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

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 Nepal.

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 Nepal are to:

1. Measure the vertical and horizontal scale of implementation of CHW and IPPFP HIPs.
2. Measure the reach of IPPFP and CHW HIPs to sub-populations by age, urban/rural location, and other dimensions of equity, as feasible and relevant.
3. Assess quality of implementation of CHW and IPPFP 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 CHW and IPPFP HIPs

3. STUDY DESIGN

This study was conducted in 7 districts of Nepal. The IPPFP HIP was assessed in a subset of 7 districts: Kailali, Dang, Makawanput, Mugu, Dhanusha, Dhankuta, and Kaski, while the CHW HIP was assessed in a subset of 4 districts: Dhanusha, Kaski, Dang and Kailali. 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 within the Family Welfare Division (FWD) supplemented with desk review of relevant national-level documents (all HIPs)
- KIIs with program managers at organizations implementing/supporting implementation of the HIPs and desk review of relevant records or documents (all HIPs)
- Service statistics (all HIPs)
- Health facility assessment and a survey with FP providers (IPPFP)
- Surveys with CHWs (CHWs)
- 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 FWD focusing on the HIPs
- Program managers at organizations implementing/supporting the implementation of the relevant HIPs in the past 2 years

Facilities

- Birthing centers with at least 1 delivery per month for the previous 3 months

Providers

- Provider who has provided FP counseling to a postpartum mother within the last 3 months

CHWs

- Trained CHW who has been providing FP for at least 3 months

All study participants were 18 years old or older and consented to be interviewed. Data were collected between October and December 2023.

Sampling & Recruitment

Key Informants

The sampling unit for scale, reach, and policy core components is organizations, or managing authorities, that support the HIPs. Sample size estimates were based on preliminary information collected through an indicator inventory exercise. One or more key informants were recruited from each managing authority through a consultative process, and one or more KIIs with MOH FP program managers and/or policy makers were conducted to collect data on vertical scale.

Health facility population (conducted with facility in-charge) (IPPFP)

Facilities were eligible if they were a birthing center and had at least 1 delivery per month for the previous 3 months. All eligible facilities were selected.

Primary respondents to the health facility questionnaire were the in-charge of the facility; after they provided written consent for the health facility, these respondents could solicit input from other staff based on expertise relevant to specific questions.

Providers (IPPFP)

Provider participants must have provided FP counseling to a postpartum mother within the last 3 months. All participants had to be at least 18 years old and consent to participate in the interview. 2 providers were interviewed who have provided FP counseling to a postpartum mother within the last 3 months at an eligible health facility.

Female Community Health Volunteers (FCHVs) (CHW)

Facilities were randomly sampled from a sample of facilities that had at least 10 FCHVs. 10 FCHVs who were trained and had been providing FP for at least 3 months were interviewed from each selected health facility. If there were more than 10 FCHVs, a systematic random sampling technique was applied.

Sample Size

	IPPFP	**CHW**
Facility	140	21
Provider	270	176

4. DATA COLLECTION

Data were collected from:

- All data for readiness assessments were collected between October and December 2023
- KIIs were conducted between September and November 2022.
- Data were collected by trained research assistants with in-person interviews. Data were entered at the time of the interview onto tablets in Open Data Kit (ODK).

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 SPSS. Study data are contained in 3 datasets:

- Dataset 1 – HIPs_Nepal_Dataset_CHW
- Dataset 2 – HIPs_Nepal_Dataset_IPPFP_Health_Facility
- Dataset 3 – HIPs_Nepal_Dataset_Service_Provider

In dataset 1, each row represents an individual (female community health volunteer (FCHV)). In dataset two, each row represents a health facility. Finally, in dataset 3, each row of data represents an individual (healthcare provider).

Variable Naming Conventions

Variables in the 3 datasets were aligned to their respective questionnaires. Variables were named according to the question numbers (e.g., Question 101 is variable q101).

