EngenderHealth
for a better life

SEED™ Assessment Guide
for Family Planning Programming

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In 2009, EngenderHealth conducted a systematic literature review to identify the best practices in planning, implementation, and assessment of family planning (FP) programs, including searching for FP program models and conceptual frameworks. Most of the literature compiled focused on individual elements of FP programs, with service delivery models (particularly for clinical services) being the most common. Very few documents addressed FP programs in their entirety, from a conceptual and holistic perspective. Two documents of particular note, however, were identified and have influenced the development of this assessment tool:

- *The Family Planning Effort Index: 1999, 2004, and 2009* (Ross & Smith, 2010) is an analysis of national FP programs. The latest in a series of comparable studies that have been conducted seven times from 1972 through 2009, it measures the strength of national FP programs as perceived by knowledgeable observers.
- *Elements of Success in Family Planning Programming* (Richey & Salem, 2008) provides an overview of 10 key elements of successful FP programs and includes a useful checklist called "Assessing the Elements of Success in Your Program."

ACRONYMS AND ABBREVIATIONS

AIDS .....acquired immune deficiency syndrome
CBHW.....community-based health worker
CBO .....community-based organization
CBS .....community-based services
CHW.....community health worker
CIA .....Central Intelligence Agency (U.S.)
CPR.....contraceptive prevalence rate
CS .....contraceptive security
DFID .....Department for International Development (U.K.)
DHS .....Demographic and Health Survey
FBO.....faith-based organization
FP .....family planning
HCT .....HIV counseling and testing
HEW .....health extension worker
HMIS.....health management information system
HIV .....human immunodeficiency virus
HRIS .....human resource information systems
IEC.....information, education, and communication
IP .....infection prevention
IUD .....intrauterine device
LAM .....lactational amenorrhea method
LA/PM .....long-acting and permanent methods (of contraception)
LMIS .....logistics management information system
MCH .....maternal and child health
MOH.....Ministry of Health
NGO .....nongovernmental organization
PLHIV .....people living with HIV
PMTCT .....prevention of mother-to-child transmission (of HIV)
PRB .....Population Reference Bureau
PRSP .....Poverty-Reduction Strategy Program
QA .....quality assurance
QI .....quality improvement
RH.....reproductive health
SBCC.....social and behavior change communication
SDM .....standard days method
SDP .....service delivery point
SEED.....Supply–Enabling Environment–Demand
SRH.....sexual and reproductive health
STI .....sexually transmitted infection
SWAp.....sector-wide approach
TFR .....total fertility rate
UN .....United Nations
UNESCO.....United Nations Economic, Scientific, and Cultural Organization
UNFPA.....United Nations Population Fund
USAID.....U.S. Agency for International Development
WHO .....World Health Organization

INTRODUCTION

INTRODUCTION

All couples and individuals have the basic right to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and to attain the highest standard of sexual and reproductive health (SRH).[1] In recent decades, the availability and use of family planning (FP) services have risen dramatically (Sitruk-Ware, 2006). Nevertheless, unmet need[2] for contraception remains high, particularly in the world's poorest countries (Sedgh et al., 2007). Due to continuing population growth and changing fertility preferences, the need for FP services in developing countries is projected to increase in the coming decades (RHSC, 2009). Comprehensive assessments are needed to improve FP programs and ensure that they meet the reproductive intentions of their beneficiaries.

The Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning Programming is a tool for identifying strengths and weaknesses in national FP programs through the identification of programmatic gaps that require intervention or more in-depth assessment through other methodologies. The Assessment Guide is primarily written for high- or mid-level FP program managers in ministries of health, donor agencies, or technical organizations, though others working in the area of FP could also find it useful.

What distinguishes this Assessment Guide from previously developed FP assessment tools is its holistic view of FP programming. The Assessment Guide is grounded in EngenderHealth's SEED Programming Model™, which highlights three major components of FP/SRH programs: supply, the enabling environment, and demand. While most other models and approaches[3] focus on one or two of these components, the SEED Programming Model and this Assessment Guide emphasize all three.

1. The Programme of Action from the International Conference on Population and Development (ICPD) in 1994 defined reprodutive health (RH) as "a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. RH therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (UNDPI, 1995, principle 8 and paragraph 7.2).
2. Unmet need for contraception is defined as the percentage of women of reproductive age who would like to prevent or delay pregnancy but are not currently using contraception (IPPF, 2011).
3. Other models or approaches to consider include: the systems framework guiding the ***WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programs*** (WHO, 2007c); Management Sciences for Health's Framework for People-Centered Health Systems Strengthening, in ***Health Systems in Action*** (MSH, 2010); the United Nations' Global Consensus on Maternal, Newborn and Child Health model, presented in ***Investing in our Common Future*** (Ban, 2010); the nine elements of organization of work, presented in an issue of ***Population Reports*** (Setty, 2004); and the ecological model, which originated with Bronfenbrenner (1979).

EngenderHealth's SEED Programming Model

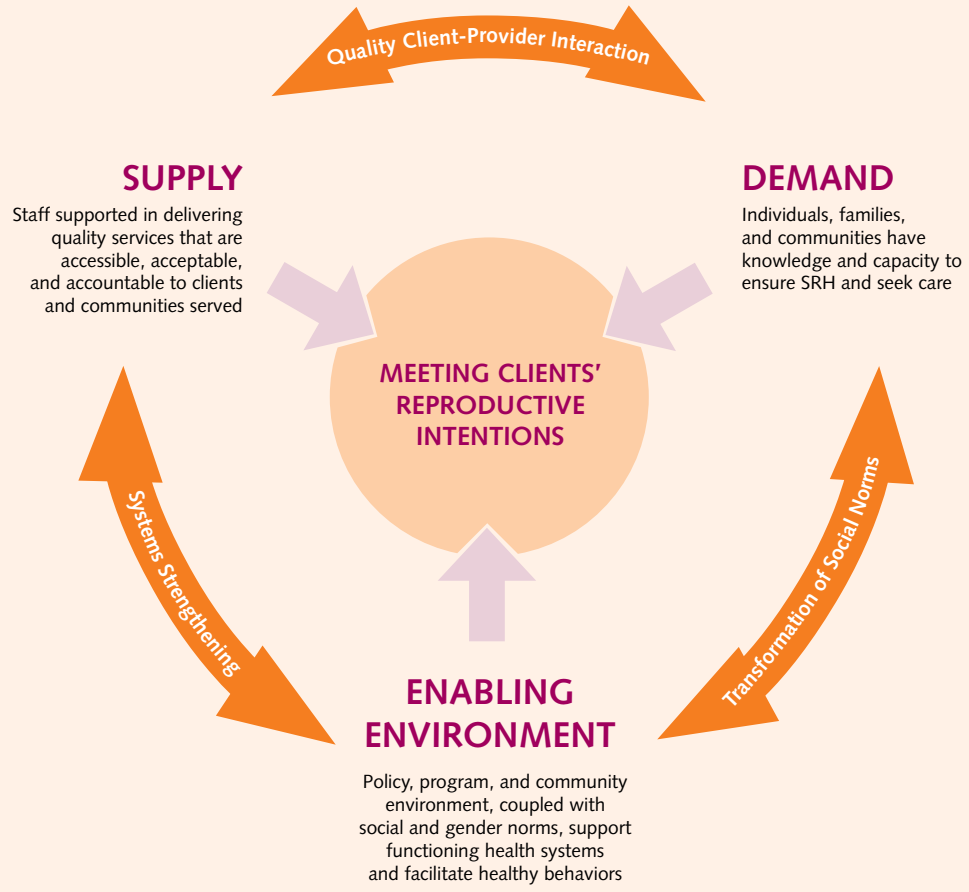
EngenderHealth's SEED Programming Model is based on the principle that FP/SRH programs will be more successful and sustainable if they comprehensively address the multifaceted determinants of health, and if they include synergistic interventions that:

- Attend to the availability and quality of services and other supply-related issues
- Strengthen health systems and foster an enabling environment for FP/SRH-seeking behavior
- Improve knowledge of FP/SRH and cultivate demand for FP/SRH services

The SEED Programming Model explicitly recognizes and responds to the complexity of improving health outcomes, reflecting a growing global recognition of the need for a holistic approach to SRH programming. The SEED Programming Model also recognizes that these three components (supply, enabling environment, and demand) are interdependent and mutually supportive, and suggests that a combination of interventions in these three areas will enable people to meet their reproductive intentions.

The SEED Programming Model builds on much of the thinking that has emerged from decades of FP/SRH program experience, both that of EngenderHealth and that of other technical organizations. In particular, the SEED Programming Model emerged from an earlier iteration—the Supply-Demand-Advocacy (SDA) Model, which was developed by EngenderHealth under the ACQUIRE Project (ACQUIRE Project, 2007).

EngenderHealth's Supply–Enabling Environment–Demand (SEED) Model for Family Planning Programming



Component 1: Supply

Improvements in FP/SRH cannot be achieved without quality services.[4] Quality is considered good when adequate infrastructure, supplies, and equipment are in place. In addition, critical to the provision of high-quality care is the availability of well-trained, skilled, motivated, and supported staff who are performing to established standards and providing services that are accessible, acceptable, and accountable to the clients and communities they serve.[5]

Effective training, supervision, logistics, and referral systems are essential for the delivery of high-quality services. Program managers may need to address the organization of work and service integration, as well as explore public-private partnerships. At the facility level, or for community-based or mobile services, infrastructure may need to be upgraded and the reliable and sustained availability of commodities, equipment, and supplies ensured. Staff must be of adequate number, motivated to provide quality services, and enabled (through managerial support and proper infrastructure) to manage services effectively.

Administrative, financial, and management systems also need to be in place, with administrators focused on evidence-based medicine and the use of data for decision making to improve service quality and plan and manage programs. Further, to ensure quality, health services should be strongly linked with and accountable to the communities they serve. Communities can also be valuable partners in defining and maintaining quality services when given opportunities to participate in overseeing and managing health services.

Component 2: Enabling Environment

A range of interlinked sociocultural, economic, and policy factors influence both the functioning and sustainability of health services, as well as social norms and practices related to health, including FP. An enabling environment for FP requires equitable policies; adequate resources; good governance, management, and accountability; and supportive social norms, including the transformation of inequitable gender norms. If these needs are not addressed during program design and implementation, investments in supply and demand interventions may be neither effective in the short term nor sustainable over time.

Strong and effective leadership is crucial for creating an enabling environment at all levels of the health system and within the community to support and advance FP/SRH. This leadership is needed to promote evidence-based policies, guidelines, and approaches; support the allocation of human and financial resources for FP/SRH; ensure that the health system has the capacity to provide quality services; and challenge social and gender norms that may adversely affect an individual's SRH.

Pivotal to fostering an enabling environment is the need to engage governments, communities, and other members of civil society to move discourse about FP/SRH from the private to the public realm. This encourages discussion and recognition of FP/SRH as both a public health and a rights issue, wherein everyone has a stake in ensuring sexual and reproductive well-being.

4. For a more in-depth discussion of quality, see the Bruce-Jain Framework (Bruce, 1990; Jain, 1989) and Creel et al., 2002.

5. Service providers may be doctors, midwives, clinical officers, nurses, counselors, peer educators, pharmacists, outreach workers, or community health workers. Service sites may be clinical facilities, health and other outreach posts, pharmacies, drug shops, or other venues used to deliver SRH services (e.g., community health worker outlets or visits to clients' homes).

6. Reasons for not using FP might include lack of access, fear of side effects, cost, husband's or religious opposition, etc.

Component 3: Demand

The demand for FP exists in different forms; actual *use* of methods gives only a minimum estimate of total demand. Latent demand exists among two types of nonusers: those who wish to avoid pregnancy but are not currently using FP (those with an unmet need for FP),[6] and those who might wish to avoid pregnancy if they had more information about the benefits of spacing or limiting births. For many, latent demand can be translated into actual use when programs advance positive attitudes toward FP/SRH, address myths and misconceptions, provide evidence-based information about FP/SRH-related issues and risks, and promote available services.

Individuals, families, and communities need the knowledge, capacity, and motivation to ensure FP/SRH and to encourage people to seek services. This requires a range of social and behavior change communication (SBCC) interventions—from reducing the direct and indirect costs of FP to mass media communication, community outreach, and peer education. Such SBCC approaches need to provide clear, factual, and unbiased information, so as to increase people's knowledge and self-efficacy; promote communication among couples, among peers, and within families; and encourage people to seek care and use services. Further, such interventions should be synergistic and mutually reinforcing; this ensures that individuals and families receive consistent information and messages from a variety of different sources and in a range of formats—critical to the adoption and maintenance of new behaviors (Kincaid, 2000).

Synergies among Components

Interventions within any of the three program components—Supply, Enabling Environment, and Demand—do not operate in isolation, as represented in the visual model by the bridging arrows connecting these three areas (page 7). Investments in one component can and will have an impact on the other components, and activities that are well-coordinated and mutually reinforcing will yield optimal impact. The SEED Programming Model highlights three areas of synergy between the program components—quality client-provider interaction, systems strengthening, and the transformation of social norms.

The SEED Model as a Framework for FP Programming

The SEED Programming Model informs this Assessment Guide and contributes to a wide range of program planning functions. Using it can help FP program planners foster a comprehensive approach to program assessment, design, implementation, and evaluation; it also can highlight for them the need to effectively and synergistically address factors related to service delivery and support systems, culture, and communities, as well as policy, governance, and accountability. The Model may also offer a framework for partnering, given that no single entity is likely to have the capacity or interest to address all components of supply, enabling environment, and demand. While one stakeholder may use the Assessment Guide to assess an FP program, implementation of the full SEED Programming Model commonly requires the collaboration of multiple stakeholders with complementary expertise. Finally, the SEED Programming Model can be adapted for use for other health programs beyond FP/SRH.

How to Use This Assessment Guide

This Assessment Guide is informed by existing literature on the characteristics of strong, comprehensive, and high-quality FP programs and distills the most important lessons learned about FP programming into 25 crucial programming elements in the areas of Supply, Enabling Environment, and Demand.

Accompanying each element is a series of detailed assessment criteria to help the assessment team explore the extent to which programming currently addresses the element. The list of elements and accompanying assessment criteria is not meant to be exhaustive, nor are all criteria required to be met. **The team should feel free to exclude, add, and/or modify any of the elements or assessment criteria to make them fit more appropriately into a particular country context or the areas of greatest interest to stakeholders**. Likewise, just as the components of Supply, Enabling Environment, and Demand are interdependent and mutually supportive, there is natural overlap between many of the elements and criteria. The focus should be on assessing whether the relevant elements and criteria are present and indicative of a strong FP program, regardless of whether the assessors consider them as falling strictly within the areas of Supply, Enabling Environment, or Demand. To illustrate such programmatic overlaps, this Assessment Guide indicates where the same assessment criteria apply to multiple elements of strong FP programs. For example, the existence of a reliable supply of contraceptives is listed as a criterion under both Supply and Enabling Environment, to highlight the synergy between these in strengthening contraceptive security (CS). (Assessment criteria listed more than once in the Guide are indicated by a note saying "See also Element X.")

Each program element is laid out in the following format:

1. An *operational definition* of the key concept(s) related to that program element
2. A *rationale* as to why that particular program area was included as a primary element of a holistic FP program
3. A *list of data sources* where the assessment team/key informant interviewer may find information on this program element
4. *A set of assessment criteria*—indicators that the assessment team can look at to help them determine if the program element is in place and what its relative strength is

This Assessment Guide can assist FP program managers to identify key programmatic gaps and areas where a more in-depth assessment with other tools/methodologies might be needed prior to designing programmatic interventions. It focuses on questions that can be answered through a desk review; interviews with FP providers, program managers, and other relevant key informants, such as community representatives; and informal observations of service delivery points. The Guide's users should be sure to seek the appropriate ethical review and approvals before undertaking such information-gathering efforts, in accordance with local procedures.

While this Guide is meant to assess the entirety of FP efforts in place at the national level, it may be adapted to assess the comprehensiveness of a single FP project or the situation at a regional/provincial or district level.

Assessment Team

The scope of the assessment will determine who should comprise the assessment team. The engagement of multiple partners, especially the Ministry of Health (MOH), is essential. It is recommended that evaluators form a small team (3–5 people) to undertake this assessment as a group effort, with one member designated as the Team Leader. The assessment team should include representatives from partners and stakeholders that are positioned to address or implement findings from the assessment; this could include a representative from the national MOH, a major FP donor, and/or staff from an organization implementing large-scale FP activities.

It may also be helpful to have an external (nonnational) member of the team—a consultant or representative of an international nongovernmental organization (NGO) working in FP who is a mid-level or senior professional with experience in designing and implementing FP programs and who may be able to contribute experiences and lessons learned from other countries. This type of assessment does not require clinical expertise to implement, though it may be helpful for at least one member of the team to have a clinical background.

Assessment Process

The amount of time needed to complete this assessment process will vary, depending on its scope, the background knowledge of the assessment team, the ease of obtaining documents for the desk review, and the schedules and availability of key informants. Ideally, for a full program assessment that encompasses multiple levels and geographic areas, a **minimum** of 4–6 weeks should be allotted to complete all four phases of this assessment, from the initial desk review through to the write-up of the final report.

This Guide suggests a four-phase approach:

- Phase I: Desk review
- Phase II: Key informant interviews
- Phase III: Analysis and write-up of the final report
- Phase IV: Discussion of findings with key stakeholders/partners

Phase I: Desk Review

The desk review should produce an evidence-based snapshot of the status of key variables under consideration in the assessment. It should also provide background material for the preparation of the key informant interviews and a framework for the final report. Below are some suggested tasks and resources:

- Review and compile relevant FP/SRH country statistics from key sources, such as project documents; Service Provision Assessments; Demographic and Health Survey (DHS) reports; United Nations Population Fund (UNFPA), U.S. Agency for International Development (USAID), or World Health Organization (WHO) documents; and reports on commodity procurement, among others. Include related development statistics (e.g., poverty levels, geographic access to health services, literacy rates, gender equality).
- Review national policies and guidelines. For example, are national-level FP policy goals focused on improving women's health, decreasing unplanned pregnancies, or lowering national fertility levels? How evidence-based are national guidelines?
- Assess the current programmatic context in which the national FP program operates. Map out who is involved in FP programming (e.g., donors, international and local NGOs, the private sector, specific MOH divisions/departments, and other government entities, such as the Ministry of Education or the Ministry of Finance). Are some partner organizations focused solely on advocacy interventions, while others direct their resources toward service delivery or demand-creation activities?
- Conduct literature reviews of recent research studies (within the past 5–10 years) on FP/SRH-related issues for that country.

The desk review should be as comprehensive as possible, exploring available information on all of the 25 programming elements outlined in the Assessment Guide. Once this information has been compiled and synthesized, key informant interviews should be conducted to investigate outstanding information gaps, as well as to verify or expand on the information in the desk review. It is recommended that the desk review be used as a first draft of the final report. A sample Desk Review and Final Report outline can be found in Appendix A.

Phase II: Key Informant Interviews

The purpose of the key informant interviews is to expand on and supplement information found in the desk review. Interviews should be conducted in teams of two or three. If the assessment team includes more than three members, it is advisable to split into two groups and conduct interviews concurrently. Each group may be able to conduct three to four interviews per day, although this will vary greatly depending on the schedules of key informants, time needed to travel between meetings, etc. Ideally, the full team will debrief daily, sharing notes and impressions, tailoring questionnaires, and preparing for future meetings. The team should avoid conducting more interviews than they have time to analyze.

