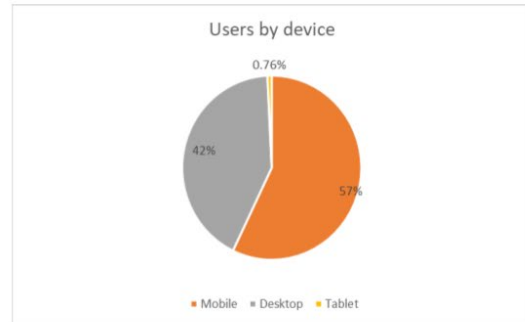
Country	Number of Users
1. US	19,261 (17%)
2. France	7,726 (7%)
3. Colombia	5,346 (5%)
4. Mexico	4,248 (4%)
5. Nigeria	3,878 (3%)
6. Cameroon	3,469 (3%)
7. India	3,145 (2.8)
8. DRC	3,050 (2.5)
9. Peru	2,998 (2.4%)
10. Mozambique	2,662 (2.2%)

Website Users by Device

As of June 2022

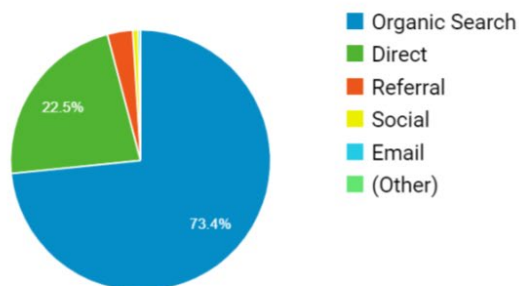


FY2023

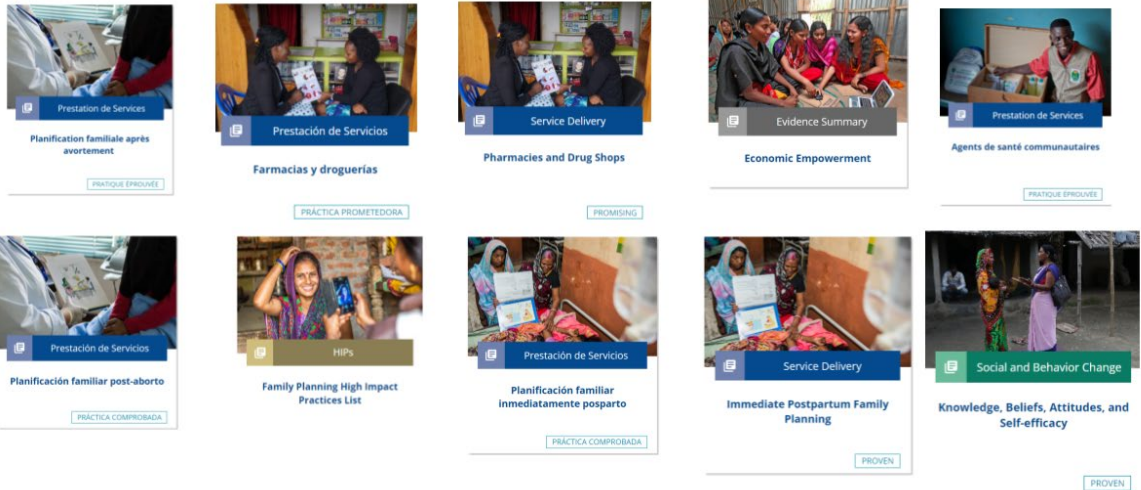


Website Users – Acquisition Overview

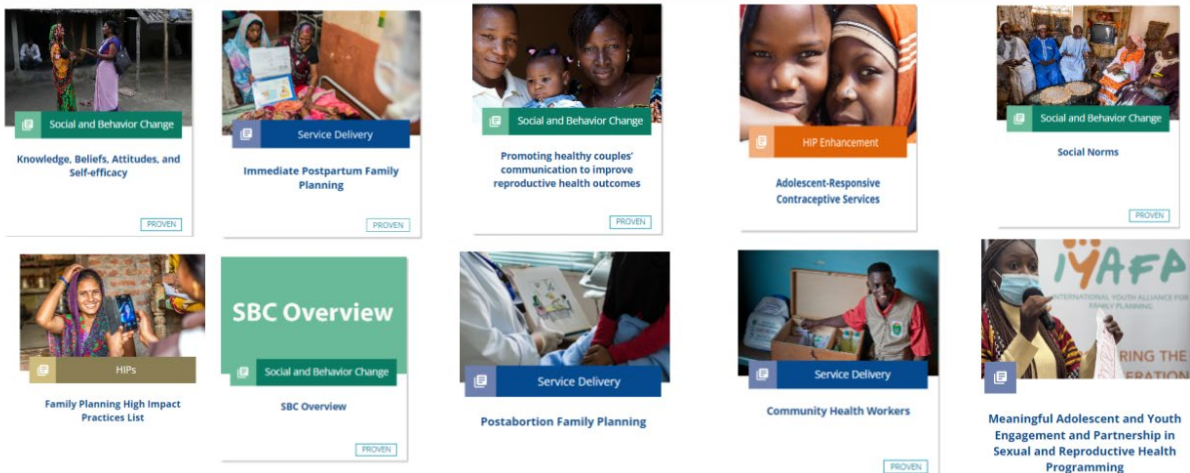
Top Channels



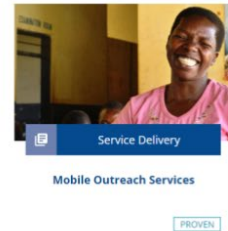
Top 10 HIP Products June 2022 - Present



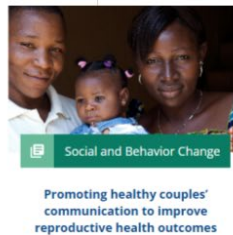
Top 10 Downloads June 2022 - Present



Top 5 Presentation Downloads June 2022 - Present



Presentations available soon:



HIP Webinars in 2023



Knowledge, Beliefs, Attitudes, and Self-efficacy: strengthening an individual's ability to achieve their reproductive intentions webinar



SBC Series:

Couples' Communication - 108 participants

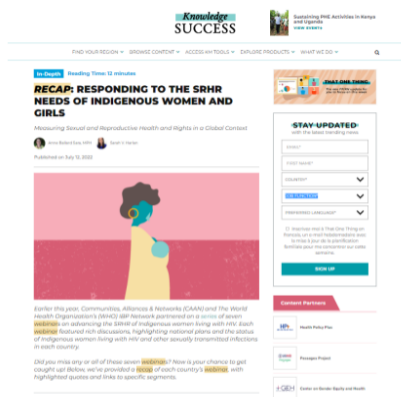
KAB - 140 participants

Social Norms - 216 participants (highest # so far)

Planned:

- PLWD SPG
- HIPs Overview
- Strengthening of EFAs SPG
- Social Accountability
- Comprehensive Policy Processes

SBC Webinar Recap



Recap:

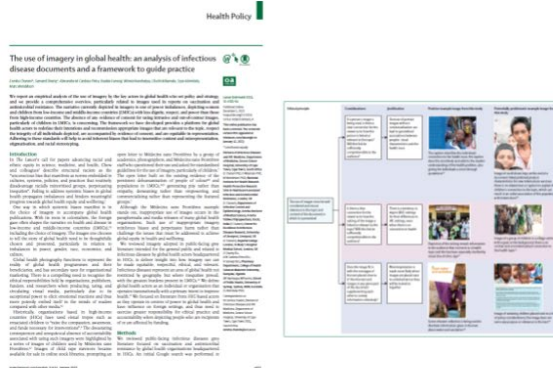
- Connecting global launch at SBCC Summit to the webinar series
- Will include: Couples' Communication, Social Norms and Knowledge, Beliefs, Attitudes and Self-efficacy
- HIPs and KS websites
- Expanded reach

HIPs Website Image Audit

The use of imagery in global health article

[https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(22\)00465-X/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00465-X/fulltext)

- Review current images
- Redefine intention
- Recommission appropriate images
- Create SOP for the HIPs P&D Team



Twitter: Consistent Engagement from Reliable Partners

Average # of monthly Tweets: 60
Average monthly reach: 1 million

Top 5 by # of Tweets:	Top Influencers
Knowledge SUCCESS	FP 2030
R4S Project	USAID GH
FP 2030	Knowledge SUCCESS
Dr. Abduljabbar Hassan	JSI Health
Farhan Yusuf	



HIP Newsletter

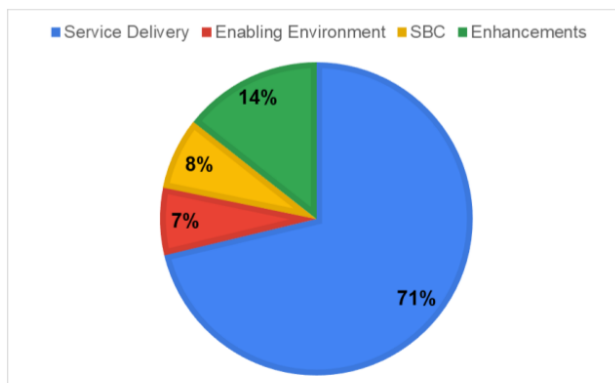
Since the newsletter's launch in June 2020, over **800** FP stakeholders from over **86** countries have subscribed to the HIPs newsletter.

Top Countries	# of Subscribers
United States	329
India	42
Kenya	38
Nigeria	36
United Kingdom	29



HIPs in Peer-Reviewed Literature

From January- June 2023, **15 peer-reviewed publications** cited a HIP brief, bringing the total to 202 publications since 2014.



KS Essential Resource List for HIP briefs

- Call for Resources requested on HIP implementation and scale-up of HIP briefs circulated
- Resource list for 6 service delivery and 2 SBC briefs are forthcoming
- Working with CoPs and TWG's who have expertise in our projects' selected HIP technical areas on call for experts to support list finalization.



 fphighimpactpractices.org

Literature review for Task Sharing brief



Literature Review Results: Task Sharing

Beth Larson and Maria Carrasco

Reviewed by Sara Stratton

HIPs TAG Meeting

June 12, 2023



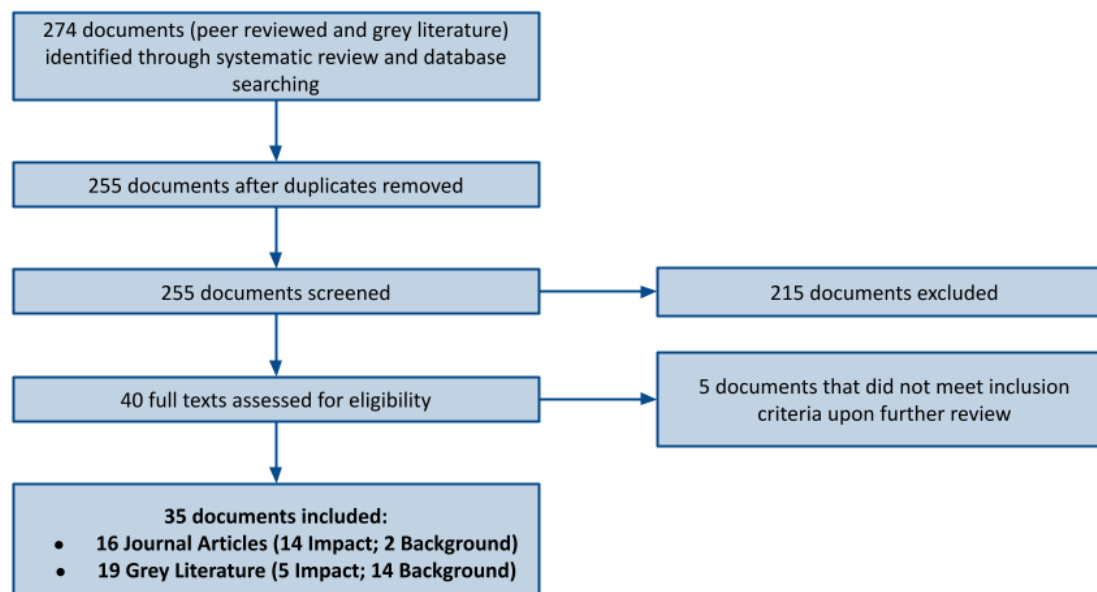
Context - Why this literature review

- TAG approved that task sharing should become a brief at the January '23 TAG meeting based on the following criteria:
 1. Relevancy to the SRH landscape
 2. Need to elevate task sharing from an SPG to a high impact practice brief
 3. Urgency for a new product based on the global landscape
- Making a task sharing brief will clarify HIP knowledge products categories to improve understanding for HIPs audiences
- There is growing evidence for where and for whom task sharing should be applied

Methods

- Search period: Open
- Review of articles included in a number of systematic reviews with “task shifting” and “task sharing” as the subject*
- Performed a review of grey literature using the following search terms: family planning, contraception, task sharing, task shifting
 - Words were truncated when appropriate
- Grey Literature Sources: Google Advanced Search, USAID Development Experience Clearinghouse
- Inclusion criteria: LMIC, family planning-related program, focus on multiple methods
- Exclusion criteria: Focus on one method
- Final number of included documents: 35
 - 19 impact articles and 16 background articles

* List of articles at end of presentation



Background

WHO Recommendations (WHO 2013, 2017)

- Use of different non-physician health worker cadres to provide the following services:
 - a. Tubal ligation, vasectomy, IUD, implants, injectables, and family planning education and counseling
- Task sharing is recommended when:
 - a. Access to service is limited by health worker shortages/unequal distribution of health workers
 - b. There are difficulties in staff retention
 - c. Budgetary constraints exist and mid- or lower-cadre workers can be deployed to reduce costs of providing services without compromising safety
 - d. There is a need to free the time of higher cadre health workers

Table of guideline recommendations for task sharing of contraception

WHO Recommendations (WHO 2013, 2017)

FP Methods and Services Typically Offered by Cadre of Service Provider

National policies and service delivery guidelines dictate which cadres of providers can offer specific FP services. The chart below shows the FP methods that are typically offered by these cadres of providers based on recommendations from WHO.

Contraceptive Service	Lay Health Workers (e.g., CHWs)	Pharmacy Workers	Pharmacist	Auxiliary Nurse	Auxiliary Nurse Midwife	Nurse	Midwives	Associate/Advanced Associate Clinicians	Non-specialist doctors	Specialist doctors
<ul style="list-style-type: none"> Informed choice counseling Combined oral contraceptives (COCs) Progestin-only oral contraceptives (POPs) Emergency contraceptive pills (ECPs) Standard Days Method and TwoDay Method Lactational amenorrhea method (LAM) Condoms (male & female), barrier methods, spermicides 	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Injectable contraceptives (DMPA, NET-EN or CICs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Implant insertion and removal	Ⓡ	✗	✗	✓	✓	✓	✓	✓	✓	✓
Intrauterine device (IUD)	✗	✗	✗	Ⓡ	✓	✓	✓	✓	✓	✓
Vasectomy (male sterilization)	✗	✗	✗	Ⓡ	Ⓡ	Ⓡ	Ⓡ	✓	✓	✓
Tubal ligation (female sterilization)	✗	✗	✗	✗	✗	Ⓡ	Ⓡ	✓	✓	✓
<div> <div>✗</div> <div>Considered outside of the typical scope of practice; evidence not assessed.</div> </div> <div> <div>✗</div> <div>Recommended against</div> </div> <div> <div>Ⓡ</div> <div>Recommended in the context of rigorous research</div> </div> <div> <div>✓</div> <div>Recommended in specific circumstances</div> </div> <div> <div>✓</div> <div>Recommended</div> </div> <div> <div>✓</div> <div>Considered within typical scope of practice, evidence not assessed.</div> </div>										



Benefits of task sharing

- **Frees time of higher level health personnel and addresses health worker shortages, especially in rural areas**
Ali 2023; Aradhya, K. 2019; Janowitz, B., Stanback, J. 2012; MSI - Impact
- **Specialization of lower-level cadres will promote quality**
Janowitz, B., Stanback, J. 2012
- **Increased access to contraceptive counseling, which increases choice**
Janowitz, B., Stanback, J. 2012; MSI - Impact; Ali 2023
- **Can lower costs of services**
Janowitz, B., Stanback, J. 2012; MSI - Impact; USAID - Task Sharing
- **Increased motivation to spend time counseling on LARC benefits**
USAID - Task Sharing
- **Potential to increase demand for LARCs**
USAID - Task Sharing

Enabling and hindering factors to task sharing

Enabling

- **Ability of all cadres to provide high quality care with proper training and supervision**
Ali 2023; Aradhya, K. 2019; Gallo, MF et al 2013; Gueye, B., et al 2016; Janowitz, B., Stanback, J. 2012; Kok, M. et al 2020
- **Strong relationships between lower-level cadres and both health workers and the community**
Kok, M. et al 2020

Hindering

- **Resistance to task sharing among some key stakeholders**
USAID 2015
- **Misconceptions about contraception that not all cadres are trained to overcome**
Kok, M. et al 2020
- **Erratic commodity supply**
Ahmad 2012; Kok, M. et al 2020

When task sharing may not be appropriate

USAID - Task Sharing: Recommendations for Implementing the Global Consensus Statement

- **“In settings where demand for LARCs is very low, task-sharing of LARC provision may not be needed, cost-effective, or safe”**
 - **A sufficient and sustained client flow is needed to maintain skills for LARC insertion and removal**

Summary of Key Themes

Task Sharing to Community Health Workers

- **Results in increased modern contraceptive use**
Aradhya, K. 2019; Douthwaite, M., Ward, P., 2005; E2A 2017; Haver, J. et al 2015; Milogo, T. et al 2019; Ojo, M - National Task Shifting/Sharing Policy; Oku 2019; Ouedraogo, L et al 2020; Ouedraogo, L et al 2021; Phillips, JF. et al 1993; Phillips, JF. et al 1996; UNFPA - Task Shifting and Task Sharing for Family Planning in Pakistan; Women Deliver 2015
- **Results in extended median birth intervals**
Haver, J. et al 2015
- **Few to no safety concerns**
Aradhya, K. 2019; Chin-Quee, D. et al. 2020; Milogo, T. et al 2019

Task Sharing to Community Health Workers cont.

- **Could positively contribute to health systems strengthening**
Ouedraogo, L et al 2020
- **High satisfaction in the provision of care**
Chin-Quee, D. et al. 2020; Ouedraogo, L et al 2020
- **Increase in the number of women intending to use contraception**
Ojo, M - National Task Shifting/Sharing Policy; Phillips, JF. et al 1993

Task Sharing to Nurses & Midwives

- **Increased modern contraceptive use**
E2A 2017; Gueye, B., et al 2016; Milogo, T. et al 2019; Ouedraogo, L et al 2021; UNFPA - Task Shifting and Task Sharing for Family Planning in Pakistan
- **Few to no safety concerns**
Aradhya, K. 2009; Chin-Quee, D. et al. 2020; Gueye, B., et al 2016; Milogo, T. et al 2019
- **Increased satisfaction with service provision from nurses**
Aradhya, K. 2019; Chin-Quee, D. et al. 2020
- **Provide more thorough counseling than doctors**
Aradhya, K. 2019

Need for Appropriate Training and Funding

Training

- **Needs to take the health system and work environment into account**
Gueye, B. et al 2016
- **Needs to include follow-up training**
Gueye, B. et al 2016
- **Adequate training can improve service provision quality**
Oku 2019
- **Inadequate trainings lead to a lack of knowledge**
Ahman, J. et al 2012

Adequate funding is key

- **Decreased provider motivation and inability to perform outreach activities**
Ahman, J. et al 2012; Oku 2019
- **Bias towards methods for which providers receive compensation**
Ahman, J. et al 2012
- **Inability to provide a range of methods (no stock)**
Ahman, J. et al 2012; Oku 2019

Task sharing alone may not be sufficient

- **Improved outcomes when task sharing initiatives are combined with community awareness raising activities**
Chin-Quee, DS et al 2020; Debpuur, C et al 2002
- **Lack of follow-up after an initial task sharing initiative can lead to high rates of discontinuation**
Hernandez, J.H. et al 2023
- **When providing LARCs via task shifting, need to also ensure there is the capacity for method removal**
Hernandez, J.H. et al 2023
- **Having too large a scope of work can negate positive impacts (CHWs focussing on MCH in addition to family planning)**
Ahmad 2012

Findings & Considerations

Key Findings

- Non-physician cadres can safely provide high quality family planning services
- Task sharing has a positive impact on family planning outcomes, particularly on increasing contraceptive use
- For task sharing initiatives to be successful, there must be an emphasis on training, including supervision and follow-up, and adequate funding
- Task sharing programs are most successful when they are paired with other initiatives

Questions for the TAG to address to guide the technical expert group

- Is the evidence varied enough about tasking sharing working in different cadres?
 - A lot of evidence available re CHWs & HIP CHW brief. Don't want to duplicate.
- Is there enough evidence to show how TS helps different HIPs (one of the enhancement purposes)
 - Table 1 in SPG cross checks TS and HIPs
- How many of the SPG steps/tips should the writers consider including?
- Need a sub-group to determine if we should keep task sharing SPG or if we should fold it into the brief

Documents

List of Systematic Reviews

1. Implementation strategies, facilitators, and barriers to scaling up and sustaining task-sharing in family planning: a mixed-methods systematic review (preprint, not peer reviewed). DOI: 10.21203/rs.3.rs-2388905/v1
2. Tieba Millogo, Eunice Chomi, Seni Kouanda, Moazzam Ali, "Getting Up to Date with What Works: A Systematic Review on the Effectiveness and Safety of Task Sharing of Modern Methods in Family Planning Services", BioMed Research International, vol. 2023, Article ID 8735563, 11 pages, 2023. <https://doi.org/10.1155/2023/8735563>
3. Okoroafor, S.C.; Christmals, C.D. Task Shifting and Task Sharing Implementation in Africa: A Scoping Review on Rationale and Scope. Healthcare 2023, 11, 1200. <https://doi.org/10.3390/healthcare11081200>
4. Polus, S., Lewin, S., Glenton, C. et al. Optimizing the delivery of contraceptives in low- and middle-income countries through task shifting: a systematic review of effectiveness and safety. Reprod Health 12, 27 (2015). <https://doi.org/10.1186/s12978-015-0002-2>
5. Scott, V.K., Gottschalk, L.B., Wright, K.Q., Twose, C., Bohren, M.A., Schmitt, M.E. and Ortayli, N. (2015), Community Health Workers' Provision of Family Planning Services in Low- and Middle-Income Countries: A Systematic Review of Effectiveness. Studies in Family Planning, 46: 241-261. <https://doi.org/10.1111/j.1728-4465.2015.00028.x>
6. IMPLEMENTATION OF THE WORLD HEALTH ORGANIZATION'S TASK SHARING GUIDELINES FOR LONG-ACTING REVERSIBLE CONTRACEPTIVES AND PERMANENT METHODS ACROSS MOMENTUM SAFE SURGERY IN FAMILY PLANNING AND OBSTETRICS COUNTRIES (<https://usaidmomentum.org/resource/larc-pm-task-sharing-desk-review/>)

Key Impact Documents

1. Aradhya, Kerry. "Task shifting is expanding the roles of family planning providers." Medical education resource Africa (2009): 36.
2. Gueye B, Wesson J, Koumtingue D, Stratton S, Viadro C, Talla H, Dioh E, Cissé C, Sebikali B, Mamadou Daff B. Mentoring, Task Sharing, and Community Outreach Through the TutoratPlus Approach: Increasing Use of Long-Acting Reversible Contraceptives in Senegal. Glob Health Sci Pract. 2016 Aug 18;4 Suppl 2(Suppl 2):S33-43.
3. Hernandez, J.H., LaNasa, K.H. & Koba, T. Task-shifting and family planning continuation: contraceptive trajectories of women who received their method at a community-based event in Kinshasa, DRC. Reprod Health 20, 24 (2023).
4. Ouedraogo, L., Habonimana, D., Nkurunziza, T. et al. Towards achieving the family planning targets in the African region: a rapid review of task sharing policies. Reprod Health 18, 22 (2021).

