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

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). In Nigeria 4 HIPs was selected. These are IPPFP, PAFP, PDS and MM. In Nigeria four HIPs was selected. These are Immediate Postpartum Family Planning (IPPFP), Post Abortion Family Planning (PAFP)Pharmacy and Drug shop (PDS) and Mass Media (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 Nigeria are to:

- Measure the vertical and horizontal scale of implementation of selected HIPs.
- Measure the reach of selected HIPs to sub-populations by age, urban/rural location, and other dimensions of equity, as feasible and relevant.
- 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.
- 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 two states of the country – Kadouna and Lagos states and covers IPPFP, PFPA, PDS 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 relevant SBC technical leads within health promotion-focused units in the MOH supplemented with desk review of relevant national-level documents (all HIPs)
- KIIs with program managers at managing authorities and desk review of relevant records or documents (all HIPs)
- Service statistics (IPPFP)
- Health facility assessment and a survey with FP providers (IPPFP)
- Analysis of SBC strategies/plans and mass media products (mass media)
- 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) focusing on PAFP, IPPFP, MM and PDS
- Program managers at managing authorities currently supporting implementation of one or more of the selected HIPs in Lagos state;
- SBC technical leads within health promotion-focused units or vertical health units within the state MOH;
- Program managers/SBC technical advisors at managing authorities supporting MM implementation with active mass media programming within the past nine months.

Facilities

- Facility providing PAFP, IPPFP

Providers

- Provider providing PAFP, IPPFP

The PAFP and IPPFP participants were 18 years old or older and consented to be interviewed, responsible for providing PAFP services and finally, has provided PAFP services to at least one client in prior 3 months.

- Patent and Proprietary Medicine Vendors (PPMV) PMVs and Community Pharmacists (CPs) working in selected sites who are responsible for providing PAFP services

The inclusion criteria of PPMVs are being the PPMV, or, if not the owner, the primary operator of the Patent Medicine Shop (PMS), registered with PCN and have been trained and offer family planning services.

The inclusion criteria (CPs) are registered with PCN and have been trained and offer family planning services

Sampling & Recruitment

Key Informants

PAFP, IPPFP, and PDS: One initial Key Informant Interview (KII) was conducted per managing authority, with follow-up interviews conducted with additional key informants within the same managing authority to obtain clarification after reviewing supporting documentation. We interviewed key informants from all managing authorities that met our criteria. We selected a purposive sample of 20 managing authorities to ensure broad representation of the range of programming across the State Ministry of Health (MOH), international implementing partners, local partners, and the private sector.

Mass Media: For mass media, we selected a purposive sample of 20 programs representing the breadth of family planning (FP) mass media programming in study sites. The sample was stratified by type of implementer (government, international implementing partners, local partners, and other organizations) and approximate annual family planning-related mass media budget. Like other High-Impact Practices (HIPs), we anticipated conducting one KII per managing authority, although some follow-up might have been necessary in some cases. Table 4 below provides a summary of the samples by instrument and HIP.

Health Facility Population

We randomly selected a sample of health facilities, community pharmacies (CPs), and Patent and Proprietary Medicine Vendors (PPMV)-operated drug shops within a subset of local government authorities (LGAs) in study states. For CPs and PPMVs, we anticipated selecting a subset of six LGAs to facilitate data collection. The purposive selection of LGAs was informed by the geographic coverage of selected HIPs based on the independent mapping process and discussions with country stakeholders. Selection criteria included representation of different contexts and ongoing implementation of the selected HIPs in the LGA. For practical reasons, preference among the six selected LGAs was given to those with ongoing implementation of all selected HIPs and those incorporating a mix of managing authorities implementing each HIP.

PAFP, IPPFP: A master listing of public and private health facilities was obtained from relevant managing authorities for the selected LGAs. The subset of health facilities implementing PAFP and IPPFP was ascertained by collaborating with state health teams and program managers. A proportionate stratified random sample of health facilities was selected, 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: For providers, managers were informed of eligibility criteria for providers and asked to request that eligible providers be available at the facility on the scheduled date. All providers who were eligible and available were interviewed.

PDS: CPs and PPMVs that were licensed and actively operating were identified by collaborating with the Ministry of Health, the Pharmacy Council of Nigeria, state health offices, state drug inspectors, and, where relevant, implementing partners. A random sample of CPs and PPMVs was selected.

Sample Size

Table 4. Summary of sample sizes per data collection activity and HIP.

	PAFP	PDS	MM	IPPFP
KIIs with national/state level authorities	All relevant			
KIIs with managing authorities	Up to 20	Up to 20	12-20	Up to 20
Facility assessments	73 facilities	---	---	73 facilities
PAFP providers	73+ (at least one provider per facility)	---	---	73+ (at least one provider per facility)
CPs	---	Up to 146	---	
PPMVs	---	Up to 146	---	

4. DATA COLLECTION

Key informant interviews (KIIs) with FP program managers and relevant SBC technical leads within health promotion-focused units in the MOH supplemented with desk review of relevant national-level documents (all HIPs)

- KIIs with program managers at managing authorities and desk review of relevant records or documents (all HIPs)
- Health facility assessment (PAFP)
- A survey/structured questionnaire with FP providers (PAFP),
- A survey/structured questionnaire with FP providers (IPPFP)
- A survey/structured questionnaire with PPMVs and a survey/structured questionnaire with CPs (PDS)
- Review of SBC strategies/plans and media products (mass media)
- Routine service statistics (service delivery HIPs)
- Activity-based cost data (all HIPs)

Prior to data collection, the study team-oriented research assistants (RA) to the specific procedures and tools for the assessment and developed their skills in interviewing techniques. All RAs underwent training in research ethics prior to interacting with participants. Data collection instruments, and relevant informed consent forms, have been discussed in detail to ensure proper understanding. We pre-tested the surveys during training through role play and a field pre-test. Participants in the field pre-test have been recruited based on logistical ease with the assistance of staff at facilities near the training site. Pre-test data were obtained in the same way as analyzable study data; however, they have only been used to finalize the survey. Pre-test data have been deleted from the server once the survey is finalized. No pre-test for KIIs; however, the study team organized debriefs and/or reviewed transcripts after the first few interviews to provide opportunities for detailed feedback to strengthen interviewing skills.
Data were entered at the time of the interview onto tablets in Open Data Kit (ODK).