Appendix B provides sample Discussion Guides for each of the eight categories of key informants, which are outlined below:

1. Government Policymakers and Program Planners/Managers

- Officials in relevant ministries (e.g., Health, Education, Women, Youth, Social Services, Finance)
- Program directors and managers in relevant MOH departments (e.g., SRH, FP, Maternal and Child Health [MCH], the National Pharmacy) at the national, regional, and district levels
- Parliamentarians (e.g., members of FP/SRH-related working groups)
- Representatives of national committees or working groups that address FP

2. Donors and Development Partners

- Representatives of relevant United Nations (UN) agencies
- Representatives of bilateral or multilateral development agencies such as USAID, the UK Department for International Development (DFID), World Bank, Swedish International Development Cooperation Agency (SIDA), Kreditanstalt für Wiederaufbau (KfW), and others

3. Technical Organizations

- Representatives of national NGOs
- Representatives of locally-based international NGOs
- Representatives of for-profit development partners
- Other civil society groups (e.g., an advocacy coalition on FP)

4. Facility-Based FP Providers, Managers, and Other Staff

The team should select service delivery points (SDPs) that are most applicable to the scope and objectives of the assessment. The team may want to interview several staff at a site, including FP providers, managers, and supply clerks. If time allows, it may be informative to visit a selection of various sites, such as:

- Public and private (for-profit or not-for-profit) health centers, dispensaries, and other facilities
- SDPs based in schools and youth centers
- SDPs in rural and urban areas
- SDPs in areas with high, average, and low contraceptive prevalence rates (CPR)
- SDPs in areas that differ demographically or culturally
- SDPs serving special populations, if relevant (e.g., SDPs in refugee camps, people living with HIV [PLHIV])

5. Community-Based Health Workers (CBHWs)

- Community health workers (CHWs)
- Peer educators (e.g., youth, men, satisfied clients, PLHIV)

6. Community Leaders/Groups

- Representatives of relevant community-based organizations (CBOs), especially associations of CBOs (e.g., networks of youth groups, women's groups, PLHIV)
- Religious leaders and representatives of networks of religious leaders
- Traditional leaders

7. Professional Associations of FP Providers

- Representatives of national associations of nurses, midwives, gynecologists, and any other FP providers

8. Trainers of FP Providers

- Representatives of preservice training institutions for nurses, midwives, gynecologists, and other FP providers
- Program managers responsible for in-service training of nurses, midwives, gynecologists, and other FP providers
- Trainers of CBHWs

The assessment team may not have time to interview all potential key informants. It is important to select those who can fill gaps uncovered from the desk review. It is also advisable to prioritize key informants who may have a broader view of the FP program to obtain a more representative picture—for example, representatives of national NGOs, compared with those from a localized community group that works only in a single district or region—to obtain a more representative picture of the national FP program. Further, it is recommended that assessors choose interviewees with an appropriate level of knowledge in their area of expertise, to obtain the most accurate and thorough information possible.

The Discussion Guides will need to be adapted based on the desk review and reflect the objectives of the assessment; they include many more questions than the team will have time to ask. Questions that are answered by the desk review should be removed from the Discussion Guides unless there is a need to confirm the information. The sample questions should be tailored to focus on the expertise of each individual or group interviewed. The process of tailoring or adapting the Discussion Guides should begin during Phase I of the assessment, based on findings from the desk review and identification of areas for which particular information on the national FP program is lacking. In addition, it will be helpful for the assessment team to modify the Discussion Guides between interviews, as some topics may become redundant or additional questions/issues may arise.

The interviewers should become thoroughly familiar with the elements, criteria, and tailored key informant questionnaires prior to commencing interviews. This will allow for the conversation to flow and for the interviewers to ask follow-up questions to gain more in-depth information. Reading directly from the Discussion Guides is not recommended.

A small meeting among assessment team members (and possibly other selected key stakeholders) prior to embarking on the key informant interviews will facilitate group understanding of the scope of work and the approach to the assessment, as well as provide a venue for finalizing the key informant interview list, Discussion Guide questions, and assessment criteria. Appendix C provides a sample SEED Assessment Team Planning Meeting Agenda.

Phase III: Analysis and Write-Up of the Final Report

The team should conduct continuous analysis as they collect data gathered from the desk review and key informant interviews. As data are gathered, analysis will involve comparing data with the assessment criteria listed under each of the guide's 25 elements of a well-designed FP program.

The final report should summarize the assessment's findings, drawing conclusions about the state of the national FP program and highlighting programmatic gaps uncovered during the assessment process. The report should identify where programmatic interventions are needed or where more in-depth investigation is warranted prior to designing programmatic interventions. The final report can also identify areas of the FP program that seemed particularly strong, with demonstrated promising practices that might be further evaluated and/or scaled up. The team may also want to involve additional stakeholders, such as MOH staff and representatives of relevant civil society organizations, in the identification of recommendations and finalization of the report. Appendix A presents a suggested outline for the Desk Review and Final Report. Appendix C presents a suggested outline for a SEED Assessment Findings Review Meeting.

Phase IV: Discussion and Dissemination of the Findings and Recommendations

It is essential for the assessment team to discuss their findings and recommendations with stakeholders to ensure that the assessment will inform programming. An executive summary of the report should be promptly sent to all stakeholders who were involved in the process of implementing the assessment. The assessment team should consider holding an advocacy or dissemination workshop to present findings and recommendations, answer questions, set priorities, and plan next steps. A sample agenda for a SEED Assessment Results Dissemination Meeting is included in Appendix C.

Key Considerations

The value of this Assessment Guide is its ability to present the three components (Supply, Enabling Environment, and Demand) and the respective elements needed for a comprehensive FP program. This Assessment Guide can help to identify areas where more investment may be needed and to encourage FP program managers to pursue a range of programmatic interventions.

However, the assessment team should be aware of some important considerations in the use of this Guide:

- The usefulness of this assessment relies on the quality of the desk review, as well as the assessment team's ability to engage appropriate stakeholders, reconcile different perspectives, and identify critical gaps that may exist, either nationally or in particular geographic regions, or for certain subsets of the population.
- This Assessment Guide is not intended to be used for an in-depth research study or program evaluation. Rather, it is meant to help users broadly explore the key features of an FP program and identify areas of strength, as well as critical programming gaps. Information gained through site observations and interviews with service providers, facility managers, and community representatives should be treated as illustrative rather than representative. Findings from such observations and interviews may need to be substantiated or investigated further through more in-depth research.
- The criteria outlined in this Assessment Guide may be interpreted differently by different members of the assessment team, and from one country to another, making it challenging to compare results from different programs or countries. To minimize such differences within an assessment team, and to develop a common understanding of the criteria, team members should spend time together at the beginning of the assessment process (and periodically throughout) reviewing the Assessment Guide together and sharing perspectives on how best to interpret the assessment criteria.

COMPONENT 1: SUPPLY

COMPONENT 1: SUPPLY

Improvements in FP/SRH cannot be achieved without quality services.[7] Quality is considered good when adequate infrastructure, supplies, and equipment are in place. In addition, critical to the provision of high-quality care is the availability of well-trained, skilled, motivated, and supported staff who are performing to established standards and providing services that are accessible, acceptable, and accountable to the clients and communities they serve.[8]

Effective training, supervision, logistics, and referral systems are essential for the delivery of high-quality services. Program managers may need to address organization of work and service integration, as well as explore public-private partnerships. At the facility level, or for community-based or mobile services, infrastructure may need to be upgraded and the reliable and sustained availability of commodities, equipment, and supplies ensured. Staff must be of adequate number, motivated to provide quality services, and enabled (through managerial support and proper infrastructure) to manage services effectively.

Administrative, financial, and management systems also need to be in place, with administrators focused on evidence-based medicine and the use of data for decision making to improve service quality and plan and manage programs. Further, to ensure quality, health services should be strongly linked with and accountable to the communities they serve. Communities can also be valuable partners in defining and maintaining quality services when given opportunities to participate in overseeing and managing health services.

Elements of Supply

1. **FP is offered through a variety of service delivery modalities.**
2. **Facilities are adequately equipped and staffed to provide quality FP services.**
3. **Providers and facility staff have the necessary skills to provide quality FP services.**
4. **Management, supervision, and quality assurance (QA) and quality improvement (QI) systems are operational.**
5. **A broad mix of FP methods is available.**
6. **FP services are integrated with other health services.**
7. **Referral systems are functional where FP methods or services are unavailable.**
8. **The private sector is involved in the provision of FP services.**
9. **FP services are inclusive of youth.**
10. **Clients receive high-quality FP counseling.**

7. For a more in-depth discussion of quality, see the Bruce-Jain Framework (Bruce, 1990; Jain, 1989) and Creel et al., 2002.

8. Service providers may be doctors, midwives, clinical officers, nurses, counselors, peer educators, pharmacists, outreach workers, or community health workers. Service sites may be clinical facilities, health and other outreach posts, pharmacies, drug shops, or other venues used to deliver SRH services (e.g., community health worker outlets or visits to clients' homes).

1. FP is offered through a variety of service delivery modalities.

Operational Definition

Service delivery modalities for FP can be stationary, mobile, or community-based. Stationary facilities range from hospitals, health centers, and employment- or school-based SDPs to pharmacies and shops/kiosks that sell condoms. Mobile outreach services can range from simply a trained provider traveling from one facility to another to a fully equipped mobile unit traveling to an area with limited or no FP services. These temporary services can be offered in a lower-level facility, in a non–health-related building (e.g., a school or community center), or even in a vehicle that is equipped to serve as an SDP (USAID, 2010). Community-based health workers (CBHWs) (also known as community health workers [CHWs]) are trained[9] and trusted community members who provide FP/SRH education, services, and/or referrals in their homes, in clients' homes, or at stationary or mobile community posts (Uganda MOH & FHI, 2007). These services are often called "community-based services" (CBS) when they involve direct service provision and may also include pharmacies, mobile services, and other strategies for providing a range of services at the community level.

Rationale

A variety of service delivery modalities are needed to ensure access to a range of FP methods. In many countries, a significant proportion of the population lives in rural and remote areas, far from health services. Even where a facility is located nearby, many clients prefer a more convenient, comfortable, private, and/or confidential setting to receive FP services, such as a CBHW's home (Uganda MOH & FHI, 2007). CBS have been shown to increase access to FP in countries with few health care providers, low modern-method CPRs, and high unmet need for FP (USAID & FHI, 2007). CBHWs typically provide pills, condoms, and fertility awareness methods, and refer clients to facilities for other methods. CBHWs can also safely provide injectable contraceptives (WHO, USAID, & FHI, 2009). Mobile outreach services are particularly important for expanding access to long-acting and permanent methods of contraception (LA/PMs), which are not offered by CBS (USAID, 2010). Furthermore, FP clinics in non–health-related buildings (e.g., schools, community centers, workplaces) can create demand by making FP services more visible and convenient (USAID, 2010). The local setting, including health infrastructure, human resources, and barriers to access, will determine which service delivery modalities will be most strategic and effective.

Data Sources

- *Desk review*: National policies/guidelines, DHS surveys, program records, service delivery protocols
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, and trainers (see Discussion Guides 1–8)

Assessment Criteria

- FP services are offered through a variety of SDPs that are appropriate to the local setting, such as:
  - Stationary facilities in the public and private sectors (as in Element 8)
  - Nontraditional sites (e.g., employment- or school-based SDPs)
  - Mobile outreach services
  - Community-based health services
- All SDPs are supported by training and management systems (e.g., QA systems, referral systems, CS systems). (Also see Elements 2, 3, 4, 7, 10, and 15.)
- If mobile outreach services are offered, they take place with adequate frequency to ensure that the communities served have regular access to follow-up services (e.g., resupply or removal of a method, support for side effects or complications).
- If relevant to the local setting, national policies support the community-based provision of:
  - Male condoms
  - Female condoms
  - Fertility awareness/standard days method (SDM)
  - Education on the lactational amenorrhea method (LAM)
  - Oral contraceptives
  - Injectables

9. CBHWs may receive formal training, but this training typically does not form part of a tertiary education certificate (WHO, 2007a).

2. Facilities are adequately equipped and staffed to provide quality FP services.

Operational Definition

An adequately equipped facility in which to provide quality FP services requires minimum infrastructure (e.g., a clean water source, waiting area), equipment (e.g., sterilizing equipment, implant insertion kit), and supplies (e.g., contraceptive products, disposable gloves) (Measure DHS, [no date]). Staffing needs vary based on the size of the population that the facility serves, as well as on the specific services being provided.

Rationale

Some of the primary challenges facing the provision of quality FP services include weak facility infrastructure, insufficient equipment, and inadequate human resources. Service providers need up-to-date job aids, guidelines, and/or other screening tools to enable them to appropriately screen, counsel, and serve clients (Lantis et el., 2002; Vernon et al., 2008). Likewise, the facility's physical space is important. For example, a separate room for FP counseling can provide clients with privacy during their visit and protect them from stigma in communities where FP may not be accepted or openly discussed (Miller et al., 1998). Lastly, when a facility is adequately staffed by well-qualified personnel, FP providers can serve a greater number of clients more effectively and efficiently, thus improving the quality of services (Dussault & Franceschini, 2006).

Data Sources

- *Desk review*: Service Provision Assessments
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, and professional associations (see Discussion Guides 1–5 and 7)

Assessment Criteria

- At facilities, contraceptive products and FP-related medical instruments and supplies are consistently available in adequate quantities (see also Element 5 to assess the range of methods available; see also Element 15 to assess CS measures).
- There is adequate storage for contraceptive methods (e.g., commodities are stored in a dry location, off the ground, and protected from exposure to sunlight and pests).
- Facilities have basic client amenities (e.g., a basic level of cleanliness, a waiting area protected from rain/sunlight, a functioning client latrine, clean water, electricity, adequate lighting) with a separate space that ensures client privacy and confidentiality.
- A system is in place to assure the timely maintenance, repair, and/or replacement of equipment.
- Facilities have external signs advertising the availability of FP services.
- Printed FP materials for clients (e.g., wall charts, flipcharts, pamphlets):
  - Are visible
  - Are consistently available
  - Are up-to-date
  - Target men, youth, and other specific audiences
  - Reflect local languages, customs, and literacy levels
- Service providers are supplied with up-to-date job aids, guidelines, and/or other screening tools to enable them to appropriately screen, counsel, and serve clients.
- The facility has an adequate number of appropriately trained staff to meet the FP needs of the average daily client flow (e.g., client waiting time is within a reasonable range).
- If relevant, CBHWs have access to reliable stocks of FP commodities, supplies, equipment, and job aids, as well as adequate storage for the FP methods they offer.

3. Providers and facility staff have the necessary skills to provide quality FP services.

Operational Definition

To ensure that FP clients have access to high-quality services, providers should be adequately trained to offer comprehensive FP counseling, provide a range of FP methods,[10] practice infection prevention (IP), provide male- and youth-friendly services, integrate FP services into other health services when possible, and refer FP clients, when possible and/or appropriate (see also Elements 5, 7, 9, and 10).

Rationale

It is essential that FP providers have the skills to provide quality services. For example, counseling skills are crucial for ensuring that clients make an informed and voluntary contraceptive choice and for maximizing their correct and consistent use of the method (Hock-Long, Whittaker, & Herceg-Baron, 2010). In addition to preservice training, ongoing training and professional development opportunities are necessary for staff to remain current in their technical knowledge and skills and continuously improve the quality of services they deliver (EngenderHealth, 2003). However, not all providers need every skill mentioned in the operational definition. For instance, the level of skill needed depends upon the division of labor within a facility and the level of the facility itself (FHI, 2008). Likewise, it is critical that CBHWs have the skills relevant to providing quality FP services in their communities, as this is a significant determinant of program success (Phillips et al., 1999).

Data Sources

- *Desk review*: National/regional/local policies, professional association policies, training curricula
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations, and trainers (see Key Informant Discussion Guides 1–4 and 6–8)

Assessment Criteria

- Written national and facility-level policies and procedures for staff training are in place and adhered to.
- Providers, including CBHWs, have high-quality preservice and in-service training in the following areas:
  - FP basics
  - Client screening
  - Referral
  - Individual and couples counseling
  - IP
  - Method provision
  - Gender-sensitive counseling
  - Youth-friendly services
  - Integration of services
- Both the theoretical and the practical elements of training cover a broad range of FP methods, according to the level of the provider.
- Preservice training gives providers adequate practice in FP through an internship/practicum.
- The trainer-to-student ratio, curriculum design, and teaching methods in pre- and in-service training support mastery of the skills needed to provide high-quality FP services.
- Preservice and in-service training curricula reflect current international standards.
- There is an adequate supply of training materials (e.g., pelvic models for preservice and in-service training).
- In-service trainings and follow-up are conducted periodically, as specified in a training strategy.
- Staff are oriented to evidence-based national and international FP guidelines/standards.
- Staff have other opportunities to improve their knowledge and skills (e.g., contraceptive technology updates).

10. Method provision includes dispensing or inserting the method (if applicable), giving the client instructions, managing side effects and complications, scheduling and performing follow-up, and referring the client for management beyond the provider's capability or scope of practice.

4. Management, supervision, and QA/QI systems are operational.

Operational Definition

Good management requires that managers effectively make plans, organize resources, structures, and processes, implement plans, and monitor and evaluate actions and results (Galer, Vriesendorp, & Ellis, 2005). QA focuses on measuring and improving compliance with standards, such as clinical guidelines (Heiby, 2001). QI focuses on measuring and improving performance more broadly (Tawfik et al., 2010). QA and QI (often used interchangeably) offer a variety of tools for understanding the causes of a compliance or performance gap and for planning, implementing, and monitoring interventions to close the gap (Heiby, 2001; Tawfik et al., 2010). An important QA/QI approach is facilitative supervision, a supportive approach to supervision that emphasizes monitoring, joint problem solving, and two-way communication (EngenderHealth, 2008).

Rationale

Experts point to the quality of FP services, and not just availability, as a key factor affecting reproductive health (RH) outcomes (Kols & Sherman, 1998). For example, higher quality services can reduce complications, method failure, and discontinuation. Improving the quality of care can also attract more clients, increase client satisfaction, and raise contraceptive continuation rates. Providers who work in a supportive environment are more motivated and strive to produce better results, are better able to address challenges creatively and cooperatively, and improve their performance through this process, which leads to a better quality of care for clients (Galer, Vriesendorp, & Ellis, 2005; MSH, 2002).

Data Sources

- *Desk review*: Service delivery guidelines and protocols, supervision guidelines, QA/QI guidelines and tools, human resource policies, health facility management guidelines
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, and trainers (see Discussion Guides 1–8)

Assessment Criteria

- National service delivery policies and guidelines define quality of care.
- Managers are trained in:
  - Facilitative supervision
  - Logistics/commodity management
  - Analysis of data for decision making and QI
- A functional supervision system is in place at all levels of the health care system, including community-based and mobile outreach services, if relevant:
  - Staff have job descriptions in which roles, responsibilities, and performance objectives are clearly defined individually, as well as in teams, such that staff know what is expected of them.
  - Supervision visits occur regularly.
  - Supervisors use a facilitative supervision approach.
  - Employee performance reviews are done regularly and collaboratively; staff are given constructive, prompt, and effective feedback on whether they are meeting clearly defined performance objectives.
- Facility staff are engaged in QA/QI:
  - Facility managers, providers, and other staff are involved in continually assessing the quality of their services in relation to national policies and guidelines, clients' rights, and staff needs; in identifying solutions; and taking action to ensure client-centered care.

- Clients and communities are engaged in QA/QI:
  - A system is in place to encourage feedback from clients on the quality of their visit.
- Community members or community representatives serving on health management committees or boards are involved in defining, appraising, and improving service quality.
- Public meetings/forums give community members an opportunity to learn about FP services and make suggestions on how to improve them.
- Managers receive adequate training and retraining in supervisory/managerial skills.
- Managers are held accountable through performance planning and evaluation systems.
- Management regularly seeks input from staff, and staff are included in decision making, as appropriate.
- There are functioning processes and systems for:
  - Managing facility revenues transparently
  - Managing facility resources and assets, such as equipment and supplies
  - Tracking the in-service training of providers
- Various nonmonetary incentives are in place to ensure job satisfaction and high performance, recruitment, and retention, including those that satisfy employees (e.g., compensation, accommodation), as well as those that motivate employees (e.g., professional growth and learning, career progression, recognition).
- Staff are rewarded individually and as teams for providing quality care (e.g., recognition, bonuses, career development opportunities, and/or other nonfinancial rewards).
- Staff reward mechanisms do not contravene voluntarism and informed choice in FP.

5. A broad mix of FP methods is available.

Operational Definition

A broad mix of FP methods is available when clients have access to a choice of short-acting, long-acting, and permanent methods of contraception. The technical term "method mix" refers to the proportion of contraceptive users in a population who use each method (IPPF, 2011).

Rationale

There is no internationally recognized "ideal" method mix, just as there is no "single best contraceptive" (Sullivan et al., 2006). Method mix is influenced by a variety of factors, including clients' contraceptive preferences, provider biases, regulatory barriers, funding, etc. (Sullivan et al., 2006). "Method skew"—when a single contraceptive method dominates a country's method mix—is an indication that a broad mix of FP methods may not be available. When the range of available methods is narrow, reproductive choice is compromised, CPRs are lower (Ross et al., 2002), and discontinuation rates are higher (Sullivan et al., 2006). For clients to have free and voluntary choice, they need access to a broad range of methods. This will help them meet their reproductive intentions throughout their reproductive life cycle.[11] Clients must also receive clear, factual, and unbiased information about all methods, and the methods must be routinely provided, or available by referral, at the lowest levels of the health system that can safely offer such services.