Key Background Documents

1. HRH2030 (2020) Technical Report, National Family Planning Guidelines in 10 Countries: How well do they align with current evidence and WHO recommendations on task sharing and self-care?
2. Janowitz, B., Stanback, J., Boyer, B., Task sharing in family planning. Stud Fam Plann. 2012 Mar; 43(1):57-62.
3. MSI - Impact: task sharing
4. UNFPA (2017) Family Planning Task Shifting: A Review of Approaches in East and Southern Africa
5. WHO (2017) Task sharing to improve access to Family Planning/Contraception

HIP Task Sharing SPG

Objective: Lead program managers, planners, and policymakers through a strategic process to determine if and how task sharing family planning (FP) services can be used to help achieve development goals

Considerations:

1. How will task sharing help you achieve your goals?
2. Defining your task sharing strategy – which family planning services providers and which methods
3. Which stakeholders should be involved in developing the task sharing strategy?
4. What components are recommended to ensure the cadre is supported by the health system?
5. How will beneficiaries be informed of task sharing and benefit from service?

Literature review for Mobile Outreach brief



Literature Review Results: Mobile Outreach

Beth Larson and Maria Carrasco

Reviewed by Erin Mielke and Heidi Quinn

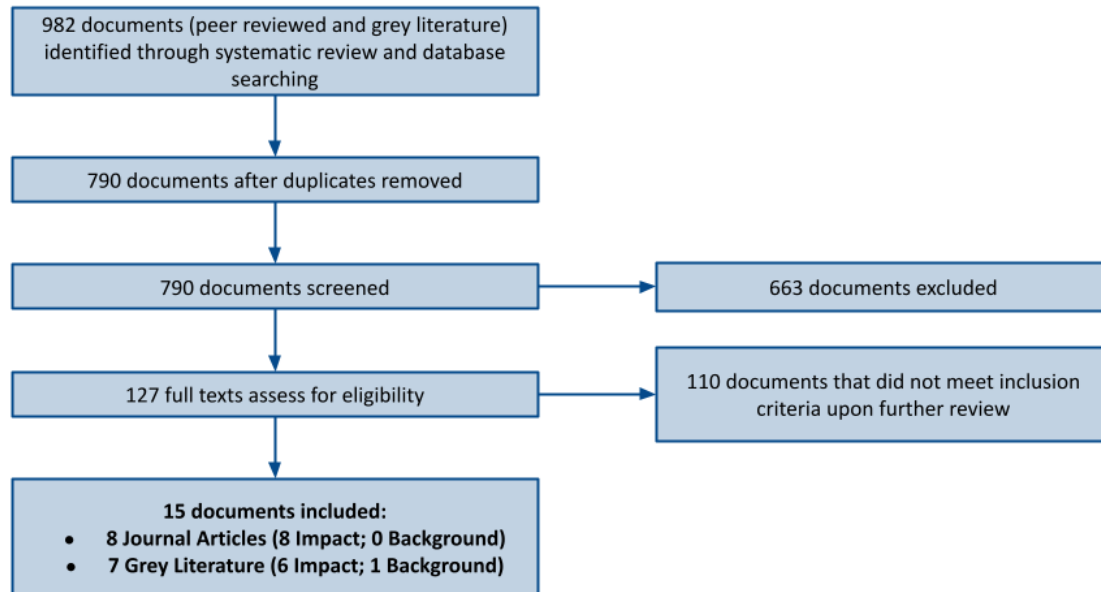
HIPs TAG Meeting

June 12, 2023



Methods

1. Search Period: January 1, 2014 to May 17, 2023
2. Example search words: family planning, contraception, mobile outreach , mobile unit, mobile clinic, mobile service, portable clinic, portable unit, portable service
 - a. Search terms were truncated when applicable
3. Database types: PubMed, Embase, Scopus, LILACS, USAID Development Experience Clearinghouse, Google Advanced Search, etc.
4. Inclusion criteria: LMIC, family planning-related program, focus on multiple methods
5. Exclusion criteria: Focus on one method
6. Final number of included documents: 17
 - a. 15 impact articles and 2 background articles



Current Brief

Challenges mobile outreach can address

- Serve communities with limited access to clinical providers and supplies
- Services reach new and underserved populations by bringing health services closer to the client
- Services expand FP method choice/mix by offering LARCs and PMs which are less accessible in many places
- Support capacity building of local providers to deliver LARCs and PMs via on-the-job training and supervision from mobile providers

Impact of mobile outreach services

- Increase contraceptive use
 - Data from Zimbabwe, Nepal, Malawi, Northern Uganda, and Tanzania
- Cost effectiveness should be evaluated while designing a mobile outreach program
- Mobile outreach services can provide high-quality care

Implementation Tips

- Coordinate with community leaders to identify appropriate locations
- Map the geographic area
- Ensure that sites are clean, safe, and private
- Develop effective public-private partnerships
- Ensure clients have access to follow-up care
- Recruit and support dedicated staff
- Invest in sustained awareness-raising and communication activities
- Link outreach programs with CHWs and local clinics for family planning counseling, referrals, and community mobilization
- Anticipate and address challenges

New & Updated Evidence

Increase contraceptive use

- **Mobile outreach services are effective at generating couple years protection, particularly through LARCs**
E2A 2021; Jarvis, L. et al 2018; ; MSI 2015; Ngo, TD. et al 2014; Nyirenda, LF. et al 2020; PSI 2014; SHOPS 2016; TCI Global Toolkit; Temba, A. et al 2021
- **Many clients *accessing contraception* at mobile outreach clinics had not previously used a method (new users or adopters who have not used in 3 months). In several studies, they made up the majority of clients**
E2A 2021; MSI 2015; Ngo, TD. et al 2014, Nyirenda, LF, et al 2020; PSI 2014; TCI Global Toolkit
- **Mobile outreach services increase access to contraception for adolescents and young adults and other hard to reach populations (advancing equity)**
E2A 2021; MSI 2015; Ngo, TD. et al 2014; Nyirenda, LF, et al 2020; TCI Global Toolkit

Costing & Reach

- **Mobile clinics are more expensive than static clinics, but they produce more CYPs due to increased LARC provision**
Al-Attar, G. S. T., et al 2017
- **Increasing time between visits can increase client volume because there is more time for demand generation and awareness raising activities to reach the population**
De Vries, H. et al 2021
- **The number of clients accessing mobile outreach services increases over time**
Krenn, S. et al 2014

Quality of care

- **Mobile outreach services can effectively and safely provide LARCs**
MSI 2015; Ngo, TD. et al 2014
- **Client satisfaction with mobile outreach services varied by study**
 - **Clients are satisfied with the mobile outreach services**
MSI 2015; Ngo, TD et al 2014
 - **Lower percentages of mobile outreach than static service clients reported satisfaction**
Jarvis, L. et al 2018

Free and Informed Choice (Jarvis, L. et al 2018)

- **Mobile outreach services are able to provide the same level of free and informed choice as static services**
MSI 2015
 - The vast majority of clients receive their method of choice
 - Full, free and informed choice for mobile was lower than in static services in Tanzania
 - No significant differences in full, free and informed choice at mobile and static services in the DRC or Uganda
 - Clients reporting increased full, free and informed choice also were more likely to report being “very satisfied” with services

Recommended approaches (RESPOND project 2014)

- To provide high quality care, services need to be adaptive, have appropriate levels of supervision, and ensure the availability of necessary commodities
- Services provide an opportunity for training, coaching and skills improvement in the provision of LARCs/PMs
- Careful planning and coordination is necessary to ensure the effectiveness of demand generation activities via community mobilization
- Public-private partnerships should be coordinated at the district level
- Governments should ensure services are affordable or free-of-charge
- Improved monitoring and evaluation of delivery systems is needed to facilitate evidence-based planning and decision making

Recommended approaches cont. (MSI 2015)

- **Using a split approach to mobile outreach can further increase access**
 - *Split approach:* Mobile outreach team is split into 2 sub-units allowing them to reach two geographically close facilities/sites in the same day. The split mobile outreach services are supported by government providers

Findings & Considerations

Key Findings

- Mobile outreach can safely provide high quality family planning services
- Mobile outreach has a positive impact on family planning outcomes, particularly on increasing contraceptive use among hard to reach populations, adolescent, first time users, and contraceptive adopters
- Mobile outreach services have the greatest reach if they identify an ideal visit frequency and sustain service delivery over time
- Using a split approach to mobile outreach can further increase access

Questions for the TAG to address to guide the technical expert group

- What is the role of the government, in mobile outreach service delivery?
 - Should this practice focus on CSO as the service provider?
- What information should the brief provide to ensure method choice in this practice?
- What is the value add of mobile outreach in the health system on top of the expansion in importance of CHWs?
 - What linkages should be made between this brief and an updated CHW brief?
 - Do mobile programmes have a role to reach particular groups? What are the links between this brief and the Equity SPG in terms of reaching underserved groups?
 - What are the important factors to managing an outreach programme?
 - Which models of outreach provide good value for money ?
 - Can FP be integrated with other services in mobile outreach?
 - Does this model strengthen health systems?

Documents

Key Impact Documents

1. MSI (2015) Support for International Family Planning Organizations
2. Ngo TD, Nuccio O, Pereira SK, Footman K, Reiss K. Evaluating a LARC Expansion Program in 14 Sub-Saharan African Countries: A Service Delivery Model for Meeting FP2020 Goals. Matern Child Health J. 2017 Sep;21(9):1734-1743.
3. TCI Global Toolkit: Service Delivery, Mobile Outreach Services

Presentation on IPPF's new FP Strategy

Come Together

IPPF Strategy 2028

Come Together

Quality SRHR for **Everyone, Everywhere, Breaking Barriers**

IPPF is a global Federation of SRHR organisations.

We are radically committed to social and gender justice.

We provide care and promote choice.

Center Care on People

Expand Choice

Widen Access

Advance Digital &
Self Care

Move the Sexuality Agenda

Ground Advocacy

Shift Norms

Act with Youth

Solidarity for Change

Build Strategic
Partnerships

Support Social
Movements

Innovate & Share
Knowledge

Nurture the Federation

Chart our Identity

Grow the Federation

Walk the Talk

Synergies



Center Care on People

Goal: Quality person-centered care to more people, in more places

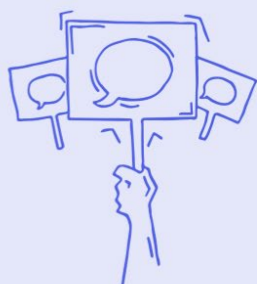


Critical pathways	Expand choice	Widen access	Advance DHI & self-care
Priority actions	Boost safe abortion & infertility care Integrate HIV into SRHR package Expand contraceptive choice	Reach marginalised communities Deliver youth-centred care Grow crisis settings preparedness and care	Invest in digital health interventions Offer quality self-care



Move the Sexuality Agenda

Goal: Societal and legislative change for universal sexual and reproductive rights



Connect advocacy at all levels	Prevent sexual & gender-based violence	Bring youth voices to the fore
Amplify community voices	Take intersectional & feminist action	Advance comprehensive sexuality education
Monitor commitments	Share winning narratives	Engage & influence on social media



Solidarity for Change

Goal: Amplify impact by building bridges, shaping discourse and connecting communities, movements and sectors



Collaborate across sectors	Connect capacity	Grow the IPPF centers & funds
Build alliances & consortia	Amplify messages	Communicate learning
Host and support community groups and networks	Re-grant	Incubate ideas and &tech

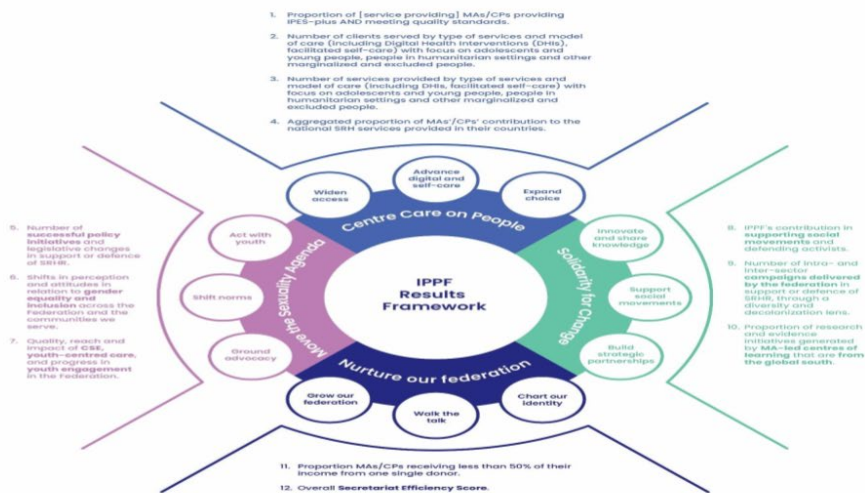


Nurture the Federation

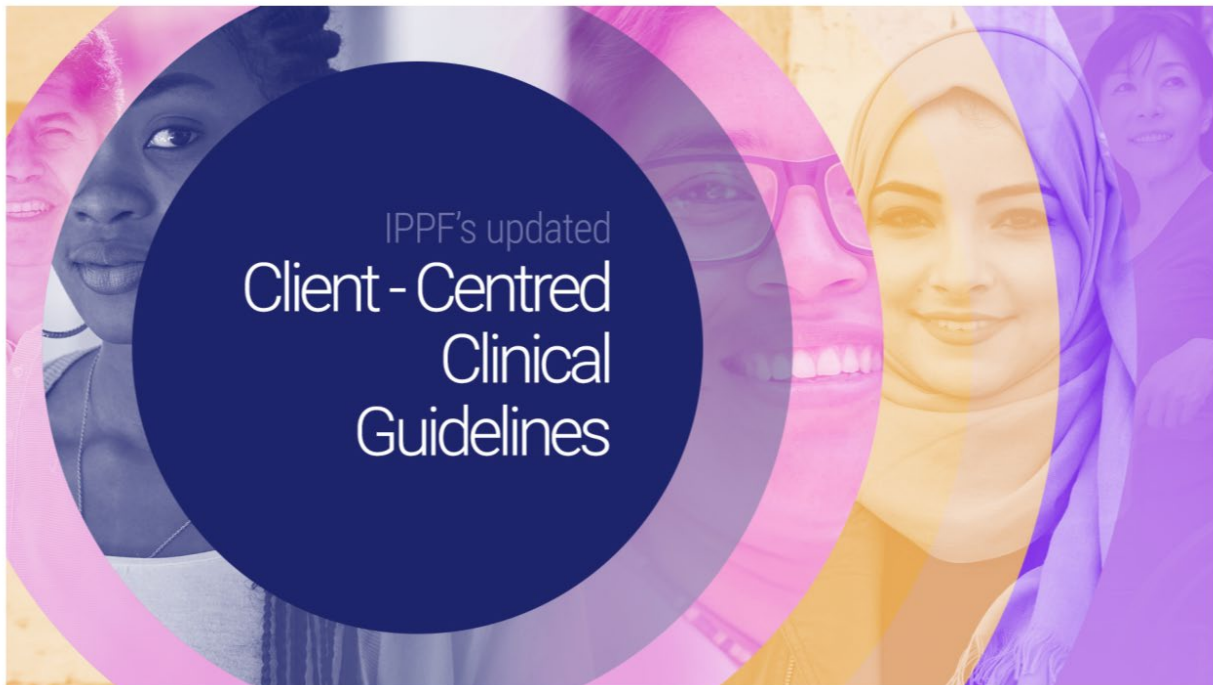
Goal: Renew our charter, live our values, and unleash our collective power



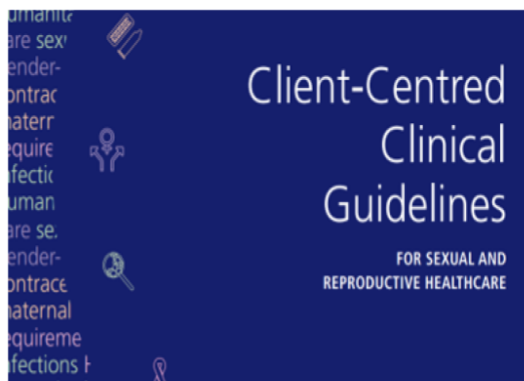
Draft federation charter	Find new members	Challenge discrimination
Renew our brand	Modernise systems & grow skills	Embrace gender & sexual diversity
Build our culture	Mobilise resource & diversify income	Youth structures & leadership



* IPF Integrated Package of Essential Services (IPES) will be revisited to reflect additional priority services such as identity care, services provided to adolescents etc.
 ** Quality standards and review of SRH components to be informed by the ongoing discussion with the Secretariat and MA colleagues.
 *** 10 component growth score proposed that include improvement in MA base, Systems strengthening (IT, HR, Finance, Data), learning and resource mobilization, TBC.



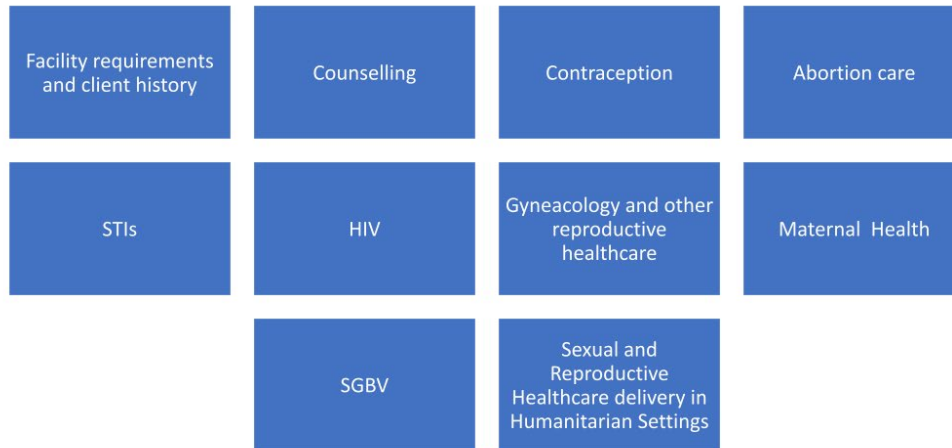
Rationale: Need for up-to-date evidence-based guidance



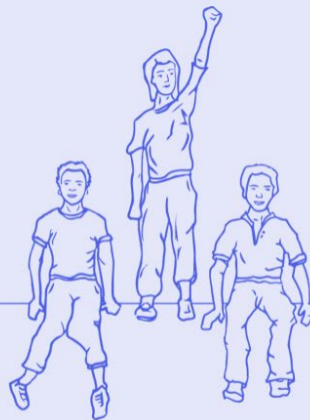
- To base SRH practices on the best available published evidence and recommendations
- To address misconceptions regarding SRH services
- To reduce medical barriers
- To improve access and quality of care in SRH

www.ippf.org/cccg

Service Areas



Thank you



Preliminary Findings from R4S self-care studies from a user perspective



Self-care in family planning: Understanding end-user perspectives



JUNE 2023



1

Background

Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker. (WHO Guideline on Self-Care Interventions)

People-centered framing*



Capacity to make decisions and to make use of available resources

Health-system centered framing*



Self-injectable contraceptives; oral contraceptives; emergency contraception; male and female condoms; diaphragm; foam/jelly; SDM; LAM

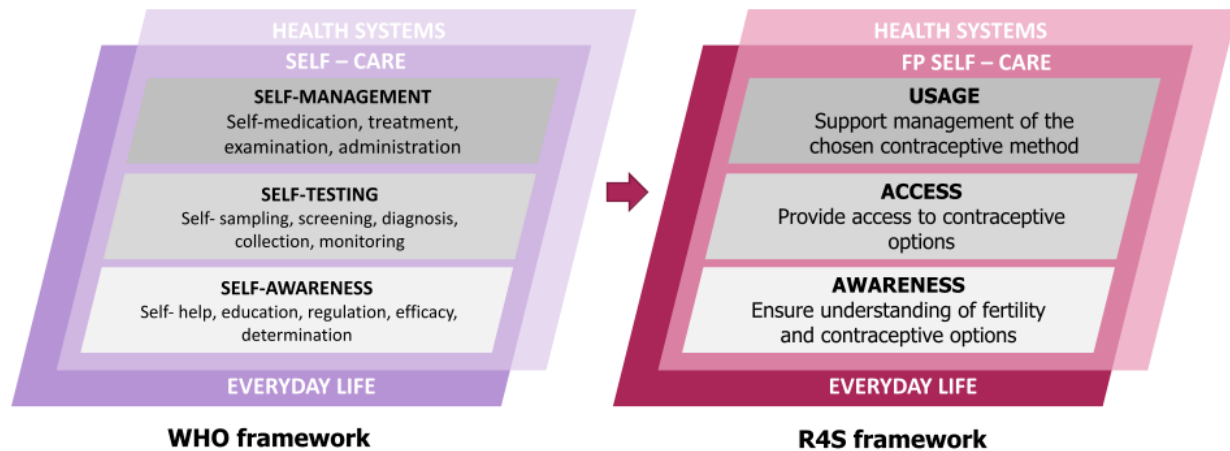


Family planning information found online or on mobile phone apps

*Narashiman M, Allotey P, Hardon A. Self care interventions to advance health and wellbeing: a conceptual framework to inform normative guidance. BMJ 2018;365:l668

➤ R4S FP self-care framework






- Exploration of FP self-care under R4S is:
 - **Holistic:** spans the three stages of self-care adapted from WHO
 - **Inductive:** accounts for contextualized understanding of family planning self-care



Methods

Study 1: Explore understanding of self-care and describe FP behaviors and preferences

Cross-sectional, mixed method study including a survey with women and men and in-depth interviews (IDIs) with women, men, and providers in Nepal, Niger and Uganda and IDIs with community leaders in Niger

			
 Women	430	510	374
 Women	35	30	36
Men	19	13	20
Providers	12	10	12

Study 2: Examine interests and preferences related to FP self-care interventions

Addition of a mini-module of 21 survey questions to the PMA female questionnaire








Kenya (n=9,271)



Kano (n=1,121)
Lagos (n=1,291)



› Scope of the presentation

	Study 1			Study 2	
	<div> <div>  IDIs </div> <div>  Surveys </div> <div>  </div> </div>			<div> <div>  PMA mini-module </div> <div>  </div> </div>	
1. Overall understanding of self-care	X	X	X		
2. Deep dive into each stage (awareness, access, usage)					
- Associated family planning behaviors	X	X		X	X
- Preferences related to WHO self-care interventions <ul style="list-style-type: none"> Awareness : Mobile access to information Access/usage : Methods that can be self-administered 	X	X		X	X



Research for Scalable Solutions

Understanding of self-care



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› IDIs with women, men and providers

- Exploration of self-care perceptions

- When I use the term “self-care”, what does that mean for you?
 - How would you describe it when it comes to family planning?

