Framework for Monitoring and Evaluating Efforts to Reposition Family Planning

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Cover photograph by Virginia Lamprecht, Courtesy of Photoshare, shows a young Ethiopian women and her children at a village gathering to discuss family planning.

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Background

Since 2001, USAID's Office of Population and Reproductive Health (PRH), in collaboration with the Africa Bureau, USAID Missions, the World Health Organization and other partners, has engaged in an initiative to reposition family planning in sub-Saharan Africa. In an era in which HIV/AIDS, malaria, and tuberculosis programs dominate the global health agenda and receive a majority of the global health resources, the initiative was established to ensure family planning remains a priority for donors, policy-makers, and providers in sub-Saharan Africa.

The stated goal of USAID's Repositioning Family Planning initiative is to increase political and financial commitment to family planning in sub-Saharan Africa, which will lead to expanded access and help meet women's stated desires for safe, effective modern contraception.[1] The initiative has identified three key approaches or intervention areas for achieving this goal: advocating for policy change, strengthening leadership, and improving capacity to deliver services. Many tools and approaches have been developed in the research, policy, contraceptive security, and service delivery arenas to support these efforts, such as the Repositioning Family Planning Advocacy Toolkit,[2] SPARHCS,[3] and Reality √.[4] As a result, countries are in various stages of repositioning family planning. Currently, however, there is a gap in the ability of countries to assess the success of efforts to reprioritize family planning.

As a result, there is a need for a framework by which countries and programs can monitor and evaluate their progress toward repositioning family planning. The results framework includes illustrative indicators, which maximize the use of existing information. This framework for monitoring and evaluating (M&E) the repositioning of family planning services can ultimately be used by international donors, governments, and programs to assess their efforts, identify gaps in strategies to reposition family planning in countries, and to inform funding, program design, policy and advocacy, and program planning and improvement.

MEASURE Evaluation Population and Reproductive Health (PRH) adopted the following participatory approach to developing the framework:

- key informant interviews with members of the USAID Repositioning Family Planning Working Group
- key informant interviews with implementing partners outside of USAID
- key informant interviews with USAID missions from nine African countries
- synthesis of key informant input into conceptual background for framework
- compiling, reviewing, and refining indicators from interviewee organizations
- draft framework review by USAID

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[1] U.S. Agency for International Development (USAID). (2009). Repositioning family planning operational plan 2008-2013 [unpublished]. Washington: USAID.

[2] Academy for Educational Development (AED), World Health Organization (WHO) Regional Office for Africa. (2008). *Repositioning Family Planning: Guidelines for Advocacy Action*. Washington: AED and WHO.

[3] Hare, L., Hart, C., Scribner, S., Shepherd, C., Pandit, T. (ed.), and Bornbusch, A. (ed.). 2004. *SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation.* Baltimore, MD: Information and Knowledge for Optimal Health (INFO) Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

[4] EngenderHealth. (2007). *Reality Check: Family Planning Forecasting Tool*. New York: EngenderHealth.

Information Gathering

To learn from the efforts of USAID'S implementing partners, MEASURE Evaluation PRH consulted members of the USAID's Repositioning Family Planning Working Group to discuss the development of this framework. MEASURE Evaluation PRH conducted telephone interviews with key informants from the following projects:

- PSP-One and HS2020 Projects, Abt Associates
- AIM Global Health
- DELIVER Project, John Snow, Inc.
- Extending Service Delivery (ESD), Pathfinder
- Health Policy Initiative (HPI), Futures Group
- Leadership, Management, and Sustainability (LMS) Project, Management Sciences for Health
- BRIDGE Project, Population Reference Bureau
- RESPOND Project, EngenderHealth

This group of implementers provided information and insights about their respective projects' efforts to reposition family planning. Many of these organizations also contributed literature and indicators used to create the following results framework.

After interviewing each of the implementing partners (IPs), an effort was made to understand repositioning outside of the USAID context. Key informants were interviewed from

- Population Action International
- Urban Reproductive Health Initiative
- Futures Institute
- Bill and Melinda Gates Institute for Population and Reproductive Health of the Johns Hopkins Bloomberg School of Public Health
- World Health Organization (WHO)'s Implementing Best Practices Initiative

Finally, representatives from the USAID missions of the following nine priority countries were interviewed to provide the country perspective on repositioning family planning efforts amidst the current health priorities:

- Democratic Republic of Congo
- Kenya
- Madagascar
- Malawi
- Namibia
- Nigeria
- Senegal
- Tanzania
- Uganda

Defining Key Components of Repositioning Family Planning

During these key informant interviews, conducted from October 2009 through February 2010, many respondents from USAID missions were unsure of the definition of repositioning. A frequent request from missions that arose at the beginning of the interview was: "Please tell us your understanding of repositioning family planning." Upon an initial explanation, though, respondents provided a rich description of efforts to reposition family planning in their country and elements that are involved in repositioning family planning. In some cases, these included elements that extend beyond the strategies and approaches described in USAID's Repositioning Family Planning Initiative's Operational Plan:[1]

- resources allocated to family planning
- successful advocacy to different influential groups
- inclusion of family planning in national policy documents and plans
- country-level stewardship or ownership of family planning
- gaining the support of a leader to champion family planning
- section in the Ministry of Health dedicated to reproductive health (RH) and family planning (FP)
- community support or demand for the use of family planning, including support of men, traditional and religious leaders
- demand among the population—individuals and families
- including a strong communication component across communities and facilities
- reaching those most in need of family planning services
- commodity security and local procurement and distribution
- providing long-acting methods at the community level

There was disagreement on whether or not integrated services promote family planning or hinder efforts to reposition family planning. Some respondents felt that integration was essential, while others lamented that vertical family planning programs had been much more successful than integrated programs.

Representatives of USAID IPs often accurately described the overall goal of repositioning family planning, but consistently focused on the contributions of their own project or organization to the initiative. Admittedly, these respondents were asked to talk primarily about their own work, while USAID missions were asked about the country context and situation with family planning in general. Nearly all respondents from USAID missions, IPs, and international organizations underscored the importance of "evidence of action." Documents and statements of commitment are not sufficient for repositioning, but real action, funding, and implementation are evidence of action.

Barriers to Repositioning Family Planning

Respondents from USAID missions were asked about potential barriers or challenges to repositioning family planning in their country. Some representatives of IPs and international organizations also provided insight into challenges that they face across countries. Missions

specifically cited *demand* for family planning as a barrier to securing commitment to and resources for family planning. For example, USAID mission representatives stated:

- "Family planning is still a taboo subject."
- "The issue of cultural and religious barriers is strong…"
- There are "no communication programs in this country to generate demand."

Not surprisingly, USAID missions consistently revealed an interest in and understanding of the broader context within a country and its impact on family planning. Many cited the importance of maintaining a focus on *gender and family planning*. One respondent from a USAID mission stated, "We need to see men more strongly involved in repositioning family planning. When it focuses on women, it's a woman's problem and gets no attention."

Representatives of implementing partners and international organizations also discussed barriers to repositioning family planning, including:

- turnover and "brain drain" of health workers moving away from family planning and reproductive health to U.S. President's Emergency Fund for AIDS Relief (PEPFAR)-funded programs or to other higher paying donor-funded positions;
- insufficient resources for supporting consistent follow-up, which makes it difficult to know the extent of commitments;.
- capacity of individuals and organizations are sometimes insufficient to sustain efforts;
- country stewardship is often weak, which results in competing donor/IP efforts, poor coordination, and few synergies; and
- information produced for advocacy and policy-making may not be used once the international organization has moved on to another initiative.

Information from each set of interviews, as well as documents and project performance monitoring plans (PMPs), were compiled and reviewed as the basis for the results framework. The interviews provided insight into the key factors and components involved in repositioning family planning, potential barriers to repositioning, and provided key themes for measuring progress in repositioning family planning. These key components and themes informed the structure of the framework and the relationships between the intermediate results (IRs) described below.

Respondents noted some important facilitating factors or barriers to repositioning family planning, which are not specifically captured in the results framework and list of illustrative indicators. In some cases, these factors are functional areas, such as contraceptive security or human resources for health. The illustrative indicators can be used to monitor efforts in these areas, but may require additional indicators to address the range of efforts in these areas completely.

Results Framework for Strengthening the Enabling Environment for Family Planning

When is a country *"repositioned"?* And how does a country know that it is going down the right path in its efforts to increase access to and demand for quality family planning services? Assessing and measuring the extent to which a country has repositioned family planning in the broader health and development agenda will involve a focus on documenting results at the national and subnational levels, monitoring change in traditionally monitored family planning indicators, as well as sharing and replicating best practices. Monitoring and evaluating many of these indicators will require baseline data in order to demonstrate an improvement or increased focus on technically sound family planning programs.

The results framework is a planning, monitoring and management tool that links the conceptual design of a program intervention to the reality of program implementation. It allows the user to understand linkages between program interventions and potential results, and monitor progress. At a country level, the breadth and range of indicators presented in this framework may be used to assess the overall effort to reposition family planning. On the other hand, organizations may select key indicators that are relevant to the types of programs being implemented by their team.

Strategic Objective: *Increased Stewardship of and Strengthened Enabling Environment for Effective, Equitable and Sustainable Family Planning Programming*

Based on the goal of USAID's repositioning family planning initiative, we propose the overarching strategic objective (SO) in the results framework (figure 1) be: *Increased stewardship of and strengthened enabling environment for effective, equitable and sustainable family planning programming*. The initiative's operational plan notes a goal of increasing both political and financial commitment to family planning in sub-Saharan Africa. MEASURE Evaluation PRH, with input from key stakeholders in the Repositioning Family Planning Working Group, has chosen to broaden the language in the strategic objective.

To assess whether strengthening has occurred, a baseline in addition to a set of criteria should be established in advance.

Stewardship in this framework is defined as the responsible and attentive management of something entrusted to your care. Respondents in the missions, as well as respondents from projects addressing policy and financing issues, noted that a sustainable repositioning of family planning would not take place without leadership and stewardship of family planning from within the country. Respondents cited successes in Rwanda and Madagascar as clear examples of true changes being made only after public officials took over responsibility for family planning. In particular, these respondents noted that in these countries a specific individual became a "champion" for family planning in the country. Family planning and reproductive health programs are often the responsibility of the public sector; however, family planning may not be a priority in the country. Strengthened stewardship within and between any sectors involves leadership and active management from within the country to provide family planning services.

Stewardship is one of the six building blocks in the World Health Organization's health systems framework.[5] The principles defining stewardship for the overall health system may be adapted to family planning and map clearly to this results framework, for example:

- overseeing and guiding the overall provision of family planning services, provided by private as well as public sources, in order to protect the public interest (SO);
- formulating strategies and also specific technical policies for family planning which define goals, directions and spending priorities across services, and identify the roles of public, private and voluntary actors and the role of civil society (IR1 and IR3);
- intelligence and oversight, including measuring trends in population and family planning measures, including access to services (IR4);
- collaboration and coalition building across sectors in government and with actors outside government, including civil society, to influence action on key determinants of population and access to family planning services (IR2);
- regulation and the design of performance measures, and ensuring they uphold the principles of voluntariness and informed choice in family planning (IR3 and IR5);
- ensuring a fit between strategy and structure and reducing duplication and fragmentation in the organization and delivery of services (IR3); and
- ensuring accountability and transparency in the delivery of family planning services (SO).