Data Sources

- *Desk review*: National FP policy/strategy documents, National List of Essential Medicines, Service Provision Assessments, DHS surveys, service statistics (e.g., number and type of commodities distributed), job aids/counseling tools
- *Key informant interviews*: Policymakers and government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations (see Discussion Guides 1–4 and 6–7)

Assessment Criteria

- A range of short-acting, long-acting, and permanent FP methods are consistently available to clients, including:
  - Male condoms
  - Female condoms
  - Oral contraceptives (including emergency contraception)
  - Injectables
  - Implants
  - IUDs
  - Male sterilization
  - Female sterilization
  - Fertility awareness/SDM
  - Education on the lactational amenorrhea method (LAM)
- Clients are counseled on the full range of FP methods that are accessible, even if they are not available on-site.
- Where/when methods are unavailable, there is a functional referral system to help clients obtain their preferred FP method (see also Element 7).
- Providers are not biased for or against any particular FP method(s).
- National policies and guidelines authorize the provision of FP methods and services at the lowest levels of the system that can safely provide them.
- The National List of Essential Medicines includes the contraceptives found in the WHO's Model List of Essential Medicines (WHO, 2010a) (see also Elements 12 and 15).
- FP screening, counseling, and service provision are based on the WHO Medical Eligibility Criteria for Contraceptive Use (WHO, 2010b) and WHO Selected Practice Recommendations for Contraceptive Use (WHO, 2004) (see also Elements 10 and 12).
- There are no unnecessary medical or administrative restrictions on contraceptive use and/or provision (e.g., menstruation or Pap smear requirements; age or marital status; or parental or spousal consent requirements) (see also Element 12).

11. See UNFPA's web site for more information on meeting the FP needs of individuals throughout their reproductive life cycle: www.unfpa.org/rh/lifecycle.htm.

6. FP services are integrated with other health services.

Operational Definition

"Integration is an approach in which health care providers use opportunities to engage the client in addressing broader health and social needs than those prompting the health encounter" (Farrell, 2007, p. 3). When services are integrated, the provider screens the client for a wide range of health and social needs, even if the client came seeking care for only one particular health issue. Once needs are identified, the provider offers services to meet those needs or refers the client to another provider or facility where they can receive the other service(s) (WHO, 2008a).

Rationale

Where appropriate and feasible, the integration of FP with other health care serves clients better and can be more cost-efficient for both the client and the health system. By treating multiple health needs, integrated services can give clients greater continuity of care (WHO, 2008a) and can bring services to new clients. For example, service integration allows providers to offer FP to mothers seeking immunization for their children, or to men seeking HIV counseling and testing (HCT). In addition, integration can reduce duplication of efforts and competition for resources, which can lead to increased program efficiency and better use of scarce public resources (Singh et al., 2009). Nonetheless, integration may not be appropriate in all settings and for all services (Magtymova, 2007).

Data Sources

- *Desk review*: Service delivery guidelines or policies relating to service integration, inventory of services, service statistics, job aids that remind providers to inquire about the client's interest in other services, screening assessment criteria for integration
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, and trainers (see Discussion Guides 1–8)

Assessment Criteria

- FP services are a fully functional part of the design of the following health services:
  - Primary care
  - Postabortion care
  - Postpartum care
  - Prevention of mother-to-child transmission (PMTCT) of HIV
- Where appropriate, FP services are integrated with the following health services:
  - HIV and AIDS services (e.g., HCT, AIDS care and treatment, male circumcision)
  - Sexually transmitted infection (STI) services
  - Antenatal care
  - Child immunization and well-baby visits
- FP services for men are integrated into other health services for men.
- FP counseling messages include each method's degree of protection against HIV and STIs.
- There is a functioning system of communication[12] between the facility/provider making the referral and the facility/provider accepting the referral, so that client information is shared in a timely and confidential manner.

12. Communication between providers or facilities could take place by phone, forms, or other means. A system of communication for referrals supports continuity of care, which is key to the quality of health services.

7. Referral systems are functional where FP methods or services are unavailable.

Operational Definition

Referral systems are prearranged, formalized agreements between health care providers and/or facilities to send clients to another source for specified services (Health Governance Research Center & MSH, 2006). Referral can be made to another facility or to another unit or skilled provider within the same facility. When making a referral, the provider gives the client information about the alternative facility or provider, including the location, directions, hours, fees, and contact person(s) (Farrell, 2007).

Rationale

Referral systems are critical to ensuring informed choice, especially in rural areas where peripheral health centers and CBS may offer some, but not all, FP methods. An operational referral system can help health care providers increase clients' access to a complete range of services, including FP services or specific FP methods that are not available on-site (Setty, 2004). For example, if a client in a peripheral health structure without the equipment or skilled provider for IUD insertion requests the IUD, the provider should refer the client to a provider or health structure that offers it. In addition, referral systems can help clients obtain their preferred FP method, even if the method is out of stock at the facility. Referral also supports integration of services within a site (see also Element 6). For a referral system to be operational, providers must listen to clients' preferences, provide them with adequate information to seek services at the referral facility, provide the referral facility with adequate client information, and participate in monitoring the referral system. Also, the provider at the referral facility should give feedback to the referring provider to facilitate continuity of care (Farrell, 2007).

Data Sources

- *Desk review*: National and facility-level policies/guidelines, facility records, service delivery protocols, systematic screening tools, job aids
- *Key informant interviews*: Policymakers and government program managers, providers/managers/staff, CBHWs (see Discussion Guides 1 and 4–5)

Assessment Criteria

- Policies endorsing referral systems are in place at all levels of the health care system, including referrals from the public to the private (for-profit and not-for-profit) sector and vice versa.
- Service delivery guidelines for referral are in place and operational.
- Providers, including CBHWs, are trained to counsel and refer FP clients for those methods and services that they do not provide.
- To make referrals, providers use up-to-date lists of referral facilities that show services, locations, and contact persons.
- There is a functioning system of communication[13] between the referring facility/provider and the facility/provider accepting the referral, so that client information is shared and services are delivered in a timely and confidential manner.
- A monitoring mechanism for the referral system collects data on the numbers of referrals in, the number of referrals out, reasons for referral, sources of referral, and outcomes of referral.

13. Communication between providers or facilities could take place by phone, forms, or other means. A system of communication for referrals supports continuity of care, which is key to the quality of health services.

8. The private sector is involved in the provision of FP services.

Operational Definition

The private sector is comprised of "all providers who exist outside the public sector, whether their aim is philanthropic or commercial" (Mills et al., 2002, p. 325). Private-sector FP entities with philanthropic ("not-for-profit") goals include NGOs, such as faith-based health facilities, at the community, national, and international levels. Private-sector FP entities with commercial ("for-profit") goals include pharmacies, shops/kiosks, private health facilities, and providers who are in private practice. Manufacturers, importers, and distributors of contraceptives are also private, for-profit companies.

Rationale

The private sector is a significant and growing source of FP services in developing countries (Conteh & Hanson, 2003). Private-sector services often offer clients better locations, more convenient hours, shorter waiting times, and greater anonymity (Kols, 2008). In some health systems, the private sector provides FP methods not usually available in the public sector. The not-for-profit private sector can contribute to FP through approaches like social marketing and social franchising, which use commercial marketing and franchising techniques to sell subsidized FP products and services (PSI, 2003; WHO, 2007c) (see also Element 22).

Data Sources

- *Desk review*: National policy documents, DHS surveys, contracts with private providers, reports from social franchising or social marketing organizations
- *Key informant interviews*: Policymakers and government program managers, donors, technical organizations, private-sector providers/managers/staff, community leaders, professional associations (see Discussion Guides 1–4 and 6–7)

Assessment Criteria

- Government policies support private-sector participation in the provision of FP services or commodities.[14]
- The government subsidizes private FP services and commodities (e.g., through tax breaks for private-sector providers, a public voucher system, national insurance schemes, contracts with NGOs).
- For-profit and/or not-for-profit partners in the private sector (e.g., women's groups, faith-based organizations, pharmaceutical companies) have been identified for FP advocacy efforts, educational outreach, and service delivery.
- Social marketing is used to expand the distribution of FP information, products, and services (see also Element 22).
- Social franchising is operational and inclusive in its geographic and demographic reach (e.g., the rural poor) (see also Element 22).
- Government policy has set and enforces national service delivery standards that apply to the private, as well as the public, sector.
- Two-way referral systems link public and private health facilities and ensure clients the widest possible choice of FP methods.

14. While governments and donors cannot mandate private-sector expansion and roles, they can create favorable policy conditions to encourage private providers to provide FP/SRH services (Sharma & Dayaratna, 2004).

9. FP services are inclusive of youth.

Operational Definition

Youth-friendly FP/SRH services are those that are based on an understanding of what youth[15] (married or unmarried) in the target community want and need. For example, youth-friendly FP/SRH services have providers who are trained to work sensitively and respectfully with youth to meet their needs, convenient operating hours for youth, and information, education, and communication (IEC) materials that specifically target youth (IPPF, 2008).

Rationale

It is essential for programs to address clients' RH needs throughout the life cycle, so as to meet changing FP/SRH needs over time. To do so, FP/SRH services need to focus on generating customers for life, beginning with young people. Overlooking the FP/SRH needs of youth can have significant ramifications. Each year, more than 10% of births worldwide are to young women aged 15–19, and in some countries, upwards of 50% of births are to adolescents (WHO, 2008b). Many of these births are unintended and high-risk. Compared with older adults, adolescent mothers are much more likely to have pregnancies that result in the mortality or morbidity of mothers and newborns (WHO, 2008b; Klein & the Committee on Adolescence, 2005). Strong FP/SRH services for youth are also critically needed to fulfill the RH rights of young men and women and to prevent unintended pregnancies and unsafe abortion (Shaw, 2009). As the population of youth continues to grow worldwide, the need will also grow for services targeting youth (PRB, 2009).

Data Sources

- *Desk review*: National policy documents, DHS surveys, reports from technical organizations, market segmentation analysis documents, service statistics, qualitative studies
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, trainers, representatives from key youth organizations (see Discussion Guides 1–8)

Assessment Criteria

- Policies and guidelines support the provision of FP services to youth (married or unmarried), in accordance with WHO Medical Eligibility Criteria for Contraceptive Use (WHO, 2010b) and WHO Selected Practice Recommendations for Contraceptive Use (WHO, 2004), and administrative barriers (e.g., notification or consent requirements, fees) are minimized, to ensure access to services.
- Providers are trained in youth-friendly counseling.
- Providers are welcoming to clients and provide unbiased information about all methods regardless of their age, marital status, and number of children.
- Trained female and male peer educators for youth are active.
- The facility's infrastructure ensures the comfort, confidentiality, and privacy of all clients.
- Service availability for youth is widely publicized and signs welcoming youth are clearly displayed.
- Readily available SBCC materials specifically target youth; the materials encourage youth to prevent unintended pregnancy and STIs, and they address common questions and concerns of youth.
- Youth community members are involved in the design and implementation of FP services.
- FP services are offered alongside other health services that youth may seek (e.g., HCT; see also Element 6 on integration).
- A range of programs (e.g., health, education, gender) build supportive social norms, empowerment, and self-respect among youth as well as the skills to negotiate contraceptive use with a partner and correctly use contraceptive methods.
- Schools have comprehensive SRH curricula and after-school programs that address FP/SRH.

15. The United Nations defines youth as those individuals ranging in age from 15 to 24 (UN, [no date]); however, youth-friendly FP/SRH services may also need to target younger adolescents or older youth, depending on local needs.

10. Clients receive high-quality FP counseling.

Operational Definition

Counseling is an essential element in the provision of high-quality FP services (Solter, 1998). Through this process, providers help clients make decisions with respect to their FP method of choice or to solve an FP/SRH problem (Rinehart, Rudy, & Drennan, 1998). For the interaction between the client and the provider to be considered high-quality, providers must engage clients in a two-way discussion about FP, encouraging them to actively ask questions and share their thinking, preferences, and concerns; providers must show respect for clients' decision-making ability (Rudy et al., 2003).

Rationale

High-quality counseling is needed to ensure that clients make informed and voluntary choices about FP, and it allows them to choose the method that best meets their reproductive intentions and individual circumstances (Upadhyay, 2001). When counselors treat clients with respect, listen to their concerns, and support them in identifying and meeting their reproductive needs, clients report greater satisfaction with the service they received (Ramchandran, 2007). High-quality counseling leads to improved client satisfaction, which in turn decreases rates of discontinuation (Solter, 1998). Research also shows that when clients are counseled on contraceptive side effects in advance, they are more likely to use their chosen method correctly and longer (Upadhyay, 2001). Further, well-counseled, satisfied clients are more likely to become FP champions and recommend FP to others, generating demand for services (Williams et al., 2000).

Data Sources

- *Desk review*: Program/facility policies, service delivery guidelines, training curricula, SBCC materials
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, and trainers (see Discussion Guides 1–8)

Assessment Criteria

- A quality client-provider interaction (two-way, client-centered counseling) is supported.
- Staff counsel all types of FP clients, including men, couples, married/unmarried women, married/unmarried youth, and continuing clients.
- Clients are encouraged to invite their partners to FP counseling sessions for couples, which encourages joint decision making.
- For programs that offer female or male sterilization, providers secure and document clients' informed consent as part of counseling.
- Staff and (where relevant) CBHWs counsel clients on the full range of methods available on-site and via referral.
- Providers use job aids and other tools for counseling, such as FP flipcharts and/or samples of various FP methods to show clients (see also Elements 2 and 3).
- Clients receive individual or couples counseling in a private space.
- SBCC pamphlets or posters (which reflect local languages, customs, and literacy levels) support client education, decision making, and FP use.

COMPONENT 2: ENABLING ENVIRONMENT

COMPONENT 2: ENABLING ENVIRONMENT

A range of interlinked sociocultural, economic, and policy factors influence both the functioning and sustainability of health services, as well as social norms and practices related to health, including FP. An enabling environment for FP requires equitable policies; adequate resources; good governance, management, and accountability; and supportive social norms, including the transformation of inequitable gender norms. If these needs are not addressed during program design and implementation, investments in supply and demand interventions may be neither effective in the short term nor sustainable over time.

Strong and effective leadership is crucial for creating an enabling environment at all levels of the health system and within the community to support and advance FP/SRH. This leadership is needed to promote evidence-based policies, guidelines, and approaches; support the allocation of human and financial resources for FP/SRH; ensure that the health system has the capacity to provide quality services; and challenge social and gender norms that may adversely affect an individual's SRH.

Pivotal to fostering an enabling environment is the need to engage governments, communities, and other members of civil society to move discourse about FP/SRH from the private to the public realm. This encourages discussion and recognition of FP/SRH as both a public health and a rights issue, wherein everyone has a stake in ensuring sexual and reproductive well-being.

Elements of Enabling Environment

11. The FP program has effective leadership and management.
12. Supportive laws, policies, and guidelines for FP are operational at all levels.
13. Human and financial resources are available for FP and are allocated effectively.
14. Programmatic decision making is evidence-based.
15. Contraceptive security measures are in place.
16. Advocacy efforts support the FP program.
17. Champions at all levels advocate for FP.
18. Communities are engaged in addressing barriers to FP use.
19. The FP program works to foster positive social norms and transform gender roles.

11. The FP program has effective leadership and management.

Operational Definition

An FP program with effective leadership and management has a vision and a clearly laid-out and effective strategy for achieving it. Such a program integrates leadership and management practices into its systems and processes and is guided by long-range planning (at least 3–5 years). It has also adapted to past challenges and has shown measurable and sustainable improvements in service delivery and health outcomes (Galer, Vriesendorp, & Ellis, 2005).

Rationale

In the increasingly complex and changing health care environment (e.g., health reform, decentralization, changing levels and focus of donor funds, changing client needs), good leadership and management are critical for a program's capacity to adapt to change and continue to meet its goals (Galer, Vriesendorp, & Ellis, 2005). Although the policy and program environment is likely to change from year to year, long-range strategic planning[16] helps a program to manage and adapt to change. Developing the leadership and management skills of FP program managers is important for ensuring high-quality service delivery. Good managers are able to effectively plan program activities and allocate resources so as to achieve program objectives; they can also create an enabling environment of teamwork, trust, open-mindedness, transparency, and shared accountability (Richey & Salem, 2008). On a macro level, countries are better able to sustainably serve their population's needs, including the need for FP, when strong programmatic leadership and management exists (Dwyer & Wilhelmsen, 2010).

Data Sources

- ***Desk review:*** National policies, strategic plans, costed implementation plans,[17] budgets, MOH workplans, records of trainings on leadership and management, records of donor coordination meetings, program monitoring and evaluation reports, performance planning documents
- ***Key informant interviews:*** Policymakers and government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations, and trainers (see Discussion Guides 1–4 and 6–8)

Assessment Criteria

- The FP program has a formal statement of its vision or primary purpose (e.g., mission, goals, strategy), and program leadership and managers organize and allocate resources in line with program goals and objectives.
- The FP program is guided by a realistic, multiyear strategic plan that reflects realistic forecasts of population growth, includes preparations for possible scale-up to address unmet need and potential increased demand, and addresses both long-range human resource/staffing needs and financial/budget projections.
- Long-term plans are reviewed at set intervals (e.g., annually).
- Program leadership has facilitated the development of a detailed FP workplan.
- The program convenes regular meetings with donors and technical organizations to coordinate FP support and minimize duplication of efforts and gaps in resources, programs, and services.

16. A long-term strategic plan might ask what the organization is trying to achieve, where the organization is now, where the organization wants to be in five years (and beyond), how the organization is going to get there, and how the program will finance achieving its programmatic goals.

17. A costed implementation plan identifies activities to be implemented and calculates the financial resources that will be needed to implement them (United Republic of Tanzania, 2010).

12. Supportive laws, policies, and guidelines are operational at all levels.

Operational Definition

FP laws and policies are documents that regulate and standardize which types of FP services are delivered within a country, to whom, and under what conditions (Bertrand & Escudero, 2002). While laws and policies outline government intentions regarding FP services, operational guidelines explain how such policies will be implemented and establish systems for service delivery (Richey & Salem, 2008).

Rationale

The existence of explicit FP/SRH laws and policies is indicative of the level of commitment to FP among governments and policymakers.[18] Laws guaranteeing FP/SRH rights provide a more enabling environment for FP programming. Likewise, national policies help programs succeed by prioritizing FP in a country's development agenda, securing adequate human and financial resources, and establishing favorable FP regulations. For example, supportive national laws and/or policies often guide the regulation, marketing, sales, and distribution of contraceptives, as well as FP service delivery, screening criteria, and access to health insurance (Richey & Salem, 2008, p. 5). Policy support for FP is "key to ensuring political commitment, adequate resources, and, ultimately, [the] quality of FP services" (WHO & USAID, 2008, p. 1). Supportive laws and policies alone, however, will not necessarily guarantee adequate or appropriate implementation unless they are operational. Operational guidelines, such as national strategies and service delivery standards, are the roadmap for implementation (Richey & Salem, 2008).

Data Sources

- *Desk review*: National population, health, and FP policies; national health strategies and implementation plans; FP policies and guidelines; health budgets; National List of Essential Medicines
- *Key informant interviews*: Policymakers and government program managers, donors, technical organizations, providers/managers/staff, professional associations (see Discussion Guides 1–4 and 7)

Assessment Criteria

- The government has adopted evidence-based policies that are supportive of FP, such as:
  - A national CS policy
  - A national youth FP/SRH policy
  - A policy that mandates regular updates of the curricula and materials used to train FP providers
  - Policies that encourage constructive male involvement in FP
  - Policies or guidelines on QA/QI
  - Policies or guidelines on community engagement
- Every policy on FP is accompanied by operational plans, strategies, and/or guidelines that:
  - Designate institutional roles and responsibilities
  - Create time frames and activity plans
  - Delineate plans for monitoring and evaluation
- The National List of Essential Medicines includes the contraceptives found in the WHO's most recent Model List of Essential Medicines (see also Elements 5 and 15).
- The country has no legal barriers prohibiting the importation or marketing of contraceptives (or related equipment/supplies), provision of certain FP services, or access to the full range of contraceptives.
- There are no unnecessary medical or administrative restrictions on contraceptive use and/or provision (e.g., menstruation or Pap smear requirements, age or marital status, parental or spousal consent requirements) (see also Element 5).

18. Policymakers include high-level political leaders and officials in various ministries (e.g., Health, Finance, Education, etc.), legislators, national religious leaders, leaders of NGOs, and media institutions.

13. Human and financial resources are available for FP and are allocated effectively.

Operational Definition

"Human resources" for FP include the people at all levels of the health system who work on FP programs (e.g., providers, program managers, contraceptive commodity logistics managers). "Financial resources" for FP include funding at all levels of the health system that affect FP programs (e.g., international donor funding, national government spending, regional and district budgets). Other key resources for ensuring sound FP programming and service delivery include physical infrastructure, equipment, and supplies (see also Element 2) (Bertrand & Escudero, 2002).

Rationale

At the national policy level, political commitment expressed through strong, supportive policies cannot be made operational unless human, financial, and material resources are allocated in a timely and appropriate manner (Saunders & Sharma, 2008). When a developing country includes a dedicated line item for FP in its budget, it demonstrates commitment to FP, even if it receives significant donor funding to supplement its contribution (Richey & Salem, 2008). Quality FP/SRH services also require "an adequate supply of appropriately trained and supervised staff equipped and empowered to meet the needs of their clients" (USAID, 2006, p. 1). Likewise, facilitative supervision of FP providers plays an important role in improving morale, motivation, and performance (Lantis et al., 2002). Further, to allocate personnel effectively, attention should be paid to addressing inequities in staffing between rural and urban areas (Leon & Riise Kolstad, 2010).

