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

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 Burkina Faso.

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

Finally, two HIPs were implemented in Burkina Faso as the previous table show. These HIPs are IPPFP and MM.

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 Burkina Faso are to:

1. Measure the vertical and horizontal scale of implementation of selected HIPs.
2. Measure the reach of selected HIPs to sub-populations by age, urban/rural location, and other dimensions of equity, as feasible and relevant.
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
5. Develop and recommend measurement standards for HIPs implementation and scale-up, including the definition of core components and indicators, through an iterative consultative process with country and global stakeholders.

3. STUDY DESIGN

This study was conducted in 2 regions Burkina Faso – the Centre region (Ouagadougou), the Haut-Bassins region and covers IPPFP and MM. 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 and health promotion/Social and behavioral communication (SBC)/Information, education and communication (IEC) program managers at the Ministry of Health (MOH) and desk review of relevant national-level documents.
- KIIs with program managers at implementing partners and managing authorities and desk review of relevant records or documents.
- Analysis of service statistics (IPPFP) and media plans (MM).
- Readiness assessment, including a health facility questionnaire and a survey with FP providers (IPPFP) and a desk review of media plans and strategies of mass media products (MM).
- Activity-based costing.

This current document includes only information related to 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 MOH

- Program managers at managing authorities are currently supporting implementation of IPPFP in Centre and Hauts-Bassins regions.
- Relevant SBC technical leads within health promotion-focused units or vertical health units within the MOH
- Program managers/SBC technical advisors at managing authorities supporting MM implementation with active mass media programming in the past nine months in Centre and Hauts-Bassins regions (sub-contractors that are disseminating mass media, such as creative firms, may also be included if some information on relevant topics cannot directly be obtained from initial key informants).

Facilities

- Facilities providing IPPFP

Providers

- Providers providing IPPFP

All study participants were 18 years old or older and consented to be interviewed.

Sampling & Recruitment

Key Informants

A full list of managing authorities that implemented IPPFP and mass media in Centre and Hauts-Bassins was developed through an independent, participatory mapping process. Key informants were adults selected based on their relevant experience by virtue of their professional positions. We conducted interviews with a range of key informants, as noted below.

Health Facility Population (conducted with facility in-charge)

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 confirm the subset of health facilities that implemented IPPFP. We then selected a proportionate stratified random sample of health facilities, with the relevant type of managing authority (MOH, implementing partner, private) and facility type/level in the health system as stratification variables.

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 solicited input from other staff based on expertise relevant to specific questions.

Providers

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 confirm the subset of health facilities that implemented IPPFP. We then selected a proportionate stratified random sample of health facilities, with the relevant type of managing authority (MOH, implementing partner, private) and facility type/level in the health system as stratification variables.

Respondents for the health facility survey were the in-charge or manager of the health facility. All providers who had provided FP counseling to a postpartum mother (after delivery and before discharge from the facility) within the three months preceding the survey and who were available on the day of the visit were invited to participate in an interview for the provider survey.

Sample Size

	IPPFP	MM
Key informants	20	15
Facility	73 Health facilities	
Provider	144	

4. DATA COLLECTION

Data were collected by trained research assistants through in-person interviews and entered onto tablets using Open Data Kit (ODK) at the time of the interview.

5. DATA MANAGEMENT

Management of Fieldwork: All participants in KIIs, the health facility assessment, and the provider survey were assigned unique identification numbers to facilitate data tracking and management. Contact lists, including names and contact details of key informants and health facility managers, were maintained to facilitate arrangements during the data collection period and track response rates. These lists, whether paper or electronic, were used for organizational purposes only and were not linked to any data collected. They were kept secure and destroyed after data collection was complete.

Survey ID numbers were not linked to any identifiable information. Research assistants did not have documents identifying participants' names and addresses in KIIs, the health facility survey, and provider interviews. All results were aggregated to appropriate levels when sharing findings to prevent deductive disclosure. Final datasets, KII transcripts, and costing matrices will be kept in project files at FHI 360 for three years, as per FHI 360 policy.

Key Informant Interviews (KIIs): KIIs were recorded and transcribed directly from the interview language into French by research assistants into word-processing files. Potentially identifying information, such as proper names of people or places, was redacted from transcripts before data or results dissemination outside of the study team. The local co-investigator or a designated representative (such as RA supervisors) checked transcripts against audio recordings for completeness and accuracy. De-identified transcripts and audio recordings were uploaded onto a secure portal; some transcripts were sent via secure email (e.g., as password-protected files) during data collection for rapid feedback by investigators. All audio recordings were deleted after receiving confirmation from the investigators that the analysis was complete.

Service Statistics (Service Delivery HIPs): Service statistics were collected electronically. They were extracted from the national HMIS or obtained directly from participants in the format used by the program or by completing an Excel workbook shared by the study team based on data availability, practicality, and preference. Datasets contained aggregated, routine service statistics but did not include any individual-level data. They were downloaded directly (HMIS) or received from participants via email or on an external drive. Datasets were uploaded to a secure server for cleaning and analysis.

Health Facility Assessment and Survey with FP Providers: Survey data were collected electronically on password-protected tablets. Procedures were put in place to minimize errors in data entry, including

restricting value ranges, establishing logic checks, and automated warnings if data fields were incomplete for any question. During data collection, data were uploaded to a secure server daily or as soon as an internet connection permitted for monitoring. Survey data underwent a quality assurance check. Quality assurance procedures were jointly developed and agreed upon by FHI 360, Makerere University School of Public Health, and EVIHDAF.