Strengthened enabling environment for family planning is an observable improvement in the conditions that facilitate the efforts of all sectors to implement FP programs. Key elements of an enabling environment are described in greater detail through the IRs in this framework. The enabling environment may include such elements as an increase in financial support for FP; appropriate curricula for health workers, including international best practices in FP; or a regulatory environment favorable for procurement of a variety of different FP methods.

Equitable refers to ensuring that all segments of a country's population—especially the poor, children and adolescents, women, men, and inhabitants of rural areas—have fair and equal access to services.

Sustainable refers to the ability of host country entities to strengthen or maintain the enabling environment and meet established objectives for family planning over a period of time, and to do so in spite of the strength or weakness of external funding and/or focus on family planning. This framework's definition of "sustainable" loosely builds on the Africa Bureau Office of Sustainable Development's definition, which states that sustainability is "the ability of host country entities

[5] World Health Organization (WHO). (2007). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: WHO.

(community, public and/or private) to assume responsibility for programs and/or outcomes without adversely affecting the ability to maintain or continue program objectives or outcomes."[6]

Strengthened stewardship and enabling environment for family planning described in the SO helps contribute to a positive change in country-level, long-term outcome indicators for family planning. These long-term outcome indictors include the contraceptive prevalence rate, shift in method mix to long-acting and permanent methods of contraception, and unmet need. However, because these indicators are also highly dependent on service delivery and other program variables, they have not been included in the framework as a direct measurable and manageable outcome of repositioning family planning efforts. It is important to monitor these and other established outcome/impact indicators, but weakness may or may not be directly attributable to the repositioning efforts.

Through the series of IP and mission interviews, a review of current literature and prevailing indicators used by USAID-funded projects, MEASURE Evaluation PRH has identified five IR areas:

Intermediate Result 1: *Resources for Family Planning Increased, Allocated and Spent More Effectively and Equitably*

This IR describes improvement in a key element of an enabling environment. As described above, nearly all respondents interviewed by MEASURE Evaluation PRH underscored the importance of "evidence of action." One representative of an international organization asserted, "It doesn't make sense to bump up something to the forefront without thinking about whether or not there are resources to pick it up when you leave." Increased resources for family planning is evidence to document that action.

Representatives from missions and IPs alike described the allocation and actual expenditure of resources on family planning commodities and services as a key measure of repositioning. One respondent noted that even if family planning is included in country plans or policies, this "still requires financial support to be repositioned."

In this framework, increased resources does not refer to only financial resources, but can also be material such as additional doctors, new facilities, furniture, and vehicles. Resources can derive from many sources including, national/subnational governments, nongovernmental organizations (NGOs), donors, individuals, foundations, etc. There are several possible mechanisms to increase the pool of resources available for health-related activities: line items in budgets, money from government budgets, donor funds, taxes, user fees, privatization, community-based financing, and health insurance schemes, among others. This selection of indicators can help to track sustainability of family planning in a country.

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[6] USAID Africa Bureau, Office of Sustainable Development (AFR/SD). (1999). *Health and Family Planning Indicators: A Tool for Results Frameworks*. Volume I. Washington: USAID AFR/SD.

Allocation refers to the assignment of resources to a specific purpose. Financial, human, and other types of resources may be allocated to different activities/needs/clinics/geographical locations based on evidence and information, modeling, advocacy and policy dialogue, a costing exercise, or part of a policy or operational plan.

Equitably refers to ensuring that all segments of a country's population—especially the poor, adolescents, women, men, and inhabitants of rural areas—have fair and equal access to services.

Intermediate Result 2: *Increased Multisectoral Coordination in the Design, Implementation, and Financing of Family Planning Policies and Programs*

Sector refers to a subset of institutions, organizations, or body of knowledge. For instance, at the institutional level, sectors can be defined in relation to government or the private sector. Within the private sector, institutions can further be defined as for-profit entities or nonprofit entities, such as NGOs/community-based organizations, civil society groups, religious groups, etc. Sectors may also be defined in relation to the discipline or body of knowledge under which the entity operates (e.g., education, agriculture, health, and the environment).

Multisectoral structures can be any entities, bodies, partners that are made up of groups or individuals from different sectors (government, nongovernment, civil society) and/or different disciplines (health, education, environment, etc.).

Coordination is an effort, process, or system of operating that involves bringing together multiple parties to work toward a unifying objective or output. The parties involved may include ministry of health (MOH) representatives, NGOs, parliamentary committees, U.S. government representatives, donors, leaders from various sectors in a country, etc.

Demand for FP or social acceptability of FP can be influenced by efforts to reposition family planning. For instance, the framework includes indicators that reflect multisectoral involvement in strengthening the enabling environment for FP (IR2). Multisectoral involvement, including entities representing community and religious groups, can reflect existing acceptance and interest in family planning in the community.

Intermediate Result 3: *Policies that Improve Equitable and Affordable Access to High-Quality Family Planning Services and Information, Adopted and Put into Place*

Policies include laws and plans that provide the broad vision and framework for action within an enabling environment for family planning. One of the first components of repositioning family planning mentioned by each respondent was a strong family planning policy and inclusion of family planning in national and subnational documents and plans. Based on country examples conveyed by missions and implementing partners, as well as through the document review, it is clear that merely the existence of a policy, document, or plan is insufficient to ensure commitment to and resources for family planning. This IR also includes indicators to measure

the essential steps from policy to practice, including the existence of an operational plan, measures to address barriers to policy implementation, and evidence of policy implementation.

Adoption and implementation of policies often occur at different points in time. In some contexts, a policy will first need to be adopted, which would be reported using one indicator. If a policy is already in place and a plan is developed, a result corresponding to another indicator can be claimed.

Put into place refers to various implementation mechanisms such as adopting operational policies, establishment of monitoring bodies, training on how to use/implement policy or guidelines, etc.

As mentioned above, equitable refers to ensuring that all segments of a country's population—especially the poor, children and adolescents, women, or inhabitants of rural areas—have access to services.

Intermediate Result 4: *Evidence-Based Data or Information Used to Inform Policy Dialogue, Policy Development, Planning, Resource Allocation, Budgeting, Advocacy, Program Design, Guidelines, Regulations, Program Improvement and Management*

Nearly every implementing partner interviewed by MEASURE Evaluation PRH shared their project's performance monitoring plan (PMP). Each of these PMPs included an indicator to monitor the use of information generated by the project. These sources of information included national health accounts and-sub accounts information, documented best practices, modeling information for advocacy purposes, and program evaluation or information produced through a model for strategic planning.

Projects and missions alike underscored the importance of "using evidence to inform decision making and resource allocation," "institutionalizing the collection" of important routine information, and "using information from advocacy models to increase visibility of family planning." Respondents also noted that resources may be spent on "producing information for advocacy, policymaking or planning, but the information may not be used." It is important to monitor efforts to reposition family planning by considering the evidence behind certain decisions. Through the process of mapping indicators, MEASURE Evaluation PRH discovered that this result area is fundamental to achieving IR 1, IR 2, IR 3, and the SO, and, thus, have depicted this IR as well as IR 5 as foundational elements of the repositioning family planning initiative (figure 1).

IR 4 links the collection of data, development of tools, such as models, and the application of these sources of evidence. Achievement of this indicator occurs when a policy-maker (such as a minister of health) or a representative from an NGO, on his or her own initiative, uses evidence-based information for policy dialogue, planning, or advocacy. Evidence of achievement for this indicator does not include dissemination (printing and distributing reports), but rather actual use of the information for advocacy, policy dialogue, planning, resource allocation, and program improvement.

Intermediate Result 5: *Individual or Institutional Capacity Strengthened in the Public Sector, Civil Society, and Private Sector to Assume Leadership and/or Support the Family Planning Agenda*

This result area measures strengthened capacity to support the family planning agenda and assure sustainability of family planning. Forms of capacity may include leadership, management, monitoring and evaluation, advocacy, policy development, program content, etc. Capacity is not defined in this document because the framework is meant to be used and adapted across country and program settings, which require varied definitions. In addition, projects, donors, or countries may want to apply their own definitions. It may be useful to refer to the Health Policy Project's document *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation,* which defines various forms of capacity in the policy environment.[7] The result area also reflects the importance of the involvement of varied sectors. During interviews with missions, respondents expressed the concern that capacity to sustain efforts to reposition family planning and keep it on the agenda is lacking. Many also asserted that well-positioned, prepared champions throughout the public, private, and NGO sectors play a vital role. One respondent expressed concern that without strong local capacity, the initiative would not continue to promote family planning once donor support has shifted to competing priorities or left the country.

This result area also includes an indicator (IR5.3) that can be used to monitor social acceptability of FP. As many interviewees noted, FP champions can create social acceptability of contraception, and statements by community leaders in support of family planning can reflect existing acceptance and interest in family planning in the community.

Through the process of mapping indicators, MEASURE Evaluation PRH discovered that this result area is fundamental to achieving IR 1, IR 2, IR 3, and the SO, and thus have depicted this IR as well as IR 4 as foundational elements of the initiative (figure 1).

[7] Jorgensen AK, Hardee K, Rottach A, et al. (In press). *Capacity Development Framework and Approach for Health Policy, Governance, and Social Participation.* Washington, DC: Futures Group, Health Policy Project.