Data Sources

- *Desk review:* National policies, national budget documents, statistics on the sources of expenditures in national health accounts,[19] donor documents, data on the geographic distribution of the health workforce, costed implementation plans, operational plans for staffing, human resources information systems (HRIS)
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations, and trainers (see Discussion Guides 1–4 and 6–8)

Assessment Criteria

- Funding for the FP program is generated from diverse sources (e.g., government, donors, the private sector, clients).
- FP is a funding priority at all levels of the health system. Examples of this can include:
  - The national RH or FP strategy includes a costed implementation plan.
  - The annual national/MOH budget contains a dedicated line item for FP.
  - The annual national/MOH budget for FP has increased annually, in line with changing program needs.
  - There are government-backed initiatives to facilitate FP financing, such as national health insurance schemes.
- Allocated funds are adequate to meet the FP program's stated goals.
- Allocated funds are appropriately distributed throughout the health care system.
- Allocated funds are released/expended at all levels of the health system in a timely manner.
- An HRIS is in place to train human resource managers to ensure the supply and retention of well-trained providers and staff.
- The minimum staffing standards for health facilities are adequate for high-quality FP provision.
- The geographic distribution of human resources is adequate to meet FP needs.
  - If needed, the program offers providers incentives to work in underserved areas, such as remote rural areas.
- Salaries are adequate and appropriately set to ensure a highly motivated staff.

19. National health account information is available from WHO at: https://www.who.int/nha/country/en.

14. Programmatic decision making is evidence-based.

Operational Definition

Evidence-based programming is the explicit use of data and scientific evidence during the design and implementation of a program. It has many manifestations and can include:[20]

- Formative research to assess needs and inform the design of a program
- Use of survey data (e.g., from the DHS) to define need and scope of a program
- Use of literature reviews and international guidelines or standards to update policies and service protocols
- Incorporation of behavioral theory and research on the target audiences into SBCC interventions
- Use of service delivery statistics and other data for QI or program planning
- Contraceptive commodity forecasting
- Operations research during implementation and scale-up
- Monitoring and evaluation of a program

Rationale

Sound FP programming requires the collection, analysis, use, and dissemination of accurate information for use in program strategy, design, implementation, resource allocation, evaluation, course correction, advocacy, and policymaking. Taking an evidence-based approach allows programs to target priority needs and use resources efficiently. For instance, DHS data and population projections can be used to estimate contraceptive needs by method and thus, estimate future resource requirements (Bagga et al., 2009). A health management information system (HMIS)[21] also allows managers to better track how well staff and organizational systems are performing, which assists in identifying and solving problems (PATH & UNFPA, 2006). When evidence of impacts or results is derived either from systematic evaluations or from operations research in more than one setting, best practices can emerge.[22] Local policies, guidelines, and standards should be based on international evidence-based guidelines, such as the WHO Medical Eligibility Criteria for Contraceptive Use (WHO, 2010b) and WHO Selected Practice Recommendations for Contraceptive Use (WHO, 2004). In addition, evidence is critical to support advocacy: For instance, evidence of successful programmatic outcomes can show policymakers the benefits of investing in FP (Richey & Salem, 2008; Singh et al., 2009).

Data Sources

- *Desk review*: National/regional/local policies, monitoring and evaluation reports, program records, market segmentation analysis documents, logistics management information system (LMIS) records, evidence of government involvement in operational research, records of pilot projects; advocacy strategies
- *Key informant interviews*: Policymakers and government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations, trainers (see Discussion Guides 1–4 and 6–8)

20. Some examples taken from: Healthy Teen Network, 2006.

21. An HMIS is "a system that integrates data collection, processing, reporting, and use of information necessary for improved decision making, management, and health service effectiveness. An HMIS gathers data on vital registration (birth and death records), service statistics (facility utilization rates, types and numbers of health problems treated), surveillance data, and financial and management data" (USAID/DELIVER. 2008a).

22. Best practices are those successful program innovations, improved technologies, approaches, practices or materials that have been demonstrated to yield greater impact or higher quality results in service programs.

Assessment Criteria

- Evidence-based clinical and program guidance issued by WHO and relevant international professional associations (e.g., the International Federation of Gynecology and Obstetrics, the International Confederation of Midwives) are adopted and used as the basis for the development and review/updating of national standards, guidelines, and protocols.
- Systems for data collection, such as HMIS, LMIS, and HRIS are operational
- Monitoring and evaluation data, DHS data, RH surveys, and facility/use data to inform programmatic decision making at all levels.
- Staff are trained to monitor data quality, analyze data, and interpret results to inform decisions about contraceptive commodity procurement, training, and other service delivery issues.
- To more effectively convey the benefits of and best practices in FP programming, the advocacy strategy is driven by evidence (e.g., international standards, research studies, projections of future FP needs).
- Relevant data and resources on best practices are made easily accessible to managers, providers, and decision makers at all levels of the program (e.g., through a knowledge management system, professional organizations, the MOH web site).

15. Contraceptive security measures are in place.

Operational Definition

Contraceptive security (CS) exists "when people have regular, reliable, and equitable access to a choice of contraceptive methods to meet their reproductive health needs" (Wickstrom & Jacobstein, 2008, p. 1). CS requires the commodities, supplies, and equipment necessary for contraceptive use to be available at all times (Sciortino, 2010).

Rationale

CS is essential to the success of an FP program. When CS systems are in place, clients have more consistent access to the FP method of their choice, when and where it is convenient for them to obtain it (Bertrand & Escudero, 2002). Evidence indicates that a restricted choice of FP methods inhibits a client from obtaining a method that suits his or her needs, resulting in lower levels of contraceptive prevalence (Ross et al., 2002). Similarly, when products or equipment are not consistently available, clients may interrupt contraceptive use, putting them at risk for unintended pregnancy (Richey & Salem, 2008). A strong, dependable, and sustainable logistics system is key to ensuring an uninterrupted supply of FP commodities, supplies, and equipment. This is comprised of 1) an LMIS capable of accurately forecasting contraceptive commodity and equipment needs; 2) efficient procurement practices; 3) proper storage; 4) a reliable distribution system; and 5) adequate funds to purchase necessary supplies and equipment (Setty-Venugopal, Jacoby, & Hart, 2002). Improving the logistics system helps managers better estimate the number of supplies needed, track products already in the supply chain, reduce the occurrence of stock-outs, and avoid wasting commodities (Setty-Venugopal, Jacoby, & Hart, 2002).

Data Sources

- *Desk review:* National CS policies/regulations, Service Provision Assessments, commodity forecasts, Contraceptive Security Index, National List of Essential Medicines
- *Key informant interviews:* Policymakers and government program managers, donors, technical organizations, providers/managers/staff, CBHWs, professional associations, trainers (see Discussion Guides 1–5 and 7–8)

Assessment Criteria

- National policies/procedures are in place to ensure product quality and availability (e.g., a CS strategy).
- The National List of Essential Medicines includes the contraceptives found in the WHO's most recent Model List of Essential Medicines.
- A well-functioning LMIS is in place to collect and report data.
- A commodity forecast is completed every three years and is updated annually.[23]
- CS at the "last mile"—i.e., to the SDP—is ensured through proper requisition and allocation procedures:
  - Facility managers have the service delivery statistics and forecasting ability to predict and request the commodities, supplies, and equipment needed.
  - Warehouse managers receive, fill, and transport orders to facilities in a timely manner.
  - CS measures support CBS and mobile outreach services, where offered.

23. At a minimum, program managers should complete a commodity forecast once per year to cover a three-year period, taking into account any expected increases in demand for certain contraceptive methods (Shawkey & Hart, 2000).

16. Advocacy efforts support the FP program.

Operational Definition

Advocacy is a set of strategic actions carried out by individuals and/or groups committed to a common cause, to influence specific policies, positions, programs, legislation, and/or the allocation of resources in a way that is favorable to their cause (Sprechmann & Pelton, 2001; WHO & USAID, 2008).

Rationale

The actions and attitudes of leaders and decision makers can have a significant impact on the success or failure of FP programs and on the people served by those programs. Advocacy efforts with a focus on the benefits of FP and sexual and reproductive rights can build political will, support, and commitment (Richey & Salem, 2008). Advocacy can also reinforce and support SBCC activities, particularly those addressing social norms. An advocacy strategy that involves strategic alliances or partnerships can mobilize support for policy change or for the implementation of existing policies, including the allocation of funds for FP (WHO & USAID, 2008). Advocacy efforts that seek to change policies on FP or ensure implementation of existing policies can be undertaken by the advocates within the national program itself, by NGOs, or by coalitions and can be directed toward multiple audiences at all levels, including various ministries (e.g., Health, Finance, Education), parliamentarians, or other policymakers and community leaders.

Data Sources

- *Desk review:* Advocacy strategy documents, advocacy coalition records
- *Key informant interviews:* Policymakers and government program managers, donors, technical organizations, community leaders, professional associations, and other key representatives of civil society (see Discussion Guides 1–3 and 6–7)

Assessment Criteria

- An advocacy strategy has been developed, is being implemented, and includes the following:
  - An emphasis on advocacy at all levels (e.g., national, regional, community)
  - The establishment of an advocacy committee to plan and coordinate activities
  - Evidence from a situational analysis/ environmental scan
  - Advocacy objectives and expected outcomes that are clearly defined, realistic, achievable, and measurable
  - Partnership (e.g., working groups of parliamentarians, coalitions of NGOs or religious leaders, individual champions[24]) to advance advocacy objectives
  - Target audiences, including the decision makers who can realize the advocacy objectives, primary audiences such as legislators or government officials, as well as people in a position to influence those decision makers (secondary audiences), such as religious leaders and journalists
  - Channels of communication, activities, and materials
  - Tailored messages that have been pretested (if applicable)
  - A monitoring and evaluation plan
- The program trains members of the media on FP basics and encourages them to cover FP issues regularly (e.g., through radio talk show debates about religion and FP, through investigative journalism about the factors that influence low CPRs).
- Stakeholders, including the government, donors, and service delivery and communications organizations coordinate their FP activities, including advocacy efforts.
- Advocacy strategy, implementation, and monitoring and evaluation activities are guided by data.

24. FP champions are respected and influential leaders within their communities who advocate for FP at all levels. Examples of FP champions include community-level activists, FP clients, satisfied users, health-sector leaders, government officials, journalists, religious leaders, academics, village chieftains, local celebrities, donors, researchers, and leaders within women's and men's groups.

17. Champions at all levels advocate for FP.

Operational Definition

FP "champions" are respected and influential leaders within their communities, or nationally, who publicly support FP (Mugirwa, 2010). Examples of FP champions include government officials, community-level activists, satisfied FP clients, providers, journalists, religious leaders, academics, village chieftains, local celebrities, donors, researchers, and leaders within women's and men's groups. Championing FP could take the form of a religious leader's public statement supporting FP, for example, or a government official's political support for a favorable FP policy.

Rationale

Strong political support for FP at all levels of government strengthens FP programs, contributes to positive social norms, and is crucial for programmatic success (Robey et al., 1994). Political commitment for FP is not only critical to ensuring that supportive policies are implemented, but also that resources are adequate and allocated appropriately. In addition to changing policies directly, government leaders can influence others in positions of power, as well as the general public, through speeches and statements. Champions who are not political leaders can successfully advocate for FP as well. For example, as opinion leaders, they can lobby policymakers to enact legislation that is supportive of FP or for increased funding to implement FP programs (WHO & USAID, 2008). To engage champions in advocacy, programs must identify and support them, provide them with the necessary training, tools, and accurate and up-to-date information (e.g., briefing papers, fact sheets, SBCC materials), and invite them to participate in community outreach activities and advocacy (WHO & USAID, 2008).

Data Sources

- *Desk review*: Public speeches and/or statements by political leaders, reports in the news media, national policies, program/advocacy documents, training curricula for champions
- *Key informant interviews*: Policymakers and government program managers, technical organizations, donors, community leaders, professional associations (see Discussion Guides 1–3 and 6–7)

Assessment Criteria

- The head of government and/or other prominent political leaders at the national level speak publicly and favorably about FP.
- Officials in the MOH and other ministries speak publicly and favorably about FP.
- District/provincial political leaders speak publicly and favorably about FP.
- The FP program director is placed at a high administrative level, either within the MOH or elsewhere.
- Ministries other than Health (e.g., Finance, Education, Communication, Social and Women's Affairs, Youth) are supportive of FP.
- The national FP program identifies, trains, and supports FP champions at all levels.
- The program tracks the activities of champions to learn how numerous they are and to identify which activities are the most effective in advocating for FP.

18. Communities are engaged in addressing barriers to FP use.

Operational Definition

Community engagement is a capacity-building process through which community members, groups, or institutions—affiliated by interlinked interests, similar situations, or geographic proximity—plan, implement, and evaluate activities on a participatory and sustained basis to address issues affecting their well-being, either on their own initiative or supported by others (NIH, 2008).

Rationale

When communities take part in program planning, they become agents of their own change. Through the community engagement process, community groups collaboratively plan, implement, and evaluate FP/SRH-related activities on a participatory and sustained basis to promote healthy behavior. This process can result in complementary interventions undertaken by community partners to address various contextual barriers to FP use, ranging from physical access to social, cultural, and gender norms (Howard-Grabman & Snetro, 2003). Communities can plan and implement actions to meet their own priorities better, build upon the community's strengths, and adapt actions to the local culture, which can result in greater programmatic sustainability and impact (Gryboski et al., 2006).

Data Sources

- *Desk review:* National health policies, strategies, and plans; FP program guidelines and tools
- *Key informant interviews:* Policymakers and government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders (see Discussion Guides 1–6)

Assessment Criteria

- Explicit efforts are made to link FP program features to the community's own priorities (e.g., improved maternal health, fewer unsafe abortions, enhanced economic well-being of the family).
- Policy statements, strategy documents, and related implementation plans promote and support community engagement and participation in addressing FP and other health priorities.
- Health facility managers have the knowledge, skills, and tools needed to support participatory community action planning processes to identify and address barriers to FP service use; regular meetings are held between providers (and other health staff) and community representatives.
- Community resource persons (e.g., community leaders, CBOs, CBHWs) have been oriented to FP basics and the benefits of FP and have the knowledge, skills, and tools needed to lead and support community action planning processes that engage broader members of the community, including marginalized and disadvantaged groups, to identify and address barriers to FP service use.
- Community advisory groups (composed of women and men, as well as members of marginalized and vulnerable populations [e.g., PLHIV]) actively participate in decision making regarding FP program design, budgeting, implementation, and evaluation.

19. The FP program works to foster positive social norms and transform gender roles.

Operational Definition

A social norm is a value, belief, attitude, or behavior pattern to which most people in a particular community or culture adhere and to which individuals are often expected to conform.[25] Gender norms are the social norms associated with being male or female (IPPF, 2011). Gender transformative approaches to FP/SRH programming strive to examine, question, and change harmful gender norms and power imbalances between women and men (Greene & Levack, 2010).

Rationale

Social norms significantly influence an individual's SRH, in that they lay out expectations of behavior that may conflict with the behavior needed to safeguard one's health and well-being. In such cases, a holistic FP program needs to undertake interventions that will work toward changing harmful social norms that inhibit individuals from ensuring their SRH and strengthening positive social norms that encourage health-seeking behavior. Gender norms strongly influence sexual decision making, including contraceptive use (Varga, 2003). Gender-sensitive approaches to FP/SRH counseling recognize and respond to the different needs and societal pressures of women and men. Gender-transformative approaches to programming not only recognize these needs and pressures; they actively work to change gender norms (Gupta, 2000).[26] This approach to programming can create a more supportive environment for empowering women and men to fulfill their reproductive intentions. Furthermore, gender transformative programming can influence the human and financial resources available for FP at the national level by shaping the larger sociocultural environment (Lusthaus et al., 2002).

Data Sources

- *Desk review:* National policies, guidelines, and/or training curricula; program records; workplans; local qualitative research.
- *Key informant interviews:* Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, and trainers (see Discussion Guides 1–8)

Assessment Criteria

- National FP strategies and implementation plans identify specific gender norms, practices, power imbalances, and other social norms (e.g., early marriage/childbearing, religious beliefs) affecting FP use, as well as specific steps to address these norms.
- National FP strategies and implementation plans recognize men as FP clients and as key partners for interventions to promote FP/SRH and transform gender norms (e.g., through trainings, workshops).
- A range of intervention approaches—from service delivery strategies, SBCC campaigns, advocacy efforts at all levels, and community engagement—are being implemented to address social norms that hinder people from realizing their FP/SRH goals.
- Activities addressing social norms involve the arbiters of social norms, including opinion leaders, religious leaders, traditional leaders, and FP champions at all levels.
- FP providers are trained in gender-sensitive counseling.
- SBCC strategies, messages, and materials are male-friendly and promote the transformation of gender norms (see also Element 21).

25. Among the many social norms that influence FP are pronatalism, early marriage/early childbearing, and religious or traditional prohibitions on contraceptive use.

26. For example, a woman's lack of decision-making power can impact what FP services she can seek. A female-focused FP facility can also inhibit men from seeking FP services or participating in couple's counseling. Gender-sensitive providers who are aware of such social constraints can better serve all clients and ensure women's and men's ability and willingness to seek, and continue using, FP.

COMPONENT 3: DEMAND

COMPONENT 3: DEMAND

The demand for FP exists in different forms; actual use of methods gives only a minimum estimate of total demand. Latent demand exists among two types of nonusers: those who wish to avoid pregnancy but are not currently using FP (those with an unmet need for FP),[27] and those who might wish to avoid pregnancy if they had more information about the benefits of spacing or limiting births. For many, latent demand can be translated into actual use when programs advance positive attitudes toward FP/SRH, address myths and misconceptions, provide evidence-based information about FP/SRH-related issues and risks, and promote available services.

Individuals, families, and communities need the knowledge, capacity, and motivation to ensure FP/SRH and to encourage people to seek services. This requires a range of SBCC interventions—from reducing the direct and indirect costs of FP to mass media communication, community outreach, and peer education. Such SBCC approaches need to provide clear, factual, and unbiased information, so as to increase people's knowledge and self-efficacy; promote communication among couples, among peers, and within families; and encourage people to seek care and use services. Further, such interventions should be synergistic and mutually reinforcing; this ensures that individuals and families receive consistent information and messages from a variety of different sources and in a range of formats—critical to the adoption and maintenance of new behaviors (Kincaid, 2000).

Elements of Demand

20. The program reduces the cost of FP to increase demand.
21. An SBCC strategy for FP is in place.
22. Commercial and social marketing are used to create demand.
23. The FP program utilizes mass media SBCC approaches.
24. The FP program engages communities and champions in SBCC.
25. The FP program utilizes peer education.

27. Reasons for not using FP might include lack of access, fear of side effects, cost, husband's or religious opposition, etc.

20. The program reduces the cost of FP to increase demand.

Operational Definition

The financial costs of FP services to clients include the official price of contraceptive products, supplies, and service provision. They may also include travel costs, the cost of lost work due to time spent seeking FP, and, in some cases, unofficial charges demanded by providers and/or staff (Ensor & Cooper, 2004). Means testing, needs assessments, and wealth index analysis can assist in determining how much clients can afford to pay for the direct and indirect costs of FP services (Richey & Salem, 2008).

Rationale

The Programme of Action endorsed at the 1994 International Conference on Population and Development (ICPD) in Cairo explicitly states that it is considered a fundamental human right for all individuals to freely determine if and when to have children (UNDPI, 1995). Yet, many individuals are unable to put this right into practice because they cannot afford FP services. Women in resource-poor settings, in particular, tend to have the lowest CPRs, have the highest unmet need for contraception, and face significant cost-related obstacles to obtaining FP services (Prata, 2009). Discontinuation rates are also higher for individuals for whom the cost of accessing FP facilities is prohibitive (Bradley, Schwandt, & Khan, 2009). For those living in rural areas where access to FP/SRH facilities is limited, travel costs often impede their ability to access services (Ensor & Cooper, 2004). Likewise, the time spent traveling to facilities and waiting to receive care once there (regardless of its proximity) represents an indirect opportunity cost for many clients, who may forfeit earned income to receive care (Ensor & Cooper, 2004).

Data Sources

- *Desk review*: National policies and guidelines; DHS surveys; market segmentation analysis documents; records from voucher systems, sliding-scale systems, and/or health insurance schemes
- *Key informant interviews*: Policymakers and government program managers, donors, technical organizations, providers/managers/staff, CBHWs community leaders (See Discussion Guides 1–6)

Assessment Criteria

- Where the health system allows, the government provides FP services and commodities free of charge at public facilities.
- Market segmentation analysis or other research has been conducted to help program managers target subsidies more efficiently.
- Mechanisms are in place to ensure that FP services in the public and private[28] sectors are affordable to all. For example:
  - Service fees are based on a sliding scale of the client's ability to pay and are available for free for those who cannot afford them.
  - A voucher system is in place to assist low-income clients in accessing FP services.
  - Health insurance eliminates or significantly reduces out-of-pocket payments for FP services. Health insurance may be public or private, including community-based health insurance.
- FP services are geographically accessible to all (see also Element 1).
- FP services are available at hours that are convenient for all clients.