SBC Strategies/Plans and Media Products (Mass Media): Desk reviews of these program documents were conducted by trained SBC consultants using structured templates and checklists in Excel or Word, though some handwritten notes were taken first. Handwritten notes were destroyed after confirmation by the study team that no clarifications were needed. SBC strategies/plans and media products are program documents and do not contain any individual-level data. Electronic copies of SBC strategies/plans and media products and completed templates and checklists were uploaded to a secure server by research assistants or supervisors.

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. Study data are contained in quantitative datasets:

Dataset 1 – HIPs_BurkinaFaso_Data_IPPFP_Health_Facility: Each row represents the surveyed health facilities providing IPPFP services in the Centre and Haut Bassins regions.

Dataset 2 – HIPs_BurkinaFaso_Data_IPPFP_Provider: Each row represents the available providers who provided IPPFP services in the surveyed facilities within the last three months.

Quantitative data (service statistics, survey data, and costing data) were analyzed in Excel, SAS, SPSS, and/or Stata. Quantitative analyses were primarily descriptive. To respond to objective 3 on quality, the primary outcome for the readiness assessment for IPPFP was the proportion of health facilities that attained a passing readiness score. Variables related to these outcomes were presented as proportions with 95% confidence intervals or as means and standard errors. For mass media, a similar report on the proportion of programs meeting pre-determined quality standards was provided. However, this outcome was reported descriptively because it was based on a purposive sample of programs selected to illustrate the breadth of mass media programming. The cost of HIP implementation was initially calculated for each managing authority. Given the heterogeneity in program implementation and to prevent deductive disclosure, pooled findings highlighting the midpoint and range of cost across managing authorities that met a passing readiness score for a given HIP were presented.

Research analysts coded responses from KII transcripts using a codebook. Analytic memos were prepared to summarize the main themes. Excel and/or NVivo were used to organize the data and support analysis. A detailed analysis plan was developed.

Variable Naming Conventions

Variables had consistent names across the 2 datasets. Variables were named for the question number (ex. Question 101 is variable s101). Variables that do not follow this naming convention are variables that

are not present in the questionnaires, but that may prove helpful in analyzing the data or assessing its quality. They are as follows:

Variable name	Description
eligibility_confirmed	Takes the value 1 if all eligibility criteria are met (e1 - e4) and 0 otherwise.
times_visited	Number of visits to the respondent
results	Interview completed and reasons for non-completion, otherwise
_uuid	Universally unique identifier (metadata) generated by the data collection program. Should not be used to perform any merging operation.

In the codebooks, variable labels are stored under the 'Variable labels' section, and value labels are stored under the 'Value labels' section. Variables can be linked to value labels using labels under the column 'choices' in the 'Variable labels' section. For instance, for the variable id1 in the 'HIPs_BurkinaFaso_Codebook_IPPFP_Health_Facility' document, please refer to 'region_list' in the value labels section for the list of value labels for this variable.

Please also note that the values 88 (Don't know) and 99 (No response) in the data collection form are coded as -88 and -99, respectively, in the datasets and codebooks. For details on variable and value labels, please refer to the codebooks.

Merging datasets

Provider data can be merged with the corresponding health facility data using either the id3 variable or id1-id3 variables. The output will be the same.

Data deidentification process

We systematically removed identifiable data elements, such as names, interview dates, device identifiers, serial numbers, and URLs. Health facilities were randomly ordered, and facility names were replaced with a sequential number from 1 to n. However, the region and district names were retained for analysis purposes.

6. LIMITATIONS

The proposed strategy to rely on service statistics for service delivery HIPs (IPPFP) and on intended media mix, frequency and target audiences in SBC strategies/plans for the mass media HIP supports the goal of helping countries and global actors intentionally reflect on a feasible set of core indicators using an approach they can replicate for measuring HIP implementation and scale-up. However, the use of HMIS and program data brings challenges, such as missing data and lack of standardization of indicators and reporting formats across managing authorities for service delivery HIPs (IPPFP). Additional challenges related to capturing certain data elements such as training indicators as a measure of scale may arise as numbers of trained providers are not typically reported through the HMIS. Similarly, although there are additional dimensions of equity, we anticipate that measures of reach will primarily focus on rural/urban location of service delivery points, client age, and the ability to attract previously untapped population segments such as first-time users of modern contraception.

Despite the use of probability sampling of health facilities from select districts, results from the readiness assessment for IPPFP are applicable to the geographic areas selected and may not adequately represent other parts of Burkina Faso. In assessing policy core components of quality, reliance on self-reporting carries a risk of reporting bias. To mitigate this risk, we will request supporting documentation as a verification. For mass media, our approach involves a purposive sample of programs intended to illustrate the breadth of mass media programming. Related findings will be descriptive and should be interpreted accordingly.

Differences in existing indicators, 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. For example, cost drivers in one context may not be applied elsewhere. To mitigate these risks, we will rely on information gleaned from key informant interviews on implementation challenges to contextualize findings as best as possible. Finally, it may be challenging for certain managing authorities to estimate costs of implementing certain HIPs; as such, we will be clear that our costing work presents best estimates but could include some inaccuracies relative to true costs.