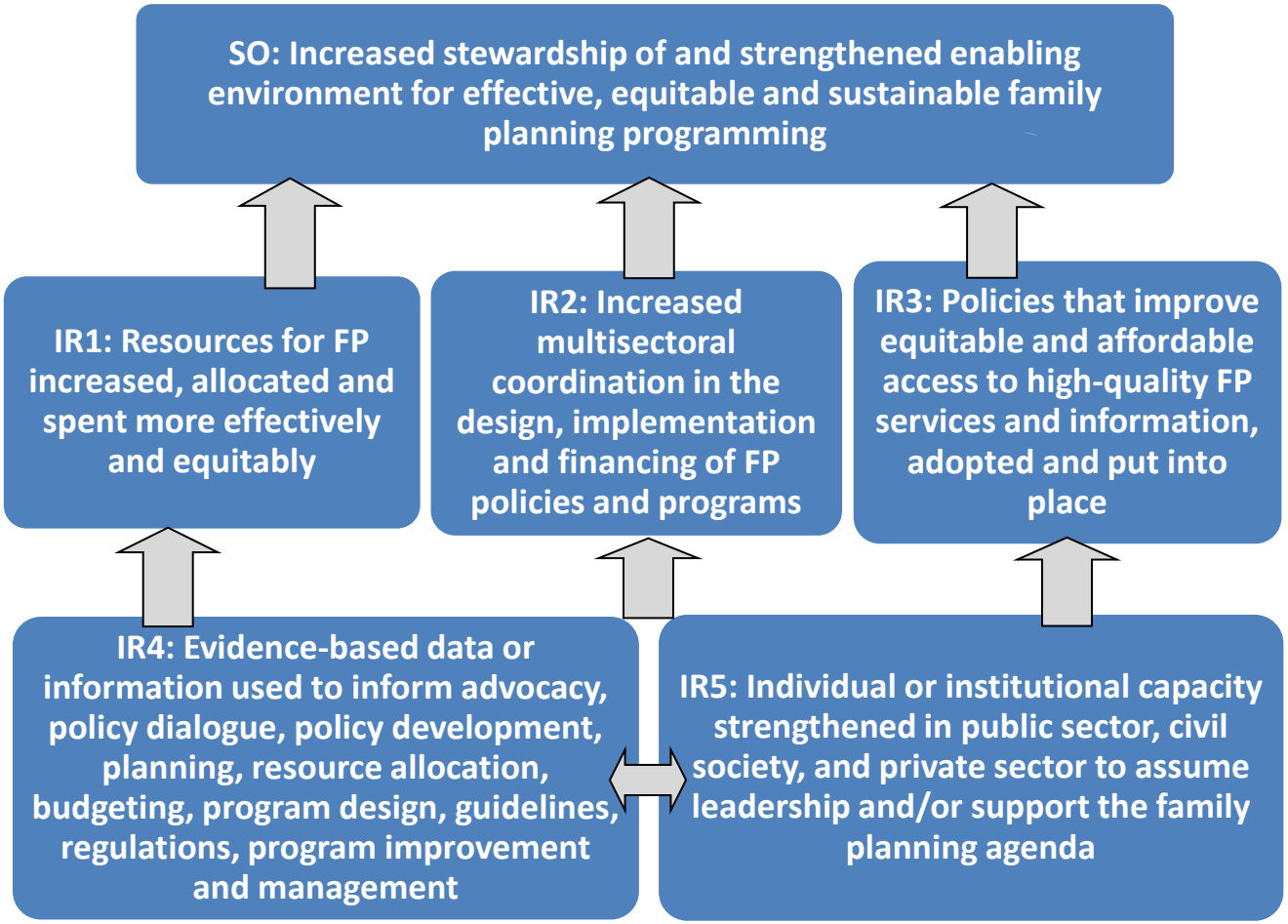

Figure 1. Results framework for strengthening commitment to and increased resources for family planning.

Linkages to the Global Health Initiative

The framework for M&E efforts to reposition family planning links directly to the principles of the Global Health Initiative and can be used to help monitor implementation of those principles.

The GHI principles are:

- implement a woman- and girl-centered approach
- increase impact through strategic coordination and integration
- strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
- encourage country ownership and invest in country-led plans
- build sustainability through health systems strengthening
    - improved health financing strategies that reduce financial barriers to essential services, including increased government and/or private sector funding for health and reduced out-of-pocket payments for health services where appropriate
    - increased numbers of trained health workers and community workers appropriately deployed in the country
    - improved functioning of health management information and pharmaceutical management systems to reduce stock-outs
- improve metrics, monitoring, and evaluation
- promote research and innovation

Table 1 provides a mapping of GHI principles and the framework results areas.

Potential Gaps and Limitations of the Framework

The results framework does not address specific functional areas of family planning, rather it provides a framework for monitoring progress across these functional areas. Examples of a functional area include management, commodities supply and logistics, human resources, performance improvement, and behavior change communication. Thus, specialists in a specific area may wish to adapt these indicators to reflect nuances of their functional area. Also, as mentioned below, many projects and organizations that concentrate their efforts on a specific functional area have developed their own tools, approaches, and frameworks. These specific tools and approaches provide more detail about that functional area than is required to understand progress in repositioning family planning overall.

Strengthened stewardship and enabling environment for family planning described in the SO helps contribute to a positive change in country-level, long-term outcome indicators for family planning. These long-term outcome indictors include the contraceptive prevalence rate, shift in method mix to long acting and permanent methods of contraception, and unmet need. However, because these indicators are also highly dependent on service delivery and other program variables, they have not been included in the framework as a direct measurable and manageable outcome of repositioning family planning efforts. It is important to monitor these and other established outcome/impact indicators, but weakness may or may not be directly attributable to the repositioning efforts.

Table 1. Matrix on Repositioning Family Planning Linkages to the GHI Principles

GHI Principles	IR1 Increased resources	IR2 Multi-sectorial	IR3 Policy	IR4 Information	IR5 Capacity built	Notes
1. Implement a woman- and girl-centered approach						Maps with the overall focus on equity in the framework
2. Increase impact through strategic coordination and integration		X				
3. Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement	X	X			X	
4. Encourage country ownership and invest in country-led plans		X		X	X	
5. Build sustainability through health systems strengthening						The overall purpose (SO) of the framework is to create a sustainable future for family planning
a. Improved health financing strategies that reduce financial barriers to essential services	X					
b. Increased numbers of trained health workers and community workers appropriately deployed in the country	X		X			
c. Improved functioning of health management information and pharmaceutical management systems to reduce stock-outs			X	X		
6. Improve metrics, monitoring and evaluation						The framework was created to provide a means for countries to monitor their own progress in repositioning FP
7. Promote research and innovation				X		

Likewise, it is important to acknowledge that other non-program factors are involved in the achievement of the SO. Non-program factors are interventions, issues, or contextual characteristics that are unrelated to the elements of repositioning family planning highlighted in the framework. These non-program factors may include a family's socio-economic situation, efforts to improve the quality of family planning commodities and services, or actual components of service delivery.

For instance, while conducting the interviews with IPs and international organizations, several respondents discussed the status of women and gender norms as a barrier to repositioning. The status of girls and women in society, girls' education, and gender-based violence can influence demand for family planning as well as perceived importance of FP/RH issues in society. Thus, programs that address issues outside of family planning can have an effect on repositioning family planning. This was such a common issue raised in the interviews that a question was included in the mission interviews to gather more input on the subject. In creating the results framework, the word "gender" was not explicitly included; however, several of the illustrative indicators can be amended to include language about gender in policies, plans, resources, and program implementation. The term "equitable," used throughout the framework, implies gender equity in family planning programming.

In addition, during the interviews with the missions, several respondents and at least one reviewer view behavior change communication (BCC) strategies and advocacy at the community level as crucial to repositioning. These individuals posited that demand generation and greater social acceptability for FP result from these activities and are a key component of the enabling environment for FP. BCC was not specifically covered in the USAID strategy, and therefore was not covered in the results framework. Demand for FP or social acceptability of FP can be influenced by efforts to reposition family planning. Although not covered in depth, the framework includes indicators that reflect the importance of supportive statements from community and government leaders and multisectoral involvement in strengthening the enabling environment for FP (IR2, IR5.3).

Selection of Indicators

MEASURE Evaluation published guidance on the steps involved in selecting indicators in the *Compendium of Indicators for Evaluating Reproductive Health Programs*.[8] In keeping with that guidance, we used the following steps to select indicators in this framework:

- Clarifying the objectives of repositioning family planning by learning what programs and donors expect to accomplish;
- Developing a list of possible indicators;
- Assessing each possible indicator; and
- Selecting the "best" indicators for repositioning family planning.

[8] Bertrand, J.T., Escudero, G. (2002). *Compendium of Indicators for Evaluating Reproductive Health Programs: Volume 1.* Chapel Hill, NC: MEASURE Evaluation.

To the extent possible, the indicators selected have been tested and applied by other organizations and projects. The project/organization that provided the indicator has been listed in the last column of the Indicators table (Table 2). It is important to note that the selection of indicators provided here for measuring progress in repositioning family planning does not include indicators specific to each functional area or in each element of family planning. Rather, one could substitute a focus on a particular functional area, such as expanding human resources for FP, for the phrase "Family Planning" in many of the indicators.

Projects and experts in specific functional areas, such as Contraceptive Security, have developed indicators and tools that are appropriate for a detailed examination of that specific functional area. For instance, the USAID DELIVER Project has identified and tested a comprehensive set of indicators for measuring contraceptive security.[9] For countries and organizations interested in exploring a specific functional area or a certain aspect of repositioning family planning in detail, these comprehensive sets of indicators should be used.

Sources of Data

To the extent possible, the data sources for each of the indicators included in table 2 include routinely-collected programmatic data or evidence rather than findings from large, population-based surveys or special studies.

Testing of the Framework

Overview

In July 2011, MEASURE Evaluation PRH and the Advance Family Planning (AFP) project funded by the Gates Foundation conducted a field test of the *Framework for Monitoring and Evaluating Efforts to Reposition Family Planning* in Tanzania. The objectives of the field test were:

- To apply the framework through semi-structured interviews with key informants representing government, donors, international organizations and local NGOs;
- To collect documents that would serve as evidence for Tanzania's efforts toward achieving the indicators in the M&E Framework for Repositioning FP;
- To pilot test the framework and make revisions and additions to indicators and indicator guidance.

Methods

MEASURE Evaluation PRH collected information defined in the framework indicators through desk review prior to travel and in-country through key informant interviews. For the

[9] USAID | DELIVER PROJECT, Task Order 1. 2010. *Measuring Contraceptive Security Indicators in 36 Countries.* Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.

key informant interviews, a semi-structured discussion guide was developed. The discussion guide had six sections – an introductory section, and a section for each of the Intermediate Result (IR) areas in the framework. In the framework, IR 1 captures resources available for FP, IR 2 concerns multisectoral engagement in repositioning FP, IR 3 addresses policy, IR 4 is related to use of evidence to strengthen the FP agenda, and IR 5 is related to capacity to support the FP agenda. The introductory section was designed to gather general background information, and to help the interviewers understand which subsequent sections of the discussion guide to complete with that specific informant. The guide was structured as such with the understanding that few interviewees could address comprehensive information relevant to each of the IR areas.

In addition to using preliminary questions to decide which questions the informant would most likely be able to address, MEASURE Evaluation PRH and AFP realized that the first few interviews provided insight into the history and status of repositioning FP efforts in Tanzania. This basic introduction to repositioning FP in Tanzania allowed the team to better understand which key informants would be most appropriate to answer specific questions based on a description of their roles, responsibilities, and activities. Prior to an interview, the team would select key questions that either had not been fully addressed through other interviews or were intended to gain additional viewpoints. The key informants provided evidence of achievement of repositioning indicators through documents, presentations, analyses and spreadsheets. MEASURE Evaluation PRH requested that key informants bring any relevant documents or publications related to repositioning FP to the interview, but in some cases evidence was discussed during the interview and then shared in a follow-up email communication.

It is important to note that the objective of gathering this evidence was not to ask a series of questions to collect generalizable knowledge from the key informants. Rather, the objective was to collect evidence of achievement for each of the indicators listed in the framework. Once appropriate evidence had been collected for a given indicator, the team did not persist in asking the same questions, but rather focused efforts on gaining evidence that had not yet been collected.

MEASURE Evaluation PRH and AFP conducted in-person; semi-structured interviews with 31 key informants either at their place of work or in a public space, and obtained agreement to meet as well as specific dates and times for each key informant through email exchanges. These key informants represented government, donors, international organizations and local NGOs, and were able to provide both historical and more recent insight on repositioning FP.