28. Research indicates that many people, including those in the lower wealth quintiles, perceive private-sector health services to be higher quality and preferable to those in the public sector (Richey & Salem, 2008).

21. An SBCC strategy for FP is in place.

Operational Definition

SBCC is the strategic use of communication techniques based on theories of behavior change and in-depth research on behavioral determinants to bring about positive social change, including increased use of FP (C-Change, 2010). In the development of SBCC campaigns, messages and materials are tailored for specific audiences and communicated through interpersonal channels (e.g., satisfied users, health talks), the mass media (e.g., television, radio, newspapers, billboards), and IEC materials (Salem et al., 2008; PATH & UNFPA, 2006). A national health communication or demand-creation strategy for FP outlines how the government will use and/or encourage partners to use multiple channels of communication to increase the utilization of FP services (National Health Education, Information and Communication Center [Nepal], 2005).

Rationale

To meet unmet need for FP, the availability of high-quality FP services must be coupled with efforts to inform potential users about FP and empower them to seek it (Piotrow et al., 1997). SBCC campaigns can inform people about the FP services available in their communities (Richey & Salem, 2008), combat myths and misconceptions that inhibit use, and increase knowledge about contraceptives, including their safety, effectiveness, and side effects (PATH & UNFPA, 2006). SBCC campaigns can also influence attitudes and reassure people that others are adopting FP methods. Analyses of DHS data show that people exposed to FP messages are more likely to use contraception or intend to use contraception in the future (Salem et al., 2008). Furthermore, women who hear about FP through multiple media channels are more likely than those who hear about it from only one channel to use contraception (Gupta, Katende, & Bessinger, 2003). To maximize the effect of an SBCC campaign, a mix of communication approaches should be used (Salem et al., 2008).

Data Sources

- *Desk review*: National FP/SRH communication strategy, training curricula, facilitation tools and guidelines, SBCC materials
- *Key informant interviews*: Policymakers and government program managers, technical organizations, donors, community leaders (see Discussion Guides 3–6)

Assessment Criteria

- A communication strategy has been developed, is being implemented, and includes the following:
  - Identification of primary and secondary target audiences
  - Identification of specific barriers to and motivations for FP use
  - Strategic selection of the communication channels and activities (e.g., participatory community theater, radio, peer education) that will be the most effective in reaching the target audience
  - A broad reach that extends into rural as well as urban areas
  - Continuous SBCC efforts throughout the year
  - Key messages that are grounded in behavioral theory and in-depth research of target audiences' knowledge, attitudes, and practices related to the use and nonuse of contraception
  - Close attention to new rumors or damaging claims about contraceptive methods, with prompt replies in the media to answer them
- SBCC messages are male-friendly and promote the transformation of gender norms (see also Element 19).
- SBCC messages emphasize the benefits of barrier methods as dual protection against unintended pregnancy, HIV, and STIs.

22. Commercial and social marketing are used to create demand.

Operational Definition

"Commercial marketing" is a strategy that the for-profit private sector uses to sell products and services. Commercial marketing involves audience research, product analysis, message design, distribution, advertising, and evaluation (Birkinshaw, 1993). In contrast, "social marketing" is a strategy that the not-for-profit private sector uses to promote voluntary behavior change, especially the use of specific services and products (e.g., FP services and contraceptive products) that will benefit the customer's health. "Social franchising" uses commercial franchising techniques to expand access to services—such as FP counseling and method provision—rather than specific products (WHO, 2007c). Donor contributions allow socially marketed products to be sold at subsidized prices, or in the case of social franchising, provide subsidized or free training and equipment to providers in the network. Social marketing and social franchising play an important role in a country's overall FP context: They serve clients who cannot afford for-profit private-sector services, while still recovering some of the cost (Rosen & Conly, 1999).

Rationale

With an orientation to the needs and desires of the consumer, market forces can reach potential users in ways that other approaches cannot (Lefebvre & Flora, 1988). Commercial and social marketers raise awareness of available FP products and services and highlight the benefits of FP that potential clients value the most. Through product development, attractive packaging, advertisements, and other approaches, marketing can tap into latent demand for FP and can motivate people to seek out or continue using FP services and products (PSI, 2003; Birkinshaw, 1993). Social franchising links providers to a brand signifying that they meet certain quality standards, which may reassure clients of the safety of using FP (Montagu et al., 2009). The private sector plays a special role in FP by using its resources and business expertise to create demand (Armand et al., 2007).

Data Sources

- *Desk review*: Social marketing program records, market segmentation analysis documents, public-private partnership contracts, advertising
- *Key informant interviews*: Policymakers and government program managers, donors, technical organizations, community leaders (see Discussion Guides 1–3 and 6)

Assessment Criteria

- There are no legal barriers in the country that prohibit the marketing of contraceptives.
- Market segmentation analysis is used to inform social marketing.[29]
- Social marketing takes place through multiple communication channels, including mass media and interpersonal communication.
- Social marketing has an extensive reach (e.g., geographic, income level).
- The FP program supports the social marketing program(s) and coordinates messages with it/them.
- Continuous monitoring is used to follow the public response to the social marketing program for each method it offers, by price and brand.
- For-profit companies are active in marketing brand-name FP products.

29. Market segmentation analysis looks at current patterns of demand and use for RH commodities and the characteristics of users—socioeconomic, sociocultural, and behavioral—to find better and more efficient ways to meet existing demand or generate increased demand. Market segmentation variables can include: demographic information (e.g., age, gender, marital status, income); geographic information (e.g., location, urban/rural); behavioral information (e.g., risk-behavior, product use); and psychographic information (e.g., personality, attitudes, and beliefs) (USAID/DELIVER. 2008a).

23. The FP program utilizes mass media SBCC approaches.

Operational Definition

"Mass media" are channels of communication designed to reach large numbers of people. Examples include television, radio, video, posters, magazines, newspapers, mass text messages, and the Internet. "Entertainment-education" (also called "edutainment")[30] uses entertainment, such as dramas or music on the radio or TV, as a forum for SBCC messages.

Rationale

Mass media channels are an effective way to communicate with broad audiences about FP. Numerous studies have shown that well-designed mass media campaigns for FP are associated with increased contraceptive use (Lieberman, Gillespie, & Loghmoni, 1973; Bogue, Tsui, & Barcelona, 1982). The more types of mass media (e.g., newspapers, television, radio) that reach women with FP messages, the more likely those women are to use contraception, even after the effects of socioeconomic factors are taken into account (Westoff & Rodríguez, 1993). Mass media can be used to expand access to information about FP, including its benefits and where it is available. At the same time, through formats such as testimonials and entertainment-education approaches, mass media can address some of the underlying concerns and motivations that influence contraceptive uptake and use. Mass media are a particularly important approach for reaching potential clients where FP is not yet a social norm (Valente & Saba, 1998). Furthermore, use of mass media is a cost-effective way to reach a large audience quickly (PATH & UNFPA, 2006).

Data Sources

- *Desk review:* National policies, program records, workplans SBCC materials, observation of mass media communications, DHS surveys, recent qualitative and quantitative studies
- *Key informant interviews:* Policymakers and government program managers, donors, technical organizations (see Discussion Guides 1–3)

Assessment Criteria

- The program utilizes a variety of mass media, print media, and new technology approaches, such as:
  - Serial dramas on the radio, television, or video that combine entertainment and education to foster positive social norms and increase FP demand
  - Radio or televised discussions between talk-show hosts, FP experts, and call-in listeners/viewers to convey factual information about FP
  - Generic (not branded) advertising for FP or specific methods
  - Posters, magazines, and other print materials that match the literacy level of the target audience and that use local languages whenever possible
  - mHealth[31] approaches (e.g., text messages) to communicate about FP
  - Toll-free information hotlines that allow the target audience to ask questions about FP
- Mass media interventions are linked with available FP services.

30. Entertainment-education can take place through mass media or through face-to-face communication, such as through community theater (Singhal & Rogers, 2002).

31. mHealth is the provision of health-related services via mobile communications, which include mobile phones and mobile data devices.

24. The FP program engages communities and champions in SBCC.

Operational Definition

"Community outreach" describes activities that bring FP messages to individuals or groups through face-to-face communication and community-based information channels. Community outreach (also called "community channels of communication") includes events designed to raise awareness of FP and stimulate discussion, such as rallies, public meetings, and interactive community theater (Salem et al., 2008). FP "champions" are respected and influential leaders within their communities or nationally who publicly support FP (Mugirwa, 2010) (see also Element 17). "Community engagement" approaches may involve champions and other respected community resource persons in addressing barriers to FP use.

Rationale

Community outreach is a powerful tool to heighten awareness about FP, address concerns and barriers, and increase FP use (Gold, 2010). In areas where mass media exposure and literacy levels are low, community outreach is particularly critical (Robey, Piotrow, & Salter, 1994). With training and tools—as well as support from local health care providers—community-level champions are uniquely positioned to provide FP information that addresses community questions/concerns, as well as to lead community action planning or community change processes that catalyze discussion and action to address barriers to FP use and influence broader social norms (Gold, 2010; Gueye et al., 2005). Community engagement approaches such as the Community Action Cycle employ problem-exploration and action-oriented discussions to involve small groups in identifying and overcoming individual and household-level barriers to FP use (RESPOND Project, 2010; Howard-Grabman, 2007). Such approaches often have a dual focus on fostering supportive social and gender norms (enabling environment) and on increasing individuals' knowledge and awareness of FP and their capacity to seek FP services (demand) (Russell & Levitt-Dayal, 2003).

Data Sources

- *Desk review:* National strategy documents and guidelines, training curricula, reports from FP outreach events
- *Key informant interviews:* Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders (see Discussion Guides 1–6)

Assessment Criteria

- National FP/SRH communication strategies and plans articulate a strategic focus for community engagement and interpersonal approaches at the community level and define the role of local-level FP champions and community resource persons in leading these approaches.
- Community-level champions and resource persons have been identified, trained, and supported with appropriate facilitation and educational tools to lead individual and/or group discussions and dialogues on FP and facilitate community action.
- Health providers, including FP staff, are responsible for liaising with community resource persons and champions in planning and conducting outreach activities and in providing technical support, as needed, to community engagement and interpersonal communication activities led by community partners.
- Community-level SBCC efforts are linked with available FP services.
- The program tracks community outreach activities and identifies which activities are the most effective in creating demand for FP.

25. The FP program utilizes peer education.

Operational Definition

Peer educators are volunteers who provide health education, counseling, and referrals to others who have similar background characteristics. Examples include youth, men, or PLHIV who counsel other youth, men, or PLHIV about FP. While peer educators are not FP professionals, they receive formal training and supervision and typically provide condoms and refer clients to nearby facilities for other FP methods (Horizons Project, UNAIDS, Jamaican Ministry of Health, et al., 2000; Pathfinder International, [no date]).

Rationale

Evidence shows that people, especially youth, often trust information from peers more than information from nonpeers; peers are often considered better, more trusted communicators of FP messages and have a demonstrated positive effect on knowledge, attitudes, social norms, motivation, and behavior related to FP (Adamchak, 2006; Kim & Free, 2008). Satisfied FP users are among the most influential peer educators (Bulatao, 1993). Additionally, peer educators themselves can improve their RH knowledge and make positive behavior changes as a result of their involvement in peer education programs (Flanagan, Williams, & Mahler, 1996).

Data Sources

- *Desk review*: National policies, program records, workplans, school curricula, prior qualitative and quantitative studies
- *Key informant interviews*: Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, trainers (see Discussion Guides 1–8)

Assessment Criteria

- Relevant types of peer educators (e.g., men, youth, PLHIV) are adequately trained in FP basics, peer education, interactive counseling, and referral.
- Peer educators receive adequate supervision.
- Peer educators conduct regular sessions/events.
- Peer education programs are monitored and evaluated.

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APPENDIX A:
Sample Outlines for a Desk Review and Final Report

APPENDIX A:
Sample Outlines for a Desk Review and Final Report

This appendix contains suggested outlines for a Desk Review and a Final Report. The format and topics covered in both the Desk Review and the Final Report should be decided at the outset, in line with the scope of the assessment. Depending on the country context and the purpose of the assessment, some topics or sections may be less emphasized or may even be omitted. Users of this Assessment Guide should feel free to adapt and rearrange the Desk Review or Final Report outlines as needed.

When writing the Desk Review, it is advisable to highlight sections where additional data can be gathered locally. For instance, if the Desk Review uncovers comprehensive information on policies and guidelines (Element 12), but little information on provider training and skills (Element 3), the team should flag Element 3, plan interviews with key informants who are knowledgeable on the topic of provider training and skills, and tailor the Discussion Guide questions to ensure that they fill that information gap for the final report.

When writing the Final Report, it is appropriate to replicate pertinent information discovered in the Desk Review and supplement it with information gathered from the key informant interviews. However, it is recommended that the Final Report not be too lengthy. The assessment team might consider attaching the Desk Review as an appendix and thus truncate the introduction and country context information in the Final Report. Developing conclusions and recommendations may be within the purview of the assessment team, or conclusions and recommendations may be generated through consensus with a small stakeholder group. This process should be decided at the beginning of the assessment and planned for accordingly; a sample meeting agenda can be found in Appendix C to assist with this.

Desk Review Sample Outline: Family Planning and Reproductive Health in *(insert country name)*

1) Introduction

a. Population data/trends (e.g., population growth, youth population, urban/rural population)
b. General health status of women (e.g., maternal mortality rate, unwanted fertility)
c. National family planning (FP) program status
d. Political/policy support for FP
e. Contraceptive prevalence rate (CPR) from the most recent Demographic and Health Survey (DHS)

Resource examples: DHS; national policy documents on FP and sexual and reproductive health (SRH), United Nations Population Fund (UNFPA), Population Reference Bureau (PRB)

2) Country Context

a. United Nations Development Programme (UNDP) Human Development Index rating, life expectancy
b. Economic status (e.g., per capita income, gross domestic product, percentage of population living on less than $1/day)
c. Rate of urbanization
d. Literacy rate

Resource examples: UNDP Human Development Index, Central Intelligence Agency (CIA) Factbook, UNFPA, World Population Data Sheets (PRB), U.S. Agency for International Development (USAID)

3) National Family Planning Program

a. History (e.g., structure, past successes/failures)
b. Current status (e.g., implementation plan, political/policy support, budget support)
c. Focus of current program (e.g., lowering maternal mortality, decreasing the total fertility rate [TFR], women's empowerment, male engagement, economic growth)

Resource examples: Ministry of Health (MOH), national FP/SRH program/policy documents, international/national NGO program documents

4) Population Growth

a. TFRs, past and present
b. Annual growth rate
c. Projected population growth

Suggested table: Trends in TFR, wanted fertility rate, and met and unmet need for modern contraception, by DHS date (covering the past 20 years)
Resource examples: DHS, MOH, international/national NGO program documents

5) Adolescent Sexual Health

a. Growing youth population cohort
b. Average age at first marriage/first intercourse
c. Rates of adolescent childbearing
d. Knowledge and use of contraception among adolescents

Resource examples: DHS, MOH, World Population Data Sheets (PRB), World Health Organization (WHO) Core Health Indicators, international/national NGO program documents

6) Total Fertility Rates

a. Country's TFR; how it compares regionally/worldwide
b. Historical change in TFR
c. Total wanted fertility rates
d. Modern CPR (past and present)
e. Internal disparities in TFR (by geographic location, income level, educational level, etc.)

Suggested table: Internal disparities in certain key health indicators (e.g., TFR, infant mortality rate, average age at which women begin childbearing, deliveries attended by skilled personnel, modern CPR, percentage of women who attend at least one antenatal visit)
Suggested graph: Wanted fertility rates (women/men), compared with actual fertility rates
Resource examples: DHS, MOH, national FP/SRH program/policy documents

7) Demand for FP

a. Data on the demand to space versus limit childbearing
b. Internal disparities in demand (by geographic location, income, education, etc.)

Suggested graph: Met and unmet demand for FP
Resource examples: DHS, MOH, national FP/SRH program/policy documents

8) Contraceptive Knowledge and Use

a. Percentage of women/men who know of at least one modern FP method
b. Knowledge of short-acting versus long-acting methods
c. Growth in knowledge and use rates historically
d. Modern method CPR
e. Government's current CPR goal; achievability

Suggested graph: TFR and CPR trends over the past 20 years; contraceptive use among currently married women[32] over the past 20 years
Resource examples: DHS, MOH, national FP/SRH program/policy documents

9) Method Preference

a. FP preference by method, among currently married women
b. Discussion as to why some methods have increased/decreased in popularity/use over time

Suggested graph: Percentage of married women using a contraceptive, by method use (comparing current DHS data with DHS data from 10–20 years ago)
Resource examples: DHS

10) Sources of Modern Contraception

a. Data on the most common sources of FP services

Suggested graph: Percentage distribution of contraceptives, by sector (comparing current DHS data with DHS data from 10–20 years ago)
Resource examples: DHS, national FP/SRH program/policy documents, international/national NGO program documents

32. For the purpose of these Desk Review and Final Report outlines, data for ***currently married women*** are suggested only because they are often the easiest for which to obtain FP information. However, it is highly recommended to use data for ***all women*** if these data exist locally.

11) Attitudes Toward FP

a. Percentage of married women who approve of FP
b. Percentage of husbands/partners who approve of FP
c. Opposition to FP

Resource examples: DHS, national FP/SRH program documents, international/national NGO program documents

12) Factors Affecting Fertility Patterns

a. Sociocultural and economic determinants of contraceptive use (e.g., urban/rural, married/unmarried, female/male, educated/uneducated)

Resource examples: DHS, national FP/SRH program/policy documents, international/national NGO program documents

13) Maternal Mortality and Morbidity

a. Maternal mortality ratio
b. Percentage of deliveries attended by a skilled provider
c. Percentage of women who receive at least one antenatal care (ANC) visit

Resource examples: DHS, MOH, national FP/SRH program/policy documents, international/national NGO program documents

14) HIV/AIDS

a. HIV/AIDS rate compared regionally and globally
b. Change in HIV rates over time (increase/decrease)
c. HIV rates among adolescents
d. Mother-to-child transmission rates
e. Impact of HIV rates on socioeconomic development factors
f. National HIV/AIDS policy
g. Donor support for HIV/AIDS

Resource examples: DHS, MOH, WHO, USAID, national FP/SRH program/policy documents, international/national NGO program documents

15) Health Sector Reform

a. History
b. Decentralization
c. Sector-wide approaches (SWAps)
d. Poverty-Reduction Strategy Program (PRSP)

Resource examples: MOH, World Bank, International Monetary Fund (IMF), USAID, national FP/SRH program/policy documents, international/national NGO program documents

16) Health System Structure

a. Health system structure (e.g., pyramid structure, where a referral hospital is at the top and community/village health services are at the bottom; number of facilities)
b. Public-sector versus private-sector health facilities

Resource examples: MOH, WHO, USAID, national FP/SRH program/policy documents, international/national NGO program documents

17) Service Delivery

a. Modes of service delivery offered in the country (e.g., static clinics, mobile services, community-based services, faith-based organizations, private providers)
b. Rural/urban distribution of service delivery options

Resource examples: MOH, USAID, national FP/SRH program/policy documents, international/national NGO program documents

18) Access to Services

a. Percentage of population with access to health care services
b. Barriers to access

Resource examples: MOH, international/national NGO program documents

19) Human Resources for Health

a. Number of various cadres of health care providers
b. Geographic distribution of health workers

Suggested graph: Distribution of health workforce, by cadre
Resource examples: USAID, WHO, MOH, international/national NGO program documents

20) Financial Resources for FP

a. Total national expenditure on health per capita
b. Total national expenditure on reproductive health
c. Is there a line item for contraception/FP in the national budget?
d. Are allocated funds released appropriately?
e. Is there a national costed implementation plan for FP/SRH?
f. Level of donor funding
g. Level of private expenditure on health/FP
h. Is FP/SRH part of the national development plan?
i. Government's current strategy with respect to sustainable health financing
j. Are national voucher or national insurance schemes available?