5. STUDY MONITORING AND DATA MANAGEMENT

FHI 360 worked in close collaboration with EVIHDAF to carry out the research. FHI 360 had ultimate responsibility for the study, provided overall direction and guidance, and coordinated data analysis and the write-up of results. EVIHDAF contracted and oversaw qualified SBC consultants and Akena Associates. The SBC consultants were responsible for the implementation of all activities related to mass media HIP, other than activity-based costing. Akena Associates implemented the assessment for all service delivery HIPs (PAFP and PDS) and the activity-based costing for all HIPs.

In collaboration with EVIHDAF and FHI 360, Akena Associates were responsible for identifying, documenting, mitigating, and reporting any social harms or protocol violations that occurred. All protocol violations were reported to the Lagos State University Teaching Hospital Health Research Ethics Committee in Lagos State, the Kaduna State Health Research Ethics Committee, Kaduna State Ministry of

Health in Kaduna State, and FHI 360's Protection of Human Subjects Committee (PHSC) in the United States.

All participants in KIIs, health facility assessments, and questionnaires with providers, PPMVs, and CPs were assigned unique identification numbers to facilitate data tracking and data management.

Analyses were conducted by staff from FHI 360 in collaboration with EVIHDAF and Makerere University School of Public Health in Uganda. 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 service delivery HIPs was the proportion of health facilities, CPs, or PPMVs that attained a passing readiness score (components of the readiness score were based on the core components described earlier).Data were cleaned in Microsoft Excel. Study data contain in 5 datasets:

- Dataset 1 - HIPs-Nigeria_Assessment_Data_IPPFP_Health_Facility.csv: Each row represents the surveyed health facilities providing IPPFP services in the Lagos and Kaduna states.
- Dataset 2 - HIPs_Nigeria_Assessment_Data_IPPFP_Provider.csv: Each row represents the available providers who have provided IPPFP services in the surveyed facilities within the last 3 months.
- Dataset 3 - HIPs_Nigeria_Assessment_Data_PAFP_Health_Facility.csv: Each row represents the surveyed health facilities providing PAFP services in the Lagos and Kaduna states.
- Dataset 4 - HIPs_Nigeria_Assessment_Data_PAFP_Provider.csv:: Each row represents the available providers who have provided PAFP services in the surveyed facilities within the last 3 months.
- Dataset 5 - HIPs_Nigeria_Assessment_Data_PDS.csv: Each row represents the individual CPs and PPMVs surveyed

Variable Naming Conventions

Variables had consistent names across the 5 datasets. Variables were named for the question number (ex. Question 101 is variable q101). 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
IPPFP Data (Health Facility and Provider)	
available	Informed if a competent respondent is available at the facility on the day of the assessment by taking a value of 1 if yes and 0 otherwise.
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.
PAFP Data (Health Facility and Provider)	

Variable name	Description
eligibility_confirmed	Takes the value 1 if all eligibility criteria are met (e1 - e4) and 0 otherwise.
_uuid	Universally unique identifier (metadata) generated by the data collection program. Should not be used to perform any merging operation.
PDS Data	
eligibility1_confirmed	Takes the value *1* if eligibility criteria *e1 - e4* are met and *0* otherwise.
eligibility2_confirmed	Takes the value *1* if eligibility criteria *Q106 - 111* are met 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.

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

For each IPPFP and PAFP-related data, the provider data can be merged with the corresponding health facility data using either the id3 or id1-id3 variables. However, it is not possible to merge data from one HIP with another (e.g. merging IPPFP data with PAFP data).

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 state and LGA (Local Government Area) names were retained for analysis purposes.

6. LIMITATIONS

The proposed strategy to rely on service statistics for service delivery HIPs 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 brought challenges, such as missing data and lack of standardization of indicators and reporting formats across managing authorities for service delivery HIPs. Additional challenges related to capturing certain data elements such as training indicators as a measure of scale arise as numbers of trained providers are not typically reported through the HMIS. Similarly, although there were additional dimensions of equity.

Despite the use of probability sampling for health facilities, results from the assessment for service delivery HIPs are applicable to the geographic areas selected and may not adequately represent other parts of each country. In assessing policy core components of quality, reliance on self-reporting carries a risk of reporting bias. To mitigate this risk, we requested supporting documentation as a verification. For mass media, our approach involved a purposive sample of programs intended to illustrate the breadth of mass media programming. Related findings have been descriptive and interpreted accordingly.

Differences in existing indicators, as well as in political, cultural, and operational contexts have limited the comparability of findings. Similarly, making broad generalizations from these data has not been possible, particularly with findings from the cost analyses. To mitigate these risks, we relied on information gleaned from key informant interviews on implementation challenges to contextualize findings as best as possible. Finally, it was challenging for certain managing authorities to estimate implementation costs for certain HIPs; as such, we will clarify that our costing work presents best estimates that may include some inaccuracies relative to true costs.