- Provision of a definition when needed

The ability of individuals, families or communities to promote and maintain sexual health and avoid unintended pregnancies with or without the help of a healthcare provider.



› What does self-care mean?

Self-care considered as a **range of behaviors to maintain health and prevent illness** for self, family and community.

- Most described maintaining good personal hygiene, eating nutritious foods, using home remedies or self-treatment for common health problems, but knowing when to go to a provider.

*In other words, **bathing well, cleaning the home and eating healthy food**. The wife must check on the cleanliness of utensils before cooking, and then rinse everything well after serving a meal.*

44-YEAR-OLD MARRIED WOMAN, NIGER

- Some men in Niger and Uganda described self-care as having the economic means to sustain the family.

*Self-care you can be taking care of yourself, you can provide everything for yourself, if it's food **you can buy it**, you have you own house, so **you can provide most of the things** for yourself sir.*

21-YEAR-OLD MARRIED MAN, URBAN UGANDA



› Perceived meaning of FP self-care

- The concept of self-care for FP was **difficult** for some women and men **to conceptualize at first**.
- Most participants suggested that self-care for FP meant **using a method to space children**, although for many, this arose after receiving the WHO definition.

*HOW DO YOUR OWN (FP) EXPERIENCES COMPARE WITH YOUR IDEA OF SELF-CARE? WHY? Yes, it does. But after talking with you I've come to realize that self-care is not only taking care of yourself, it is a lot more. **It is also about using contraceptives, to take care of your all your reproductive health as well.** I got to learn a lot of things I hadn't considered before.*

34-YEAR-OLD MARRIED WOMAN, RURAL NEPAL

- Both **modern** methods and **natural/traditional** ones were mentioned, although method composition differed across countries.



› FP self-care by country



- For some men and women, FP self-care meant obtaining methods outside the clinic – from *traveling salesmen or marabouts* or using breastfeeding (MAMA) or calendar methods. Providers acknowledged these practices but did not approve.

*In my opinion, FP self-care without seeing a provider is **not an option that should be left to the client.***

FP PROVIDER, PUBLIC CLINIC, RURAL NIGER



- FP self-care was often viewed as seeking information and selecting a modern method through a clinic – at least when first initiating FP.
- Some women and providers viewed FP self-care as managing FP appointments, seeking assistance for FP challenges and maintaining proper nutrition while using FP.



*It means that she (a woman) **keeps her appointment dates** for family planning and goes back. **When the time for the family planning method expires, she goes back, when the months she was given elapse, she goes back.***

19-YEAR-OLD SINGLE WOMAN, URBAN UGANDA



› Understanding self-care: Key take-aways

- The concept of self-care does not really exist for many people. When prompted, their definition is quite broad, and relates to general health and wellness.
- For many women, the concept of self-care for FP is hard to distinguish from their perception of FP in general but refers to spacing.
 - Not linked to specific methods.
 - Descriptions seem to emphasize feeling empowered with knowledge to make the right decision/choice for the individual/couple about how to space pregnancies.
- Perceptions of what methods “count” as self-care varied and differed from WHO guidance.



Research for Scalable Solutions

Awareness

Ensure understanding of fertility and contraceptive options

- Fertility awareness – *Study 1*
- Preferences – *Study 1, Study 2*
 - Interest in mobile channels for receiving information
 - Types of information of interest



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› Fertility awareness

	 NEPAL	 NIGER	 UGANDA
	n=430	n=510	n=374
Awareness of, %*			
Age at menarche	98	85	92
Signs a girl is able to get pregnant	95	62	72
First day of menstrual cycle	95	67	62
Length of menstrual cycle	96	71	75
Timing of fertile period	40	12	16
Duration of fertile period	44	43	48
Fertility awareness score**	4.7	3.4	3.6


* Proportion of respondents selecting the correct response from multiple response options read to them

** Additive score based on the number of correct responses across the 6 items (possible range of 0-6)


Interest in additional types of information

? What **types of information** would you be interested in?



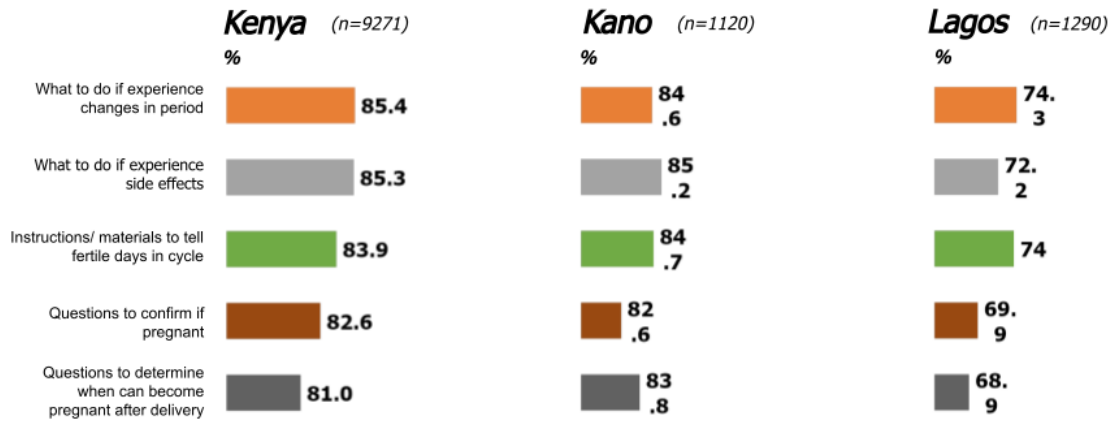
 **NEPAL**
n=430

 **NIGER**
n=510

 **UGANDA**
n=374

> Type of information interested in

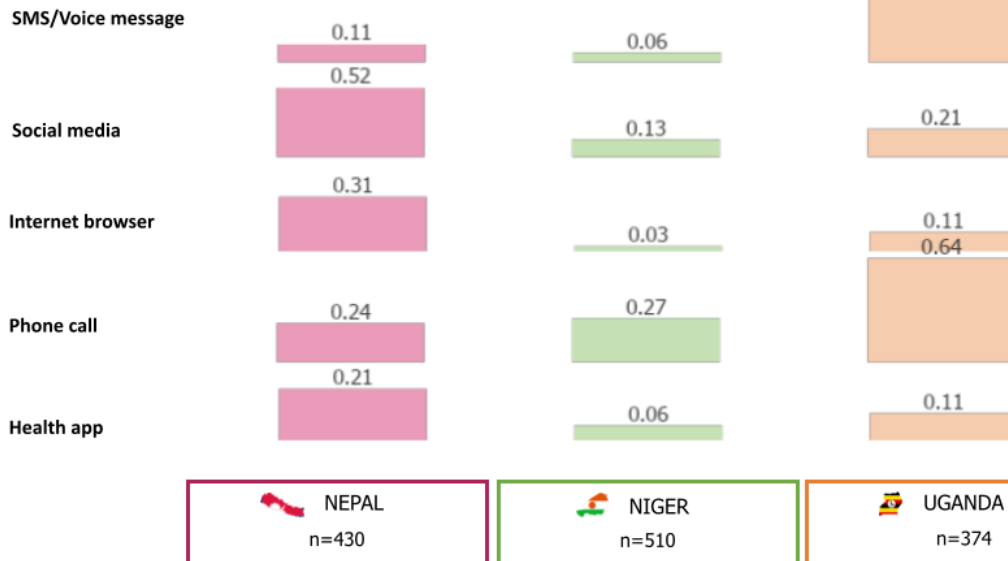
? Would you be interested in getting **information on your own** on...?



*By "on your own", we mean without necessarily having to access or speak to a healthcare provider at a facility

Interest in mobile access to information

? Would you be interested in **learning more about family planning** from:



› Interest in mobile access to information

Kenya

Kano

Lagos

? Would be interested in receiving information* via **voice or text message** on a mobile phone



90%

(n=8348)



90%

(n=954)



88%

(n=1041)

? Would be interested in receiving information* via **social media** such as Facebook, Viber, Twitter, WhatsApp or others



56%

(n=8347)



49%

(n=953)



72%

(n=1040)

*Information may include: series of questions you could use on your own to confirm if you are pregnant, series of questions you could use on your own to determine return to fertility after giving birth, instructions and materials you could use on your own to track menstrual cycle and determine fertile days, information to manage changes to menstrual bleeding you could use on your own, information to manage side effects you could use on your own.



Research for Scalable Solutions

Access

Provide access to contraceptive options

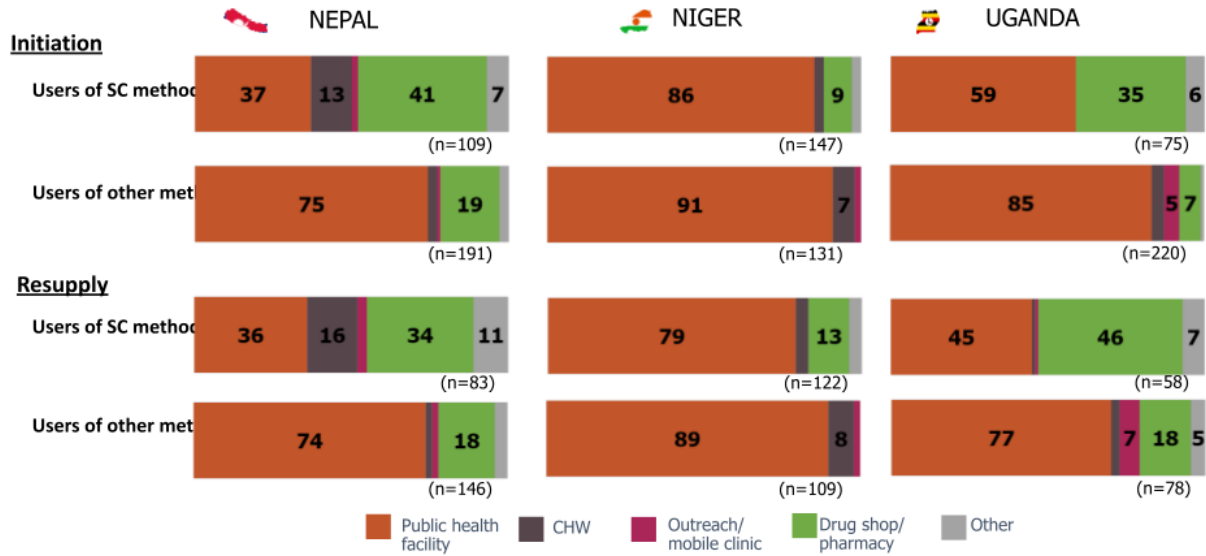
- Source of supply at initiation and resupply – *Study 1*
- Preferences – *Study 1, Study 2*
 - Interest in receiving methods from sources other than health facility and preferred source of supply
 - Importance of engaging with a provider and benefits of engaging/not engaging with a provider



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Source of supply

Among women who are current/recent users of modern contraception:



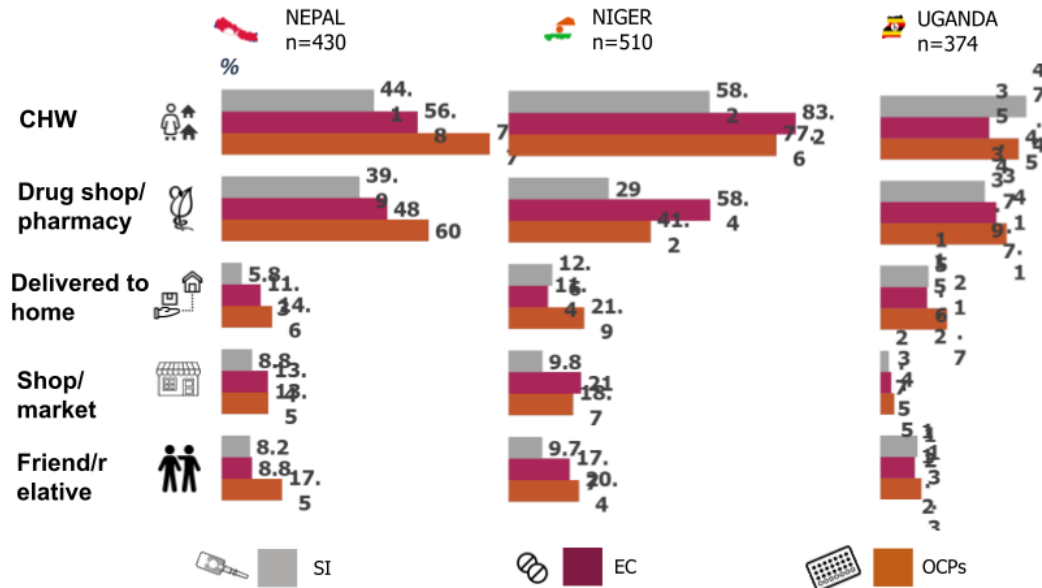
SC methods: Self-injection, pill, EC, male/female condoms, diaphragm, foam/jelly, SDM, LAM.

Other methods: IUD, implant, and injection by a provider

Values below 5% are not labelled

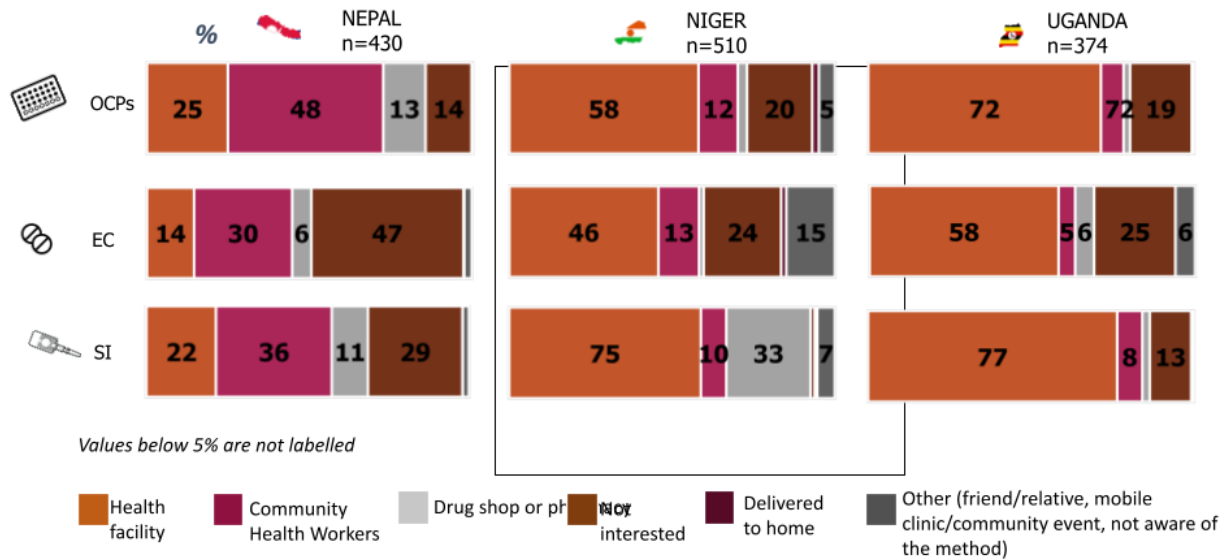
Interest in receiving method from other sources apart from health facility

? Would you be interested in receiving the following method from:

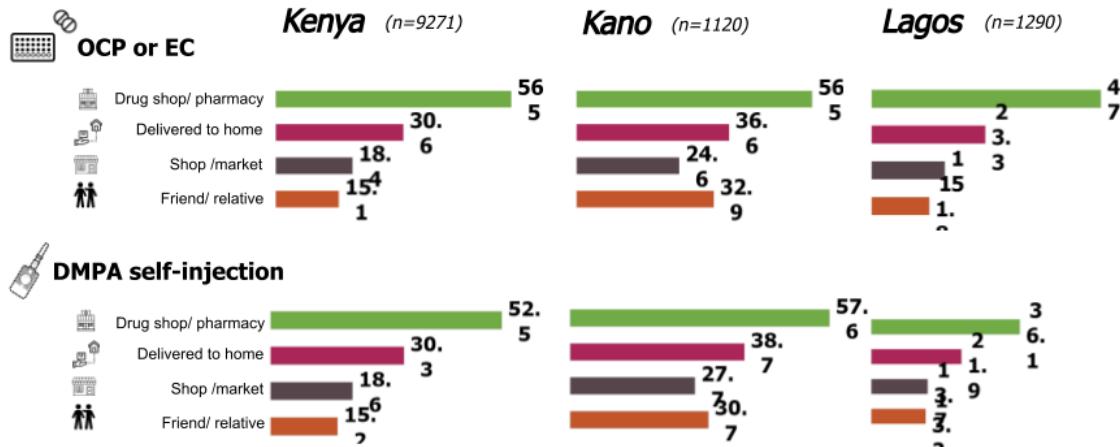


Preferred source of supply

? If you didn't have to pay for the product, where would you most like to obtain:

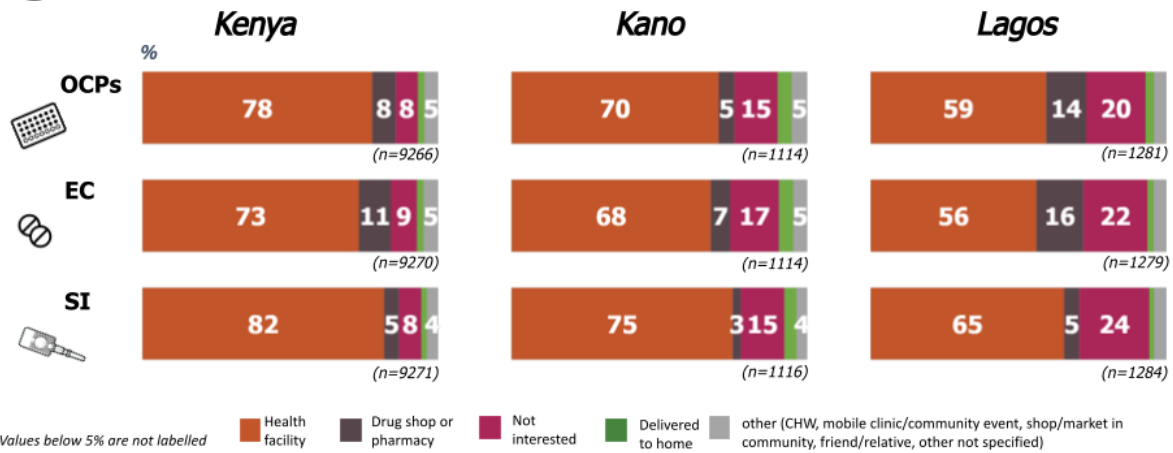


Interest in receiving method from other sources apart from health facility



Preferred source of supply

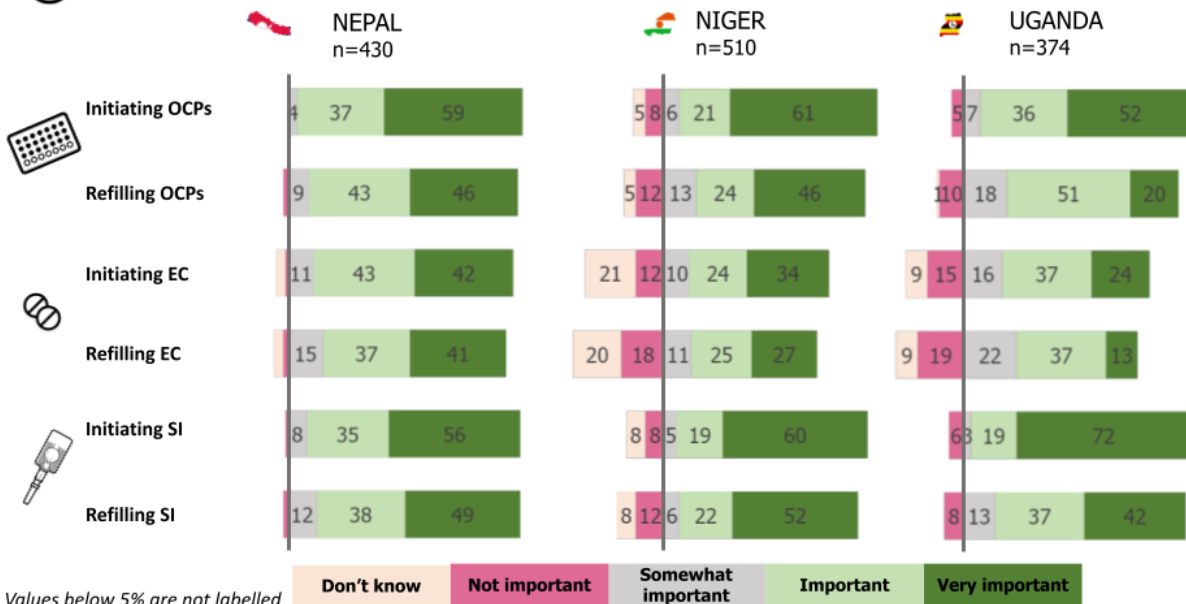
? If you didn't have to pay for the product, where would you most like to obtain:



Perceived importance of engaging with a provider or CHW

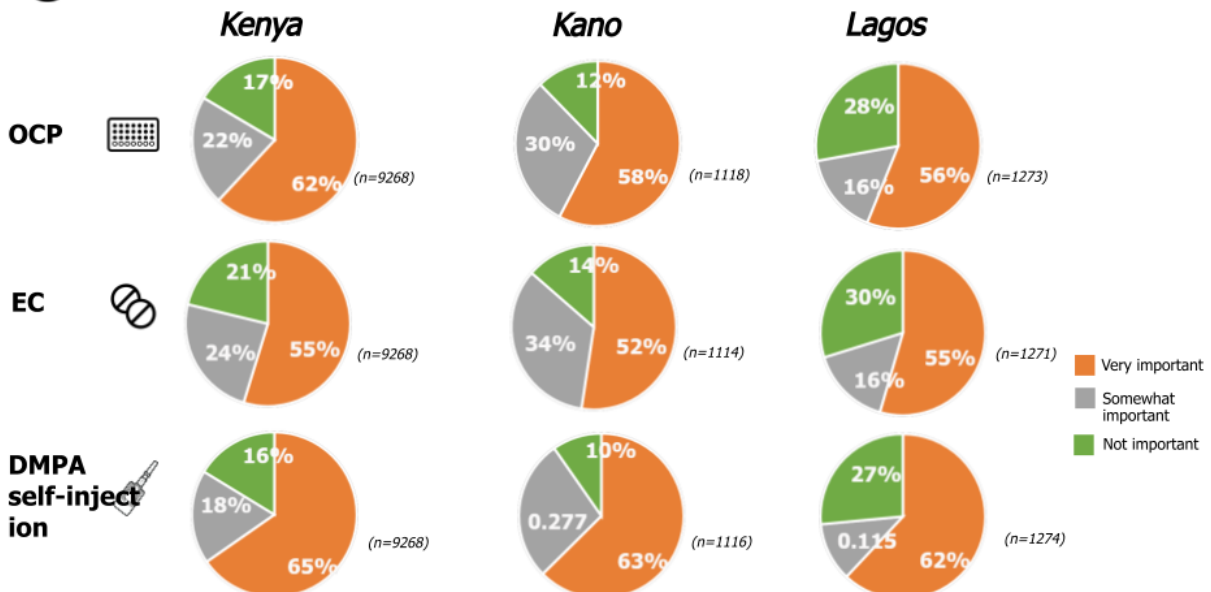


How important is it to involve a provider or CHW when:



Perceived importance of engaging with a provider

How important is it to engage with a provider when starting or while using:



› Benefits of engaging with a provider

Benefits of engaging with provider when starting or while using OCPs, ECs or Inj.