Resource examples: USAID, WHO, MOH, World Population Data Sheet (PRB), international/national NGO program documents

21) Contraceptive Security

a. Health system's logistics management information system
b. Source of contraceptive funding and its impact on commodity procurement
c. Stock-out rates (method-specific stock-outs?) and potential causes

Suggested graph: Funding for FP commodities by source (comparing current data with data from 10–20 years ago)
Resource examples: USAID, MOH, national FP/SRH program/policy documents, international/national NGO program documents

22) National Policy Documents

a. National reproductive health laws
b. FP/SRH policy documents
c. National development strategies

Resource examples: MOH, national FP/SRH program/policy documents

23) Exposure to FP Messages

a. Percentage of women/men who receive FP messaged via various modes of communication (e.g., radio, television, newspapers, billboards)
b. Disparities in exposure to FP messages via the media (e.g., urban/rural, educated/uneducated, women/men)
c. Demand-creation strategies and approaches

Resource examples: DHS, MOH, international/national NGO program documents

24) Technical Organizations Working on FP

a. A paragraph or chart outlining the work of international/national NGOs, research organizations, or other groups working on FP in the country

Resource examples: International/national NGO program documents, donor information on grantees

25) Bibliography

Final Report Sample Outline: Family Planning in *(insert country name)*

Introduction

- Country context (e.g., United Nations Development Programme [UNDP] Human Development Index ranking, percentage of population living on less than $1/day, literacy rate, life expectancy, HIV prevalence [if it is high])
- Demographic trends (e.g., population growth, youth population, urban/rural population, total fertility rate [TFR], with comparisons to other countries)
  - Population pyramid
- Maternal and child health—national goals, trends, and status (e.g., maternal mortality rate, child mortality rate, infant mortality rate, birth intervals, early marriage, adolescent childbearing)
- Contraceptive use and focus of the national family planning (FP) program (e.g., national goals and trends in contraceptive prevalence rate [CPR], method mix, internal disparities in CPR)
  - Table showing disparities in TFR, CPR, unmet need, and percentage of adolescent women who have begun childbearing, by wealth, education, rural/urban residence
  - Graph showing trends in TFR and CPR
  - Graph showing changes in the modern method mix
- Contraceptive knowledge and preferences (e.g., demand for spacing and limiting, desired fertility rate, unmet need for FP, percentage of demand met, intention to use, method preferences, women's and men's approval of FP, other sociocultural factors affecting demand)
- Table showing unmet need, met need (actual use), potential demand (unmet plus met need), and percentage of demand met for spacing and limiting

Resource examples: United Nations Development Programme (UNDP) Human Development Index, UNdata, United Nations Economic, Scientific, and Cultural Organization (UNESCO), Central Intelligence Agency (CIA) Factbook, United Nations Population Fund (UNFPA), Population Reference Bureau (PRB), U.S. Census Bureau, U.S. Agency for International Development (USAID), Demographic and Health Survey (DHS), national policy documents on FP and sexual and reproductive health (SRH)

Methodology

- Purpose of the assessment
- Desk review methodology
- In-country assessment methodology

Findings

- Supply
  1) Health system structure and range of service delivery modalities offering FP
  2) Equipment and staffing of health facilities
  3) Provider training and skills
  4) Management, supervision, and quality assurance and improvement systems
  5) Mix of available FP methods
  6) Integration of services
  7) Referral systems
  8) Private-sector involvement
     - Graph showing trends in the source (e.g., private, public) of contraception
  9) Youth-friendly services
  10) Client-provider interaction/counseling on FP

- Enabling Environment
  11) Leadership and management
  12) Supportive laws, policies, and guidelines
  13) Human and financial resources for FP
  14) Evidence-based decision making
  15) Contraceptive security
  16) Advocacy efforts
  17) Champions for FP
  18) Community engagement
  19) Efforts to foster positive social norms and transform gender roles

- Demand
  20) Strategies to reduce FP costs to increase demand
  21) The FP program's social and behavior change communication (SBCC) strategy
  22) Commercial and social marketing
  23) Mass media
     - Table showing exposure to FP methods via various modes of communication
  24) Engaging communities and champions in SBCC
  25) Peer education

Recommendations

- Supply
- Enabling Environment
- Demand

References

Appendix I: List of key informants interviewed
Appendix II: List of technical organizations working on FP in the country, and areas of focus

APPENDIX B:
Key Informant Discussion Guides

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Key Informant Discussion Guides

The following Discussion Guides will need to be adapted based on the desk review and on the objectives of the assessment; **they include many more questions than the team will have time to ask**. Questions that are answered by the desk review should be removed from the Discussion Guides, unless there is a need to confirm the information. The sample questions should be tailored to focus on the expertise of each individual or group interviewed. Additionally, phrasing of the questions may need to be adapted, depending on the style and context of the interviews; for instance, it may be appropriate to pose some questions in a more open-ended manner. It may also be helpful for the assessment team to modify the Discussion Guides between interviews, as some topics become redundant (with key informants giving the same answers as those interviewed before them) or as other questions/issues arise. It is advisable to interview those with extensive knowledge first—such as managers of the government FP program—to reduce the number of questions for the remaining key informant interviews.

The interviewers should become thoroughly familiar with the elements, criteria, and tailored key informant questionnaires prior to the interviews. This will allow for the conversation to flow and for the interviewers to ask follow-up questions to gain more in-depth information. Reading directly from the Discussion Guides is not recommended.

The assessment team may not have time to interview all potential key informants. It is important to select those who can fill gaps uncovered from the desk review. To obtain a more representative picture, it is also advisable to prioritize key informants who may have a broader view of the FP program—for example, getting a clearer perspective on the national FP program by focusing on representatives of national NGOs, as opposed to those from a localized community group that works only in a single district or region. Further, it is recommended that assessors choose interviewees with an appropriate level of knowledge in their area of expertise, to obtain the most accurate and thorough information possible.

DISCUSSION GUIDE NO. 1:
Government Policymakers[1] and Program Planners/Managers

Name of Person Interviewed:_____

Function:_____

Ministry/Organization/Body:_____

Date Interviewed: _____

Interview Conducted by: _____

1) How have you seen the family planning (FP) program evolve over the past several years?

a. What factors have been behind advances or setbacks in the program (including programmatic, political, financial, social, and/or cultural)?

2) What are the most important national laws and policies related to FP and sexual and reproductive health (SRH)?[2]

a. What are the dates of these laws and policies?

b. What national goals are related to FP use? Who are the main actors/partners involved in implementation? What is the timeframe for meeting these goals?

c. How are national goals communicated to relevant actors and stakeholders? What coordination mechanisms are used to harmonize efforts of various partners?

d. Has a long-range costed implementation plan[3] been developed for meeting these goals/objectives? Is the plan fully funded?

e. Are there any important policy gaps related to FP and SHR? What efforts are under way to address these gaps?

f. How do current laws and policies affect the importation of and provision of contraceptive commodities? Are there any legal barriers that need to be addressed?

g. How do current laws and policies related to advertising health products affect the promotion of FP or of certain brand-name contraceptives?

h. What laws or policies stipulate which cadres/types of health workers can provide FP services? In practice, do any of these laws or policies serve to limit the availability of certain FP methods?

i. Are there any important policy gaps or changes that are needed to support FP programming? What efforts are under way to address these policy gaps or make these changes? What else needs to be done?

1. It is particularly important to select only a few key questions to ask parliamentarians, since meetings with them are likely to be brief.

2. Triangulate this information with that found in the desk review.

3. A costed implementation plan identifies activities to be implemented and calculates the financial resources that will be needed to implement them (United Republic of Tanzania. 2010. The National Family Planning Costed Implementation Program: 2010-2015. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare, Reproductive & Child Health Section. Retrieved from: www.fhi.org/NR/rdonlyres/e6nfuhonaxah7wr44ys6weo72exugago57s6bs3zk7wktnqaerb4ssud5jowlaydbzntlokgwlwx3f/Natl-PlanFPImplemTZfnl2010.pdf.)

3) Have national FP service delivery guidelines[4] been developed?

a. How recently have any national FP guidelines been updated? Are there any gaps in these guidelines, in your view?

b. How are these guidelines disseminated? How is their use monitored?

4) How high is the level of political commitment to and leadership on the issue of FP?

a. Do *heads of government and other officials speak publicly and favorably* about FP? If yes, how frequently (at least once or twice a year)? What form has this taken (e.g., public speeches, radio/TV broadcasts)?

b. If not, why? (Political opposition? Religious considerations? Lack of interest?)

5) Are you aware of any FP-related advocacy efforts under way? If so, what do you see as their main goal(s)? Who are the main targets?

6) What is/are the main source(s) of funding for FP (e.g., government/internal, donor/external)? How diversified are they?

a. Is there a dedicated line item for FP in the national budget? In the Ministry of Health (MOH) budget?

b. How are FP budget forecasts made, in both the short- and long-term (over 3–5 years)? What factors are taken into consideration? How are the costs of contraceptive commodities forecast?

c. How are budget allocations tracked at the national level and at decentralized levels? Are funds allocated for FP released/made available in a timely manner? How is this process monitored?

d. Is FP funding adequate to meet the program's stated goals?

e. [If relevant] How has decentralized health planning and budgeting affected FP programming? Are districts budgeting adequately for FP? Are they receiving the funds that they request/budget in a timely manner? What additional support is needed to strengthen district planning and budgeting processes in relation to FP?

7) Is there/are there (a) point person(s) for FP within the MOH?

a. If so, do they have adequate technical and support staff?

b. Which other sectors and/or ministries complement national FP programming? What FP work do they do? How does the MOH collaborate with them?

4. Triangulate this information with that found in the desk review.

8) How, if at all, does the FP program give particular emphasis to special populations, for example:

a. Youth (married and unmarried)
- Are youth-friendly FP services widely available and accessible?
- Is there FP/SRH education in schools?

b. Couples (married and unmarried)

c. Men (individually and as part of a couple)

d. Low-income groups
- Is FP included in national health insurance policies/plans?
- Are there voucher and/or sliding scale arrangements for low-income clients?
- Are services free to those who cannot afford them?

e. Rural populations
- Is the program working to expand the availability of FP services through various sectors/sites (e.g., fixed facilities, mobile services, community-based health workers, employment-based services, pharmacies)?
- Has data-driven market segmentation[5] been conducted to determine where/to whom public vs. commercial vs. nongovernmental organization programs could best market their products/services?

f. Postpartum women for counseling and contraceptive services

g. Postabortion women for counseling and contraceptive services

h. Marginalized or vulnerable population groups (e.g., people living with HIV [PLHIV], the disabled, refugees)

9) What data are used for FP program planning and decision making

(e.g., DHS surveys; service or use statistics; formative research; pilot projects; monitoring and evaluation; best practices)?

a. What service statistics are regularly reported from service delivery points up to the district, regional, and national levels? What systems are in place to monitor the quality of these data? How are these data used?

10) How do national health policies support and promote the engagement of communities in addressing and improving health?

a. How do national policies define or envision the role of communities in improving health and meeting national health objectives?

b. What community health structures exist and what is their role in improving health? What investment has been made in building the capacity of these community health structures? How is their participation in health program planning, design, and evaluation promoted and ensured? How is the participation of women, as well as marginalized and disadvantaged groups, ensured?

c. How do national policies support and promote the involvement of community representatives in health planning and budgeting?

d. What efforts have been undertaken to build the capacity of community leaders and groups trained to promote FP and address social, cultural, and gender norms that inhibit use of FP in their communities? Are community leaders/groups active in addressing social issues that are barriers to FP use? If so, how?

5. Market segmentation analysis looks at current patterns of demand and use for RH commodities and the characteristics of users—socioeconomic, sociocultural, and behavioral—to find better and more efficient ways to meet existing demand or generate increased demand. Market segmentation variables can include: demographic information (e.g., age, gender, marital status, income); geographic information (e.g., location, urban/rural); behavioral information (e.g., risk-behavior, product use); and psychographic information (e.g., personality, attitudes, and beliefs) (USAID/DELIVER. 2008a. Market segmentation. Retrieved from: http://deliver.jsi.com/dhome/topics/policy/csinitiatives/marketsegmentation, February 13, 2011.)

11) Which FP commodities/supplies are included in the National List of Essential Medicines[6]?

How often is the drug list reviewed/updated? Who participates in these reviews? In your view, are there any critical gaps related to FP commodities or supplies?

12) Is a contraceptive security (CS) policy and corresponding operational plan, including budget, in place?

a. Is it supported by regulations[7] that facilitate the timely importation of FP commodities?
b. Is there a logistics management and procurement system[8] in place? Are there procurement, supply, and/or distribution issues?
c. Is FP funding adequate to ensure contraceptive security?
d. Have commodity stock-outs occurred in the past 12 months?
e. If so, of which FP methods? At which level(s)? Why?
f. Is there a contraceptive quality control system in place?
g. Is there a national-level CS working group? If so, who participates?

13) What national guidelines or tools have been developed to support ongoing quality improvement (QI) at the facility level?

a. What is the focus or approach used in QI?
b. To what extent are national guidelines and tools for QI in use? Who is involved in QI at the national, regional, district, and facility levels?
c. Do national guidelines and tools define any role for communities to play in QI? If so, what specifically?

14) How do FP policies and strategies address social norms (e.g., gender roles, early marriage, son preference) that influence FP choices among individuals and couples?

a. What types of data on social norms does the program use?

15) Is there a national SBCC strategy related to FP?

a. What are the overall objectives defined in the strategy?
b. What particular social, cultural, and gender norms does the strategy seek to address (e.g., roles of men and women, traditional ideas of ideal family size)?
c. What communication channels and activities (e.g., radio dramas, community theater) have been identified as priorities and why? What communication channels have been successful in the past?
d. What are the main partners working in SBCC and what are they doing? Who is involved in SBCC activities (e.g., opinion/religious/community groups, satisfied clients, peer educators)?

16) How do you coordinate with donors and other partners in support of your FP program?

a. What kind of coordination exists?
b. Who oversees coordination efforts?
c. How are coordination efforts ensured and monitored?

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6. Ask this question only if the desk review does not provide the answer.

7. Ask this question only if the desk review does not provide the answer.

8. Logistics management information systems collect data on product (e.g., contraceptive commodities) consumption and stock status. These data are used to forecast commodity needs and manage the commodity supply chain for efficiency and reliability.

17) What is the nature and extent of the (for-profit and not-for-profit) private sector's role in FP service delivery?

(e.g., nongovernmental organizations, private for-profit facilities, pharmaceutical companies, employer-based services, franchising, and social marketing)

a. Does the government encourage private-sector participation? If so, how (e.g., tax breaks, incentives)?

b. Are private FP services subsidized? If so by whom?

18) What are the main challenges facing the FP program in the following areas?

a. The ***supervision*** of FP staff: Is a supportive approach to supervision, such as facilitative supervision, widely used? How often are supervision visits carried out at each level of the health system? What is the main focus of supervision?

b. Is preservice training adequate for the various cadres involved in service provision? Are there any gaps related to FP in preservice training? If so, what are they? Are FP staff routinely offered ***in-service training and refresher courses*** in FP basics, individual and couple counseling, method provision, and male- friendly and youth-friendly services? Are you aware of how often training curricula are updated?

c. In terms of integrating FP counseling, services, and referrals with other health services, what is the main focus of integration efforts? Are there any areas in which more integration and/or a better referral system are needed?

19) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees, hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconceptions, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

20) What do you think should be done to improve the FP program?

DISCUSSION GUIDE NO. 2:
Bilateral and Multilateral Donors

Name of Person Interviewed:_____

Function:_____

Organization: _____

Date Interviewed: _____

Interview Conducted by: _____

1) Could you tell us a bit about the FP activities you support?

a. Which technical areas do you support?

Prompts, if needed:

- Health care planning, management, financing
- Infrastructure
- Aspects of training
- Supervision
- Quality assurance
- Logistics management information system or other information systems
- Commodities
- Community outreach
- Social and behavior change communication
- Primary health care
- Maternal and child health (MCH)
- Social marketing
- Franchising
- Workplace initiatives

b. Do you focus on specific geographic areas?

c. Are specific demographic groups targeted?

2) How do you channel your technical and/or financial support?

(e.g., multidonor budget support, the sector-wide approach, direct to the Ministry of Health (MOH); through international/local nongovernmental organizations (NGOs); community-based organizations; for-profit entities)

a. Which *other ministries and government agencies* assist with FP activities (e.g., through financial support, procurement of equipment/supplies, services, information dissemination, education)?

3) How is the support of various FP partners coordinated?

a. Is/are there pointperson(s)/counterpart(s) designated to work with you on FP in the MOH? In other ministries and/or agencies? Do they have enough staff for FP efforts?

b. How effective is donor coordination on FP?

- What kind of coordination exists and for what purposes (e.g., MCH/FP; contraceptive security; advocacy; SBCC)

4) [If relevant] How would you describe national-level coordination on contraceptive security (CS)? Who leads these efforts, what is involved, and which organizations participate? Is your organization actively involved?

a. Is/are there pointperson(s)/counterpart(s) designated to work with you on CS in the MOH? In other ministries?
b. Do you see evidence of leadership on and commitment to CS as a priority? If so, what?
c. Are CS efforts backed by sufficient funding?
d. What are the major challenges to CS from your perspective?

5) What is the overall political/policy environment for FP?

a. Have government and other leaders' positions been analyzed? If so, how broad is support for FP (or is it targeted to certain groups or focused on particular methods)? What is it informed by (e.g., evidence vs. beliefs/politics)?
b. Do *heads of government and other officials speak publicly and favorably* about FP? If yes, how frequently (at least once or twice a year)? What form have these statements taken (e.g., public speeches, radio/TV broadcasts)?

6) How supportive of FP are MOH policies, regulations, and budget allocations?

a. Is there a dedicated line item for FP in the national/MOH budget?
b. Is funding for FP adequate? Have the cost of FP commodities and supplies, provider training, SBCC campaigns, and other FP resource needs been forecasted? Is planning long-range (i.e., over 3–5 years), and does it include scale-up?
c. How comprehensive is the national FP policy, if one exists? Has it led to evidence-based operational plans and protocols and guidelines? Are they being used?
d. Does the program target vulnerable groups? Who/what/how?
e. What is the role of the (for-profit and not-for-profit) private sector in FP?
f. Does the government encourage private-sector participation in the provision of FP? If so, who, what, and how (e.g., through tax breaks, incentives)?
g. Are you involved in supporting public-private partnerships or social marketing? If so, how (e.g., subsidizing private services)?

7) What advocacy or SBCC efforts related to FP are you aware of at the national level? At decentralized levels? Is your organization actively involved in either or both?

a. What is the nature of your coordination with others on advocacy or SBCC efforts?
b. Do you recognize/are you aware of individuals or groups that serve as FP champions?[1]
c. If so, at which levels, and what do they do?

1. FP champions are respected and influential leaders within their communities who advocate for FP at all levels. Examples of FP champions include community-level activists, FP clients, satisfied users, health-sector leaders, government officials, journalists, religious leaders, academics, village chieftains, local celebrities, donors, researchers, and leaders within women's and men's groups.

8) Are you aware of any systemic problems in any of the following areas?

a. Are the human resources allocated for FP adequate at all levels of the health care system?

b. The ***supervision*** of FP staff: Is a supportive approach to supervision, such as facilitative supervision, widely used? How frequent are monitoring visits, and are they generally considered useful by facility staff/providers?

c. Is the preservice training of FP staff adequate? Are FP staff routinely offered ***in-service training and refresher courses*** in FP basics, individual and couple counseling, method provision, and male-friendly and youth-friendly services? Are you aware how often training curricula are updated?

d. Are ***service delivery guidelines*** and protocols sufficiently disseminated and understood/applied by providers?

e. ***Health management information systems:*** Are service statistics regularly compiled? Checked for quality? Used for decision making?

f. How well-integrated is the national health care system overall? Is the referral system considered strong? Are there any areas in which more integration and/or a better referral system are needed?

9) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

- Infrastructure
- Staffing at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Government support (e.g., budget, regulations, infrastructure)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Sociocultural issues (e.g., myths/misconceptions, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population subsets that are more difficult to reach (e.g., urban vs. rural)
- Education and outreach at all levels

10) What do you think should be done to improve the FP program?

DISCUSSION GUIDE NO. 3:
Technical Organizations (Nongovernmental Organizations, For-Profit Development Partners, or Others)[1]

Name of Person Interviewed:_____

Function:_____

Organization: _____

Date Interviewed: _____

Interview Conducted by: _____

1) What is the general focus of your involvement in family planning (FP) (e.g., financial support;[2] aspects of service delivery (supply);[3] aspects of the enabling environment;[4] demand[5])?

a. [If applicable] What is the name of your project? What are the project dates?
b. What geographic areas do you target?
c. What is the source of your funding for FP?

2) Do you target specific demographic groups (e.g., youth, men, postpartum women, low-income groups)?

a. [If relevant] Are the services you offer subsidized?

3) How do you coordinate your FP support with the government and other partners? What coordination mechanisms exist?

a. Are there FP-specific coordination efforts (e.g., a national FP working group) on contraceptive security (CS), preservice/in-service training, policies and guidelines, social and behavior change communication (SBCC), and/or advocacy? How effective are they? What could be done to improve them?
b. Does the Ministry of Health (MOH) monitor or oversee your activities? If so, how?
c. [If relevant] Does the government offer insurance/voucher schemes for lower-income people to access (for-profit or not-for-profit) private-sector FP services?
d. [If relevant] What is the nature of MOH oversight or involvement in privately run FP facilities?