Limitations

Each country situation will present unique challenges and limitations to implementing the framework.

In Tanzania in July 2011, repositioning FP efforts had been solidly led by international donors and organizations rather than by the government. Thus, most of the key informants were representatives from international organizations. Two of the key informants represented the Tanzanian government, five represented local NGOs (from a total of three different NGOs), and one respondent was an independent consultant formerly employed by both government and

international organizations. The objective of applying the framework in Tanzania was to gather evidence of achievement of indicators rather than ensure equal representation from different types of stakeholders; however, diverse sources of information are important to ensure a more complete picture of progress toward repositioning FP in the country.

The interviewers provided the framework to key informants in advance. Some informants had read the framework in advance, but many had not. At the beginning of each discussion, the interview team took a few minutes to describe the process of developing the framework, and briefly mentioned the Strategic Objective and the five IR areas. Most of the key informants were familiar with the concept of repositioning family planning, and immediately began addressing the IR areas as they described the work that they had been involved in to reposition family planning. In a few cases, elements of repositioning FP were confused with service delivery, and the questions included in the interview guide were essential to keep the discussion on track and focused on gathering evidence of indicator achievement.

Each country has different levels of achievement for indicators in the framework, and while there is documented evidence of achievement for some indicators, for other indicators there may only be a key informant's independent assessment of the situation. In some cases, documented evidence may only be available in hard copy or may not be available for the interviewer to take for records. In each situation, the organization applying the framework will have to make judgments about the range of opinions and viewpoints provided by key informants, and may have to identify creative ways to document evidence.

While most documents in Tanzania related to repositioning FP are developed in English, transcripts from Parliamentary hearings and debates are in Kiswahili. In two cases, these transcripts serve as evidence of achievement for one or more indicators related to public statements of support for FP and new commitments of resources for FP. It is important to note that translation may be required for full documentation of the framework in English.

Findings

In terms of stewardship **(SO)** there is a National FP Technical Working Group which advocates for resources, oversees planning, policy development and revision, and monitoring. The head of FP for the Reproductive and Child Health Section (RCHS) of the Ministry of Health is the chair of the working group. Interviewees indicated that the group is effective, but "donor-driven," and several felt that a "challenge remains in political leadership for FP."

There have been significant successes in Tanzania related to FP funding (**IR1**) including Members of Parliament (MPs) demanding higher budget allocations, and a line item specifically for FP. In addition the field test revealed that there are also challenges, including the erratic release of funds, and procurement and supply management difficulties. In addition, the funding levels have been increasing for contraceptives, but this is primarily a donor driven. As one interviewee said, "much of what we're celebrating as increase in funds is really from the basket funds…not really from government's own money."

Multisectoral engagement (**IR2**) is an area of both strength and challenge in Tanzania. The Poverty Reduction Strategy Paper (PRSP) in Tanzania and other national strategic papers/plans do include FP, but it is not adequately considered as economic issue across sectors. The National FP TWG is multisectoral structure, but is still focused on health. Finally, there are few barriers to private sector involvement in FP, but the "government could do more to support private sector role."

Tanzania has strong plans and policies related to FP (**IR3**). There is an adequate high-level policy framework, and the costed implementation plan has been used to help mobilize additional resources. There is also strong assistance at the district level with developing Comprehensive Council Health Plans (CCHPs) and advocacy. One noted remaining policy barrier is to the community based distribution of injectables.

Another area of noted strength is in evidence-based decision making (**IR4**). Data was used to develop the costed implementation plan and other key FP documents. One implementing partner was working with the MOH in mid-2011 to revise and publish clinical training manuals and FP guidelines, and to build country capacity in research. Other partners are working to build capacity in M&E and evidence informed decision making within the MOH. One noted challenge is that Tanzania does not currently have a defined research agenda on FP.

An area of identified challenge is in the capacity to support the FP agenda (**IR5**). Interviewees noted weak local NGO and government capacity to advocate for and deliver FP services, and the fact that only a few indigenous NGOs were actively working on FP within Tanzania. In addition, it was noted that the culture of advocacy by CSOs is not strong, thereby contributing to the lack of advocacy for FP. Despite these weaknesses, there are strong examples of donor funded programs strengthening the capacity of stakeholders to support the FP agenda. In July 2011, the Parliamentary FP Club, a group of Parliamentarians interested in supporting a strong policy environment and increasing resources for FP, was established. Religious leaders, the National Council of Muslims, the Council of Bishops, and the Christian Council of Tanzania, have also been engaged to discuss and support FP in Tanzania.

While each of the strengths and weaknesses presented refers to Tanzania specifically, the findings provided general insights into the Framework, indicators, and tool requirements. Several lessons learned should be considered when applying the Framework. First, flexibility is required. The indicators are broad by design, and should be used to capture the work in country. It will be necessary, however, to use discretion in deciding which indicators have been satisfied. A team approach to data collection is helpful for this reason. Secondly, it is important that those implementing the key informant interviews have a strong understanding of FP. Because so much discretion is needed – both during the interviews and in data compilation it is important that the interviewer(s) be able to make quick decisions about the process and be familiar enough with FP to do so. Finally, the Framework testing in Tanzania was done at the country level. The indicators could be modified and used to monitor a specific program, but one program may not be able to address each aspect of the framework. Indicators should be selected and adapted for program use. In addition, even at the country level, indicators may require different monitoring schedules. For example, a country could decide to use the indicators to track progress every six

months or even annually, but should select which indicators to monitor at what frequency. It is unlikely, for example, that a country would develop a new FP policy every six months.

Changes to the Indicators

Following the in-country data collection, MEASURE Evaluation revised the framework indicators and interview guide. Factors involved in making revisions have included the availability of the data required for each indicator, appropriateness of the data for measuring efforts to reposition FP, and appropriateness of the indicators and terminology used in the framework. Changes are listed below, and reflected in Table 2.

- One indicator was added – IR3.2 Existence of national or subnational policies or guidelines that promote access to FP services and information for underserved populations to meet the need for information about improving equity in access to FP services. In turn, the team chose to remove language about equity from several other indicators because it was unlikely that the information required to meet the conditions of the indicators were available.
- Indicators IR1.4.1 and IR 3.4.1 were removed in the draft framework, and instead language was added to the reference sheets for IR 1.4 & 3.4 explaining how to use those indicators to track either national or subnational information (or both if you wanted). Also, IR 4.3 was removed, as it was rarely collected and less applicable to a country program than to an individual organization or project.
- Significant changes were made to indicator 2.4 to incorporate both the promotion of mechanisms for private sector participation as well as the removal of barriers.
- In almost all instances where the original indicator began with the language "number of" it was changed to "evidence of." It is not realistic to assume that we will collect a representative "number of" and instead preferred to show "evidence of" movement in the right direction.
- The language of several indicators was streamlined. The meaning of the indicators did not change, but the wording is now more concise. Questions that had been developed as a part of the discussion guide were streamlined and rephrased to ensure the right information is collected.

Table 2. Repositioning Family Planning Results and Illustrative Indicators

Results	Illustrative Indicators	Illustrative Data Sources	Original Indicator Source
Strategic Objective: Increased stewardship of and strengthened enabling environment for effective, equitable and sustainable family planning programming.	**SO.1**: Instances of a government-led council, coalition or entity that oversees and actively manages the family planning program	• Council/ coalition or entity's mission statement; • Key informant interviews • Policy Environment Score, Family Planning Program Effort Score, Contraceptive Security Index conducted as baseline and at least 2 years later	Adapted from LMS, WHO
	SO.2: Evidence of documented improvement in the enabling environment for family planning using a validated instrument	• Policy Environment Score, Family Planning Program Effort Score, Contraceptive Security Index conducted as baseline and at least 2 years later • Copies of other instruments and pre- and post-tests	HPI
	SO.3: Evidence of FP policies implemented, resources allocated and subsequently used in relation to the same FP policies.	• Refer to data sources used to document related results • Percent of allocated budget spent • Budgets, line items, invoices, other evidence of allocations and expenditures	HPI

IR1:	Resources for family planning increased, allocated, and spent more effectively and equitably.	**IR1.1**: Total resources <u>spent</u> on FP (by source and by activity/program area)	• Budgets, line items, invoices, donor records, expenditure records, orders, other evidence of commitment/new resources • Donations, letters, records, or other data sources to capture non-monetary donations	ESD and HPI
		IR1.2: Evidence of new financing mechanisms for family planning identified, tested, and/or scaled-up	• Documents and meeting minutes • Pilot tests • Study results	MEASURE Evaluation Compendium
		IR1.3: Total resources <u>allocated</u> to FP (by source and by activity)	• Budgets, line items, invoices, donor records, expenditure records, orders, other evidence of commitment/new resources • Donations, letters, records, or other data sources to capture non-monetary donations	ESD and DELIVER
		IR1.4: New and/or increased resources are committed to FP in the last two years	• Budgets, line items, invoices, donor records, expenditure records, orders, other evidence of commitment/new resources, human resources records, procurement records • Donations, letters, records, or other data sources to capture non-monetary donations	HPI
IR 2:	Increased multisectoral coordination in the design, implementation, and financing of family planning policies and programs.	**IR2.1**: Evidence of family planning programs incorporated into national strategic and development plans	• SWAP or PRSP	HS2020
		IR2.2: Evidence of governments engaging multiple sectors in family planning activities	• Report from government and participants • Meeting minutes • Program evaluation	LMS and HPI
		IR2.3: Evidence of multisectoral structures that are established or strengthened to promote FP policy	• Report from government and participants • Meeting minutes, membership list, scope of work, meeting schedules • Baseline required for claiming "strengthened"	HPI and DELIVER
		IR2.4: Documentation of identified barriers to private sector participation in FP policy development and/or service delivery identified, addressed, and/or removed	• Actual policy documents with evidence of government approval, or submission for approval	MEASURE Evaluation Compendium

IR 3: Policies that improve equitable and affordable access to high-quality family planning services and information, adopted and put into place.	**IR3.1**: Existence of national or subnational policies or strategic plans that promote access to family planning services and information	• Copy of policy, strategic plan, guidelines signed with evidence of approval (signature) • Official gazette, laws, bills	HPI and MEASURE Evaluation Compendium
	IR3.2: Existence of national or subnational policies or strategic plans that promote access to family planning services and information for underserved populations	• Copy of policy, strategic plan, guidelines signed with evidence of approval (signature) • Official gazette, laws, bills	AFP
	IR3.3: Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy	• Copy of plan, document • Memos, guidelines, norms, instructions, distribution lists, memorandum of understanding (MOU)	HPI and DELIVER
	IR3.4: Evidence that policy barriers to access to family planning services and information have been identified, and/or removed	• Legal and regulatory reviews • Actual old and new policy documents showing evidence of restrictions in the old policy that do	HPI and MEASURE Evaluation Compendium
	IR3.5: Evidence of the implementation of policies that promote family planning services and information	• Directive, resolution • Tool to measure policy implementation • Meeting minutes providing evidence of dialogue among national and subnational governments on new guidelines • Evidence of activity plans or reports that show the policy is being used	HPI