Benefit of engaging	Nepal (%) n=430	Niger (%) n=510	Uganda (%) n=374
Close to home	43	12	2
Saves time	39	7	9
Learn about different methods	35	23	50
Get accurate information	34	27	31
Low cost	33	11	3
Discreet/confidential	30	14	4
Learn how to use selected method	23	39	48
Manage side effects	23	38	37
Get recommendation	13	34	50

*Multiple responses possible. Top 3 reasons noted in bold



› Benefits of engaging with a provider

Top reasons to engage with a provider when starting or while using OCPs, ECs or Inj.

Benefit of engaging	Kenya	Kano	Lagos
Learn about different methods	46.6	25.9	30.3
Learn how to use selected method	42.4	24.4	29.3
Get recommendation	41.8	27.9	35.6
Discrete/confidential	29.5	34.1	11.0
Manage side effects	37.4	31.6	24.8
Close to home	33.9	30.0	10.5
Get accurate information	40.7	28.4	30.9
Low cost	24.9	22.3	8.7

*Multiple responses possible. Top 3 reasons noted in bold



› Benefits of not engaging with a provider

Benefits of not engaging with provider when starting/while using OCPs, ECs or Inj.

Benefit of not engaging	Nepal (%) n=430	Niger (%) n=510	Uganda (%) n=374
No benefit	61	77	34
Lower cost	20	1	13
Discretion/confidentiality	20	3	11
No need to travel/less travel	16	9	22
Saves time	13	7	37
More control	12	1	15
Flexible schedule/Information when I want	6	1	12

*Multiple responses possible. Top 3 reasons noted in bold



› Benefits of not engaging with a provider

Top reasons NOT to engage with a provider when starting or while using OCPs, ECs or Inj.

Benefit of not engaging	Kenya	Kano	Lagos
Saves time	54.1	47.9	25.8
No need to travel/less travel	39.2	27.9	13.5
Lower cost	26.7	20.5	11.3
No benefit	16.3	19.1	35.3
Flexible schedule/Information when I want	18.7	6.6	5.2

*Multiple responses possible. Top 3 reasons noted in bold



Research for Scalable Solutions

Usage

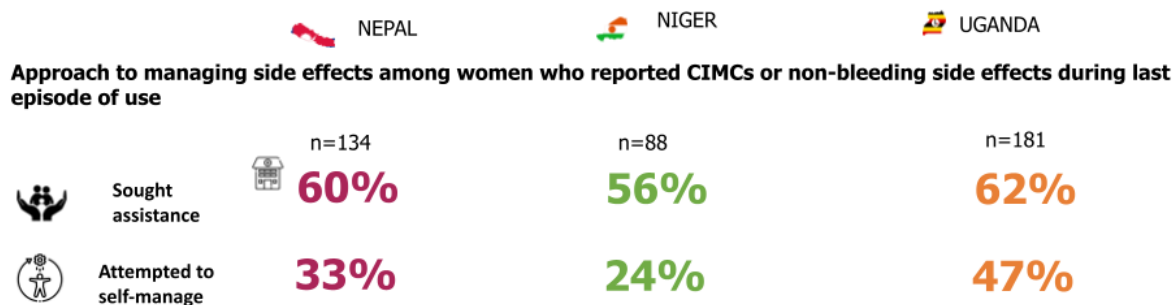
Support management of the chosen contraceptive options

- Self-management of side effects – *Study 1*
- Preferences – *Study 1*
 - Interest in receiving assistance from sources other than health facility to manage side effects
 - Importance of engaging with a provider to manage side effects

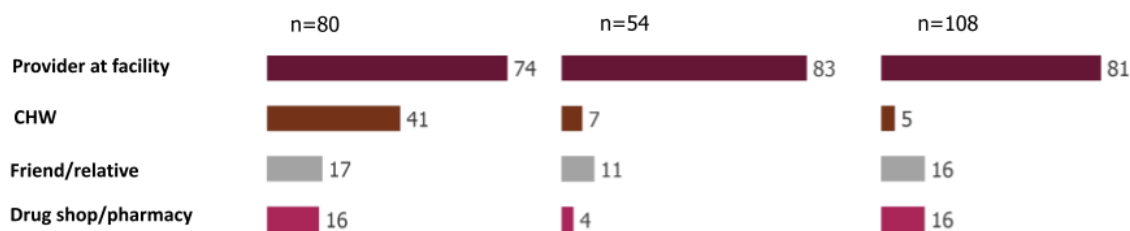


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Side effect management



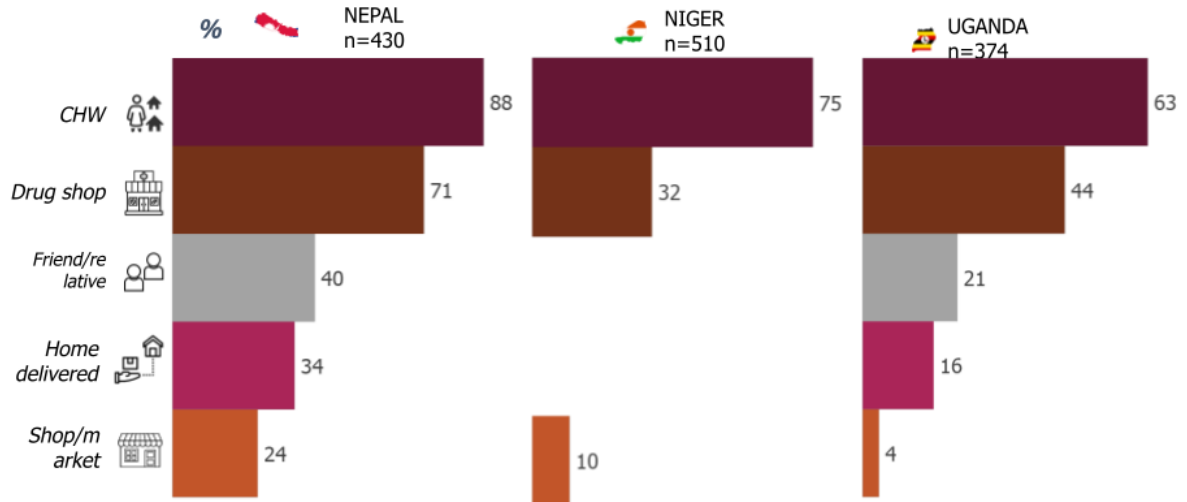
Among women who reported seeking assistance to manage CIMCs or non-bleeding side effects during last episode of use, place sought assistance:



[†]Reduced samples

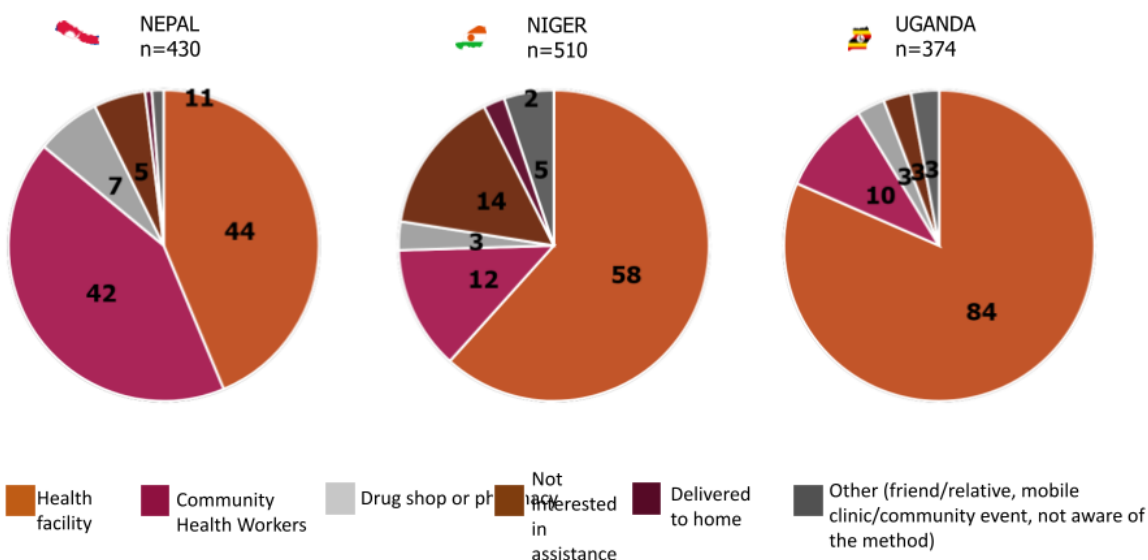
Interest in receiving assistance for side effects management from non-traditional sources

? Would you be interested in getting assistance to manage CIMCs or other side effects from:



Preferred source of assistance

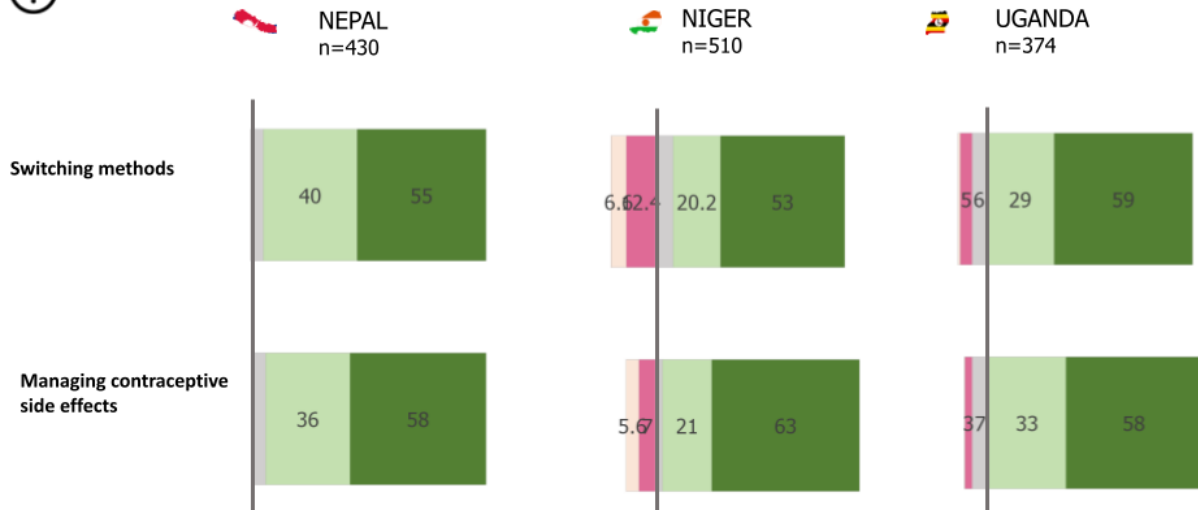
? If you didn't have to pay for this service, where would you most like to get assistance to manage menstrual changes or other side effects?



Perceived importance of engaging with a provider or CHW



How important is it to involve a provider or CHW when:



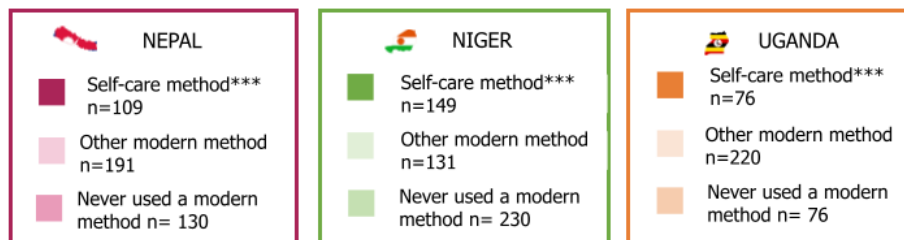
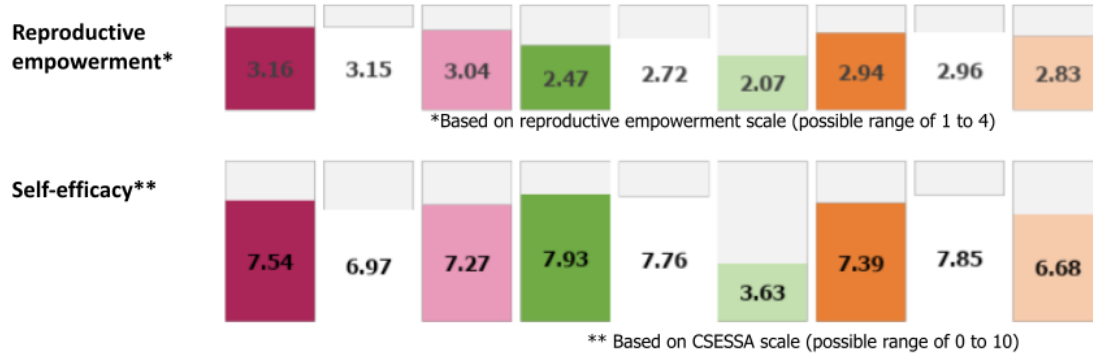
Values below 5% are not labelled

Research for Scalable Solutions



34

RE/SE by method use



***Self-injection, pill, EC, male/female condoms, diaphragm, foam/jelly, SDM, LAM

› Stages of self-care: Key take-aways

- Fertility awareness is moderate —starting point for self-care
- General reliance on and preference for linking to a health facility or to the health system to access methods and to support continuation
 - Some shift to pharmacies/drug shops (Uganda/Niger) and CHWs (Nepal) for resupply
 - Reasons similar to those often cited as barriers to access (e.g., proximity, quality of services, cost)



› Stages of self-care: Key take-aways

- Interest in more information on fertility, methods and side effects, and “windows of opportunity” for using mobile/digital technologies
- Some windows of opportunity to include new channels.
 - Drug shops, but also home delivery, market, friend.
 - Would likely need to fulfill needs similar to those being met by providers.
- No clear relationship between RE/SE and method use other than in Niger (especially for SE).
 - Surprising? Or related to little perceived difference for women between SC and FP more broadly?



› Implications



Policy and programs



Development and content of self-care guidelines



Enhance awareness of self-care among individual men, women and communities



Clarify role of providers in supporting self-care



Popularize access points for self-care interventions including CHWs, drug shops, and digital



Research



Role of empowerment/self-efficacy in self-care



Better understanding of reasons WHY people prefer interaction with providers, and WHO the people are who don't want to engage with a provider and WHY



› Anticipated timeline for publications

Study 1 – Mixed-method study

- Manuscript on qualitative findings on understanding of self-care with planned submission to *Lancet Global Health* or *SRHM* in September 2023
- Manuscript on mixed-methods findings on behaviors and preferences aligned with stages of self-care with planned submission to *PlosOne* in September 2023

Study 2 – PMA module

- Single manuscript with planned submission to *GHSP* in July 2023



Literature review on Self-Care

Literature Review Findings

Self-care

Maria A. Carrasco and Beth Larson

Reviewed by TAG members: Chris Gallavotti, Baker Maggwa, and
Caroline Kabiru

6/12/2023



Content

- WHO self-care guidelines
- Literature review
- Self-care critique
- Questions for the TAG



WHO Self-Care Guidelines



Self-care - Definition and Framing

“Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability **with or without** the support of a health worker.”

- Self-care interventions represent a significant push towards greater **self-determination, self-efficacy, autonomy and engagement** in health for self-carers and caregivers.
- Support the health system
 - Support over stretched health systems during humanitarian crisis or pandemics (i.e. COVID-19 pandemic)
- Critical components on the path to reaching universal health coverage (UHC)

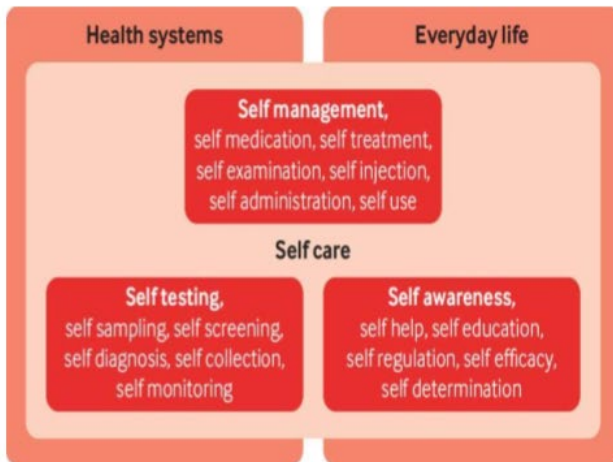
Source: [WHO guideline on self-care interventions for health and well-being](#)



Self-care interventions

Self-care interventions are evidence-based, quality drugs, devices, diagnostics and/or digital products which can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health care personnel.

Self-care in the context of interventions linked to the health system



Source: Narasimhan M, Allotey P, Hardon A. Self care interventions to advance health and wellbeing: a conceptual framework to inform normative guidance BMJ 2019; 365 :l688 doi:10.1136/bmj.l688



Source: [WHO guideline on self-care interventions for health and well-being](#)

Insights from what is included under self-care

FIG. 2.5. PLACES OF ACCESS TO SELF-CARE INTERVENTIONS



FIG. 1.4. EXAMPLE OF A WHO-RECOMMENDED SELF-CARE PRACTICE DURING THE COVID-19 PANDEMIC – HAND HYGIENE



- Certain “places” of access to self-care interventions overlap (rather than enhance) some of the HIP briefs
 - [Digital Health for SBC](#) HIP brief and Digital technology platforms
 - [Community health workers](#) HIP brief and Community
 - [Pharmacies and drug shops](#) HIP brief and Pharmacies
- Bringing self-care under the umbrella of the health system causes overlap with HIPs SBC domain

Insights from WHO Guidelines - FP section

- 8 main recommendations
- Most (7 of 8) recommendations are on **self-management**
 - **Self-injection**
 - **Unscripted over the counter OCPs**
 - **Unscripted over the counter EC**
 - **Ovulation predictor use to self-manage fertility**
 - **Multi-month scripting of OCPs**
 - **Correct and consistent condom use (also self-awareness)**
- Overlap between what we define as SBC in the HIPs (knowledge, beliefs, attitudes and self-efficacy) and what the WHO self-care guidelines define as “self-awareness”

Providing high-quality services for family planning, including infertility services

Self-administration of injectable contraception

Recommendation 14 Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age.
(Strong recommendation; moderate certainty evidence)

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

Self-management of contraceptive use with over-the-counter oral contraceptive pills

Recommendation 15 Over-the-counter oral contraceptive pills (OCPs) should be made available without a prescription for individuals using OCPs.
(Strong recommendation; very low certainty evidence)

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

Over-the-counter availability of emergency contraception

Recommendation 16 WHO recommends making over-the-counter emergency contraceptive pills available without a prescription to individuals who wish to use emergency contraception.
(Strong recommendation; moderate certainty evidence)

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

Self-screening with ovulation predictor kits for fertility regulation

Recommendation 17 Home-based ovulation predictor kits should be made available as an additional approach to fertility management for individuals attempting to become pregnant.
(Strong recommendation; low certainty evidence)

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

Condom use

Recommendation 18 The consistent and correct use of male and female condoms is highly effective in preventing the sexual transmission of HIV; reducing the risk of HIV transmission both from men to women and women to men in serodiscordant couples; reducing the risk of acquiring other STIs and associated conditions, including genital warts and cervical cancer; and preventing unintended pregnancy.

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

SELF-AWARENESS
Self-help, self-education, self-regulation, self-efficacy, self-determination

Recommendation 19 The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs.
(Strong recommendation; moderate certainty evidence)

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

SELF-AWARENESS
Self-help, self-education, self-regulation, self-efficacy, self-determination

Recommendation 20a Provide up to one year's supply of pills, depending on the woman's preference and anticipated use.

Recommendation 20b Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.

Recommendation 20c The resupply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.