1. Some of these questions may also be relevant for other key informants, such as MOH program planners/managers.
2. Multidonor budget support; the sector-wide approach.
3. Various service delivery modalities; physical infrastructure, commodities, equipment, and supplies; staff training and support; management, supervision, and quality improvement; integration and referral; private sector; counseling.
4. Leadership and management; laws, policies, and guidelines; human and financial resources; evidence-based decision making; contraceptive security; advocacy; champions for FP; community engagement; fostering of positive social norms and gender equity.
5. Financing mechanisms to increase demand; social and behavior change strategies; commercial and social marketing; engagement of communities and champions; use of peer education.

The following sections (A. Supply; B. Enabling Environment; C. Demand) seek more detailed information on respective technical organizations' support for FP.

A. SUPPLY *(see also Discussion Guide No. 4 for possibly relevant questions)*

1) Does your program support direct FP services? If yes, what type of service delivery points (SDPs) do you support?

a. What services are available at the SDPs you support (FP, male reproductive health (RH), prevention of mother-to-child transmission of HIV, maternal and child health, youth RH, HIV and AIDS services, and/or other services)?

b. Which FP methods are provided at the SDPs you support? Do you routinely experience stock-outs (of commodities or related equipment/supplies)? If so, how often and for which methods?

2) In your view, what are the main strengths and challenges related to FP service provision?

Prompts, if needed:

- Health system infrastructure and equipment
- Contraceptive security
- Number and distribution of providers
- Provider training and skills
- Availability of protocols, guidelines, and job aids
- Health service quality
- Supervision and management systems
- Mix of methods offered
- Integration with other health services
- Referral systems
- Geographic/physical access (e.g., community-based distribution; clinic hours)
- Financial access (e.g., fees for methods, supplies, equipment, or consultation; national insurance; voucher scheme; sliding scale)
- nvolvement of the for-profit and not-for-profit private sectors
- Meeting the needs of hard-to-reach populations (e.g., married and unmarried youth, men, people living with HIV, refugees)
- Engagement of communities in health service delivery issues (e.g., quality improvement, management)

3) What service delivery strategies are being implemented, or should be considered, to make FP services more available and accessible (e.g., private-sector involvement, community-based services)?

4) If this is a private (for-profit or not-for-profit) organization:

a. Generally speaking, how do clients perceive private vs. public FP/RH services?

b. What is the nature of MOH oversight or involvement in privately run FP SDPs?

c. Are there any subsidies offered for private FP services, either by your organization or by the government (e.g., insurance, voucher schemes)?

d. If this is a social franchising or workplace initiative, what motivated your organization to become an active player in FP programming? What else would facilitate your efforts?

5) What do you think should be done to improve the FP program?

B. ENABLING ENVIRONMENT

1) In your view, what are the main strengths and weaknesses of existing national policies, strategies, and guidelines related to FP?

a. To what extent are these policies, strategies, and guidelines disseminated and in use? How is this monitored and supported?

b. Do any policies or guidelines need updating to reflect current evidence or best practices?

c. How would you describe overall support for the FP program in terms of:

- Budgeting processes
- Funding allocations
- Training systems (preservice and in-service)
- Logistics systems
- Supervision and management systems

d. What are the main programming gaps that limit or constrain progress or achievement of national policy goals and objectives?

e. How is existing health management information system data used to inform programming?

2) How would you describe national leadership and commitment to FP? In what specific areas is greater leadership needed?

3) Thinking about the social, cultural, and gender norms that influence FP use/uptake, what are the main barriers that are being addressed by FP partners, and how are they being addressed?

a. What level of policy support is there for community engagement in this area? To what extent are community-level champions being involved in these efforts?

b. What do you think are the main areas in which programming in this area could be strengthened?

4) Have FP service delivery procedures and guidelines been disseminated?

a. Are they considered up-to-date and evidence-based?

b. How can they be improved upon?

c. How well do providers understand them?

d. Do you know if their use is monitored during site visits? Are they consistently applied throughout all levels of the health care system?

e. Are you aware of any current FP-related laws that place unnecessary medical restrictions on contraceptive use and/or provision?

5) Can you share some examples of data used/routinely sought for decision making (e.g., Demographic and Health Survey data, survey results, service statistics; formative research; pilot projects; monitoring and evaluation; best practices)? How does your organization adjust its programs based on successes, setbacks, challenges, and emerging needs?

6) Are there institutional mechanisms at all levels for ongoing quality improvement (e.g., facilitative supervision, performance standards, assessment of site readiness)? What efforts do you support to help ensure that good working conditions are in place?

7) Budget/funding for FP:[6]

a. Is there a dedicated line item for FP in the national budget? In the MOH budget? How has this changed over time? In the past, has funding allocated for FP been fully disbursed?

b. Do you consider the allocated FP funding adequate for meeting stated national goals? Have the cost of FP commodities and supplies, provider training, SBCC campaigns, and other FP resource needs been forecasted?

c. Is funding anticipated for the long-term (3–5 yrs) and for scale-up?

d. What is/are the main source(s) of funding for FP (e.g., government/internal; donors/external). How diversified are they?

e. How has decentralization impacted budgeting for FP? Can/do districts budget for FP, and can they access adequate FP funds in a timely manner?

8) Is a national CS policy and corresponding operational plan, including budget, in place?[7]

a. Do you participate in CS? If so, how?

b. Are you aware if the national CS strategy is supported by regulations[8] that facilitate the timely importation of FP commodities? Are you aware of legal barriers that prohibit the importation of certain commodities?

c. Is there a logistics management information system (LMIS)[9] in place? Are there any major logistical bottlenecks? If so, how can they be addressed?

d. Have commodity stock-outs occurred in the past three months? If so, of which FP methods?

e. Can you tell us which FP methods/supplies are included on the National Essential Drug List?[10] If needed, are any advocacy efforts under way to expand on this list?

9) What positions have government and other leaders taken on FP?

a. Has an analysis of government and other leaders' positions on FP been conducted?

b. How broad is support for FP (or is it targeted to certain groups or focused on specific methods)? What is it informed by (e.g., evidence vs. beliefs/politics)?

c. Do heads of government and other officials speak publicly and favorably about FP at least once or twice a year? If so, what form does this take (e.g., public speeches, radio/TV broadcast)?

d. Are you aware of district/provincial, traditional, and/or religious leaders' positions and corresponding actions or statements regarding FP?

10) Has your organization reached out to supportive (government and other) officials/leaders at all levels to serve as FP champions?[11] If so, how does your organization engage them?

6. Triangulate this information with that found in the desk review.
7. Triangulate this information with that found in the desk review.
8. Triangulate this information with that found in the desk review.
9. An LMIS collects data on product (e.g., contraceptive commodities) consumption and stock status. LMIS data are used to forecast needs and manage the commodity supply chain for efficiency and reliability.
10. Triangulate this information with that found in the desk review.
11. FP champions are respected and influential leaders within their communities who advocate for FP at all levels. Examples of FP champions include community-level activists, FP clients, satisfied users, health-sector leaders, government officials, journalists, religious leaders, academics, village chieftains, local celebrities, donors, researchers, and leaders within women's and men's groups.

11) Is there an established national-level FP advocacy committee consisting of NGOs and/or other entities working in the areas of FP and sexual and reproductive health (SRH)? If so, who is involved?

a. Is there a clear advocacy objective?

b. Can you provide examples of FP advocacy efforts currently under way, including the target(s) of these efforts?

12) What are the biggest constraints that the FP program faces?

Prompts, if needed:

- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitude)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information systems)
- Political or religious factors/opposition
- Unnecessary medical restrictions on access to services

13) What do you think should be done to improve the FP program?

C. DEMAND

1) How would you describe the main focus of the FP program's SBCC efforts?

a. What are the main barriers that are being addressed?

b. What communication approaches (e.g., counseling, mass media, peer education) are being used?

c. How could they be strengthened or better supported? Are other issues not being effectively addressed through current SBCC efforts?

2) Are peer educator[12] programs in place and operational?

a. Do peer educators include both men and women? Youth?

b. Are they trained in:

- Interactive counseling[13]
- FP basics
- Referrals

c. Are there any gaps in their training?

d. Do peer educators conduct regular sessions/events? Can you provide examples?

3) What have been the most useful means of communication (e.g., radio, TV, newspapers, posters, billboards) for generating demand, combating FP myths/misconceptions, and educating the following populations:

- Youth
- Married/unmarried couples
- Men
- Communities
- Leaders (e.g., religious, community)

12. Peer educators are generally leaders in their communities who are trained to provide FP/SRH education and counseling, as well as service referrals, to their peers (individuals with similar backgrounds—e.g., men, youth, people living with HIV).

13. "Interactive counseling" implies active listening, as well as information-giving.

4) How is social marketing[14] being used to expand the distribution of FP information and products?

a. Are socially marketed products widely available?
b. Are they advertised within the communities served?
c. Are some areas or parts of the population difficult to reach through social marketing? If so, why, and what is being done to address this?

5) Are you aware of or have you been involved in undertaking market segmentation[15] or other studies/analyses? Do you have and use information on:

a. The extent to which sociocultural norms (e.g., gender roles, social networks, religion, local beliefs) influence FP choices among individuals and/or couples?
b. Where and to whom different sectoral programs (public vs. commercial vs. NGO) can best market their products and services?
c. Hard-to-reach and/or marginalized groups in both urban and rural areas?

6) What efforts have been undertaken (or are under way) to help ensure that clients can make informed and voluntary FP choices, including choosing the method that best meets their needs?

a. Are providers trained in:
   - Interactive counseling?[16]
   - Counseling specific to the needs of different FP clients (e.g., men, couples, married/single women, married/single youth, continuing FP clients, people living with HIV, postpartum women)
b. Do you support FP outreach/counseling activities within the community? If so, how often?
c. How effective are these efforts at providing services, informing/educating potential FP clients, and generating demand for FP services?
d. Are there adequate and appropriate job aids for counseling? Are there FP pamphlets available for clients?

7) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:
- Education and outreach at all levels
- Sociocultural issues (e.g., myths/misconceptions, biases; spousal/familial opposition; gender inequalities)
- Political or religious factors/opposition
- Population subsets that are more difficult to reach (e.g., urban vs. rural)

8) What do you think should be done to improve the FP program?

14. Social marketing is the application of commercial marketing and distribution techniques to promote products that encourage individuals to adopt healthy behavior.

15. Market segmentation analysis looks at current patterns of demand and use for reproductive health commodities and the characteristics of users—socioeconomic, sociocultural, and behavioral—to find better and more efficient ways to meet existing demand or generate increased demand. Market segmentation variables can include: demographic information (e.g., age, sex, marital status, income); geographic information (e.g., location, urban/rural); behavioral information (e.g., risk behavior, product use); and psychographic information (e.g., personality, attitudes, and beliefs) (USAID/DELIVER. 2008a. Market segmentation. Retrieved from: http://deliver.jsi.com/dhome/topics/policy/csinitiatives/ marketsegmentation, February 13, 2011.)

16. "Interactive counseling" implies active listening, as well as information-giving.

DISCUSSION GUIDE NO. 4:
Facility-Based Family Planning Providers, Managers, or Other Staff

Health Facility/Site Name: _____

Location:_____

Date Visited:_____

Facility/Site Point of Contact: _____

Type of Facility (e.g., Public, Private for-Profit, Nongovernmental Organization):

_____

Assessment/Interview Conducted by:_____

OBSERVATION:

- Facility layout/condition (e.g., waiting area, toilets, running water, electricity)?
- Separate space/entrance/materials for men? For youth?
- Facility materials (e.g., communication materials—amount/type/audience; job aids/tools—used/available/up-to-date)?
- Signs on display that indicate services provided, hours of service, and/or fees?

1) What services are available at this facility?

Prompts, if needed:

- Family planning (FP)
- Male reproductive health (RH)
- Prevention of mother-to-child transmission (PMTCT) of HIV
- Maternal and child health (MCH)
- Youth RH
- HIV and AIDS services
- Other

2) What FP methods are available at this facility?

- Male condom
- Female condom
- Oral contraceptive
- Injectable
- Implant
- Intrauterine device (IUD)
- Male sterilization
- Female sterilization
- Fertility awareness/standard days method (SDM)
- Education on the lactational amenorrhea method (LAM)

a. What method is most commonly selected for use?

b. Why is that method so commonly chosen (e.g., myths/misperceptions regarding other methods, provider bias, social norms, recommendation from friends/family, cost, availability)?

3) What kinds of (and how many) trained providers are on staff?

a. Are there enough staff to handle daily client flow and needs?

b. Have (some/most/all) providers been trained in the following areas?

- FP basics
- Method provision
- Referral
- Individual and couples counseling
- Client screening
- Infection prevention
- Gender sensitivity[1]
- Youth-friendly services
- Integration
- Logistics/commodity management

c. How frequent are refresher/in-service FP trainings? What do these trainings cover?

d. Are the quality, scope, and frequency of FP trainings adequate? If not, how could they be improved? In what areas do providers need additional training?

4) What type of job aids (e.g., screening checklists) do providers use to help identify who should/should not use certain contraceptive methods?

a. Are job aids useful for interaction with clients? Do they address all of the clients' needs (and individual situations)?

b. If needed, do you have up-to-date national service delivery guidelines or other such reference materials on-site? (Ask to see what is available.) Do you have access to resource persons for help?

5) Do providers consistently counsel clients on a broad range of FP methods?

6) If a client requests or needs an FP service that staff here are not able to provide, can the provider refer him/her elsewhere?

a. If so, how often do providers at this facility refer?

b. If not, why (e.g., no institutional arrangements, not in protocols/ job function)?

7) Is FP a fully functional part of the design of the following health services?

a. Primary care

b. Postabortion care

c. Postpartum care

d. PMTCT

8) Is FP integrated with the following health services?

a. HIV and AIDS services (e.g., HIV counseling and testing, AIDS care and treatment, male circumcision)

b. Sexually transmitted infection (STI) services

c. Antenatal care

d. Child immunization and well-baby visits

1. Gender-sensitivity training is intended to sensitize providers to their own gender biases in working with women and men and to help providers become more aware of (and responsive to) their distinctive FP and SRH needs.

9) What kind of supervision do providers receive?

a. Have supervisors been trained in facilitative supervision?
b. Do providers have clear job descriptions?
c. Do providers work under a performance-based reward system? How does that work?
d. Does someone from the MOH district or regional level visit a) the facility, and b) community-based agents? If so, how often? Do these visits help address your issues?
e. How often do staff from this facility visit/supervise (if relevant) other facilities, community agents, and/or community activities? What happens during those visits?

10) Who is served/targeted by the facility?

a. Is it accessible to (some/most/all of) the catchment area?
b. Does it provide *special FP services for men*? If so, what are the challenges? What works well? Do you have specific service hours for men?
c. Does it provide *special FP services for youth*? If so, what are the challenges? What works well? Do you have specific service hours for youth?

11) Do providers require spousal consent before providing FP (or certain methods) to married clients? Do they require parental consent before providing FP (or certain methods) to youth?

12) Are there fee(s) associated with certain methods? Are clients asked to cover other costs (e.g., medical supplies)?

a. If so, for which methods and/or supplies?
b. Do you think that fees affect clients' interest in choosing a particular method?
c. Is there a national insurance/voucher scheme for FP?
d. Is there a sliding scale or fee waiver for those who cannot afford services?

13) Are FP commodities, equipment, and supplies consistently available?

a. Do you consistently have everything you need to provide the FP services sought by your clients? What do you lack most often (e.g., particular methods; equipment related to specific methods, such as IUDs or sterilization; bleach; gloves)?
b. Have stock-outs of certain methods (and/or equipment, supplies) occurred within the last three months? If so, why do you think this is happening?
c. Do you maintain and/or collect stock and consumption data (such as logistics management information system [LMIS][2] data)? How are they used?
d. How often is commodity forecasting done? For what period of time?

14) How is FP program performance measured, managed, and improved?

a. What service statistics are collected and reported to the district, regional, and/or national levels?
b. How often do you compile them, and where are they sent?
c. Do you receive feedback on the data? Are these data used for decision making at this health facility? If so, how?
d. Do you obtain feedback from clients (e.g., client exit interviews)? If so, how do you collect and use the feedback?

2. An LMIS collects data on products (e.g., contraceptive commodities) consumption and stock status. LMIS data are used to forecast needs and manage the commodity supply chain for efficiency and reliability.

15) Does the facility engage the community in health care planning and implementation?

a. How do staff here partner with communities to address barriers to FP use?

b. What are the main community health structures or partners with whom you work at the community level? Who is involved (e.g., satisfied users, community/religious leaders, chiefs)?

c. Can you provide some examples of how the community participates in program design/implementation/evaluation?

16) Does this facility support community-based and/or outreach activities? If so, which?

- Community-based health workers (CBHWs)[3]
- Mobile services[4]/FP service/outreach days
- Peer educators[5]

a. If this facility works with CBHWs, or peer educators, are they trained in:

- FP basics
- Method provision (which?)
- Referral
- Individual and couples counseling
- Screening
- Infection prevention
- Gender sensitivity[6]
- Youth-friendly services

b. What FP methods do they offer? What else do they do? How would you describe the existence and functionality of community-to-facility counseling and referral linkages for methods that community-based services cannot provide?

c. How often do you undertake mobile and/or FP outreach services/events?

d. Describe a "typical" outreach activity (what happens, who is involved, who attends).

3. CBHWs extend the reach of the fixed health facility directly into the community where they live and work. Their job title is likely to vary by country (e.g., community health worker, health extension worker). CBHWs are trained and trusted community members who provide FP/SRH education, services, and/or referrals in their homes, in clients' homes, or at stationary or mobile community posts.

4. Mobile services can be either a roving "facility" (e.g., a van or tent) or a visiting provider.

5. Peer educators are generally leaders in their communities who are trained to provide FP/SRH education and counseling, as well as service referrals, to their peers (individuals with similar backgrounds—e.g., men, youth, people living with HIV).

6. Gender-sensitivity training is intended to sensitize providers to their own gender biases in working with women and men and to help providers become more aware of (and responsive to) their distinctive FP and SRH needs.

17) In your opinion, what are the biggest constraints to offering FP services at this facility?

Prompts, if needed:

- Infrastructure (e.g., storage, privacy, utilities)
- Lack of job descriptions; poor understanding of individual and/or team roles/responsibilities
- Lack of resources for needed functions or materials (e.g., training, supervision, salaries, supplies)
- Low staff satisfaction, retention, motivation, learning opportunities; absenteeism; tardiness; recognition; salary; housing
- Printed materials (e.g., SBCC materials, job aids)
- References and resources (e.g., protocols, guidelines)
- Client access (e.g., hours, wait times)
- Client load
- Cost (including supplies)/fees
- Sociocultural issues (e.g., myths, biases, staff gender)

18) In your opinion, what do *clients* see as their biggest constraints to accessing FP services at this facility?

Prompts, if needed:

- Distance and/or access (e.g., hours, waiting times, provider availability or attitude)
- Infrastructure (e.g., privacy, utilities)
- Lack of information, including lack of (appropriate) printed materials
- Cost (including supplies)/fees
- Sociocultural issues (e.g., myths, biases, sex of staff)

19) What do you think should be done to improve the FP program?

DISCUSSION GUIDE NO. 5:
Community-Based Health Workers

Type of Community-Based Health Worker:[1] _____

Program Affiliation:[2] _____

Location:_____

Date Interviewed: _____

Interview Conducted by: _____

1) What do you do as a community-based health worker?

a. What family planning (FP) services do you offer? (If you distribute the pill, do you make the initial offer or resupply clients only?)

b. What other health services do you offer?

c. How do you organize your interactions with clients (e.g., individual sessions in homes, group sessions)? Are there special times or locations that you choose? Why?

2) Please describe a typical a) encounter with an individual client, and/or b) group outreach activity (e.g., what happens, who is involved, who/how many attend(s), how often).

a. How do you introduce or offer FP services and/or products to clients?

b. Do you inform/educate and counsel on FP?

c. Do you provide any FP products? If so, which?

d. How do you access these products? Do you have any resupply issues?

e. Do you have FP products in sufficient quantities?

3) What drew you to this work?

a. How were you selected?

b. How are you motivated?

c. Are you satisfied?

4) What kinds of training have you received to help you with your FP work?

- FP basics
- Method provision (which?)
- Referral
- Individual and couples counseling
- Infection prevention
- Gender sensitivity[3]
- Youth-friendly services
- Logistics/commodity management
- Other FP-related

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1. For example, a community health worker (CHW) or peer educator.
2. For example, Ministry of Health (MOH), nongovernmental organization (NGO), community-based organization (CBO), or faith-based organizations (FBO).
3. Gender-sensitivity training is intended to sensitize providers to their own gender biases in working with women and men and to help providers become more aware of (and responsive to) their distinctive FP and SRH needs.

a. How often do you receive refresher trainings?
b. Was your training adequate? If not, how could it have been improved?
c. Could benefit from more training? If so, in what area(s)?