To de-identify the data, all variables with identifiable data that were not ultimately used in analysis were removed from the datasets, including interviewer data and tablet ID information. For variables with identifiable data that were used in analysis, such as regions and health facility names, unique identifiers were created and assigned. Any re-assigned values matched across all datasets – for example, a unique identifier for a health facility name is the same across the provider and health facility datasets. In addition, codebooks were generated that match the de-identified datasets.

While data is accurate for the facilities in the sample, the sample is not nationally representative, so the data and any findings are not generalizable.

6. DEFINITION OF VARIABLES & VARIABLE CREATION

All variables used in the analysis are defined in the codebooks linked to each dataset, which are part of this data documentation package. In addition, the Statistical Analysis Plan (SAP) explains the combination of variables that led to the calculation of the core components.

How to identify the single response variables and multiple response variables in the dataset?

The column 'Type of response' in the 'HIPs_Nepal_Codebook_CHW_HealthFacility_ServiceProvider' document under 'Variable Information' section indicates whether the response is single or multiple response. SR represents single response whereas MR indicates multiple responses.

How are multiple responses recorded in the code book and data set?

The variables marked as MR in codebook are multiple responses and are recorded in data in list format under assigned variables. The recorded values/responses in data set are listed in order as mentioned by the respondents as shown in figure below.

CR	CS	CT	CU	CV	CW
s201a	s201b	s201c	s201d	s201e	s201f
b	c	d			
a	b	f			
a	b	c	d	f	
c	d	f			
f					

As shown in figure above, the values for s201a to s201f are entered in list format. In question s201 a total of 6 responses are possible. Here, first response is recorded as (b, c, d) which means respondent only these mentioned three responses out of total six responses. For instance, fifth response only mentioned one and it was entered in first variable column.

s201a to s201f	a	Client-centered counseling
	b	Providing short-acting FP methods to PP women
	c	Inserting PP IUD within 10 minutes of delivery
	d	Inserting IUDs more than 10 minutes but within 48 hours of delivery
	e	Inserting IUDs intra-cesarian
	f	Inserting contraceptive implants

The value labels of the multiple responses are presented in 'HIPs_Nepal_Codebook_CHW_HealthFacility_ServiceProvider' under 'Variable Values' section in the pattern as indicated in above figure.

How to link value labels with variable label?

The name of the variable and value labels are same. For instance, if a variable name is s201a in the 'Variable Information' section in the 'HIPs_Nepal_Codebook_CHW_HealthFacility_ServiceProvider' document then the name of value linked with s201a will also be s201a. The value labels are stored under 'Variable Values' section. Please refer to the images below.

s201a	Are there health care workers in this facility trained in any of the following:	MR
s201b	Are there health care workers in this facility trained in any of the following:	MR
s201c	Are there health care workers in this facility trained in any of the following:	MR
s201d	Are there health care workers in this facility trained in any of the following:	MR
s201e	Are there health care workers in this facility trained in any of the following:	MR
s201f	Are there health care workers in this facility trained in any of the following:	MR

s201a to s201f	a	Client-centered counseling
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7. LIMITATIONS

Despite the use of random sampling of health facilities from the four selected districts for the CHW HIP, results from the readiness assessment for CHWs are applicable to the geographic areas selected and may not adequately represent other parts of Nepal. Additionally, the main cadre of CHW analyzed here are FCHVs. There may be some discrepancies in how these volunteers are trained and operate compared with formal CHW guidance in Nepal.

Additionally, despite the selection of all birthing centers for the IPPFP HIP across all seven districts, the results cannot be considered nationally representative, especially as there were challenges understanding which health facilities support IPPFP and are actively conducting deliveries. Furthermore, differences in interpretation/operationalization of both HIPs across implementing partners and health facility levels in Nepal led to some challenges. The determination of what services facilities at different levels are authorized to provide was based on country guidance for the public sector. Additional adjustments may be needed in the future for the private sector. Country guidance based on facility level provides an objective benchmark; however, we note that in some contexts, actual service provision reflects availability of qualified staff and may not align with facility level. Task-sharing in particular is widespread in Nepal and can cause variation in the services available at a facility at a given time.

In KIIs, reliance on self-reporting carries a risk of reporting bias. In addition, sample sizes were small, making it hard to reach saturation.