IR 4: Evidence-based data or information used to inform advocacy, policy dialogue, policy development, planning, resource allocation, budgeting, program design, guidelines, regulations, program improvement and management.	**IR4.1**: Evidence of data or information used to support repositioning family planning efforts	• Key informant interviews, documents with citations highlighted, policies/plans • Citation in a policy or plan • Project records, case studies, mission memos	MEASURE Evaluation, HPI, ESD, DELIVER, HS2020
	IR4.2: Evidence of international family planning best practices incorporated into national health standards	• FP guidelines or standards of care	ESD
	IR4.3: Evidence of a defined and funded research agenda in family planning	• Meeting notes, consensus statements, memoranda detailing research agenda	MEASURE Evaluation PRH
	IR4.4: Evidence of in-country organizational technical capacity for the collection, analysis and communication of FP information	• Reports or briefs produced with data • Evidence of identification of data needs with stakeholder involvement	MEASURE Evaluation PRH
IR 5: Individual or institutional capacity strengthened in the public sector, civil society, and private sector to assume leadership and/or support the family planning agenda	**IR5.1**: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement repositioning family planning activities	• Key informant interviews, copy of action plans, campaign plans • Newspaper articles, published statements, speeches *Note: Policy champions/organizations must be identified in advance.*	HPI, LMS
	IR5.2: Evidence of government departments or other entities established or strengthened to support the family planning agenda	• Existence of RH/FP focused department in Ministries or gov't agencies • Group records, meeting minutes, invitations, protocols • Registration records for entity • Vision statement, charter, membership over time	HS2020, HPI
	IR5.3: Evidence of targeted public and private sector officials, FBO, or community leaders publicly demonstrating new or increased commitment to FP	• List of targeted officials/champions • Newspapers, workshop agendas, published statements, speeches, media reports, political party platforms, clipping service • Increased commitment requires a baseline; new commitment must be documented	HPI
	IR5.4: Evidence of regional/national centers or collaboratives for shared education and research in family planning	• MOU signed by center/collaborative members	MEASURE Evaluation

Appendix: Repositioning Family Planning Indicator Sheets

Strategic Objective Indicators

Indicator SO.1: *Evidence of a government-led council, coalition or entity that oversees and actively manages the national family planning program.*

Definition: Evidence of a government-led council, coalition or entity that oversees and actively manages the national family planning program will document the active role of government in family planning. Overseeing and actively managing is also described as stewardship.

"Councils" are bodies that can serve an advisory or legislative function and include representatives that are either elected or appointed by individuals or groups.

"Coalition" is a temporary union, partnership or alliance of individuals or distinct organizations that have come together for joint action.

"Entity" is used here to mean that the family planning (FP) program does not have to be led by a union of different organizations or sectors in order to fulfill the requirements of this indicator. A national ministry, such as a ministry of gender and family planning, or a unit within a larger organization could provide active management and leadership to the FP program. If the FP program is led by an individual, government-led body, it will be important to measure the indicators in result area two, which are focused on multisectoral engagement.

Data Requirements: Evidence of the existence and mandate of the government-led entity, and documentation of the work of this council/coalition to lead the FP program.

Data Source(s): Council/coalition or entity's charter or mission statement; minutes and agendas of entity's meetings; key informant interviews; Policy Environment Score, Family Planning Program Effort Score, and/or Contraceptive Security Index conducted as baseline and at least 2 years later

Purpose: The purpose of this indicator is to capture instances of government stewardship of the FP program and document progress toward sustainability of FP in the country by demonstrating that the FP program is country-led, coordinated and managed.

Issues: Evidence of the entity's role in overseeing and actively managing the FP program will have to come from multiple sources, including qualitative accounts. Stewardship is defined as the responsible and attentive management of something entrusted to your care, and is an international development concept. Stewardship is also a somewhat subjective term. In some cases there will be concrete examples of government oversight and management. In other cases, stewardship refers to *how* a country manages their FP programs (i.e., do managers really have their stakeholder's interests in mind). This is difficult to capture, as stakeholders have various priorities. Stewardship also addresses the issues of corruption and financial misconduct which are also by nature hard to document.

Reference:

World Health Organization (WHO). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva, Switzerland: WHO; 2007.

Indicator SO.2: *Evidence of documented improvement in the enabling environment for family planning using a validated instrument.*

Definition: Improvement in the enabling environment for family planning (FP) is an observable improvement in the conditions that facilitate the efforts of all sectors to implement FP programs. Key elements of an enabling environment may include such elements as an increase in financial support for FP; laws and policies that support the informed choice of contraceptive methods; appropriate curricula for health workers, including international best practices in FP; or a regulatory environment favorable for procurement of a variety of different FP methods.

A validated instrument is any tool that has been tested and proven valid and reliable in assessing the policy environment, such as the Policy Environment Score (PES), the Family Planning Effort Score (FPES), the Maternal and Neonatal Program Effort Index (MNPI), or the Contraceptive Security Index. Most instruments of this type involve use of expert informants who answer specific questions about different aspects of the policy environment. About 10 to 15 experts provide responses, representing a broad array of actors and program managers within the sector, including both public and private sector actors.

Evidence of achievement should include a brief analysis of the baseline and follow-up, a comparison of the two data points, and a copy of the survey instrument used. Ideally, documentation would also include a qualitative report describing how improvement or increased score was achieved.

Data Requirements: Since the indicator captures an improvement, it is necessary for programs to apply the chosen instrument at least twice during the life of the program. The validated instrument being used must include discussions of reliability and validity and have documentation so it can be assessed independently and used by others. Existing instruments may be customized or adapted to assess particular outputs of the policy environment, at either the national or subnational levels.

Data Source(s): Policy Environment Score, Family Planning Program Effort Score, Contraceptive Security Index, or other similar tool — conducted as baseline and at least two years later. Data will be gathered from document reviews.

Purpose: The purpose of this indicator is to describe the current policy environment, including the strongest and weakest elements, and assess the effect of repositioning efforts over time.

Issues: The validated instruments that will be used to collect data for this indicator do not include a qualitative component. In order to justify the increase in scores and provide adequate information about the improvements in the enabling environment, additional information must be collected to describe the improvement and how it was achieved.

References:

Ross J, Smith E. *The Family Planning Effort Index: 1999, 2004, and 2009*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1; 2010.

Ntabaye M, Kimambo A, Simbakalia C. 2002. *Report on the Assessment of Policy Environment for Reproductive and Child Health in Tanzania.* Washington, DC: Futures Group, POLICY Project; 2002.

USAID|DELIVER PROJECT, Task Order 1. *Contraceptive Security Index 2009: A Tool for Priority-Setting and Planning.* Arlington, Va.: USAID|DELIVER PROJECT, Task Order 1; 2009.

Indicator SO.3: *Evidence of family planning policies implemented, resources allocated and subsequently used in relation to the same family planning policies.*

Definition: Family planning (FP) policies are the laws, regulations, guidelines, and strategies related to the management and/or delivery of FP goods and services. These policies may address a diverse range of issues related to FP, such as the supply and management of contraceptive commodities, job responsibilities of different FP providers, health management information system, or the content of mass media messages related to FP. Policy implementation may require the creation of an implementation plan, guidelines for providing a service, and a budget or a budget line item to finance implementation. Evidence must include documentation that a budget line item was created to ensure that the policy is implemented in the manner that was intended by policymakers and that the resources (e.g., financial, human, material) are used to accomplish the policy objective(s).

Data Requirements: Verification of the FP policy, implementation plan, accompanying budget, and implementation of policy.

Data Source(s): Directive, resolution; tool to measure policy implementation; meeting minutes providing evidence of dialogue among national and subnational governments on new guidelines; evidence of activity plans or reports that show the policy is being used; budgets, line items, invoices, other evidence of allocations and expenditures; key informant interviews.

Purpose: This indicator measures the extent of policymakers' support for FP and the completeness of the implementation process. Policies are often created with vague wording and lack of accompanying planning or budget support. Successful implementation depends on commitment of resources and guidelines that detail the implementation specifics necessary for genuine change. It is important to note however, that some adaptation of a policy for the local context is expected, and even necessary to ensure that the spirit of the law translates into various settings. In addition, if funding is not in place and protected from re-allocation, the best policy implementation plan will not be executed. Finally, this objective captures the achievements under IR3 and therefore assumes that policy change is a positive achievement. Some policies may be implemented that work negatively against the FP program in a country. Those policies would not be captured by these indicators, but rather noted as a barrier to FP.

Issues: Each step in reaching this SO (under IR3) is progressively more difficult to track and the documentation burden to show that money was actually used for its intended purpose may be high. A method of assessing policy implementation may be useful in tracking progress against this indicator, and it may be necessary to set implementation standards prior to the implementation process in order to determine if the process is successful. Also, evaluators may face difficulty finding an "FP policy" since many countries do not have an explicit policy related to FP but rather encompass FP within a broader reproductive health policy.

Reference:

Bhuyan A, Jorgensen A, Sharma S. 2010. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1; 2010.

Indicator 1

Indicator 1.1: *Total resources spent on FP (by source and by activity/program area).*

Definition: This refers to total resources spent on family planning (FP) by source (e.g. commercial, NGO, government, individual donors), and by activity/program area. The resources can be internally generated or by donors and, ideally, should be tracked by activity area in which the resources are invested (e.g., capacity building, commodities, advocacy, and research, etc.). Data for this indicator can be tracked at the national level, subnational level, or both depending on the focus of the project or country efforts.

Resources refer not only to financial resources, but also material resources such as human resources, facilities, furniture and supplies, mass media or informational resources, and vehicles. Resources can derive from many sources including, national/subnational governments, NGOs, donors, individuals, foundations, etc.

There are several possible mechanisms to increase the pool of resources available for and allocated to FP-related activities: line items in budgets, additional/increases in funding from government budgets, donor funds, taxes, user fees, privatization, community-based financing, and health insurance schemes, among others.

This indicator is related to *Indicator 1.3 Total non-USAID resources allocated to FP*. This indicator is intended to capture resources actually spent on or expenditures related to FP. Allocation refers to the assignment of resources to a specific purpose, but does not include actual spending or use of those resources.

Data Requirements: Document reviews, policy analyses, and key informant interviews. Key informant interviews may be necessary to link the increase in FP resources to project/repositioning work.

Data Source(s): Budgets, line items, invoices, donor records, orders, other evidence of expenditures. Donations, letters, records, or other data sources to capture non-monetary donations.

Purpose: Sustainability is a significant factor in repositioning FP efforts. As more money is placed into country budgets for FP, and a more varied financial support base for the work is created, there is likely to be increased stability of FP availability. This indicator tracks support for FP in both monetary and in-kind donations (supplies, etc.) and is useful for assessing the extent to which FP is valued, implemented, and has been repositioned at the national and/or subnational level. This indicator highlights the importance of resource mobilization and expenditure from diverse sources as an essential component of repositioning FP. Diverse sources of funding will help ensure that if one source of funding is discontinued, the entire FP program will not fail.