5) Do you think clients are generally reluctant or uncomfortable when you approach them with FP education or services?

a. If so, what do you think *causes this reluctance* (e.g., method biases, myths/misconceptions, spousal/family opposition, cost)?
b. How typical is this? How do you respond?

6) Do you have clients who are (married or unmarried) youth?

a. If so, what are the challenges to providing youth with FP? What approaches work well?

7) What kinds of materials (e.g., pamphlets, job aids, sample methods) do you have/use to help you work with clients?

a. Are they helpful?
b. What other kinds of materials/tools would be useful to you?

8) Do you have/use any reference materials or checklists that help you determine who can—or should not—receive a particular FP method?

a. Is it/are they useful to you in working with clients? If needed, can you access a facility staff member or supervisor for additional information/assistance?
b. Do you counsel on other FP methods and/or do you ever make referrals? If so, when/why?
c. Do you ever recommend/refer a client for a related health condition that should be addressed? If needed, can you/the client access affordable transportation for the referral?

9) I would like to ask about supervision or interaction with a facility staff member about your work:

a. Does a facility staff member visit you for supervision purposes? Or do you visit the facility? How regular or routine are these visits?
b. What takes place during the supervision visit? (Ask agent to describe the type of feedback; reviews of work logs; assessment of commodity supply/resupply; client issues.) How useful are these visits to your work?
c. Do you know what is expected of you? If not, can you get support from your supervisor?

10) Do you have or do you assume any additional FP promotion functions within your community (e.g., committee membership, liaison, advocacy)?

a. Do you encourage community members/leaders to get involved in FP promotion and activities? If so, how and what?

11) In your opinion, what are the biggest challenges you face in promoting FP and in supporting clients in using FP?

Prompts, if needed:

- Adequacy of skills/training
- Commodity availability
- Lack of information materials and other social and behavior change communication tools
- Support from home facility/site/supervisor
- Client perceptions/biases/health-seeking behavior
- Religious and/or community leader opposition
- Distance/time/personal issues

12) In your opinion, what do clients see as their biggest constraints to accessing FP services?

Prompts, if needed:

- Distance and/or access (e.g., hours, waiting times, provider availability or attitude)
- Infrastructure (e.g., privacy, utilities)
- Lack of information, including lack of (appropriate) printed materials
- Cost (including supplies)/fees
- Sociocultural issues (e.g., myths, biases, sex of staff)

13) What do you think should be done to improve the FP program?

DISCUSSION GUIDE NO. 6:
Community Leaders/Groups[1]

Name of Interviewee: _____

Community Group Represented or Type of Leader: _____

Name/Location of Community:_____

Date Interviewed: _____

Interview Conducted by: _____

1) How are members of the community involved in family planning (FP) programming?

a. Do they participate in health planning and budgeting? If so, how?
b. Do they address social issues that act as barriers to FP use? If so, how?
c. Do they give providers and/or the facility feedback? If so, are community members' suggestions addressed?
d. If a community advisory group for FP or sexual and reproductive health (SRH) or for the health facility exists, what type of community members are involved? Both women and men? Marginalized and vulnerable population groups (e.g., people living with HIV [PLHIV], the disabled, refugees)?
e. How have they been trained or oriented on FP, if at all?

2) How are members of the community involved in advocacy as champions[2] for FP?

a. What types of community members are involved?
b. What do they do?
c. How did they become involved in advocacy?
d. How have they been trained or oriented on FP, if at all?
e. What are the strengths and challenges of the FP program's efforts to engage community-level champions in advocacy for FP?

1. Community leaders/groups can include advisory groups, village health council representatives/community representatives to the health center, representatives of community-based organizations (CBOs), chiefs, religious leaders, and champions.

2. FP champions are respected and influential leaders within their communities who advocate for FP at all levels. Examples of FP champions include community-level activists, FP clients, satisfied users, health-sector leaders, government officials, journalists, religious leaders, academics, village chieftains, local celebrities, donors, researchers, and leaders within women's and men's groups.

3) How are members of the community involved in FP education, outreach, and/or provision of community-based services?

a. What types of *peer educators*[3] (e.g., women, men, youth, PLHIV) are active in your community?

b. Do community-based health workers (CBHWs)[4] provide FP services in your community? What FP services and methods do they offer?

c. What are the strengths and challenges of the FP program's efforts to engage the community in education, outreach, and community-based service provision?

4) Do you have any suggestions on how else community members should be involved in FP programming, advocacy, education, or service provision?

5) Do FP outreach days or mobile services[5] reach your community?

If so, what are the strengths and challenges of these service delivery modalities?

6) Are socially marketed[6] products available in your community?

a. Are they widely distributed? Where? Who uses these products?

b. Are they advertised within your community?

c. Are there areas/parts of your community that cannot be reached with socially marketed information and products? If so, what can be done to address this?

7) In your opinion, what are the biggest constraints that members of your community face in accessing FP?

Prompts, if needed:

- Geographic/time barriers (e.g., facility hours, waiting times)
- Financial barriers (e.g., fees for methods, supplies, or consultation)
- Quality of services (e.g., poor management of side effects, unwelcoming provider attitudes, insufficient staff for client load)
- Lack of knowledge of the benefits of FP
- Sociocultural issues (e.g., myths/misconceptions, biases, sex of staff)

8) What do you think should be done to improve the FP program?

3. Peer educators are generally leaders in their communities who are trained to provide FP/SRH education and counseling, as well as service referrals, to their peers (individuals with similar backgrounds—e.g., men, youth, people living with HIV).

4. CBHWs extend the reach of the fixed health facility directly into the community where they live and work. Their job title is likely to vary by country (e.g., community health worker, community-based (reproductive) health worker, health extension worker). CBHWs' functions are generally focused on primary health care (instead of being specific to FP), and their commitment and compensation tend to be formal (part of the health system, rather than informal).

5. Mobile services can be either a roving "facility" (e.g., a van or tent) or a visiting provider.

6. Social marketing is the application of commercial marketing and distribution techniques to promote products that encourage individuals to adopt healthy behavior.

DISCUSSION GUIDE NO. 7:
Professional Associations[1]

Name of Interviewee: _____

Association Represented: _____

Date Interviewed: _____

Interview Conducted by: _____

1) What does your association do?

2) What is the overall family planning (FP) political/policy environment?

a. Are you aware of any current FP-related laws that place unnecessary restrictions or barriers on FP provision?

b. Which types of providers are authorized and trained to provide different FP methods? Should this distribution of responsibilities be shifted? If so, how?

3) Have FP service delivery procedures and guidelines been disseminated?

a. Are they considered up-to-date and evidence-based?

b. How can they be improved upon?

c. How well do providers understand them?

d. Do you know if their use is monitored during site visits? Are they consistently applied throughout all levels of the health care system?

4) Does preservice training for those in your profession include:

- FP basics
- Client screening
- Referral
- Individual and couples counseling
- Infection prevention
- Method provision
- Gender sensitivity
- Youth-friendly services
- Service integration
- Logistics/commodity management
- Internships/practicums

a. How frequent are refresher/in-service FP trainings? What do these trainings cover?

b. Are the quality, scope, and frequency of FP trainings adequate? If not, how could training be improved? In what areas do providers need additional training?

5) In your opinion, are providers well-prepared to deliver high-quality individual and couples' counseling? Are they well-prepared to manage side effects of FP?

1. Includes professional associations of nurses, midwives, medical doctors, gynecologists, or any other cadre or profession (like pharmacists) that might provide FP services.

6) Are you aware of any systemic problems in any of the following?

a. Are the ***human resources*** allocated for FP adequate at all levels of the health care system? Is the geographic distribution of human resources adequate?

b. The ***supervision*** of FP staff: Is facilitative supervision widely used? How frequently do monitoring visits occur, and are they generally considered useful by facility staff/providers?

c. Are ***service delivery guidelines*** and protocols sufficiently disseminated and understood/applied by providers?

d. Health management information systems: Are service statistics regularly compiled? Are they checked for quality? Are they used for decision making?

e. How well-***integrated*** is the national health care system overall? Is the referral system considered strong? Are there any areas in which more integration/a better referral system is/are needed?

7) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

8) What do you think should be done to improve the FP program?

DISCUSSION GUIDE NO. 8:
Trainers of Family Planning Providers

Name of Interviewee: _____

Institute/School Represented: _____

Date Interviewed: _____

Interview Conducted by: _____

1) What type of training do you conduct (e.g., preservice training for midwives)?

2) Is the training for family planning (FP) providers standardized across the country (for private and public training institutes)?

3) To what extent do preservice and in-service training cover the following:

- FP basics
- Client screening
- Referral
- Individual and couples counseling
- Infection prevention
- Method provision
- Gender sensitivity[1]
- Youth-friendly services
- Integration
- Logistics/commodity management

4) How much time is devoted to practicum/hands-on practice in FP during preservice trainings? During in-service trainings?

a. On what specific methods do providers get hands-on practice in providing during these trainings?

b. What do you think the main gaps are in terms of practicum training?

5) Are the quality, scope, and frequency of FP trainings adequate? If not, how could they be improved? In what areas do providers need additional training?

a. Is class size regulated in private and public training institutes across the country?

b. Are training institutes equipped with pelvic/arm models, FP methods, job aids, and other supplies needed to demonstrate FP service provision?

c. Is the *training of trainers* adequate in quality, scope, and frequency?

6) Does national policy mandate the regular revision/updating/dissemination of training curricula materials?

1. Gender-sensitivity training is intended to sensitize providers to their own gender biases in working with women and men and to help providers become more aware of (and responsive to) their distinctive FP and SRH needs.

7) What do you think should be done to improve preservice and/or in-service training of FP providers?

8) Do supervisors/managers receive training on facilitative supervision?

9) In your opinion, what are the biggest constraints that the FP program faces?

Prompts, if needed:

- Infrastructure
- Government support (e.g., budget, regulations, infrastructure)
- Staffing at national, regional, and district levels
- Staff training, motivation, oversight/supervision
- Supervision and management systems
- Education and outreach (at all levels)
- References and resources (e.g., protocols, guidelines, job aids)
- Client access (e.g., costs/fees; hours; waiting times; provider availability/attitudes)
- Commodity supply (e.g., logistics, budget, transport, warehousing, information system)
- Sociocultural issues (e.g., myths/misconception, biases; spouse/family opposition; gender inequalities)
- Political or religious factors/opposition
- Unnecessary medical policies or criteria/barriers to services (e.g., menstruation or Pap smear requirements)
- Population segments that are more difficult to reach (e.g., urban vs. rural)

10) What do you think should be done to improve the FP program?

APPENDIX C:
Sample Meeting Agendas

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Sample Meeting Agendas

This appendix contains suggested outlines for a **SEED™ Assessment Team Planning Meeting**, a **SEED Assessment Findings Review Meeting**, and a **SEED Assessment Results Dissemination Meeting**. The format and topics covered in these meetings should be decided in line with the scope of the assessment and the country context. Users of this Assessment Guide should feel free to adapt and rearrange the sample meeting agendas as needed.

SEED Assessment Team Planning Meeting: A small-scale meeting among assessment team members (and possible other select key stakeholders) prior to embarking on the key informant interviews will facilitate group understanding of the scope of work and approach to the assessment. This will provide a venue for finalizing the key informant interview list and fostering a common understanding of the assessment criteria and Discussion Guide questions.

SEED Assessment Findings Review Meeting: After completing the key informant interviews and informal site visits (if applicable), the assessment team will need to summarize the assessment's findings, draw conclusions about the state of the national FP program, and highlight programmatic gaps uncovered during the assessment process to prepare the final report. A one-day meeting will assist in this process, and the team may want to include additional stakeholders, such as the MOH, in the review of the assessment's findings and development of recommendations.

SEED Assessment Results Dissemination Meeting: It is essential for the assessment team to discuss their findings and recommendations with a larger group of stakeholders to ensure that the assessment will inform programming. The assessment team should consider holding a Stakeholders Meeting (an advocacy or dissemination workshop) to present findings and recommendations, answer questions, set priorities, and plan next steps.

SEED Assessment Team Planning Meeting

Facilitator's Agenda

Goal: To foster discussion, understanding, and group consensus on undertaking a holistic assessment of a national family planning (FP) program, using the SEED Assessment Guide.

TIME	ACTIVITY
9:00 AM	**Welcome and Overview of Assignment**
9:15 AM	**Team Introductions** Participants introduce themselves, indicating: ▪ Their relevant background—including what they bring to this team/assessment that is unique. ▪ What they are most interested in learning from the assessment. ▪ Their concerns about the assignment, if any.
9:45 AM	**Review of the Scope of the Assessment** ▪ Clarify team members' questions about the scope of the assessment. ▪ Identify and address any issues/concerns about the scope of work. ▪ Ensure that all team members are clear about the scope of work, the goal of the assessment, and the information required to produce the end product (i.e., the Final Report).
10:30 AM	**Review the SEED Programming Model for Family Planning Programming** ▪ Team leader presents overview of the SEED Programming Model for Family Planning Programming. ▪ Clarify any team members' misconceptions, concerns, or questions about the SEED Programming Model.
11:15 AM	**Break**
11:30 AM	**Review the SEED Assessment Guide/Process** ▪ Ensure that each team member has a copy of the SEED Assessment Guide. ▪ Review the structure of the Guide and the steps outlined to conduct the assessment (see "How to Use This Assessment Guide" on page 6). ▪ Review each programming component sequentially (Supply, Enabling Environment, and Demand), paying particular attention to the data sources recommended for obtaining information on each individual element. ▪ Address team members' questions/concerns about the Assessment Guide, recommended data sources, and/or the assessment process. ▪ Ensure that team members are clear about the steps required in the assessment process. ▪ Arrive at a consensus on the use of the Discussion Guides, the assessment process, and the steps needed to collect data for each element.
1:00 PM	**Lunch**

SEED Assessment Team Planning Meeting, Facilitator's Agenda, continued

2:00 PM	**Agree on Stakeholders to Be Interviewed** *(if this has not already been done, or to supplement the core list of interviewees already developed)* ▪ Conduct a brainstorming session to identify (additional) key stakeholders to interview. ▪ Agree on next steps to contact key informants as a result of the discussion.
2:45 PM	**Clarify Team Members' Roles and Responsibilities** ▪ Ensure that team members are clear on their responsibilities in terms of data collection, analysis, and report writing, to avoid duplication of efforts. ▪ Team members may choose to indicate what they see as the roles of other team members, to better understand or clarify how the team will work together to collect data, analyze findings, and contribute to the development of the Final Report.
3:30 PM	**Review Assessment Schedule/Timeline** ▪ Share with team members the country assessment schedule. ▪ Ensure that the timeline is reasonable for the key informant interviews, postassessment analysis, and development of the Final Report. ▪ Review which appointments have been confirmed with key informants and for site visits (if applicable).
4:00 PM	**Agree on Next Steps/Administrative Issues** ▪ Ensure that transportation and accommodation (as needed) have been arranged for all team members. ▪ Identify any administrative steps needing to be addressed prior to beginning the assessment (e.g., adapting and/or photocopying Key Informant Discussion Guides, scheduling additional interviews, making/finalizing travel arrangements).
4:30 PM	**Close**

SEED Assessment Findings Review Meeting

Facilitator's Agenda

Goal: To share and reflect on data collected during the desk review and key informant interviews, and to generate preliminary recommendations for the Final Report.

Note: The assessment team may choose to include additional key stakeholders in this meeting to assist with generating recommendations for the final report. In this case, the agenda will need to be adapted as needed, including dividing the participants into small groups to facilitate deeper discussion, if the numbers of attendees warrant.

TIME	ACTIVITY
9:00 AM	**Welcome and Review of Meeting Purpose**
9:15 AM	**Review Assessment Process** ▪ Each team member briefly summarizes what they did, the location of their visits, who they interviewed, and any challenges they encountered during the data collection phase of the assessment. Invite each member to mention a "highlight" and a "challenge" from their field visits/interviews.
10:00 AM	**Discussion of Key Findings: Supply** ▪ Review team members' findings within the Supply component of the assessment. ▪ Each team member may have supporting or conflicting data points for each of the findings. ▪ Each finding should be discussed and agreed upon, or noted as a discrepancy. ▪ Using either a flipchart or an LCD projector, note agreed-upon findings.
10:45 AM	**Discussion of Key Findings: Enabling Environment** ▪ Review team members' findings within the Enabling Environment component of the assessment (as above).
11:30 AM	**Break**
11:45 AM	**Discussion of Key Findings: Demand** ▪ Review the team members' findings within the Demand component of the assessment (as above).
12:30 PM	**Lunch**

SEED Assessment Findings Review Meeting, Facilitator's Agenda, continued

1:30 PM	**Identify Preliminary Recommendations** ■ For each programming component (Supply, Enabling Environment, and Demand), each team member should write down 4–5 recommendations on a piece of paper. ■ The Team Leader should read each recommendation aloud and lead a discussion about the appropriateness and feasibility of the recommendation. ■ Consensus should be reached for a set of draft recommendations to be made in the Final Report. ■ Roughly 40 minutes should be spent on each programming component.
3:30 PM	**Break**
3:45 PM	**Next Steps** ■ The Team Leader should identify the next steps and timeline for completing the Final Report. ■ Assignments should be made clear to all team members responsible for contributing to the Final Report.
4:15 PM	**Closing Remarks** ■ Each team member should reflect on their experience conducting the in-country assessment and offer any thoughts or comments about what they learned and what they hope will happen as a result of the assessment, based on the team's program recommendations. ■ The Team Leader should close the day with remarks summarizing the assessment process and thanking team members (and any others, as relevant) for their contributions.
4:30 PM	**Close**

SEED Assessment Results Dissemination Meeting

Facilitator's Agenda

Goal: To present the findings from the SEED Assessment on the state of family planning in [*insert country name*]; to foster discussion on key recommendations; and to identify actions for next steps.

TIME	ACTIVITY
9:00 AM	**Welcome and Introductions** ■ Facilitator welcomes participants, introduces conveners of meeting and the Assessment Team members. ■ Participants introduce themselves, if their number and time allows.
9:30 AM	**Opening Remarks on Purpose and Scope of the SEED Assessment** (May be presented by a key stakeholder [e.g., MOH] or by the Assessment Team Leader) ■ Why the assessment was undertaken (why now?) ■ Why the SEED approach was used (include short overview of the SEED Model for Family Planning Programming) ■ Summary of the scope of the assessment (duration, number/type of key informants, number/type of site visits [if any])
10:15 AM	**Present findings and recommendations from the Assessment** ■ *Supply*—findings and recommendations (30 minutes) • Questions and comments from stakeholders (15 minutes)
11:00 AM	**Break**
11:15 AM	■ *Enabling Environment*—findings and recommendations (30 minutes) • Questions and comments from stakeholders (15 minutes) ■ *Demand*—findings and recommendations (30 minutes) • Questions and comments from stakeholders (15 minutes) ■ Summarize conclusions from discussion (15 minutes)
1:00 PM	**Lunch**

SEED Assessment Results Dissemination Meeting, Facilitator's Agenda, continued

12:30 PM	**Lunch**
2:00 PM	**Priority Setting** ▪ Divide the participants into groups of three. ▪ Each group will discuss the recommendations of one of the SEED Components (Supply, Enabling Environment, and Demand). ▪ Each group will prioritize the top 3-5 recommendations for the component for which they have been assigned. Considerations include: 1. Level of impact on key health indicators (e.g., MDGs) 2. Consistency with national priorities and strategic frameworks 3. Extent to which recommendation offers new approaches or new evidence to be pursued 4. Feasibility of action recommendation and extent to which resources (including infrastructure) are available to address it ▪ Each group will prepare a flipchart to present their findings to the larger group.
2:45 PM	**Present Priorities** ▪ Each group will present their 3–5 top priorities for action and (if time allows) discuss the process and rationale they used to arrive at their priorities (10 minutes each). ▪ Facilitator elicits comments from other stakeholders (15 minutes total).
3:30 PM	**Consensus Building—Moving Forward** ▪ Facilitator reviews conclusions from the previous session. ▪ Facilitator reviews each recommendation and identifies an individual to take the lead in moving each recommendation forward. That individual is not responsible for carrying out each recommendation, but is instead considered its "Champion" and is responsible for initiating the necessary next steps (e.g., establishing a task force on a particular recommendation, identifying or mobilizing other resources that might be needed, etc.).
4:00 PM	**Next Steps** ▪ Facilitator summarizes agreed-upon next steps in moving this process forward, including (if needed) the inclusion of these recommendations into the proceedings of existing national Working Groups. ▪ Final remarks from Organizers and Ministry of Health.
4:30 PM	**Close**

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