SELF-MANAGEMENT
Self-medication, self-treatment, self-examination, self-injection, self-administration, self-use

Pregnancy self-testing

Recommendation 21 WHO recommends making self-testing for pregnancy available as an additional option to health worker-led testing for pregnancy, for individuals seeking pregnancy testing.
(Strong recommendation; very low certainty evidence)

SELF-TESTING
Self-sampling, self-screening, self-diagnosis, self-collection, self-monitoring

Literature Review



Methods

Search period: Open

Search words: Family planning, self-care, and limited to LMICs

Databases searched: PubMed, Embase, Scopus, LILACS

Grey literature searched: USAID Development Experience Clearinghouse, online searches of websites containing relevant policy implementation research, case studies and guidance will be conducted

Inclusion criteria: LMIC, included the term “self-care” or self-identified as “self-care”

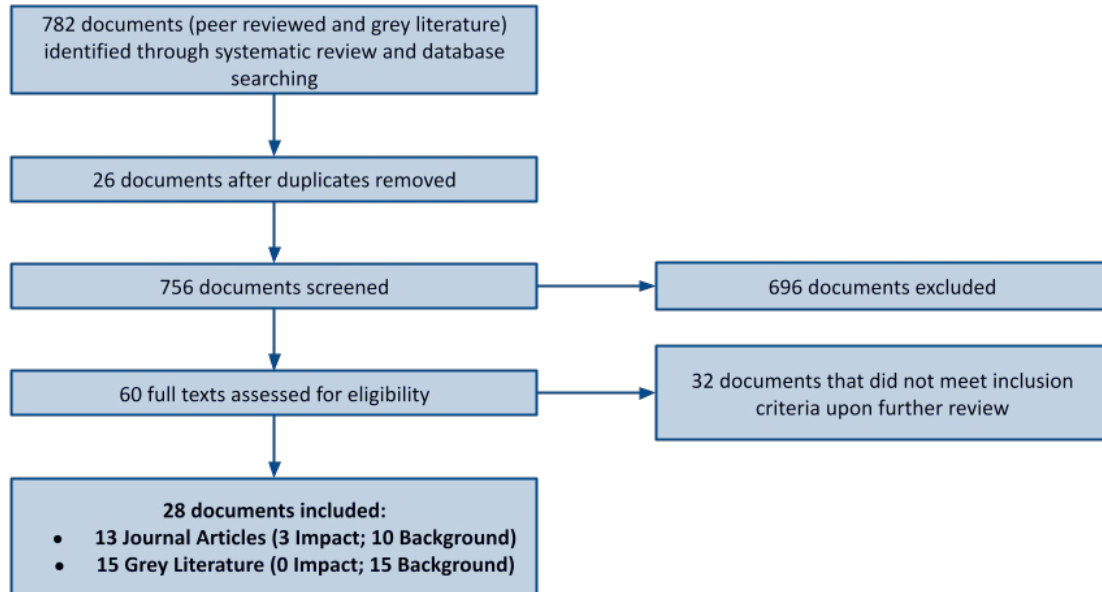
Exclusion criteria: Followed HIP brief writing guidelines but included a separate tab of interventions of “one method” for discussion

Final number of documents included: 28 (3 impact, 25 background)

Number of documents focussing on one method: 72



Document Flow



Summary of Key Themes



Background

- **Experts believe that self-care is key to improving access to family planning services and to promoting client empowerment**
Burke, H.M., et al. 2022; Christofield, M. et al. 2021; Ferguson, L. 2019; Haddad, L.B, et al 2021; Narasimhan, M., et al 2020; PATH 2017; Remme, M. 2019; SCTBG - Igniting a movement 2020; SCTBG - Insights that Ignite 2021; USAID 2020;
- **Paradox between individual power, autonomy, and agency; and marginalisation in, dependency on, and relinquishment of responsibilities of the health system**
Christofield, M. et al. 2021; Ferguson, L. 2019; Narasimhan, M., et al 2020; Remme, M. 2019; SCTBG - Insights that Ignite 2021
- **Experts argue that digital health platforms can support self-care by creating a private source of information**
SCTBG - Digital Health 2020
- Only identified one digital health article that labeled itself as self care (*Hémono, R. et al 2022*)



Background

- **Experts suggest that integration of self-care into the health system is complex, and must include changes to the legal and regulatory landscapes, and/or approaches to service delivery**

Christofield, M. et al. 2021; Ferguson, L. 2019; Haddad, L.B, et al 2021; Narasimhan, M., et al 2020; PATH 2017; PSI 2021; SCTBG - Insights that Ignite 2021; USAID 2020; WHO 2018; WHO 2019

- **Experts suggest that self-care needs to occur adjunct to the health system, not act as a replacement**

Ferguson, L. 2019; Haddad, L.B, et al 2021; Narasimhan, M., et al 2020; PATH 2017; Remme, M. 2019; SCTBG - Insights that Ignite 2021; WHO 2018; WHO 2019

- **At least 10 LMICs have begun to integrate self-care into their national SRH policy, much of which focuses on the self-injection of DMPA-SC**

Christofield, M. et al. 2021; PSI 2021; SCTBG - Policy Mapping 2021; USAID 2020



Benefits and Concerns: Views of SRH Healthcare Providers (Narasimhan, M., et al 2020)

Benefits

- Reduced exposure to stigma, discrimination, and other barriers to access
- Increased uptake of SRHR services
- Increased confidentiality
- Empowerment
- Self-confidence
- Informed decision-making

Concerns

- Insufficient knowledge
- Lack of affordability
- Possible side-effects
- Potential for misuse



QUALITY OF CARE FRAMEWORK FOR CLIENTS AND PROVIDERS IN THE DELIVERY OF SELF-CARE



Self-Care Trailblazer Group 2020

Remaining Questions (PSI 2021)

- What is the cost of self-care to the user and to the health system?
- Who will pay to ensure all people receive necessary interventions without suffering financial hardship?
- How to measure self-care? At what level of the health system?
- Who is in charge of overseeing the efficacy of self-care policy implementation?
- How do you assure, measure and report quality of self-care?
- What investments in health literacy are necessary?



Impact: Havaei, M et al 2019

- **Intervention: Six educational sessions with the goal of improving reproductive and sexual health self-care**
 - Session topics included vulnerability, perceived security, understanding of internal and external rewards, response efficacy and understanding self-efficacy
- **Self-Care Measurement**
 - Reproductive and sexual health self-care questionnaire with questions on, but not limited to, girls' empowerment factors in reproductive and sexual self-care, and self-care knowledge for reproductive and menstruation health
- **Results: Intervention participants had improved sexual and reproductive health self-care immediately following the education session and after one month, when compared to the control group**



Impact: Saggurti, N et al 2018*

- **Intervention:** Self help groups for women who had a live birth in the last 12 months (intervention), in addition to a microcredit intervention (control)
 - Session topics included ANC and birth preparedness, postnatal care, exclusive breastfeeding and supplementary nutrition, routine immunization, family planning, personal hygiene and safe water storage, and usage of toilet and garbage management
- **Results:**
 - **Women who participated in the self help groups were more likely to exclusively breastfeed and use a modern contraceptive method at follow-up than women who only received the microcredit intervention**

* Not clear whether this intervention fits the definition of self-care



Impact: Hémono, R. et al 2022

- **Intervention: Pilot digital self-care intervention providing comprehensive sexuality education and confidential online ordering of contraceptives for school-aged youth in Rwanda**
 - Platform features: Stories, Learn & Shop delivered on networked tablets
 - Self-Service Model: Youth are trained on how to use the platform and how to support their peers
 - Facilitated Model: Peer facilitators guide youth through structured sessions
- **Results:**
 - CyberRwanda platform is feasible and acceptable to students, teachers, pharmacists, and other community members
 - Some parents and teachers not keen on the platform
 - Preliminary indications that platform may improve access to FP/RH information
 - More research is needed to see whether the platform can be effective in increasing contraceptive uptake and reducing early pregnancy
 - Low usage of the ordering feature may be related to fear or embarrassment and lack of money.



One method

- Total Number of Journal Articles & Grey Literature: 72

Method	n	Explored Outcomes	Impact
DMPA-SC	59	<ul style="list-style-type: none"> • Facilitators and barriers to using DMPA-SC • DMPA-SS continuation rate • Satisfaction • Men's attitudes toward DMPA-SC • Competence to self-inject • Adolescents' views on DMPA-SC • DMPA-SC disposal practices • Reasons for DMPA-SC discontinuation • Experiences associated with DMPA-SC self-injection • Provider perceptions of DMPA-SC self-injection • Cost-effectiveness 	<ul style="list-style-type: none"> • Self-injection with DMPA-SC is feasible and accepted after women receive correct counseling • Self-injection can increase access and use for adolescents • Self-injection has higher 12-month continuation rates than injectables provided in health facilities • DMPA-SC is cost effective when compared to DMPA-IM • After initial increases in DMPA-SC prevalence, its usage has stagnated or decreased in some settings • Health systems barriers include limited availability of health workers to train on self-injection



One method

- Total Number of Journal Articles & Grey Literature: 72

Method	n	Impact
EC	4	<ul style="list-style-type: none"> • Adolescents have limited knowledge of EC • Advanced provision did not have negative outcomes on SRH behaviors and did not reduce pregnancy rates, when compared to conventional provision
Pills	4	<ul style="list-style-type: none"> • Users ability to self-screen with regard to contraindications to combined oral contraceptive pills is comparable to nurses
TwoDay Method	2	<ul style="list-style-type: none"> • Efficacy compares well with other coitus-dependent methods
Vaginal Ring	1	<ul style="list-style-type: none"> • Acceptable method in urban African settings
Female condom	1	<ul style="list-style-type: none"> • Mixed perceptions of female condoms from health worker



Self-care in other health areas



HIV

- Not framed as “self-care” but management of chronic HIV, condom use, HIV self-testing fall into WHO self-care definition
- Treatment framed as [differentiated service delivery](#)
 - Differentiated service delivery (DSD), previously referred to as differentiated care, is a **client-centred** approach that simplifies and adapts HIV services across the cascade to reflect the preferences, expectations and needs of people living with and vulnerable to HIV, while reducing unnecessary burdens on the health system.
 - There is [some guidance](#) on the need to integrate FP into DSD.

Self-management of chronic, non-communicable diseases

- Vast literature in [self-management of chronic disease](#), particularly among older adults in high income settings
- Several [evidence based education programs](#) for self-management of chronic disease
- [Frameworks](#) used in countries in OECD

	Patient Education Programmes	Training for HCPs	Awareness raising	Accessibility of SMS	Technology to support SMS
QLD	Provide evidence based programmes	Provide education and training	Social marketing campaign	Provide suitable SMS	Consumer personal health record
WL	Generic and disease specific	Skills training	Provider awareness of programmes	SM information in various formats, signposting	Technology for reminders, self-monitoring, follow-up
WA	Coordinated SMS programmes and services	Curricula, professional development, mentoring	Marketing strategy, framework endorsement	Easy referral pathways, flexible delivery of services	Website for all stakeholders
MB	Telecare programme prioritised	–	Provider awareness of programmes	Research suitability for different groups	Online health portal
TAS	Make programs available	A range of training options, evidence-based practice	Provider awareness of programmes	Provide range of flexible resources	Range of resources including online
NT	Build capacity	Training and access to evidence-based practice	Framework endorsement	Clear referral pathways, SM information through various mediums	Electronic client record, SMS through online and other media
IRL	Map and increase provision of generic and disease specific	Curricula, professional development	SMS communication plan	Resources to account for health literacy, signposting	IT systems to support delivery, electronic patient record

Questions for the TAG



Guidance for writing group

- What is the high impact practice enhancement? What should be included in the brief?
 - Should the focus be on only one aspect of self-care (i.e. self-management) where there appears to be more literature?
 - How do we avoid overlap with other briefs?
- What should NOT be included in the brief?
- Is it OK to include studies that are only one method?
 - This would be an exception to our Guidelines to Write a HIP brief and the reasoning for making an exception would need to be documented in the brief
- Do we move forward with the brief now or pause?
- How to ensure that self-care is framed as client-centered?
 - What is the best framing to ensure a empowerment-based approach?

Source: [WHO guideline on self-care interventions for health and well-being](#)



Guidance for researchers

- What are some of the evidence gaps?
- Is there any specificity needed in the three domains of self-management, self-testing and self-awareness?
 - If so, what could be some unintended consequences of the focus on the “self” and what could be done to avoid those unintended consequences?

Discussion



Evaluation of Literature in WHO Guidelines (2019)

Chapter	Number of Citations	Included	Duplicate	Excluded: One Method	Excluded: Not LMIC	Excluded: Not FP	Excluded: Not Self Care	Excluded: No Impact
1	33	1	1	0	1	14	14	0
2	20	0	1	0	0	16	3	0
3	5	0	0	2	0	3	0	0
4	72	0	5	4	3	46	14	0
5	61	0	4	0	0	54	1	2
6	4	0	1	0	0	3	0	0
7	2	0	0	0	0	2	0	0

Self-care trailblazers' presentation on self-care in FP and its operationalization in self-care policies



The Self-Care Trailblazer Group

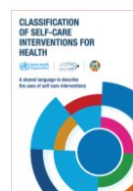
Expanding the safe and effective practice of self-care

Presentation to the HIPs TAG Meeting
June 2023



A Brief History of the Self-Care Trailblazer Group (SCTG)

WHO defines self-care as the ability of individuals, families and communities to promote their own health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health worker



2019

2020

2021

2022

Interest in self-care has exploded in recent years



SHARED MISSION AND VISION

MISSION

The SCTG is a **global coalition** dedicated to expanding the safe and effective practice of self-care so that individuals can better manage their own health, health outcomes are improved, and health systems are better equipped to achieve **universal health coverage**

VISION

A world where the practice of self-care leads to a more **inclusive, equitable, and people-centered approach** to optimizing health and well-being across the globe

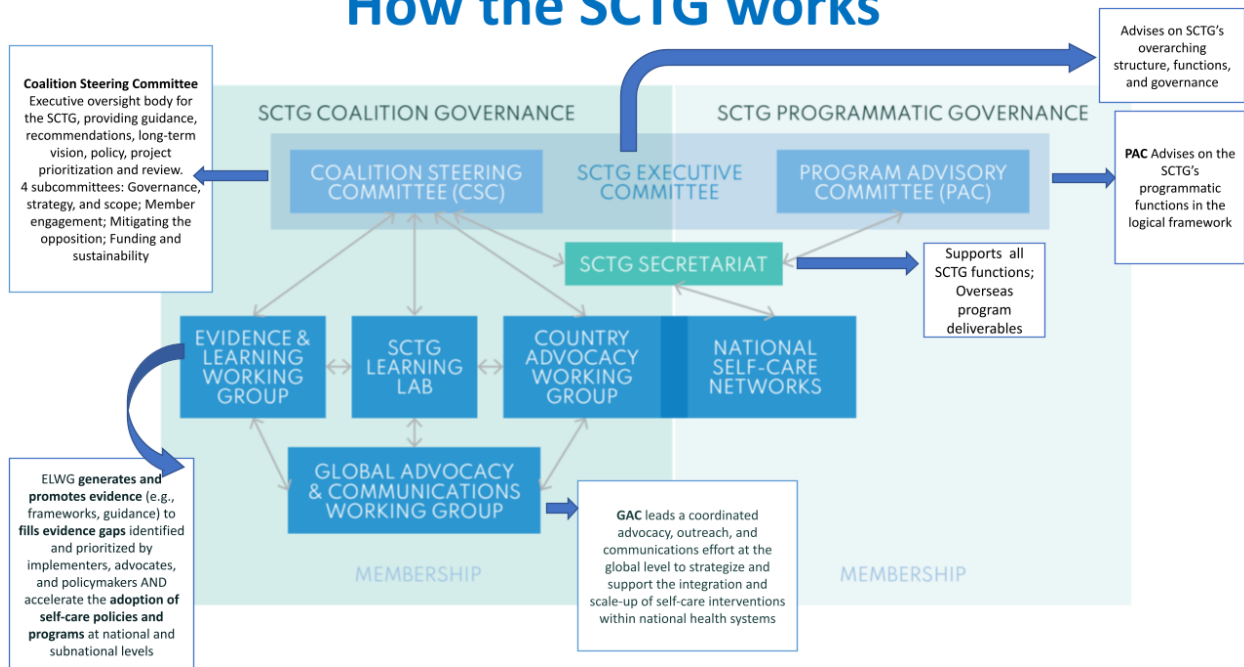
SCTG STRATEGIC PLAN 2021-2025 GOAL AND OUTCOMES

GOAL

Self-care is institutionalized into policy and integrated into national health systems.

Outcome 1	Outcome 2	Outcome 3	Outcome 4
A coordinated, diverse, and influential self-care movement is mobilized around common goals	Awareness and support for quality, evidence-based self-care increases among target audiences	Self-care policies and financing are instituted at national and subnational levels	Demand and accountability for self-care increases among target communities and constituencies

How the SCTG works



The Self-Care Trailblazer Group

Key Achievements



THE SCTG TODAY

772 total members
CAWG: 354
ELWG: 539
GAC: 379

302 Member organizations
390 Institutional members
375 Individual members
87 Countries currently represented within the SCTG
63 Percentage of members from the Global South
Types of stakeholders represented (advocates, academic/research, civil society, donors, MOH, NGOs, implementers, youth, private sector, etc)

9



Global Advocacy and Communications

SCTG's achievements at the global level include:

1. Making Commitments to advance self-care e.g.,
 - [FP2030](#) and the [Generation Equality Forum \(GEF\)](#) commitments
 - Partnering with the Global Self-Care Federation and other organization towards a *WHO Resolution on self-care in 2024*
 - *Advocating for the inclusion of self-care in the UHC 2030 agenda*
2. Developing and disseminating a wide range of advocacy publications and tools to equip self-care champions with the resources e.g.,
 - Self-Care for UHC [Advocacy Toolkit](#), published in 2022
 - SCTG Monthly Newsletter that reaches 400+ members and nearly 3,000 external partners
 - SCTG website, with various resources on self-care, features and blogs from members
3. Generating global awareness of self-care and strengthening SCTG thought leadership through:
 - Regular communications across its digital channels - the SCTG website and social media accounts on Twitter, Facebook, and LinkedIn
 - Organizing regular campaigns and special e.g., 12 Days of UHC Campaign, Self-Care month, at conferences
 - MoU with professional associations e.g., International Midwives Association, IAFM



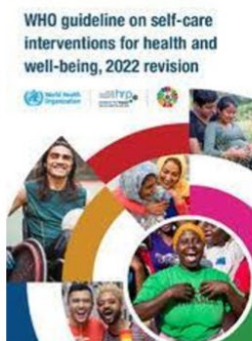


Evidence and Learning



Evidence-Based Guidance: Self-care policy, measurement, and evidence gaps. Priorities of self-care stakeholders

*The WHO guideline provides global guidance on evidence-based self-care.
ELWG aims to generate complementary evidence on the extent to which the guideline is being implemented and measured at the country level, and where evidence gaps exist*



To what extent is the WHO's self-care guideline reflected in policy at the country level?

How can we efficiently map a country's self-care policy environment?

How is self-care monitored and evaluated?

Do we have indicators for measuring the impact of self-care in SRH?

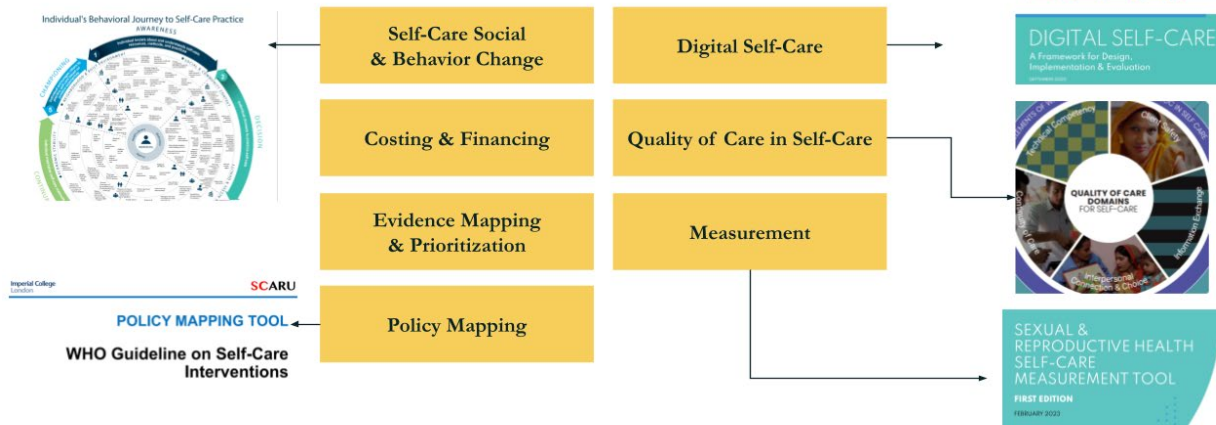
What is the current state of the evidence on self-care? Where are their important gaps in evidence, and which of these gaps are highest priority for future research?

Research commissioned or supported by ELWG



At its initiation, ELWG identified key bodies of work based on members' priorities

ELWG has since developed conceptual models, frameworks, and tools, and commissioned research across 7 priority areas of self-care evidence



WHO's Conceptual Framework for Self-Care

1. WHO's Conceptual Framework for Self-Care Interventions provides a solid basis for health practitioners to consider the important elements in introducing and scaling up self-care practices
2. It uses a people-centered approach together with a health systems' focus, incorporating places of access and the enabling environment to encourage individuals to practice self-care.
3. The framework recognizes that:
 - A supportive and safe enabling environment for the introduction of self-care interventions is essential
 - The health system supporting people for self-management of health conditions is an integral part of self-care
 - Accountability of the health sector is a key factor in the equitable support to quality self-care interventions.



Measuring impact at country level using Country Monitoring Dashboards



- The aim of the dashboard is to document the status of self-care in SCTG priority countries (Kenya, Nigeria, Senegal, Uganda). The dashboard documents progress in self-care in SRHR, contraception, abortion care, HIV, other SRHR services, NCDs
- Data is collected through review of relevant policies, guidelines and reports; with input from all key stakeholders in five thematic areas: laws, legislation and policies; regulatory approvals; service delivery practices; practice in the community; and political commitment
- The dashboard is compiled bi-annually (June and December)
- MOH-led TWGs and the NSN leads are responsible for identifying indicators, collating and verifying data, and endorsing final report
- Going forward: Simplify the tool, include visuals/graphics and link to the national HIS. This will enable us to compare countries and share lessons.

Self-Care Learning and Discovery Series (SCLADS)

- The SCTG held the inaugural SCLADS in 2021
- In 2023, SCTG will hold a re-imagined SCLADS:
 - Three-week-long, virtual mini-conference format (October 30th-November 17th)
 - 3 tracks - research, advocacy and program/implementation
 - Approximately 15-18 highly interactive, 90-minute sessions
 - **Priority Themes**
 1. Innovative Self-Care Interventions and Approaches
 2. Self-Care Quality of Care and User Experience
 3. Health Systems, Health Workforce, and Self-Care
 4. Enabling Environment for Self-Care
 5. Self-Care in Humanitarian, Fragile, and Crisis Settings
 - Call for abstracts/session proposals and abstract reviewers - week of June 12th
 - **Target audiences:** researchers, implementers, advocates, academia, health providers, government officials, journalists, community leaders, private sector representatives, product developers, feminists, youth champions, donors, and more



State of Self-care Report 2022

Progress and potential of self-care: taking stock and looking ahead

- The report aims to take stock of the sexual and reproductive health self-care field and document its progress
 - to highlight the achievements made to date and underscore opportunities for further advancing self-care
 - provide a resource for global and national advocacy, to inform implementation of self-care guidelines, as well as disseminate the evidence generated by the ELWG and other learning exchanges
- The report is organized in **4 sections**:
 - **Section 1: Self-Care Basics**
 - **Section 2: Where Self-Care Policy, Enabling Environment, Practice, and Program Strategies Meet** - lessons from a selection of SRH self-care interventions across a variety of settings
 - **Section 3: Measuring and Monitoring Self-Care Practices**
 - **Section 4: Looking Ahead**
- Several themes have emerged and continue to resonate with stakeholders:
 - Moving **from pilot to scale-up** of self-care practices
 - Ensuring that self-care is clearly articulated and strategically incorporated into **the UHC agenda**
 - Linking self-care more intentionally to **Health System Strengthening (HSS)**
 - Ensuring **sustainability of self-care** efforts
 - Building **political will and financial commitment** to self-care
 - **Financing of self-care**, including through national budgets, global commitments, and philanthropic efforts
 - **Engaging the private sector** more intentionally at key stages of the self-care journey



Self-Care policies and financing at national and subnational levels



The SCTG has partnered with 5 unique National Self-Care Network (NSN) Leads

- to support institutionalization of self-care into policy and national health systems, piloting and implementing national self-care guidelines in Ethiopia, Kenya, Nigeria, Senegal, and Uganda



Center for Health, Human Rights Development

Ugandan advocacy organization addressing human rights and health systems in East Africa with a focus on SRHR. Credible national and sub-national advocacy work.



Nigeria Chapter of WRA dedicated to activating a people-led movement for reproductive health. Focused on citizen-led accountability and adolescent health, and member of the Nigeria Self-Care TWG (*Self-Care Think Tank*)



Ethiopia Society of Obstetricians and Gynecologists (ESOG)



PATH Senegal. International NGO with a focus on strengthening health systems in Senegal. International leader in self-care.