Issues: Data collected for this indicator may not be complete as it is unlikely that countries track all examples of community-level and subnational activities; however, tracking national-level

expenditures and trends in diversifying sources of FP funding is useful and will be more feasible, but only if the expenditures are tracked as FP expenses. In many countries, health expenditures are not disaggregated, or FP is included in overall reproductive health expenses.

Another challenge is tracking shared costs. For example, a health facility worker who provides FP services, among others, may receive her salary from both the government and client payment, supplies (medical as well as administrative) from a USG-supported local NGO, and FP refresher training from a European-financed project. Determining what share of the costs related to supporting that provider's FP services were sourced from non-USG funds can be particularly difficult; especially in low resource settings where accounting practices are typically poor.

Reference:

USAID Extending Service Delivery Project. *Monitoring and Evaluation Plan 2005-2010*. Watertown, MA: Pathfinder International; 2006.

Indicator 1.2: *Evidence of new financing mechanisms for family planning identified, tested, and/or scaled-up.*

Definition: This indicator measures the investigation and/or implementation of new "financing mechanisms" – processes or mechanism to increase the pool of resources available for and allocated to family planning (FP)-related activities. These mechanisms may include: sliding fee scales, taxes, user fees, privatization, subsidized services through donor financing, community-based financing, and third-party payment mechanisms such as health insurance.

"Identified, tested, and/or scaled-up" refers to actions that assess the feasibility and appropriateness of certain funding mechanisms for providing FP services. To meet this indicator, a country or program must both identify and test a new financing mechanism. The financing mechanism need not be adopted to be included in this indicator, and can be tested in a pilot test or a subset of the country / program.

Data Requirements: Information on type of financing mechanisms identified, tested, and/or scaled up

Data Source(s): Documents and meeting minutes; pilot tests; study results; policies

Purpose: Funds for FP services can be mobilized through four main sources: direct government (central or local) financing, donor financing, user fees, and third party payment mechanisms such as health insurance.

This indicator highlights the importance of financial resource mobilization as an essential component of repositioning FP. Its purpose is to measure the extent to which governments and local NGOs initiate and experiment with different strategies aimed at increasing access to FP services.

Issues: Not all new financing mechanisms are necessarily good. Adding a new mechanism like fee for service can be good if it increases available resources for FP, or bad if it suppresses demand. Often economic barriers, such as high fees for services or high transportation costs, restrict access to FP services. On the other hand, charging nominal fees for certain services may increase demand for such services, because people may associate better quality of services or a greater need for those services with having to pay for them.

In terms of implementation, evaluators will need to distinguish between the testing of a new mechanism and the mechanism's success at increasing revenues without unduly depressing demand. Organizational willingness to test a variety of financing mechanisms signals a positive policy environment, even if the organization ultimately adopts only one or two of the mechanisms.

Reference:

MEASURE Evaluation Compendium of Indicators Database – adapted from indicator NUMBER OF NEW FINANCING MECHANISMS IDENTIFIED AND TESTED (for RH).

Indicator 1.3: *Total resources allocated to family planning (by source and activity/program area).*

Definition: This refers to total resources allocated to family planning (FP) by source (e.g. commercial, NGO, government, individual donors), and by activity/program area. The resources can be internally generated or by donors and ideally, should be tracked by activity area invested in (e.g. capacity building, commodities, advocacy, and research, etc.). Data for this indicator can be tracked at the national level, subnational level, or both depending on the focus of the project or country efforts.

Resources refer not only to financial resources, but also material resources such as human resources, facilities, furniture and supplies, mass media or informational resources, and vehicles. Resources can derive from many sources including, national/subnational governments, NGOs, donors, individuals, foundations, etc.

Allocation refers to the assignment of resources for a specific purpose. Financial, human, and other types of resources may be allocated to different activities/needs/clinics/geographical locations based on evidence and information, modeling, advocacy and policy dialogue, a costing exercise, or part of a policy or operational plan.

There are several possible mechanisms to increase the pool of resources available for and allocated to FP-related activities: line items in budgets, additional/increased money from government budgets, donor funds, taxes, user fees, privatization, community-based financing, and health insurance schemes, among others.

Data Requirements: Document reviews, policy analyses, and key informant interviews are used. Key informant interviews may be necessary to link the increase in FP resources to project/repositioning work.

Data Source(s): Budgets, line items, invoices, donor records, orders, other evidence of commitment/new resources are data sources, as are donations, letters, records, or other data sources to capture non-monetary donations.

Purpose: Sustainability is a significant factor in repositioning FP efforts. As more money is placed into country budgets for FP, and a more varied financial support base for the work is created, there is likely to be an increase in the stability of FP availability. This indicator tracks financial commitment for FP in both monetary and in-kind donations (supplies, etc.) and is useful for assessing the extent to which FP is valued, implemented, and has been repositioned at the national and/or subnational level.

This indicator highlights the importance of resource mobilization from diverse sources as an essential component of repositioning FP. Diverse sources of funding help ensure that if one source of funding is discontinued that the entire FP program will not fail. This indicator is related to *Indicator 1.1 Total resources spent on FP*. This indicator reflects an earlier stage in the process and is intended to capture resource allocation for FP, which refers to the assignment of resources to a specific purpose, but does not include actual spending or use of those resources.

Issues: Data collected for this indicator may not be complete as it is unlikely that countries track all examples of community level and subnational activity; however, tracking national level expenditures and trends in diversifying sources of FP funding is useful and will be more feasible, but only if the expenditures are tracked as FP expenses. In many countries, health expenditures are not disaggregated, or FP is included in overall reproductive health expenses.

Another challenge is tracking shared costs. For example, a health facility worker who provides FP services, among others, may receive her salary from both the government and client payment, supplies (medical as well as administrative) from a USG-supported local NGO, and FP refresher training from a European-financed project. Determining what share of the costs related to supporting that provider's FP services were sourced from non-USG funds can be particularly difficult; especially in low resource settings where accounting practices are typically poor.

Reference:

USAID Extending Service Delivery Project. *Monitoring and Evaluation Plan 2005-2010*. Watertown, MA: Pathfinder International; 2006.

Indicator 1.4: *New and/or increased resources are committed to FP in the last two years.*

Definition: This refers to new or increased resources committed to family planning (FP) at the national or subnational level in the last two years. These are not limited to financial resources, but can also be material such as additional doctors, new facilities, mass media, furniture, and vehicles. Resources can derive from many sources including, national/subnational governments, NGOs, donors, individuals, foundations, etc.

Commitment refers to the creation of a budget line item or other pronouncement that resources will be made available for a specific purpose. The pronouncement must include mention of resources (amount or estimated amount). Financial, human, and other types of resources may be committed to different activities/needs/clinics/geographical locations based on evidence and information, modeling, advocacy and policy dialogue, a costing exercise, or part of a policy or operational plan.

There are several possible mechanisms to increase the pool of resources available for health-related activities: line items in budgets, money from government budgets, donor funds, taxes, user fees, privatization, community-based financing, and health insurance schemes, among others.

Data Requirements: Evidence of the number of times additional resources were committed to FP.

Data Source(s): Sources include budgets, line items, resource tracking tools (National Health Accounts, etc.), plans or planning tools, invoices, donor records, expenditure records, orders, other evidence of original commitment and new resources, human resources records, procurement records; donations, letters, records, or other data sources to capture non-monetary donations; document reviews; policy analyses; key informant interviews to link the increase in FP resources to project/repositioning work.

Purpose: Sustainability is a significant factor in repositioning FP efforts. As more money is placed into country budgets for FP, and a more varied financial support base for the work is created, there is likely to be an increase in stability of FP availability. This indicator tracks support for FP in both monetary and in-kind donations (supplies, etc.) and is useful for assessing the extent to which FP is valued, and has been repositioned at the national or subnational level. This indicator is similar to *Indicator 1.1, Total resources spent on FP (by source and by activity/program area)* and *Indicator 1.3, Total resources allocated to family planning (by source and activity/program area).* However, those indicators take a broad look at overall FP budgets and resources, and are useful in gathering information about where resources come from and what programs are being funded. This indicator is less concerned about source or purpose, but rather is meant to capture any recent increase of resources. It could be seen as a first step in the resource allocation process.

Issues: In some countries, financial information may be difficult to obtain, which will compromise the ability to track this indicator. The link between repositioning efforts and funding may also be difficult to establish. Although commitment of resources is an important

step in implementation, it does not automatically imply that the commitment was actualized and the resources were used as planned. Therefore, this indicator should be seen as a step in the process that ultimately leads to the achievement of *Strategic Objective 3, Evidence of FP policies implemented, resources allocated and subsequently used in relation to the same FP policies.*

If a policy maker or decision maker makes commitments to support family planning, but does not commit resources, this success would be reported to *Indicator 5.3, Evidence of targeted public and private sector officials, FBOs, or community leaders publicly demonstrating new or increased commitment to FP.*

Indicator 2

Indicator 2.1: *Evidence of family planning programs incorporated into national strategic and development plans*

Definition: This refers to evidence of family planning programs incorporated into national strategic and development plans. National strategic and development plans can include, but are not limited to: Sector Wide Action Plans (SWAPs) and/or Poverty Reduction Strategy Plans (PRSPs) and/or Health Development Plans, etc.

Data Requirements: Evidence that FP has been included in SWAPs, PRSPs, or other national strategic and development plans provide data.

Data Source(s): SWAPs, PRSPs, and other national strategic and development plans are data sources.

Purpose: This indicator reflects government stewardship of FP by including family planning in broader development plans and strategies. This inclusion acknowledges the crucial role FP plays in the overall development agenda, and the need to officially incorporate FP programs into national plans to sustain FP efforts.

Issues: Inclusion in a national strategic plan does not guarantee appropriate action or follow through. It is necessary to track implementation of activities in order for the achievements under this indicator to positively impact efforts to achieve the strategic objectives. In addition, this indicator does not measure how well FP is incorporated into national strategic and development plans. A mere mention of FP is different than a comprehensive and well incorporated chapter on FP's role in development.

Indicator 2.2: *Evidence of governments engaging multiple sectors in family planning activities.*

Definition: Evidence of national/subnational/district governments engaging multiple sectors in the design, implementation, financing and/or monitoring and evaluation of family planning (FP) policies and/or programs. Examples of government engagement include:

- convening roundtables with private business owners on FP commodity distribution;
- engaging a ministry of education on adding FP content to the school health curriculum;
- assembling a multisectoral working group to develop an implementation plan for a new national FP policy; or
- establishing a multisectoral body, such as a population commission, to guide FP policy and programmatic developments.

Data Requirements: Evidence of government's engagement of other stakeholders and interviews with various sectors to determine level and extent of participation.

Data Source(s): Policy and document review and key informant interviews; reports from government and participants; meeting minutes; program evaluation.

