Supporting Measurement and Replication Techniques for Family Planning High Impact Practices: An Assessment of the Scale, Reach, Quality and cost of Implementation in Uganda

DATA DOCUMENTATION

1. INTRODUCTION

The Family Planning High Impact Practices (HIP) initiative is a multi-organization effort started in 2010 that aims to highlight evidence-based practices that are vetted by experts against specific criteria, and that, when scaled up, will maximize impact in family planning (FP). HIPs are identified based on demonstrated impact on contraceptive use, scalability, sustainability, cost-effectiveness, and applicability in a wide range of settings. The HIP initiative is supported by more than 30 organizations that play a key role in developing, reviewing, disseminating, and implementing HIPs. Since the initiative began in 2010, 20 HIP briefs which contain evidence of impact and implementation tips for each practice have been developed and shared. HIPs briefs are designed to increase the reach and impact of FP to more women, including adolescents, and men, by making evidence more available and easier to use, helping countries prioritize their investments, and, as a global FP community, building consensus around interventions that work. Each practice is classified as either a proven (sufficient evidence exists to recommend widespread implementation) or promising (some evidence exists that the practice could lead to impact, but more research is necessary to understand implementation experience and impact) across three categories of enabling environment, service delivery, and social and behavior change (SBC). HIP implementation occurs within programs and projects that can be supported by a range of international and local organizations—referred to as managing authorities in this protocol and inclusive of the MOH, international and local implementing partners and private agencies.

The promotion and implementation of HIPs has steadily grown in low- and middle-income countries over the past decade, with countries including them in their FP2020 engagements and within Costed Implementation Plans (CIPs). Yet there is a dearth of information that would help the FP community at both the country and the global level understand whether HIP adoption and scale-up are happening according to the evidence base and how best to optimize implementation and scale-up. Data about the geographic coverage, reach, and quality of HIP implementation will be beneficial to policy makers and program implementers, including Ministries of Health (MOHs), helping them make decisions about how to adjust implementation and scale-up to address issues of quality or inequitable access. Additionally, an understanding of initial versus annualized costs, key cost drivers, and potential economies of scale can help inform policy endorsing introduction or national scale-up of a HIP, along with related funding decisions.

This work to measure HIP implementation and scale-up occurred in Mozambique, Nepal, and Uganda under the USAID-funded Research for Scalable Solutions (R4S) project and Nigeria and Burkina Faso under the Gates-funded SMART HIPs project. The approach for measuring scale, reach, quality and cost was replicated in each country. HIPs varied by country and covered immediate postpartum FP (IPPFP), community health workers (CHWs), post-abortion FP (PAFP), pharmacies and drug shops (PDS), and mass media (MM). Table 1 outlines the HIPs selected in each country. This documentation is specific to Uganda.

Table 1: Country and HIP Matrix

Country	Funder	HIP				
		IPPFP	**CHW**	**PAFP**	**PDS**	**MM**
Mozambique	USAID			X		
Nepal	USAID	X	X			
Uganda	USAID	X	X		X	
Burkina Faso	Gates	X				X
Nigeria	Gates	X		X	X	X

2. STUDY OBJECTIVES

The goal of this assessment is two-fold: 1) to generate evidence to help countries reflect on and optimize implementation of HIPs and 2) to inform harmonized, globally and locally relevant measurement standards for HIPs. Specific objectives of this assessment in Uganda are to:

1. Measure the vertical scale of implementation of selected HIPs.
2. Measure the horizontal scale and reach of selected HIPs to sub-populations.
3. Assess quality of implementation of selected HIPs, including policy-level intention and readiness to offer the intended standard of care and/or to adhere to SBC industry standards.
4. Estimate the costs of implementing and sustaining implementation and identify the cost drivers and efficiencies for selected HIPs.

3. STUDY DESIGN

This study was conducted in five districts of Uganda, including Mukono, Kampala, Gulu, Tororo and Kyenjojo. The assessment covered three HIPs including Community health workers, immediate postpartum family planning and Drug shops. This assessment of scale, reach, quality and cost of HIP implementation used a cross-sectional, observational design with the following data sources:

- Key informant interviews (KIIs) with FP program managers from the different implementing partners, and MoH
- Service statistics (IPPFP)
- Review of HMIS forms
- Health facility assessment and a survey with FP providers (IPPFP)
- Survey with drug shops and drug shop operators
- Survey with Community Health workers
- Activity-based costing (all HIPs)

This document includes only information related to the quantitative data. It does not include any information about the qualitative data, service statistics, or costing data, which are not being shared due to the terms of the project open data management plan, privacy concerns, and data privacy agreements with countries.

