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

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 Mozambique.

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 Mozambique are to:

1. Assess scale of implementation of post-abortion FP High Impact Practice (HIP)in Cidade de Maputo, Província de Sofala, Província de Cabo Delgado, and Província de Nampula.
2. Assess the reach of post-abortion FP HIP to sub-populations by age, and urban/rural location.
3. Assess quality of implementation of post-abortion FP HIP, including readiness to offer the intended standard of care.
4. Estimate the costs of implementing and sustaining implementation and identify the cost drivers and efficiencies for the post-abortion FP HIP implementation in 4 provinces.

3. STUDY DESIGN

This study was conducted in four provinces in Mozambique (Cidade de Maputo, Província de Sofala, Província de Cabo Delgado, and Província de Nampula) and covers the post-abortion FP (PAFP) HIP. 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 in the MOH supplemented with desk review of relevant national-level documents
- KIIs with program managers at managing authorities and desk review of relevant records or documents
- Service statistics
- Health facility assessment and a survey with FP providers
- Activity-based costing

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) focusing on PAFP
- Program managers at managing authorities currently supporting implementation of PAFP in target provinces

Facilities

- Facility providing PAFP

Providers

- Provider providing PAFP

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

Sampling & Recruitment

Health facility population

The steps involved in this process:

1. Scheduling dates for the visit to the Provincial Directorate of Health (Direcção Provincial de Saúde – DPS), in coordination with the MoH official responsible for sexual and reproductive health.
2. Visits to the DPS to present the study, which culminated with the request to share a list of health facilities in the province, by district;
3. In parallel with request for list of health facilities, the DPS representatives were asked to use the following criteria for selection:

   a. Select 2 - 4 districts per province;

   b. Prioritize districts that offer good geographic proximity;

   c. Prioritize districts which have health facilities that offer safe abortion / post abortion care services;

The resulting lists of Health Facilities were sent in different ways. In Nampula, these were provided during the visit to the province. From Sofala, these were sent via email following the visit. Almost all provincial health authorities included HMIS data on which facilities were providing abortion services. These data only include # of women admitted for abortion or post abortion care, not those which received a FP method, since the information on FP provision is available at HF level only.

Private sector HFs (for which HMIS data is not available) were added to the list based on discussions with managing authorities which took place in Phase I of the study, and by asking the provincial health authorities if they were aware of private sector providers. The criteria for inclusion of a private sector HF was: must be providing abortion services and cannot be a private practice of an individual provider. Private sector HFs are low in the sample: eight (8) HFs are from private sector and only in Maputo City, Nampula and Cabo Delgado provinces.

The lists made available by the provinces included health facilities which did not meet the established inclusion criteria based on # of abortions performed in last 3 months and geographic proximity), which is the basis for how the team made the selection, leaving only 63 Health Facilities. There was not an exact

/ standard cut off number for number of abortions performed which was applied to all districts, rather we looked for higher number of abortions performed combined with geographic proximity on a province-by-province basis.

Key Informants

A full list of managing authorities for implementation of post-abortion family planning in four provinces (Cidade de Maputo, Província de Sofala, Província de Cabo Delgado, and Província de Nampula) was developed through an independent, participatory mapping process between R4S, MISAU and other key stakeholders. It was updated by the study's consultant before data collection. Initial points of contact were asked to facilitate an introduction with the project/program director with whom a letter of information about the project will be shared. Directors were asked to recommend individuals within their organization with relevant input to contribute and to provide contact information for them. The process was repeated as needed by going back to the director or points of contact until knowledgeable key informants could be found.

Sample Size

	PAFP
Key informants	
KI MoH	2
KI MA	18
Facility	61
Provider	122
Costing	10
Facility register review	48

4. DATA COLLECTION

All data were collected from November to December 2023. 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 Stata. Study data are contained in 2 datasets:

- HIPs_Moz_HF_PAFP_Data.csv
- HIPs_Moz_PROV_PAFP_Data.csv

Variable Naming Conventions

Variables in each dataset correspond to questions asked within the health facility and provider questionnaires. The codebook shows 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. The "id facility" variable can be used to understand which provider responses are aligned to which facility and link the health facility and provider datasets. This unique facility number was randomly assigned and deidentified.

6. LIMITATIONS

One study limitation is reliance on HMIS and program data which may contain missing data or lack of standardization of indicators and reporting formats across managing authorities implementing or supporting PAFP. Additional challenges are related to capturing training indicators as these may be captured in different formats depending on the managing authority. Differences in indicators and reporting processes, as well as in political, cultural and operational contexts may limit the comparability of findings. Similarly, making broad generalizations from these data may not be possible, particularly with findings from the cost analyses.

Results from the readiness assessment for PAFP are applicable to the geographic areas selected and may not adequately represent other parts of Mozambique.

In assessing policy core components of quality, reliance on self-reporting carries a risk of reporting bias.