Purpose: FP is inextricably linked to all sectors in society and is therefore conducive to integrated and coordinated approaches rather than being addressed in isolation. This indicator reflects government stewardship of FP by engaging various groups and sectors throughout the country in family planning, recognizing the role each can play in improving FP quality and access. Example groups and sectors include but are not limited to: pharmacists; private facilities; other businesses; private providers; departments of education, development, population, environment, labor, agriculture, gender/women's affairs, or health; NGOs; community-based organizations (CBOs); FBOs; donors.

Issues: Documentation of multisectoral engagement may be difficult to obtain. Evidence must show that the various sectors are partners at the table and specify the role each plays in the policy process or in design, implementation, and/or financing of FP programs. It may also be difficult to assess if the appropriate and/or sufficient number of sectors have been engaged for each FP activity, how often they meet, how productive the meeting and coordination is, and if positive results have been achieved.

Reference:

Health Policy Initiative Project management plan (unpublished). Washlington, DC: U.S. Agency for International Development; 2007.

Indicator 2.3: *Evidence of multisectoral structures that are established or strengthened to promote FP policy.*

Definition: Evidence of multisectoral structures that are established or strengthened to do one or more of the following:

- analyze family planning (FP) policies
- advise on or develop FP policies
- develop plans to implement FP policies
- ensure compliance to FP polices or norms
- monitor and evaluate FP policy implementation

A structure can be a task force, technical working group, advisory group, council, or coalition, but should meet consistently and have a defined purpose and objectives.

Data Requirements: List of structures having been established or strengthened to promote FP policy; baseline information for claiming "strengthened."

Data Source(s): Policies, assessment reports from government and participants; meeting minutes; agendas; membership list; scope of work, meeting schedules; key informant interviews to determine level of participation.

Purpose: FP is inextricably linked to all sectors in society and is therefore conducive to integrated and coordinated approaches rather than being addressed in isolation. Achievement of this indicator reflects the crucial role FP plays in the overall development agenda, and the need for integration, collaboration and coordination to promote ownership and sustainability of FP. Example groups and sectors include but are not limited to: pharmacists; private facilities; other businesses; private providers; departments of education, development, population, environment, labor, agriculture, gender/women's affairs, or health; NGOs; CBOs; FBOs; donors.

Issues: Documentation of multi-sectoral engagement may be difficult to obtain. Evidence must show that the various sectors are partners at the table and specify the role each play in structure. It may also be difficult to assess if the engagement is appropriate and/or enough sectors have been engaged for each FP activity. In addition, the term "strengthen" is subjective. Where a structure exists, it is important to capture evidence of initial weaknesses and the subsequent improvements made.

Reference:

Health Policy Initiative Project management plan (unpublished). Washlington, DC: U.S. Agency for International Development; 2007.

Indicator 2.4: *Evidence of government support for private sector participation in FP.*

Definition: This indicator focuses attention on the private sector, and the role government plays in supporting or enhancing the private sector's efforts to provide FP services and information. Government support can include the identification of barriers to private sector participation in FP (especially in policy development and/or service delivery) and/or the removal of previously identified barriers. It can also refer to mechanisms that facilitate private sector participation in providing FP services. Such mechanisms may include tax incentives for private sector organizations providing FP services, or for individuals who contribute to registered non-governmental organizations (NGOs) or hospitals providing FP. Other examples include: tariff relief, public vouchers, removing restrictions around the provision of FP methods, including FP training into in-service training for public and private providers, and insurance schemes.

Tariff relief that exempts contraceptives from import duties is the most widely-practiced policy incentive to private sector service delivery. Another example is a country that provided one time vouchers to reimburse private sector physicians for performing voluntary sterilizations and IUD insertions. Another country is testing a similar voucher system with private midwives, and has tested the voucher system for sex workers seeking care.

Removal of policy barriers is especially important to private sector participation, because policies can intentionally or unintentionally create barriers to private sector participation, in turn affecting service providers, potential clients, and ultimately families and communities. Policies may affect both the public and private sectors (such as restrictions on particular contraceptive methods or eligibility requirements for services) but may also solely affect the private sector's ability to provide FP services efficiently and effectively.

Data Requirements: Policy documents with evidence of government approval, or submission for approval of supportive mechanisms; old and updated policy documents, showing evidence of restrictions in the old policy that do not appear in the new policy.

This indicator can be quantified in several ways. As a baseline measure, it may be expressed as the number and type of barriers that significantly hinder private sector participation in FP. To measure change over time in a country application, the evaluator should count and qualify the policy barriers identified at baseline, which were subsequently removed. Evaluators can measure change through naming and counting those identified barriers that do not appear in the new policy. Evaluators should link clearly the barriers identified at baseline, the policy interventions carried out, and the barriers identified at follow-up.

Because barriers to private sector participation, by their nature tend to be very specific, evaluators can readily assess whether the new policy removes them. For example, if the barrier removed is import duties on contraceptives, evaluators can interview commercial distributors to determine if they no longer pay duties.

Data Source(s): Policy and document review; key informant interviews; evidence of mechanisms put in place to support private sector. If the mechanism does not require legal or regulatory

intervention, data sources may include evidence of the design and subsequent implementation of the mechanism.

Purpose: Governments can hinder private sector participation through the policy barriers described in IR 3.4: Evidence that policy barriers to access family planning services and information have been identified and/or removed. The reverse does not hold — governments cannot mandate private providers to offer FP services. However, private sector involvement in FP is becoming more common and critical as the demand for FP services continues to increase with governments and donors finding it increasingly difficult to cover the costs of providing these services.

The purpose of this indicator is to measure the extent to which governments remove limitations or obstacles to and facilitate the private sector's involvement in providing FP services. It may also indicate the relative importance governments place on the role the private sector can play in providing FP services. Tax codes may offer deductions for charitable contributions to NGOs. Policy incentives attempt to increase private sector participation.

Issues: In order to evaluate the mechanism, evaluators would need to assess not only the presence of incentives (e.g., are vouchers available), but also consider their effectiveness (e.g., whether private practitioners are serving more clients than they did before receiving incentives). While the indicator does not explicitly measure the effectiveness of a mechanism, a poor mechanism put into place that is obviously ineffective or has been put into place for questionable purposes would not satisfy the indicator.

In addition, although a policy barrier may have legally been removed, the change may not be effectively practiced. For example, if a barrier constraining contraceptive options is eliminated — such as limiting who can provide particular methods of family planning — in addition to conducting a legal and regulatory review, evaluators should also interview providers to assess their awareness of the barrier removal as well as interview women to assess their ability to obtain services.

Indicator 3

Indicator 3.1: *Existence of national or subnational policies or strategic plans that promote access to family planning services and information*

Definition: Existence of national or subnational policies, guidelines or strategic plans that promote access to family planning services and information. Family planning (FP) policies are the laws and regulations related to the management and/or delivery of FP goods and services. These policies may address a diverse range of issues related to FP, such as the supply and management of contraceptive commodities, job responsibilities of different FP providers, health management information system, or the content of mass media messages related to FP.

Strategic plans outline a country's strategy for the management and/or delivery of FP goods and services. These plans may be found in larger strategic documents such as a National Strategic Plan, SWAP, or PRSP. These plans may also be included in guidelines and/or development roadmaps.

Data Requirements: Verification of the FP policy, implementation plan, guideline or strategy.

Data Source(s): Directive, resolution; guideline or strategy; meeting minutes providing evidence of dialogue among national and subnational governments on new guidelines; key informant interviews.

Purpose: This indicator measures the extent of policy makers' support for FP. It is meant to capture earlier stages of support for the policy continuum, whereas SO.3 captures a policy that has been implemented and funded and IR3.4 captures policy implementation. In many cases it takes time to strengthen the policy environment and in the meantime, policies drafted reflect a measure of support for FP. It is important to note that when a national policy is adopted at the subnational level, some adaptation of the policy for the local context is expected, and even necessary to ensure that the spirit of the law translates into various settings.

Issues: Evaluators may face difficulty finding an "FP policy" since many countries do not have an explicit policy related to FP but rather encompass FP within a broader RH policy. In addition, guidelines or strategies in place may not be implemented. Further work is needed to ensure implementation and funding of guidelines and policies.

Reference:

Bhuyan A, Jorgensen A, Sharma S. 2010. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1; 2010.

Indicator 3.2: *Existence of national or subnational policies or strategic plans that promote access to family planning services and information for underserved populations.*

Definition: Existence of national or subnational policies or guidelines that promote access to family planning services and information for underserved populations such as youth, men, postpartum women, people living with HIV (PLHIV), the poor, and those living in rural areas. The specific populations that are considered underserved may differ by country context.

Family planning (FP) policies are the laws and regulations related to the management and/or delivery of FP goods and services. These policies may address a diverse range of issues related to FP, such as the supply and management of contraceptive commodities, job responsibilities of different FP providers, health management information system, or the content of mass media messages related to FP.

Strategic plans outline a country's strategy for the management and/or delivery of FP goods and services. These plans may be found in larger strategic documents such as a National Strategic Plan, SWAP, or PRSP. These plans may also be included in guidelines and/or development roadmaps.

Data Requirements: Verification of the FP policy, implementation plan, guideline or strategy.

Data Source(s): Directive, resolution; guideline or strategy; meeting minutes providing evidence of dialogue among national and subnational governments on new guidelines; key informant interviews.

Purpose: This indicator measures the extent of policy makers' support for FP for all populations — especially the most needy. This indicator is directly related to indicator 3.1, but specifically aims to capture a country's commitment to serving populations that often have the highest unmet need for FP. These populations may be underserved for many reasons, such as logistics, excessive financial burden, and socio-cultural factors. It is important to note that when a national policy is adopted at the subnational level, some adaptation of the policy for the local context is expected, and even necessary to ensure that the spirit of the law translates into various settings.

Issues: Evaluators may face difficulty finding an "FP policy" since many countries do not have an explicit policy related to FP but rather encompass FP within a broader RH policy. In addition, guidelines or strategies in place may not be implemented. Further work is needed to ensure implementation and funding of guidelines and policies.

In addition, in different countries, the underserved populations may be different, and evaluators should look to existing evidence in the country to determine the appropriateness of the chosen underserved populations.

Reference:

Bhuyan A, Jorgensen A, Sharma S. 2010. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1; 2010.

Indicator 3.3: *Documentation of instances in which a formal implementation plan or operational directive is issued to accompany a national or subnational family planning policy*

Definition: Family planning (FP) policies are the laws and regulations related to the management and/or delivery of FP goods and services.

Implementation plans or operational directives are the rules, regulations, codes, guidelines, plans, budgets, procedures, or administrative norms that organizations use to translate laws and policies into programs and services. This includes programmatic and organizational documents that regulate what kinds of services may be delivered, to whom, and under what conditions. Typically, the plan specifies how the work should be completed and the responsible implementing agency. These plans and regulations may address a diverse range of issues related to FP, such as the supply and management of contraceptive commodities, job responsibilities of different FP providers, health management information system, or the content of mass media messages related to FP.

Instances refer to the number of examples of government, NGOs, or private sector organizations issuing an implementation or operational directive or plan. Finally, this indicator supports the achievements captured under other IR3 indicators and therefore assumes that policy change is a positive achievement. Some policies may be implemented that work negatively against the FP program in a country. Those policies would not be captured here, but rather noted as a barrier to FP.