Study Populations

Key Informants

- National FP program managers at the Ministry of Health (MOH)
- Technical staff from managing authorities supporting HIP implementation in Uganda

Facilities

- Facility providing IPPFP

- Drug shops providing FP

Providers

- IPPFP Providers
- Community health workers providing FP
- Drug shop operators providing FP

All study participants were 18-years-old or older and consented to be interviewed. Data were collected between August 2023 and September 2023

Sampling & Recruitment

Key Informants

The sampling unit for scale and reach was organizations, or managing authorities, that support the practices to be assessed (CHWs, drug shops and IPPFP). We conducted a census sampling by collecting data from all managing authorities supporting one or more of the selected HIPs (i.e., MOH, implementing partners and private/not-for-profit agencies). To conduct the initial interview, the local research team first re-contacted all managing authorities that are supporting the implementation of the relevant priority HIPs in Uganda to introduce the assessment. Initial points of contact were asked to 1) make introductions with project/program directors to seek consent for inclusion in the assessment and 2) recommend individuals within their organization with relevant input to contribute and provide contact information for them. The process was repeated as needed until knowledgeable informants were identified. Key informants were contacted through their work by phone, e-mail or in person, as appropriate, to set up a time for an interview. The research team sent an e-mail reminder one day prior to the interview, and interviews were re-scheduled, as necessary, up to three times. After three requests to re-schedule, the research team reverted to the program/project director that assisted with sampling and requested for an alternative candidate to interview.

Readiness assessment

Sampling frame: The readiness assessment was conducted at the level of service delivery we generated the appropriate sampling frame for each population as follow:

- For IPPFP, we obtained master listings of public and private health facilities from relevant managing authorities for the selected districts. We collaborated with district health teams and program managers to identify the subset of health facilities implementing IPPFP.
- For CHWs we worked with district health teams and implementing partners to generate a list of public health facilities to which eligible CHWs are linked for reporting.
- For drug shops, we collaborated with the Ministry of Health, the National Drug Authority, district drug inspectors to identify drug shops that are registered and actively operating. we also attempted to establish a list of non-reporting drug shops to the extent possible in order to support an exploration of the services they are actually delivering and the reasons why they are not reporting into the HMIS.

We also used the HMIS as a starting point for verifying basic eligibility across HIPs.

Sample selection

IPPFP

- The readiness assessment for IPPFP consisted of two surveys: a health facility questionnaire administered to the facility in-charge and a provider survey. The sampling design for IPPFP included a random selection of health facilities. A 95% facility response rate would resulted into a target of 136 sampled facilities, hence targeted to conduct 136 interviews with the in-charge or managers across the selected districts.
- Within each facility, we purposively selected up to two providers that had provided FP counseling to a postpartum mother (after delivery and before discharge from the facility) within the three months preceding the survey and were available on the day of the visit. Purposive sampling was used given the narrow eligibility criteria (e.g., some facilities may had only one eligible provider) and the logistics of needing to interview appropriate providers that were available on the day of data collection. Given that we targeted 136 facilities, this would result in up to 272 provider interviews for IPPFP.

CHWs

- Sampling for CHWs was conducted in two stages. Assuming an ICC of 0.05, an average number of 10 eligible CHWs per reporting facility, and a response rate of 90%, we would need approximately 210 CHWs selected for the survey. Since we planned to interview 10 providers per health facility, this equaled to 21 total health facilities randomly selected using proportional allocation by strata across the five districts. Within each of the 21 facilities, CHWs were also selected using systematic sampling.

DSOs

- Assuming a 90% drug shops response rate, we needed 144 interviews with the in-charge or managers of randomly sampled drug shops. In addition, based on practical considerations, we included up to 10 non-reporting drug shops across selected districts to support a descriptive exploration of the services being offered and the reasons for non-reporting, which would correspond to interviews with an additional 10 DSOs.