Reproductive Health Network Kenya
Kenya NGO focused on bringing together public and private health workers in SRHR



Progress across focus countries



Uganda
(CEHURD)

1. **National Self-Care Guidelines** developed in collaboration with MOH & partners. Piloted in Mukono District in 2022. Dissemination of key findings on-going and will inform scale up decision.
2. Key findings of pilot:
 - Self-care has the potential to improve access to SRHR
 - Health workers positive about scaling up self-care
 - There is limited knowledge about self-care in the community
3. **Strong SC Expert group**, bringing together diverse stakeholders, incl professional health associations.
4. Self-care guidance incorporated into **key policies** (National Adolescent Health Policy and Strategy, National SRHR Policy, Uganda Clinical Guidelines and National Essential Medicines list, FP Costed Implementation Plan 2021/22 - 2025/26)
5. Advocacy to include self-care in **Uganda's Clinical Guidelines** and **National Essential Medicines list**

Progress across focus countries



1. **National Self-Care Guideline for Sexual, Reproductive and Maternal Health** finalized, approved and launched by FMOH in 2021, domesticated in 19 states, implementation in 3 states (Bauchi, Oyo and Niger states). Several other states are implementing selected elements of self-care that are incorporated into RH, HIV or malaria programmes (HIVST, DMPA-SC...)
2. National **BCC and Demand Generation strategies for self-care** developed and disseminated in 36 states
3. **Sub-committees for self-care** established by FMOH and Self-Care Think Tank to advance policies at national and sub-national levels
4. FMOH is leading the development of a **M&E Framework for self-care** with the aim of including self-care indicators in the national health management information system (NHMIS)

Progress focus across countries contd.



1. **National Self-Care Guideline** finalized in 2021 and validated in December 2022 - goes beyond SRHR and is in line with WHO's 2022 Guideline.
2. Focus on advocating and **mobilizing support** from MOH and partners for funding and implementation of the guideline and continuing to generate evidence to support the value of self-care to the health system
3. Technical support provided in collaboration with MOH to **incorporate self-care** into two key policies
4. Documenting the 2-year experience of developing the guidelines and sharing learnings through - learning exchange, regular meetings of Pioneers Group, webinars on SC etc.

Progress focus across countries contd.



Kenya
(RHNK)

1. Kenya **Family Planning Self-care Guidelines** and **Reproductive Health Self-care Guidelines** drafted and validated. To be launched in June 2023
2. The SCTG NSN lead:
 - Conducted a **legal and policy landscape and stakeholder analysis**
 - Supporting **MOH-led Self-Care Technical Working Group** with identified stakeholders
 - Creating awareness and building support for advancing self-care policy and practice
 - Initiated the piloting of National Guideline for Self-Care in Reproductive Health in Bungoma County

Ethiopia
(ESOG)



1. **National Self-Care Guideline** is currently undergoing validation by the Federal Ministry of Health.
2. February 2023 – SCTG engaged the Ethiopia Obstetrics and Gynecological Society (**ESOG**) as the NSN lead for Ethiopia
3. The Ethiopian MOH agrees to form a NSN as a subgroup of the MCH TWG, with 60 members, to lead self-care advocacy and guide implementation of self-care activities
4. NSN members will include MOH, ESOG, WHO, Engender Health, PATH, Ipas-E, PSI-E, Pathfinder, Ethiopian Midwife Association, MSI-E, AMREF, Consortium of RH Associations, Ethiopian Public Health Association, and Ethiopian Public Health Institute among others

Highlights of SCTG's 2023 Plan

1. *Accelerate dissemination of key achievements/learnings of the SCTG* and their contribution towards institutionalization of self-care in country health systems and to achieving UHC
 - Annual Member Summit (June 2023)
 - Webinar to launch State of Self-Care Report (July 2023)
 - Mini-conference of the Self-Care Learning and Discovery Series (SCLAD) (November 2023)
 - Quarterly meetings of ELWG, GAC and CAWG to share learnings and disseminate ELWG and GAC tools
 - Disseminate lessons from SCTG programming and the SCTG model at critical global moments, including in conferences, through webinars, peer review journals, the SCTG newsletter and website and other fora.
2. On the programmatic front - work with NSNs, CAWG, GAC, ELWG and members to *accelerate the achievement of key deliverables* globally and at country level, including:
 - Contribute to multi-partner effort to *support the adoption of a WHA Resolution on self-care*
 - Complete the *Costing and Financing workstream*
3. *Develop strategy for moving the SCTG to the next level*



Conclusion

- The SCTG is committed to advancing self-care and its potential to promote the achievement of Universal Health Care (UHC) by enabling more people to access health services while contributing to reducing the burden on the health workforce and health systems
- The SCTG is also committed to supporting the development of resources that position self-care as an essential part of the health system and welcome the opportunity to develop a High Impact Practice or an Enhancement Brief on self-care.

“When it comes to family planning, we know that the most effective system is one that covers the broadest range of contraceptive choices – including self-care options”

Dr. Samukeliso Dube, Executive Director, FP2030



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SPG Guidance



HIP SPG Guidance

Maria Carrasco
TAG meeting 6/13/2023



SPG vs. HIP Brief

- See [HIP product table](#) for differences
- SPG is a 4 page paper summarizing how to achieve a strategic objective.

Example

“This document is intended to lead program managers, planners, and decision-makers through a strategic process to identify effective investments for engaging men in efforts to improve sexual and reproductive health. In this guide, male engagement refers to the involvement of men and boys in family planning programs across life stages, including addressing gender norms and gender equality.”

SPG guidance provided to writing teams

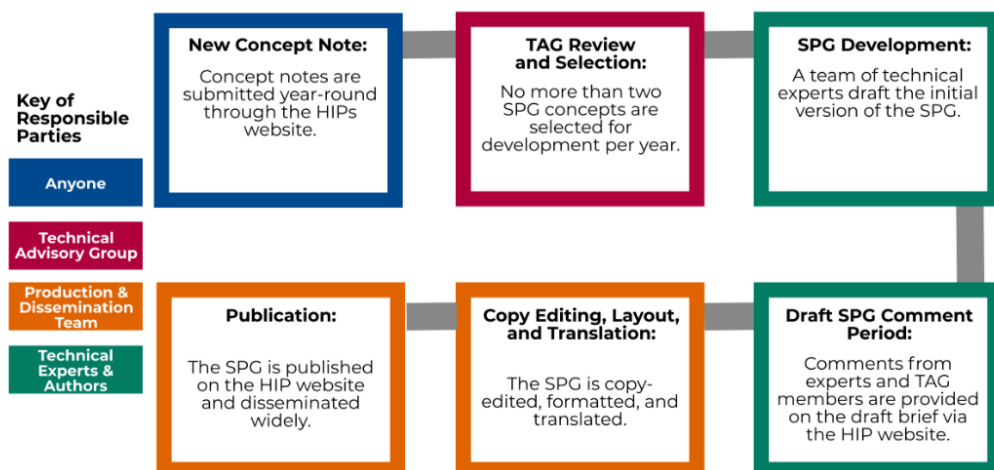
- [SPG guidance](#)

What is an SPG?

What is the format of an SPG?

Process

[SPG Guidance](#) on HIP website



Contrast with HIP brief development process



Decision 1: TAG review of draft

- Currently TAG does not review
- Update: Should we add a step for TAG review?
 - Does it need to be in plenary?
 - Can it be done by a sub-group?

Decision 2: Who works on the SPG

- Currently: Group that submitted the concept note develops it with some funding from co-sponsors
 - Group is encouraged to follow a participatory process to integrate diverse stakeholders
- Update: Is there any guidance on who should be engaged?

Decision 3: Small group to work with Maria

- Update current file and post on HIP website



 fphighimpactpractices.org

HIP criteria tool

HIP Evidence Criteria: Proven vs. Promising

Sub-group: Karen Hardee, Michelle Weinberger, Saad Abdulmumin,
Caroline Kabiru, Maria Carrasco

HIP TAG Meeting, June 2023

From January 2023 HIP TAG meeting

- The TAG noted that:
 - the **HIPs have an evidence scale** (i.e., the HIPs Criteria Tool) that was adapted from a scale used for programmatic evidence on HIV/AIDS and has also been used for PAC and FGM. The scale was adopted for those topics based on review of a range of tools to assess strength of programmatic evidence.
 - The HIP TAG has **tailored this scale specifically for the HIP initiative** and has incorporated it into a Excel file for use in development of HIP briefs.
 - The scale, which has been used for a number of HIP Briefs, is **currently being calibrated to determine proven/promising**.



Methodology: Gathered SD and SBC briefs and evidence summaries

- Created a spreadsheet with
 - Brief
 - Year
 - Designation
 - Evidence scale used & available
 - Version of HIP Evidence Scale used
 - Notes
 - Using to assess proven & promising
- Accessed the Excel files of evidence summaries (if available).
- Also reviewed relevant HIP TAG meeting reports for TAG review of HIP briefs (this is done prior to publication of the HIP brief).
- Not all of the briefs were subject to the same version of the HIP Criteria Tool
- KH filled in some information in order to be able to compare the briefs

Review of HIP criteria, including evidence in the impact section, in Service Delivery and Social Behavior Change HIP briefs

Compiled by Khadee, March 28, 2023

Brief	Year	Designation	Evidence scale used/available	HIP Evidence Scale Used (Early, later, latest)	Notes	Using to assess proven/promising
Service Delivery						
Community Health Workers: Bringing FP services to where people live and work	2015	Proven	X	Early version	Have slide from June 2017 TAG; CHW being updated now so new review using the HIP Evidence Criteria Tool not ready yet	X
Immediate Postpartum Family Planning: A key component of childbirth care	2022	Proven	X	Later version	Have the Excel file from the June 2018 TAG meeting; Have a ppt from 2020 TAG meeting - extracted from the HIP Criteria tool.	X
Mobile outreach services: Expanding access to a full range of modern contraceptives	2014	Proven	Being updated	Latest (TBD for new update)	No record of any version of the HIP Criteria tool being used in the 2014 version; brief is being updated so no evidence to run through the HIP Evidence Scale. Since it is already a proven practice the HIP Criteria Tool will not be used.	NA
Postabortion Family Planning: a critical component of postabortion care	2019	Proven	See notes	Not used (see notes)	Original 2012 version did not have an evidence scale review because it was developed prior to use of the HIP Evidence Scale (modified Gray Scale). No record of evidence scale review on the 2021 version (because it was already a "proven" practice. But the TAG recommended at the November 2018 meeting, "include the range of impact from quasi-experimental design" (that is a IIIa in the HIP Evidence Scale).	

Compiled evidence for each of the 5 criteria for HIPs for 6 SD HIPs and 5 SCB HIPs

HIP Evidence Criteria for 5 SD Briefs

- 6 SD HIPs: 3 proven & 3 promising
- 5 SBC HIPs: 4 proven & 1 promising
- HIP criteria
 - Impact
 - Applicability, reliability, generalizability
 - Scalability
 - Affordability
 - Sustainability
- Created a visual snapshot of the 5 criteria for each brief

HIP Criteria: Summary from Selected HIP Briefs (Proven and Promising)

Proven Promising

HIP Criteria	Proven (SD)	Promising (SD)	Proven (SBC)	Promising (SBC)
1. Impact	Proven	Promising	Proven	Promising
2. Applicability, Reliability, Generalizability	Proven	Promising	Proven	Promising
3. Scalability	Proven	Promising	Proven	Promising
4. Affordability	Proven	Promising	Proven	Promising
5. Sustainability	Proven	Promising	Proven	Promising

Status of briefs & evidence Evidence Scales for briefs

HIP Evidence Criteria for 5 SBC Briefs

Proven

Promising

HIP Criteria	Mass Media	Google Communications	Social Norms (Beverly Hills)	M&E & Self-Efficacy (2003)	Digital Health (2016)
Impact	Proven (2003)	Proven (2003)	Proven (2003)	Proven (2003)	Promising (2016)
Assessment of impact within evidence					
Level	Type of study	Proven (2003)	Proven (2003)	Proven (2003)	Proven (2003)
I	Systematic review of RCT				
II	Control with pre/post design (non-randomized/quasi-experimental)				
IIIa	Control with post-only design (non-randomized)				
IIIb	Other rigorous design (e.g., propensity score matching)				
IV	Systematic review of non-RCTs (quantitative)				
V	Routine/program data				
n/a	Qualitative				
Other/unsure					
Applicability, Reliability, Generalizability					
Scalability					
Affordability					
Sustainability					
Notes					

HIP Evidence Scale (for the Impact section)

(adapted Gray Scale)

Level	Type of Study
I	Systematic review of randomized control trials (RCT)
II	Randomized control trials
IIIa	Control with pre/post design (non-randomized/quasi-experimental)
IIIa	Control with post-only design (non-randomized)
IIIa	Other rigorous design (e.g., propensity score matching)
IIIa	Systematic review of non-RCTs (quantitative)
IIIb	Pre/post design, no control
IV	Routine/program data (e.g., service statistics or other M&E data)
V	Qualitative
V	Systematic review of non-RCTs (qualitative)
n/a	Other/unsure

Adapted from: Gray, J. 1997. Evidence Based Health Care: How to Make Health Policy and Management Decisions. London, UK: Churchill Livingstone; Gray, J. 2009. Evidence-Based Health Care and Public Health: How to Make Decisions About Health Services and Public Health. 3rd Edition. Edinburgh, Scotland: Churchill Livingstone Elsevier. Also see <http://www.whatworksassociation.org/strength-of-evidence-methodology.html>

Impact section of Service Delivery briefs

HIP Criteria: Summary from Selected HIP Briefs (Proven and Promising)														
HIP Criteria		Selected Service Delivery HIPs												
		CHW (see note 1)		Immediate Postpartum FP (see note 2)		Social Marketing		Pharmacies and Drug Shops		FP & Immunization (see note 3)		Social Franchising		
		Proven (2015)		Proven (2022)		Proven (2021)		Promising (2021)		Promising (2021)		Promising (2018)		
1. Impact														
Assessment of impact section evidence														
Level	Type of study	Pos/Signif	Pos/no signif test	Pos/Signif	Pos/no signif test	Pos/Signif	Pos/no signif test	Pos/Signif	Pos/no signif test	Outcomes other than contraceptive use	Pos/Signif	Pos/no signif test	Pos/Signif	Not signif
I	Systematic Review of RCT	1												
II	RCT										1			
IIIa	Control with pre/post (non randomized/quasi-experimental)	6									1		1	2
	Control with post only (not randomized)													1
	Other Rigorous Design (e.g. propensity score matching)													
IIIb	Systematic Review of non-RCTs (quantitative)					4				2				
	Pre/post no control	8								4				
IV	Routine/program data	5		1	4							4		
V	Other non-rigorous design									6				
	Qualitative	3												
n/a	Systematic Review of non-RCTs (qualitative)													
	Other/unknown													

- Green highlighted evidence is Gray level I, II and IIIa (Evidence with a control group)
- Orange is IIIb, IV, V (Evidence without a control group)

Impact section of Social Behavior Change briefs

HIP Criteria: Summary from Selected HIP Briefs (Proven and Promising)											
HIP Criteria		Selected Social Behavior Change HIPs									
		Mass Media	Couple Communication		Social Norms (Note 4)		KAB & Self-efficacy (2022)		Digital Health (Note 4)		
		Proven (2017)	Proven (2022)		Proven (2022)		Proven (42 studies)		Promising (2018)		
Impact											
Assessment of impact section evidence											
Level	Type of study	Pos/Signif	Pos/no signif test	Pos/Signif	Pos/no signif test	Pos/Signif	Pos/no signif test	Pos/Signif	Pos/no signif test	Other	
I	Systematic Review of RCT										
II	RCT			2			6			1	
IIIa	Control with pre/post (non randomized/quasi-experimental)				1		8		2		
	Control with post only (not randomized)						1				
	Other Rigorous Design (e.g., propensity score matching)	11		1			2				
IIIb	Systematic Review of non-RCTs (quantitative)		1								
	Pre/post no control				1			1		1	
IV	Routine/program data										
	Other non-rigorous design				4						
V	Qualitative				1		12			1	
n/a	Systematic Review of non-RCTs (qualitative)										
	Other/Unknown										

- Green highlighted evidence is Gray level I, II and IIIa (Evidence with a control group)
- Orange is IIIb, IV, V (Evidence without a control group)

Summary of findings

- To keep in mind:
 - HIPs are not based on a systematic review process
 - Proven/promising isn't only determined by the impact section
 - TAG retains ability to make the determination – not based on rigid criteria
- HIPs have different number of studies; difficult to have a set number of studies for 'proven' designation
- There are some exceptions (IPFP and social norms) (see next slide)

HIP Criteria: Summary from Selected HIP Briefs (Proven and Promising)

HIP Criteria		CROW (see note 1)		Immediate Postpartum FP (see note 2)
1. Impact		Proven (2015)		Proven (2022)
Assessment of impact section evidence				
Level	Type of study	Positive / Significant	Positive / no significance test	Positive / Significant
I	Systematic Review of RCT	5		
II	RCT	6		
IIIa	Control with pre/post (non randomized/quasi experimental)			
IIIb	Control with post only (not randomized)			
IIIc	Other Rigorous Designs (e.g., propensity score matching)			
IIIb	Systematic Review of non-RCTs (quantitative)	8		
IV	Pre/post, no control	5	1	4
V	Routine/program data			
V	Other non-rigorous design	3		
V	Qualitative			
V	Systematic Review of non-RCTs (qualitative)			
N/A	Other sources			
2. Applicability, Reliability, Generalizability		11 countries across regions		Multiple countries across regions
3. Scalability		Broad evidence of scale		Broad evidence of scale
4. Affordability		Evidence of cost effectiveness		Affordability not covered in the brief
5. Sustainability		Broad evidence of sustainability		Broad evidence of sustainability
Notes		Note 1 (CROW, 2015): The CROW assessment of evidence was conducted using an early version of the HIP Evidence Scale before significance was included. The brief is undergoing an update and the evidence will be assessed.		Note 2 (IPFP, 2022): The TAG agreed that evidence related to measurement of use of only one contraceptive method related to IPFP should not be included in the evidence of impact, further limiting the evidence in the impact section.

Proven HIPs are based on stronger evidence – two exceptions

IPFP: Proven

- Evidence based on routine data
- Note about the evidence: The TAG agreed that evidence related to measurement of use of only one contraceptive method related to PPFP should not be included in the evidence of impact, further limiting the evidence in the impact section.

Social norms: Proven

- Note about the evidence in the HIP Brief: "measurement challenges are a factor in the limited evidence available to demonstrate how interventions can successfully address family planning-related social norms."
- Doesn't fare well on 3 of the other 4 criteria.

Selected Social Behavior Change HIPs		KAB & self-efficacy (2015)		Proven (2022)
Assessment of impact section evidence				
Level	Type of study	Positive / Significant	Positive / no significance test	Positive / Significant
I	Systematic Review of RCT	5		
II	RCT	6		
IIIa	Control with pre/post (non randomized/quasi experimental)			
IIIb	Control with post only (not randomized)			
IIIc	Other Rigorous Designs (e.g., propensity score matching)			
IIIb	Systematic Review of non-RCTs (quantitative)	8		
IV	Pre/post, no control	5	1	4
V	Routine/program data			
V	Other non-rigorous design	3		
V	Qualitative			
V	Systematic Review of non-RCTs (qualitative)			
N/A	Other sources			
2. Applicability, Reliability, Generalizability		11 countries across regions		Multiple countries across regions
3. Scalability		Broad evidence of scale		Broad evidence of scale
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Notes		Note 1 (CROW, 2015): The CROW assessment of evidence was conducted using an early version of the HIP Evidence Scale before significance was included. The brief is undergoing an update and the evidence will be assessed.		Note 2 (IPFP, 2022): The TAG agreed that evidence related to measurement of use of only one contraceptive method related to IPFP should not be included in the evidence of impact, further limiting the evidence in the impact section.

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- Doesn't fare well on 3 of the other 4 criteria.

Proposed tips for determining proven/promising designation for HIPs using the 5 HIP Criteria

HIP Criteria	Proven	Promising
Impact	At least 4 studies with positive evidence at level I, II, or IIIa on the HIP Evidence Scale (with at least 3 studies with statistically significant results), with explanation for exceptions	At least one study at levels I, II and IIIa and/or at least 4 studies at levels IIIb, IV or V in only 1 country or region, with explanation for exceptions
Applicability, reliability, generalizability	At least 4 countries across more than one region	Fewer than 4 countries or evidence from only one region
Scalability	Broad evidence of implementation at reasonable scale (for the HIP)	Evidence from pilots and/or small-scale implementation
Affordability	?	?
Sustainability	Suggest merging scalability and sustainability	

Applying the recommended tips on proven/promising for the evidence in the impact section

(Proven and Promising)											
Selected Service Delivery HIPs											
CHW (see note 1)		Immediate Postpartum FP (see note 2)		Social Marketing		Pharmacies and Drug Shops		FP & Immunization (see note 3)		Social Franchising	
Proven (2015)		Proven (2022)		Proven (2021)		Promising (2021)		Promising (2021)		Promising (2018)	
Positive / Significant	Positive / no significance test	Positive / Significant	Positive / no significance test	Positive / Significant	Positive / no significance test	Positive / Significant	Outcomes other than contraceptive use	Positive / Significant	Positive / no significance test	Positive / Significant	Not signif
7	0	0	4	2	2	4					
16	5	0	10	4	0						
23	5	4	12	6	4						

Selected Social Behavior Change HIPs									
Mass Media		Couple Communication		Social Norms (Note 4)		KAB & Self-efficacy (2022)		Digital Health (Note 4)	
Proven (2017)		Proven (2022)		Proven (2022)		Proven (42 studies)		Promising (2018)	
Positive / Significant	Positive / no significance test	Positive / Significant	Positive / no significance test	Positive / Significant	Positive / no significance test	Positive / Significant	Positive / no significance test	Positive / Significant	Other
12	4	0	17	3					
0	2	16	1	2					
12	6	16	18	5					

Notes for consideration/discussion

- **Is suggestion for proven/promising ok?**
- **What outcome is used for proven/promising?**
 - Is proven/promising only determined on contraceptive use? Or at least on the dominant outcome (if not contraceptive use?) Otherwise, it could be confusing if a practice is proven for one outcome but not another.
- **Inconsistent mention of the HIP criteria in the briefs – particularly sustainability and affordability**
 - Should all of the criteria be mentioned in the briefs?

Notes for consideration/discussion

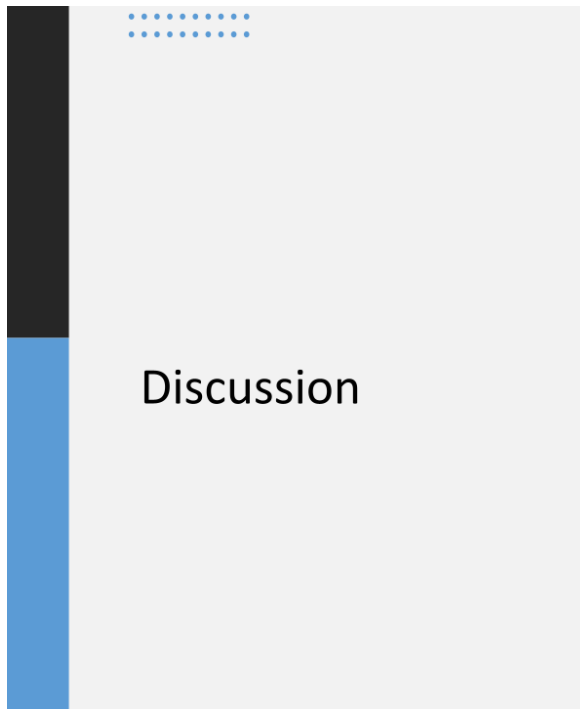
- **Need some summary of the evidence publicly available** (e.g. the summary of evidence table)

- Updated, as needed, after TAG approval and decision on proven/promising
- This will force adding the notes on justification.
 - There is a tab for this in the newest version of the tool.
 - Make sure it is filled out – 1) to present to the TAG, and 2) after the TAG meeting if there are any adjustments needed?
 - Make sure to add an explanation of the TAG decision.