Sampling procedure

We drew the samples for each HIP separately. From all regions/districts, we created a master list of all eligible facilities (or drug shops). Each facility was labeled by its facility type (e.g., referral hospital, Level 4, Level 3, Level 2, etc.). We also included a list of all managing authorities categorized by type (e.g., public, international organization, local organization) operating in each district. The list of facilities implementing IPPFP across all selected districts were stratified by facility level as well as type of managing authority. One list of facilities with reporting CHWs from all selected districts was stratified by type of managing authority (e.g., public, international organizations, and local organizations). One list of drug shops was stratified by type of managing authority only (e.g., public, international organizations, and local organizations. We sought to select at least two facilities per strata, but strata were collapsed depending on size. We selected a proportionate stratified random sample of the 144 drug shops facilities across all districts.

Participant recruitment and selection

- For IPPFP, respondents for the health facility survey were the in-charge or manager of the health facility. We worked with district health offices (DHOs) in each district to identify a list of appropriate facilities and made contact with the facility in-charge via phone. These initial contacts were to inform the in-charge of the survey and to coordinate a date to visit the facility. In-charges were asked to request that all eligible providers of IPPFP also be available at the facility on the scheduled date to participate in a provider interview.
- For CHWs and drug shops, eligible participants consisted of CHWs and DSOs who had received training and had been providing FP services for at least three months and who have served at least one client in the past three months. Because CHWs are affiliated with local health facilities, RAs worked with health facility managers to generate a sampling list of all CHWs working in the facility catchment area.
- For drug shops, RAs requested district drug inspectors, to generate a list of known DSOs to approach. The study team made initial contacts with DSOs via phone, email, or in person to introduce the study, confirm eligibility, and gauge interest. The study team worked with the DSO to schedule a date, time, and location for the survey with interested participants.

Sample Size

	IPPFP	**CHW**	**PDS**
Key informants			
MoH	3	3	3
IPs managing authorities	11	8	5
Facility	96	-	110
Provider			
IPPFP provider	179	-	-
CHWs	-	78	-
DSO	-	-	110

4. DATA COLLECTION

Data were collected from:

- Key informants from June 2022 to August 2022
- Readiness assessment, August 2023 and September 2023

Data were collected by trained research assistants with both virtual and in-person interviews. Quantitative Data were entered at the time of the interview onto tablets in Open Data Kit (ODK). Qualitative interviews were audio recorded.

5. DATA MANAGEMENT

Research assistants collected and entered data in the field using tablets. Data were transferred to a secure server when a wireless connection was available.

Data were cleaned in STATA. Study data are contained in 4 datasets:

- Uganda_CHW_data.csv
- Uganda IPPFP facility data.csv
- Uganda IPPFP prov data.csv
- Uganda_PDS_data.csv

Qualitative data was audio recorded and transcribed verbatim.

Variable Naming Conventions

Variables in each dataset correspond to questions asked within the questionnaires. The codebooks show which variables correspond to which questions.

Datasets were cleaned to deidentify or remove variables that may be used to triangulate which facilities were visited during data collection.

6. LIMITATIONS

The goal of this assessment was to develop and apply an approach to measure scale, reach, quality, and cost of service delivery HIPs that is replicable to the extent possible. The use of program data is both a strength and a weakness. On the one hand, making use of regularly collected data provides an opportunity for countries and implementing partners to replicate this approach. However, program data was not consistent across managing authorities, and certain data elements were not captured. Furthermore, the HMIS does not capture service data per HIP, making it difficult to assess reach of the HIPs. We worked with implementing partners to capture some reach data and also reviewed HMIS forms. We documented data quality challenges and provided recommendations for improving the collection of key indicators as part of our findings. Relatedly, because of these gaps in existing data, we conducted primary data collection to fully meet our research objectives. In addition, results from the readiness assessment are applicable to the districts selected and may not adequately represent other districts in each country. However, due to the fact it was challenging to locate some of the drug shops, some had shifted, it was not possible to obtain all the targeted sample sizes. In assessing policy core components of quality, reliance on self-reporting carries a risk of reporting bias. To mitigate this risk, we triangulated this with observations and requested for supporting documentation as a verification.