Summary of HIP Criteria

Ratings and notes for the first three HIP Criteria are automatically populated from the information entered on the previous tab (to revise these please return to the previous tabs). Ratings and notes should be added for the affordability and sustainability HIP Criteria below.

Criteria	How defined for HIP Review purpose	Source	Rating	Notes on Selection
Impact	Sufficient evidence of impact as per the HIP Evidence Scale	Based on the HIP Evidence Scale (see tab 2)	Green	Most of evidence included shows positive results.
Applicability, Reliability, Generalizability	Broad evidence of impact from multiple contexts or settings	Based on a summary of evidence included in HIP Evidence Scale (see tab 2)	Yellow	The evidence is almost exclusively from Africa and a lot is from specific sub-populations or contexts which may limit generalizability.
Scalability	Evidence of impact being implemented at scale (not only from pilots)	Based on a summary of evidence included in HIP Evidence Scale (see tab 2)	Green	Most of the evidence comes from interventions implemented at scale.
Affordability	Qualitative rating based on what we know about cost and affordability. This is not the same as cost-effectiveness.	Experience/expert opinion (select rating from dropdown list)	MAKE SELECTION	Add notes on selected rating here
Sustainability	Organizational, political, and financial sustainability of practices, while maintaining equity of access and quality of services.	Based on HIP Sustainability Checklist (see tab 3)	Yellow	Limited evidence of operation under routine settings



The Challenge Initiative (TCI)



TCI HIPs Overview

HIPs Technical Advisory Group Meeting

Kojo Lokko

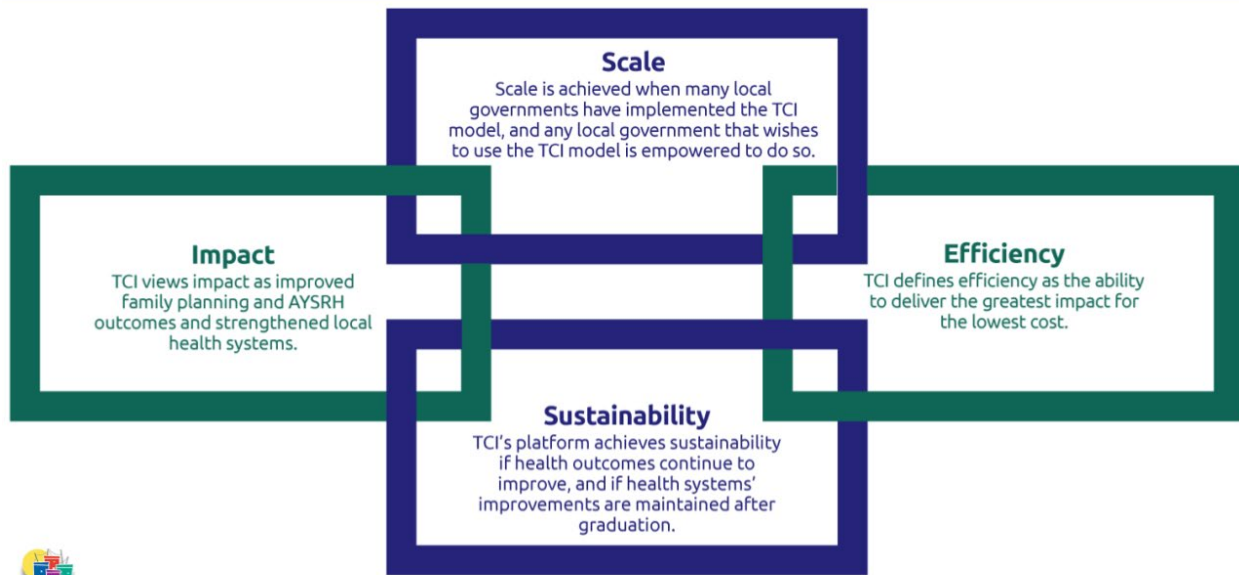
June 13, 2023

What is The Challenge Initiative?

- TCI enables local governments to scale up high-impact family planning practices and other interventions in under-resourced, marginalized urban communities across 13 countries
- When it launched in 2016, TCI's mandate was to scale up interventions proven effective under the Urban Reproductive Health Initiative (URHI) but with local governments at the helm.
- This has now evolved to include global high-impact practices and locally specific interventions.



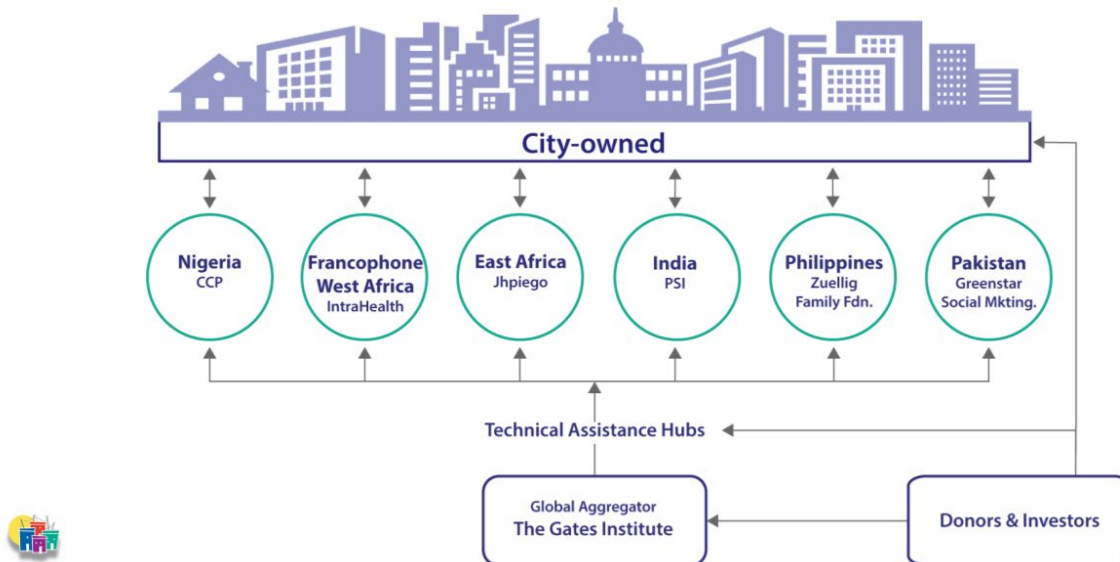
Four Foundational Interlocking Tenets



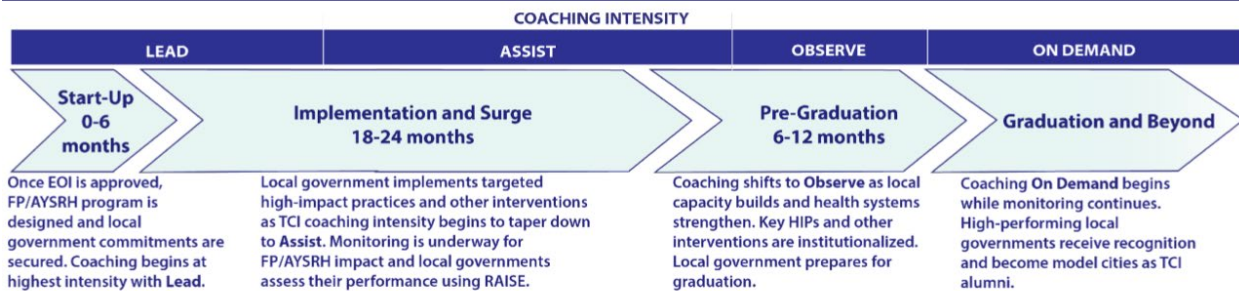
TCI Guiding Principles



The TCI Ecosystem



How TCI Engages Local Governments



Scaling Up High-Impact Practices & Other Interventions

176

Cities



86 actively implementing;
90 cities graduated from
TCI support

222M

Population
Footprint



Estimated population of
the geography in which
TCI works

3.2M

Additional
FP Clients



Since engagement in
each TCI-supported city

\$102M

Local Government
Commitment



More than 40%
spent thus far

38,000

HIPs/HIs conducted



Across 4,500
facilities



Mapping & Aligning TCI Interventions with Global HIPs

Service Delivery

1. Community Health Workers
2. Immediate Postpartum Family Planning
3. Mobile Outreach Services
4. Pharmacies and Drug Shops
5. Family Planning and Immunization Integration

Social Behavior Change

6. Mass Media
7. Community Engagement

Enabling Environment

8. Domestic Public Financing
9. Galvanizing Commitment
10. Leaders and Managers

HIP Enhancement

11. Adolescent-Responsive Contraceptive Services



Core Package

<https://tciurbanhealth.org/courses/core-package/>

Community Health Workers	Immediate PPF	Mass Media	Post-Abortion Care*				
<ul style="list-style-type: none"> • East Africa • India • Nigeria • Pakistan • Philippines 	<ul style="list-style-type: none"> • East Africa • FWA • India • Nigeria • Pakistan • Philippines 	<ul style="list-style-type: none"> • East Africa • FWA • Nigeria • Pakistan 	<ul style="list-style-type: none"> • Pakistan 				
Mobile Outreach Services	Pharmacies & Drug Shops	FP & Immunization Integration	Community Group Engagement	Domestic Public Financing	Galvanizing Commitment	Leaders & managers	ARCS
<ul style="list-style-type: none"> • East Africa • Nigeria 	<ul style="list-style-type: none"> • East Africa • Nigeria 	<ul style="list-style-type: none"> • East Africa • FWA 	<ul style="list-style-type: none"> • East Africa • FWA • India • Nigeria • Philippines 	<ul style="list-style-type: none"> • East Africa • India • Nigeria • Philippines 	<ul style="list-style-type: none"> • East Africa • FWA • India • Nigeria • Pakistan 	<ul style="list-style-type: none"> • East Africa • FWA • India • Nigeria • Pakistan • Philippines 	<ul style="list-style-type: none"> • East Africa • India • Nigeria • Philippines



*As the newest hub, this intervention is being monitored to see what adaptations are required to make this scalable through public sector implementation. As a result, it is not currently listed in the core package, just the Pakistan toolkit.

TCI Global Toolkit: Service Delivery Community Health Workers

★ PROVEN HIPI!

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SEARCH...

★ High-Impact Practice

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

What Is It?

Volunteers or paid employees that bring health information and services to people where they live and work, rather than requiring clients to visit a facility. Community health workers (CHWs) are an important cadre of workers in a health system. Personal contact with such a well-informed community member can help alleviate women's and men's fears about family planning, present contraceptive method options for spacing or limiting births, and facilitate access to family planning and other related services, such as maternal, neonatal and child health services, in both the government and private sector.



Using CHWs is a globally recognized effective approach to increasing uptake of family planning. When trained and provided with the necessary tools and resources, CHWs can help fill gaps in both demand generation and service delivery.* These community-based activities can take place at the home, at work, or other spaces where people gather, such as marketplaces, mosques or churches, and community meetings and celebrations.

*Most CHWs are allowed to provide non-clinical contraceptive methods - condoms, pills, fertility awareness methods. Many countries also allow CHWs to give injectable contraceptives, and some are even moving toward allowing them to give implants. You should check with your country's family planning service delivery guidelines to see who is allowed to provide



Related Hub Interventions

East Africa



Working with Community Health Volunteers/Workers and Village Health Teams to Promote Family Planning

Francophone West Africa

Community Health Workers Hub Equivalent

tcu

ABOUT WHERE WE WORK TCI UNIVERSITY NEWS WORK WITH US SEARCH...

East Africa Toolkit: Demand Creation

Home Toolkits Resource Collection Community Of Practice Coaching Log Out My Profile English SEARCH...

Working with Community Health Volunteers/Workers and Village Health Teams to Promote Family Planning

★ High-impact Practice

This approach provides guidance on how to engage Community Health Volunteers/Workers and Village Health Teams (CHVs/CHWs/VHTs) in promote family planning (FP) demand generation and service delivery at the community level. It provides information related to:

- Ministry of Health (MOH) guidelines on CHVs/CHWs/VHTs selection criteria and formation of functional community units
- Training CHVs/CHWs/VHTs in community-based FP using country-specific guidelines and training packages/manuals
- Providing the CHVs/CHWs/VHTs with relevant tools and resources to facilitate FP service delivery and promotion at the community level
- Linking CHVs/CHWs/VHTs to health facilities for commodities, supplies and referrals for services beyond their scope
- Strengthening community-based distribution of FP methods, counseling, effective referrals to health facilities and

Gender Intentional

A community health volunteer during a household visit to mobilize clients for FP services in Vihiga County, Kenya.

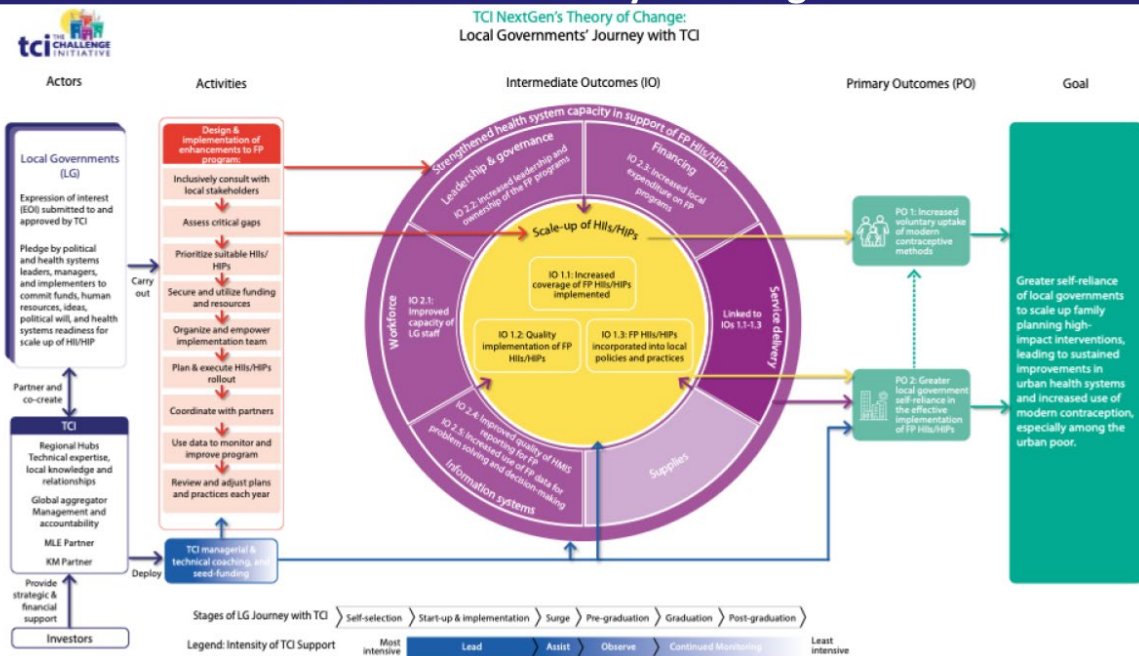
Demand Creation Approaches

Family Planning

- Working with Community Health Volunteers/Workers and Village Health Teams to Promote Family Planning
 - 14 Tools 1 Quiz
- Community Health Volunteers/Workers and Village Health Teams Checklist
- Mobilisation Leaflets - Uganda
- Community Health Worker Performance Evaluation Form
- Interpersonal Communication

- Gender strategy and workshop
- Gender mapping and tagging on TCI-U
- Gender mini-course to be added later this summer

TCI NextGen Theory of Change

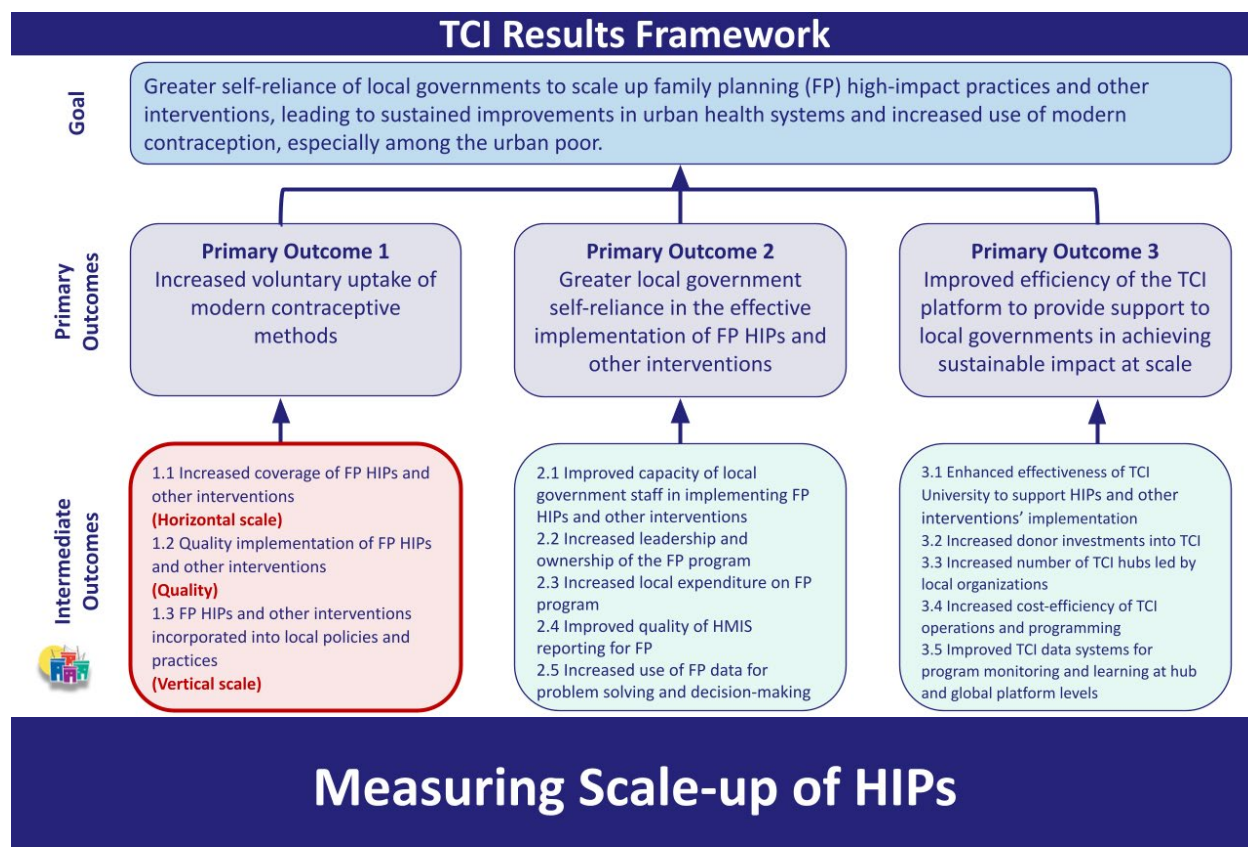


TCI Theory of Change



Greater self-reliance of local governments to scale up family planning (FP) high-impact practices and other





	Horizontal scale (coverage)	Quality implementation	Vertical scale (institutionalization)
TCI NextGen tool	HIP records	Quality implementation checklist	HIP records, RAISE
What it measures	<ul style="list-style-type: none"> # of local governments (LGs) implementing specific HIP # of graduated LGs continuing to implement specific HIP # of facilities covered by specific service delivery HIP # of relevant staff oriented/built capacity on specific HIP # of activities for each service delivery HIP, where relevant 	<ul style="list-style-type: none"> #/% of health facilities / local government staff / health worker scoring $\geq 80\%$ in their latest specific HIP quality assessment 	<ul style="list-style-type: none"> #/% of LGs that have incorporated specific HIP in the LG policies, workplans, or guidelines and standards

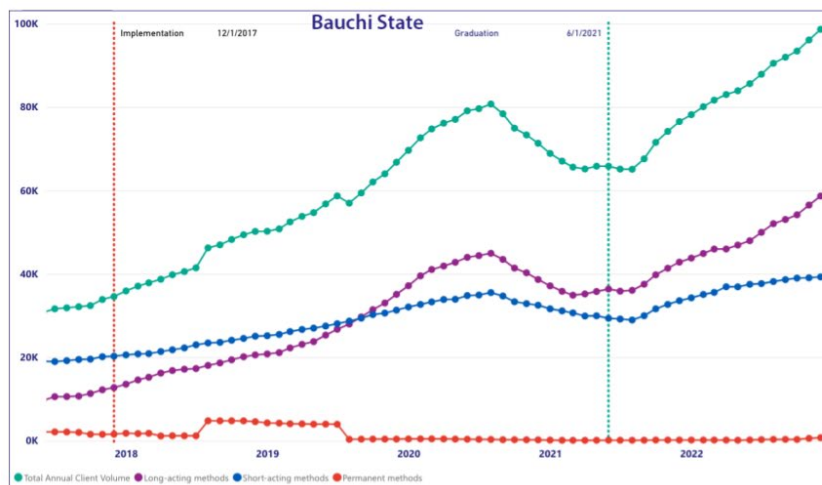
Example: CHW Quality Checklist

Working with CHW/ CHV/ VHTs to Promote and Provide Family Planning

Region:				
Date completed:				
By whom:				
Verification criteria	Yes	No	NA	Comment
1. Availability of trained CHW/ CHV/ VHTs and actively submitting monthly reports on Family Planning services <i>(Probe H/F or Unit In-Charge or CHW Coordinator and observe submitted reports)</i>				
2. There is evidence of CHW/CHV/ VHT submitting FP/AYSRH reports monthly				
3. Evidence of periodic CHV/ CHVs/ VHTs review meetings conducted and action plan developed <i>(Look at the meeting report or minutes and participants' registration forms Meetings can be conducted on a monthly or bi-monthly or quarterly basis. Geography should specify on the timelines for the meetings)</i>				
4. Stock cards or proof of contraceptives were distributed to VHTs from the facilities <i>(Review stock cards)</i>				
5. Availability of IEC materials for demand generations <i>(Review available IEC material stock)</i>				
6. Availability of data collections tools <i>(Review available data collection tools).</i>				
7. Complete referral forms are available and accessible to CHWS and facility				
8. Availability of community to facility client referral list				
Total performance Score (%)				



Measuring Sustainability

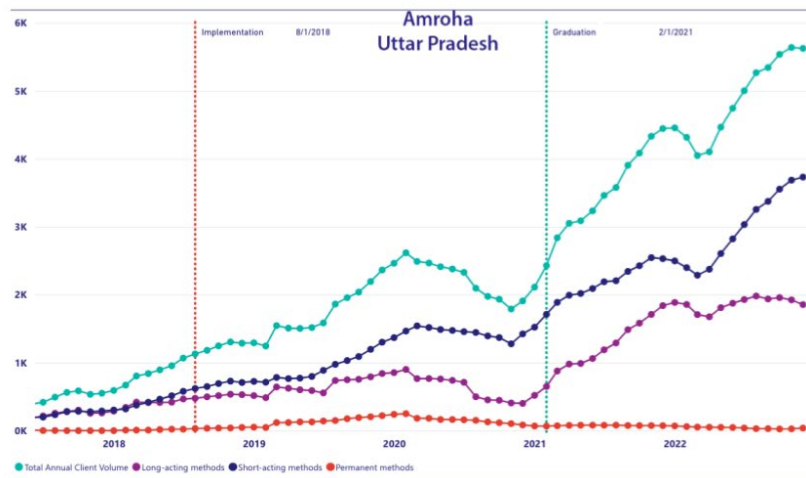


"The state now has a recurrent budget line for FP as a result of the efforts of the ACG. The annual operational plan will coordinate partners, activities and funding commitments so that there is no duplication of efforts and a reduction in waste of funds. Starting at the state level, the technical working group tracks implementation and resolves challenges and gaps and supportive supervision and on-the-job training ensures community members are satisfied by the quality of services. --- These interventions don't need excessive funding to be successful and are led by the state government agency."

— Hajiya Hajara Yahaya
Bauchi State FP Coordinator



Measuring Sustainability (cont'd)



"In February 2021, Amroha moved to the graduation stage. And since then, we have not faced any major challenge. Since graduation, I have mainly utilized approaches such as using data effectively, fixed-day static (FDS) service, strengthening urban ASHAs and convergence for implementation and to coach staff of the health department. The best part is, without any follow-up, every Thursday all urban primary health centers (UPHCs) are organizing weekly FDS/Antral diwas because facility staff, ANMs (auxiliary nurse midwives), and ASHAs (accredited social health activists) are well-coached on their responsibilities.

– Ahsan Ali

Urban Health Coordinator
National Urban Health Mission, Amroha



In Summary

- TCI's coaching model enables the successful operationalization of HIPs
- Bidirectional learning between TCI and local governments helped capture the core components for implementation of each HIP
- Starting with rich landscape and gap analysis ensures the HIPs selected allow for the biggest bang for the buck
- Monitoring HIPs implementation and impact should triangulate data sources such as the HMIS, quality checklists and program records



Thank You



JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Bill & Melinda Gates Institute for
Population and Reproductive Health



JOHNS HOPKINS
Center for Communication
Programs



greenstar
health • prosperity • future

IntraHealth
INTERNATIONAL
Because Health Workers Save Lives.



jhpiego
Johns Hopkins University Affiliate

psi
India



ZUELLIG FAMILY
FOUNDATION

HIPs products table

HIP Products Table

Erin, Karen, Michelle
June 13, 2023

HIP PRODUCTS					
	The purpose of this table is to define and distinguish the range of HIP products. A High Impact Practice (HIP) is a measurable evidence-based family planning practice supported by the scientific and gray literature as having demonstrable impact in achieving various family planning outcomes including: modern contraceptive uptake, reduction in unintended pregnancy, reduction in overall fertility, or one of the primary proximate determinants of fertility (delay of marriage, birth spacing, breastfeeding and postpartum abstinence, or facilitating access to family planning services). The main audience for all of these products includes FP decision makers, policy makers, program implementers, and individuals managing FP programs or investments.				
1	HIP Overview HIP Overviews provide an introduction, overarching framework and broad definition for a category of HIPs (e.g., Enabling Environment, Social and Behavior Change, and Service Delivery). HIP Overviews help show how HIPs in the category link together, and provide tips for implementation and tools and resources.	HIP Briefs HIPs provide concise summaries around what exists in family planning, and are intended to facilitate the use of evidence to inform program investments in low and middle income countries. HIP Briefs provide an unbiased synthesis of the evidence and experience on implementing the practice to date. HIP Briefs describe family planning practices that have demonstrated impact, are applicable across settings, and are scalable, sustainable, and cost-effective. HIP Briefs include a theory of change, summary of why the practice is important, summary of impact, tips for implementation, links to resources, indicators, and priority research questions. See HIP Brief Guidance	HIP Enhancements A HIP Enhancement is a tool or approach that is not a standalone practice, but it can be used in conjunction with HIPs to maximize impact by strengthening implementation quality or increasing the reach and access for specific audiences. HIP Enhancements provide examples and evidence as well as tips for implementation.	HIP Strategic Planning Guides Strategic Planning Guides (SPGs) are designed to lead actors through a strategic process to plan FP programming for a specific population or program area. They are not implementation guides, but rather provide a starting point to reflect on key considerations and identify the most effective and efficient investments to address the focus area. SPGs are tailored for each topic, and include key actions, a strategic, step-wise process for engagement with the focus population or issue. See SPG Development	HIP White Discussion Papers HIP White Paper/Conversation Papers build upon various thematic areas that are central to the HIP Principles. These conversational papers reflect ongoing discussions from TAd meetings, as well as other topics of interest. White papers could lead to other HIP products in the future. The key consideration here is a "review of a thematic area to provide preliminary understanding of the area and state of the evidence that is available." Shine light on a topic that needs attention and consideration in the family planning space to achieve FP outcomes following the key HIP principles.
2	Standard of evidence Standard of evidence is not applicable. Purpose is to provide framework for briefs; evidence summary is included within the individual HIP briefs.	Includes an "Impact section" summarizing the evidence that demonstrates the impact of the HIP on a family planning outcome. Briefs are rated by the HIP Technical Advisory Group as proven or promising, based on the HIP Criteria Tool, including the HIP evidence scale to demonstrate sufficient evidence of impact on FP outcomes. HIP evidence reviews are not systematic reviews, and take account of both published and gray evidence and implementation experience.	Enhancements are held to different standards of evidence, focusing on examples of their contribution to enhancing the implementation of HIPs. Enhancements must show programmatic evidence that the enhancement has been successfully integrated with at least two HIPs leading to improved implementation. Evidence of impact, scalability, sustainability and cost-effectiveness should be included if available, but is not required.	Standard of evidence is not applicable. Purpose is to outline a strategic process, not to summarize evidence.	Standard of evidence is not applicable. Refers to evidence but purpose is not to summarize evidence.
3	Length 4-6 pages (including references)	8 pages (not including appendices or references)	8 pages (not including appendices or references)	4 pages (not including appendices or references)	No specific page limit
4	Indicators Does not apply (indicators are in specific HIP briefs)	The practice should be amenable to being measured and top 2-3 recommended indicators should be included.	The practice should be amenable to being measured and top 2-3 recommended indicators should be included.	Does not apply	Does not apply
5	Current Products 1. Enabling Environment 2. Social and Behavior Change (as of June 2023)	7. Enabling Environment (EE) Briefs: - Comprehensive Policy Processes - Domestic Public Financing (2018) - Educating Girls (2014) - Organizing Commitment (2018) - Leaders and Managers (2022) - Social Accountability to Improve FP Information and Services (2022) - Supply Chain Management (2023) 8. Service Delivery Briefs: - Community Health Workers (2016) - FP Immunization Integration (2021) - Immediate Postpartum FP (2022) - Mobile Outreach Services (2014) - Pharmacies and Drug Shops (2021) - Postpartum FP (2018) - Social Franchising (2018) - Social Marketing (2021) 8. Sexual and Behavior Change (SBC) Briefs:	1. Adolescent-Responsive Contraceptive Services: Institutionalizing adolescent-responsive elements to expand access and choice (2021) 2. Digital Health to Support Family Planning Providers: Improving knowledge, capacity, and service quality (2022) 3. Digital Health for Systems Strengthening Family Planning Systems Through Time and Resource Efficiencies (2017) 4. Family Planning Voucher: A tool to boost contraceptive method access and choice (2022) 5. Task Sharing Family Planning Services to Increase Health Workforce Efficiency and Expand Access (2019) (currently a SPG to be revised into an enhancement)	1. Adolescents: Improving SRH of Young People: A Strategic Planning Guide (2015) 2. Meaningful Adolescent and Youth Engagement and Partnership in SRH Programming (2022) 3. Engaging Men and Boys in Family Planning: A Strategic Planning Guide (2018) 4. Family Planning in Humanitarian Settings: A Strategic Planning Guide (2022) 5. Creating equitable access to high-quality family planning information and services: A Strategic Planning Guide (2021) 6. Contraceptive Method Introduction to Expand Choice: A Strategic Planning Guide (2022) 7. Facilitating the Inclusion of Persons with Disabilities in Family Planning Programming: A Strategic Planning Guide (2022) 8. Strengthening Partnership with Faith Actors in Family Planning (in development)	1. Discussion Paper on Equity for the HIP Partnership (2019) 2. Guidance on assessing the potential sustainability of Practices as part of an evidence review: Considerations for High Impact Practices in Family Planning (2017) 3. Economic Empowerment: A Potential Pathway for Women and Girls to Gain Control Over Their Sexual and Reproductive Health (2017) (currently an evidence summary to be revised into a White Paper)

Revised 4.25.2023 - Old Version with Comments

Latest Updates

- Link to the [HIP Products Table](#) here
- Inserted links to guidance where relevant (ex: HIP Brief Guidance)
- Reformatted lists of publications with dates
- Added more summary info at top of the table

Questions or pending actions for discussion (by type of product)

Across all products - Standard of Evidence

- Reading across the products and seeing "standard of evidence does not apply" raises a question for me. We do use evidence for SPGs, for example as noted. Is there another term that might convey that evidence is used but the types vary? I'm trying to think from country-based perspective. Maybe other TAG members have reactions?

HIP Overviews

- Service delivery overview - not yet developed

Questions or pending actions for discussion (by type of product)

HIP Briefs

- Should we mention that HIP Briefs are purposefully not contraceptive method specific?
- Confirm wording of Definition and Purpose
- For Standard of Evidence, add link to the criteria tool here

Questions or pending actions for discussion (by type of product)

HIP Enhancements

- Adolescent Responsive Contraceptive Services (is this still needed with the SPG? It does not fit the "enhancement" definition as well as the others. Or this could become a HIP Brief? Or does the SPG on adolescents need to be revisited? There are now 3 products on adolescents - are they well-connected?)
- I think this ARCS HIP Enhancement makes sense specifically for the Service delivery briefs. But agree we should revisit the links between all Adolescent/Youth HIP products.
- Adding a voice to idea of revisiting the adolescent documents, with aim to streamline and/or condense. (+1)

Questions or pending actions for discussion (by type of product)

HIP Strategic Planning Guides

- Human Rights Based SPG - TBD?

HIP White Papers/Discussion Papers

- Recommendation to turn the Economic Empowerment Evidence summary into a White Paper (and eliminate the separate category of Evidence Summaries)
- Do we expect future topics for this category?

Thanks for all the
feedback to make
this more useful!

HIP Updates



HIP Product Updates

Maria Carrasco
TAG meeting 6/13/2023



HIP product updates

- [Facilitate inclusion of persons with disabilities in FP programming \(SPG\)](#)
- Inclusion of faith actors in FP programming (forthcoming in 3 months)
- Translations

Brief update/development process

- ~120 experts submitted their names to be in the writing groups for:
 - Mobile outreaches (brief update)
 - Task sharing (enhancement)
 - Community health workers
- Form groups by June 26
- Volunteers to help
 - Form groups
 - Think about any preparation tasks for self-care group and CHW group

Decision 1: Way forward with CHW

- Revisit:
 - [Community Health Workers](#) (2015)

Decision 2: Call for concept notes

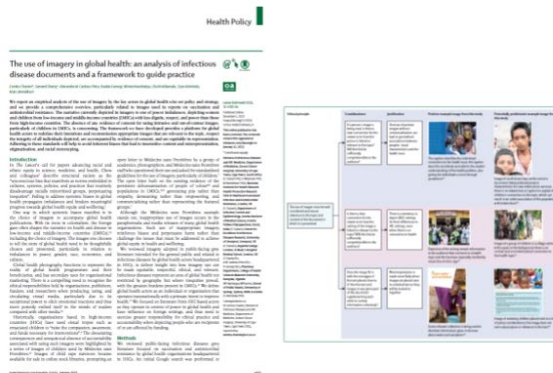
- Current cadence is 3 briefs/enhancement per year
 - In the next meeting we will be reviewing concept notes

HIPs Website Image Audit

The use of imagery in global health article

[https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(22\)00465-X/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00465-X/fulltext)

- Review current images
- Redefine intention
- Recommission appropriate images
- Create SOP for the HIPs P&D Team





 fphighimpactpractices.org

Revisit literature review process for HIPs and any updates needed in the “Guidance for Developing a HIP brief”



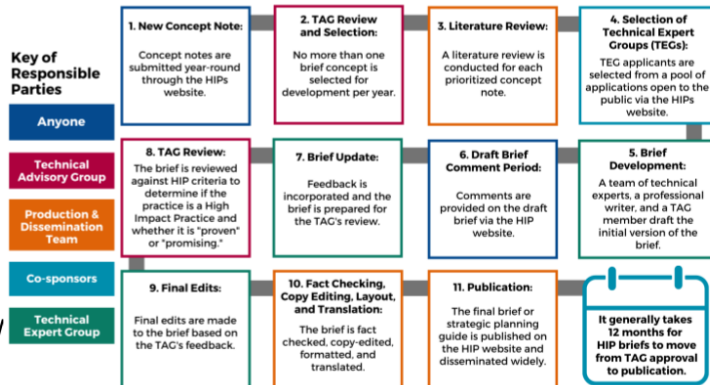
Updates to the
Guidance to
Develop a HIP
Brief

Maria Carrasco

HIP brief development process

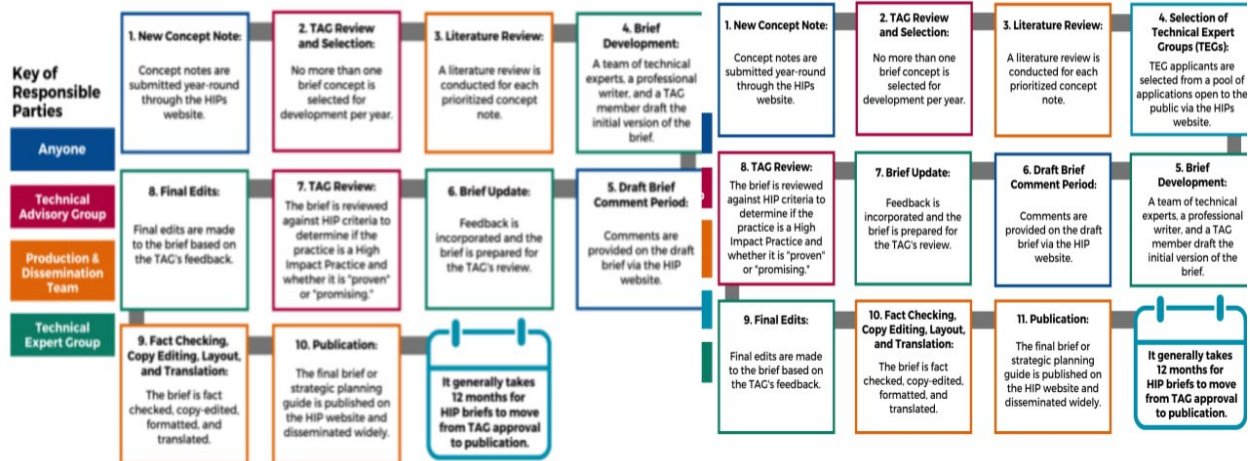
HIP briefs are co-created in a highly participatory process that democratizes RU and KM

- **Anyone** can submit a concept note for a brief
- Technical experts (**TAG**) determine what becomes a HIP
- **Anyone** can apply to be in the groups writing the briefs
- Brief goes through **public** review and **TAG** review



Decision 1: Update process graphic to include TEG selection

Current Graphic



Decision 2: When should the TAG look at the literature review?

- Potential new briefs or enhancements
- Brief updates

Decision 3: Articles covering only one method

Currently reads: “Exclude studies that only focus on ONE contraceptive method”

Change to: “Articles focusing on only ONE contraceptive method should be tagged as “one method” and should only be included when **ADD**”

Decision 4: Add hyperlinks (Decided)

- To the new HIP criteria tool
- To the new HIP products table



 fphighimpactpractices.org

HIP User Roadmap

User Roadmap for the HIPs

HIP TAG Meeting June 14, 2023
Erin, Laura, Maggwa, Maria, Michelle, Sara

What is the problem?

- 2022 HIPs User Survey showed people want:
 - Guidance on how to prioritize among the HIPs
 - Detailed guidance on how to implement the HIPs
 - Guidance and tools to measure HIPs implementation
- HIP briefs were developed to promote high impact practices in FP programs, but our audience is broad and expects more detailed information and guidance
- Meanwhile many other resources exist that do not need to be reinvented

The idea for the solution

<https://usaidmomentum.org/resource/empowering-family-planning-reproductive-health-innovations-for-scale-momentum-innovation-accelerator/>

Summary and User's Guide



Different journeys for different users

Depending on where you and your organization are on the journey of supporting FP/RH innovations, you can start at different points in this guide. While this guide provides a flow, it is also designed to be modular and users can use various elements of the guide as is helpful for them. Supporting FP/RH innovations is an ongoing journey that this guide can help support.

Regardless of where you are in this journey, you can review the separate scale-up lessons and case studies to understand key insights and experiences.



Empowering FP/RH Innovations for Scale 6

What have we done to date?

Reviewed what HIPs are (ex: components of an evidence-based FP program) and are not (ex: not stand alone or cookie cutter interventions)

Discussed who the primary audience is. The HIPs website notes the briefs are for advocacy, strategic planning, program design, exploration of research gaps, to inform policies and guidelines, and to support implementation

Brainstormed examples or categories of external resources the HIPs website can link to (ex: FP Goals, ExpandNet Scale Up, TCI University Toolkits)

What have we done to date?

Brainstormed what the steps would be along a user's (or FP program's) journey with the HIPs:

Early stage

Middle stage

Later stage

Brainstormed resources that are relevant for each of these stages:

- Illustrative but not exhaustive lists
- Including HIPs products and external resources

Early Stage

Planning:

1. Get stakeholder buy-in
 - a) MOH (of course)
 - b) FP TWG
 - c) other partners

2. Obtain stakeholders' commitment to join planning process (this will be to determine which HIP/s and their implementation & monitoring)

Selecting the HIP

1. Refer to existing situational analyses or plans such as the CIP to identify the specific need/gap to be addressed. Should have details on population/s affected, geographies, funding availability
2. Review the different HIPs by category to select possible ones.
 - consider experiences from other countries that may resonate with yours
 - consider practical barriers you may encounter with the different HIPs
3. Prioritize (!!!) the types of interventions that will respond to the identified gap/s
4. Consider what funding you already have to respond to gaps and what additional funding will be needed, to fill gaps and to scale up prioritized interventions.
5. Determine which HIPs will be best suited to the gap and country (national and/or subnational) context and funding availability/resource demands.

Resources:

1. HIPs overview (the list)
2. SBC and EE overview docs
3. Plan for scale up from the beginning of HIPs implementation (NEED GOOD RESOURCE TO LINK TO - EXPANDNET??)
4. HIP SPGs depending on setting/population of focus
5. FP Goals
6. FP Insight
7. FP Financing Roadmap
8. TCI tools
9. FP2030 Rights & Empowerment Principles
10. Equity tools
11. Root cause analysis/prioritization tools
12. FP2030 readiness checklists for PPFP/PAFP and FP-Immunization implementation and Adolescent-Responsive Services

Middle Stage Implementation phase

Conduct baseline so you know where your journey begins and identify indicators to be used to track progress

Plan to conduct regular monitoring - build into implementation plan - inputs and process indicators

Develop implementation plan that includes how HIP will be scaled up.

Consider using a SPG if relevant to HIP (e.g. for adolescents, men, introducing new method) and concurrently walk through the SPG steps to help with planning.

Consider pairing HIP Enhancements with specific HIPs (e.g., Digital Health to Support FP Providers with Community Health Workers)

Consider the other HSS building blocks that your program will need to partner with and build upon (e.g., supply chain, information systems, etc).

Have a health systems approach to examine all factors. Note that the HIPs practices do not address provider training. (could also go in early stage)

Plan for routine pause/reflect review (or program reviews to take stock on implementation & tweak as needed.

Document cost of interventions

Resources:

1. FP Insight
2. CIP Toolkit
3. FP Financing Roadmap
4. MOMENTUM Suite of projects for learnings on service delivery
5. Breakthrough ACTION for SBC
6. TCI
7. FP2030 Rights & Empowerment Principles
8. HMIS/DHIS2/LMIS data
9. IBP Implementation Stories

Later Stage

Plan for routine pause/reflect review (or program reviews to take stock on implementation & tweak as needed.

Monitor and evaluate the implementation

Outcome indicators, measures of sustainability

Reassess equity to identify gaps

Assess cost-effectiveness of interventions

Contribute to IBP Implementation Stories

Resources

1. CIP Toolkit
2. FP2030
3. Track20
4. DHS
5. PMA data (9 countries)
6. HMIS data/DHIS2/LMIS
7. Equity SPG and other tools
8. HIP Briefs
9. Upcoming D4I and R4S tools on monitoring HIPs implementation (just FYI that TAG member may need reminder on those tools)

Next Steps

1. Get HIP TAG input on the main steps and resources for the 3 stages
Any glaring omissions?
Any additions for stage 3?
2. HIP TAG will work with MOMENTUM Country and Global Leadership to develop the visual of the user's roadmap
3. Incorporate the HIP TAG's earlier table showing HIPs by Outcomes and the Track20 visual of the S-curve and program maturity level

Annex: Mapping HIPS to Equity Dimensions

		Increase mCPR Primary HIP Outcome	Expand Method Choice, Quality, and Coverage Environmental Equity Quality, Availability	Reach Diverse Underserved Groups Social Equity Availability	Address Social Cultural Barriers Social Equity (esp for SBC briefs)	Reduce Financial Barriers Economic Equity
How link to AAAQ:						
Post-abortion FP	Proactively offer voluntary contraceptive counseling and services at the same time and location where women receive facility-based post-abortion care.			Reach women who might not have been reached otherwise (may not seek services)		Secondary: integrating services reduces number of visits needed
Immediate PPFP	Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the health facility.			Reach women who might not have been reached otherwise (may not seek services)		Secondary: integrating services reduces number of visits needed
Integrate FP into Immunization	Offer family planning information and services proactively to women in the extended postpartum period during routine child immunization contacts.			Reach women who might not have been reached otherwise (may not seek services)		Secondary: integrating services reduces number of visits needed
Mobile Outreach	Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods.		Increase coverage of LARC services			Secondary: provide free services
Social Franchising/ Quality Assured Networks	Organize private providers into branded, quality-assured networks to increase access to provider-dependent contraceptive methods and related services.		Increase coverage of private sector services			
Drug Shops/ Pharmacies	Train and support drug-shop and pharmacy staff to provide a wider variety of family planning methods and information.		Increase coverage of private sector services			
Social Marketing	Support distribution of a wide range of contraceptive methods and promotion of healthy family planning behaviors through social marketing.		Increase coverage of private sector services			Secondary: provide subsidized products
Community Health Workers	Integrate trained, equipped, and supported community health workers (ChWs) into the health system.		Secondary: reach remote populations	Reach underserved communities		