Data Requirements: Document reviews and key informant interviews; verification of the FP implementation or operational plan, directive, guideline or strategy.

Data Source(s): Directive, resolution; guideline or strategy; meeting minutes providing evidence of link between document and original national or subnational policy.

Purpose: This indicator measures the extent of policy makers' support for FP. This indicator documents evidence of progress toward policy implementation and flows as a logical next step after achieving a result corresponding to indicator 3.1, existence of national or subnational policies or guidelines that promote access to FP services and information. Once the policy is approved, then a plan may be put in place to operationalize the policy. It is meant to capture earlier stages of support for the policy continuum, whereas SO.3 captures a policy that has been implemented and funded and IR3.5 captures policy implementation. In many cases it takes time to strengthen the policy environment and in the meantime, issuance of a formal plan or directive linked to a national or subnational policy reflects a measure of support for FP.

Issues: Strategic plans that are developed and put into place may not be implemented. Further work is needed to ensure implementation and funding of plans and policies. In addition, this indicator captures the existence of a plan or policy, but does not assess its completeness. As mentioned above, policies can address a broad range of issues such as the supply and management of contraceptive commodities, job responsibilities of different FP providers, health management information system, or the content of mass media messages related to FP. Operational plans are ideally thorough and reflective of the comprehensive range of FP issues involved in FP policy and planning.

Indicator 3.4: *Evidence that policy barriers to access family planning services and information have been identified and/or removed.*

Definition: Evidence that policy barriers to access family planning services and information have been identified and/or removed. This indicator is related to indicator 3.1, existence of national or subnational policies or guidelines that promote access to FP services and information. Whereas the previous indicator includes the broad rubric of policies, laws, and program documents, this indicator focuses on modifying or removing existing policies which create obstacles to FP services and information.

This is especially pertinent to legal and regulatory reform. Policies can intentionally or unintentionally create barriers to access, in turn affecting service providers, potential clients, and ultimately families and communities. They may affect both the public and private sectors (such as restrictions on particular contraceptive methods or eligibility requirements for services) or may affect primarily the private sector. Kenney (1993) distinguishes five categories of regulatory barriers:

- regulations that constrain contraceptive options;
- tax and import policies;
- advertising and promotion regulations;
- other regulations affecting the commercial sector; and
- regulations affecting non-profit organizations.

Added to these are restrictions on access to training and exclusions from policy formulation meetings and other arenas in which policies are made. Cross and colleagues (2001) identify additional categories of operational policy barriers, including organizational structures, regulations regarding personnel, vital statistics and health information, and procurement.

Data Requirements: Old and updated policy documents, showing evidence of restrictions in the old policy that do not appear in the new policy.

This indicator can be quantified in several ways. As a baseline measure, it may be expressed as the number and type of policy barriers that significantly hinder FP service delivery. To measure change over time in a country application, the evaluator should count and qualify the policy barriers identified at baseline, which were subsequently removed. Evaluators can measure change through naming and counting those identified policy barriers that do not appear in the new policy. Evaluators should link clearly the barriers identified at baseline, the policy interventions carried out, and the barriers identified at follow-up.

Because policy barriers by their nature tend to be very specific, evaluators can readily assess whether the new policy removes them. For example, if the barrier removed is import duties on contraceptives, evaluators can interview commercial distributors to determine if they no longer pay duties.

Data Sources: Policy, document, legal and regulatory reviews; policy documents with evidence of government approval, or submissions for approval; key informant interviews.

Purpose: The purpose of this indicator is to measure the extent to which national governments expand participation in developing policy and in providing FP services; facilitate increased access to FP services for all sectors of the population; and address potential policy roadblocks to effective and efficient delivery of FP services and information. Removing client eligibility requirements — such as marital status, minimum age, or parity for receiving FP methods — empowers women and youth to demand the services and products they want. Private sector participation in policy development may ensure that FP programs address the needs of all different groups in a population. The private sector can also be an important provider of services, especially in countries where government programs are either overburdened by demand or are unable to reach certain population groups.

Issue(s): Although a policy barrier may have legally been removed, the change may not be effectively practiced. For example, if a barrier constraining contraceptive options is eliminated — such as requiring parental consent to provide services to unmarried youth under age 18 — in addition to conducting a legal and regulatory review, evaluators should also interview providers to assess their awareness of the barrier removal as well as interview youth to assess their ability to obtain services.

Also, because changing laws or policies is typically a lengthy process, evaluators may not have evidence of actual modifications or removal of policy barriers within a project time frame of five years, for example. Therefore, evaluators may wish to break the indicator into two parts, such that "evidence that policy barriers to access to FP services and information have been identified" is a separate indicator, in order to capture the process of change.

References:

Kenney GM. *Assessing Legal and Regulatory Reform in Family Planning* [OPTIONS for Population Policy, Policy Paper Series No. 1]. Washington, DC: The Futures Group International; 1993.

Cross H, Hardee K, Jewell N. *Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs* [POLICY Project, Policy Occasional Papers No. 7]. Washington, DC: The Futures Group International; 2001.

Indicator 3.5: *Evidence of instances of the implementation of policies that promote family planning services and information.*

Definition: Instances in which there is concrete evidence of implementation for new or existing national/subnational policies or strategic plans that promote family planning (FP) services and information. Policy implementation is the process of carrying out and accomplishing a policy. This may require the creation of an implementation plan, policy guidelines and a budget line item to ensure that the policy is carried out in the manner that was intended by policy makers. These policies may address a diverse range of issues related to FP, such as the supply and management of contraceptive commodities, job responsibilities of different FP providers, health management information system, or the content of mass media messages related to FP.

Data Requirements: Evidence of the implementation of policies supporting FP services and information.

Data Source(s): Directive, resolution; tool to measure policy implementation; meeting minutes providing evidence of dialogue among national and subnational governments on new guidelines; evidence of activity plans or reports that show the policy is being used; key informant interviews.

Purpose: This is very similar to the policy indicator 3.1: existence of national or subnational policies or guidelines that promote access to FP services and information. However, this indicator reflects a later point in the policy continuum. It requires evidence that a policy or strategic plan has been implemented, but it does not require proof of budget. In addition, this indicator is a measure of explicit support for FP services by the government. SO.3 reflects the most advanced point on the policy continuum with a policy both implemented, and funded, with the resources being used for their intended purpose.

Issues: Evaluators may face difficulty finding an "FP policy" since many countries do not have an explicit policy related to FP but rather encompass FP within a broader RH policy. In addition, it is somewhat subjective to determine if implementation is complete and effective.

Indicator 4

Indicator 4.1: *Evidence of data or information used to support repositioning family planning efforts.*

Definition: Evidence of data or information used to support repositioning family planning efforts. "Data use" refers to data or information being reviewed to create or revise a program or strategic plan, inform policy dialogue, develop or revise a policy, advocate for a policy or program, create a budget for a policy or program, allocate resources, or used in the process of program monitoring and improvement. The review of the data could have led to an action or no action if no change was necessary.

FP data or information can include service statistics (e.g., number of condoms distributed, number of couples counseled), analyses of surveys, study findings, information arising from use of tools, modeling outputs, financial information, and information about human resources for health. Dissemination, such as printing and distributing reports, is not sufficient evidence of achievement for this indicator.

Data Requirements: Documentation of evidence of data use should include the specific information used, its source, a description of the decision made using the information, and the outcome (or intended outcome) of the decision. Use of information for planning refers to using data or information (results from a model, for example) as an integral part of the planning process or as the basis for a planning decision. Use of information in advocacy must show how the information was included in key messages that form part of a planned advocacy campaign or event.

Data Source(s): Key informant interviews, documents with data citations highlighted; citation in a policy or plan; project records demonstrating data use, case studies, mission memos; meeting minutes; letter or statement from decision maker about specific instances of information use.

Purpose: This indicator shows a reliance on data, information and accepted best practices for decision making with regard to FP. It is an extension of stewardship and evidence-based decision making when leaders seek to use quality information as an objective basis for their decisions.

Issues: Documentation for this result is often difficult to obtain especially when there is no published report to show how or what information was used (e.g., information used in policy dialogue). Key informant interviews may be necessary to link data to decisions. Note that in some instances incorrect data or misinformation may be used as the basis for policy dialogue, planning, resource allocation, and/or advocacy, in which case the example may be counted, but not actually fulfill what this indicator intends to track.

Reference:

Health Policy Initiative Project management plan (unpublished). Washlington, DC: U.S. Agency for International Development; 2007.

Indicator 4.2: *Evidence of international family planning best practices incorporated into national health standards*

Definition: Evidence of international family planning (FP) best practices incorporated into national health standards. National health standards are any official standards of care or protocols for providing health care and treatment for health issues.

Although there is no standardized or universal definition of a "best practice," it is defined here as a specific action or set of actions with proven evidence of success in multiple applications and the potential for replication or adaption. Evidence of success is demonstrated through qualitative and quantitative information. Practice(s) refers either to a single action such as implementing a technique or tool, or to a thematically interrelated set of activities, a "package" of elements that form a cohesive set of actions that can be implemented to improve already existing programs that enhance FP.

General criteria for an FP best practice include: the potential for high impact on increasing contraceptive prevalence rate, increasing uptake of contraceptive use or decreasing contraceptive discontinuation; and available, solid evidence of its value.

For reference, USAID has identified High Impact Practices, and these can be used as a proxy for assessing adherence to international best practices.

Data Requirements: Document review or policy analysis for evidence that FP best practices have been incorporated into national health standards.

Data Source(s): FP guidelines, protocols, or standards of practice; national health standards. For this framework, to identify the best practices in FP, USAID's High Impact Practices and best practices identified by the Implementing Best Practices initiatives (IBP), housed at WHO, should be used.

Purpose: This indicator measures the degree to which FP programming in a country is evidence or data informed. It reflects a country's recognition of and commitment to global and country best practices. It also reflects efforts to provide efficient, effective and high-quality FP care, as well as a reliance on evidence and data in decision making.

Issues: Not all countries have formalized health care standards so the inclusion of FP may be difficult to capture. There may be other measures of evidence based programming and planning that will not be captured by this indicator. In the absence of a complete, central repository of internationally accepted best practices, it is difficult to objectively verify the degree to which national standards of care include international best practices.

Indicator 4.3: *Evidence of a defined and funded research agenda in family planning.*

Definition: Evidence of a defined and funded research agenda in family planning (FP). A research or data collection agenda is a plan that helps orient researchers, donors, policy makers, service providers and program managers toward short-, medium- and long-term research and data collection goals. Research agendas are intended to be dynamic; data collection priorities change over time as knowledge grows and as new questions emerge. The agenda may take the form of a report, plan, or a memorandum issued based on a consultative process.

To satisfy the requirements of this indicator, the research agenda for FP must not only be defined but also funded. Full or complete funding is not required; partial funding also demonstrates a country's interest in and ownership of the research agenda. For instance, some of the research priorities in the agenda may be of long-term interest, and may not have funds available at this point. It is also unnecessary for the government to implement the research. Implementation may be carried out by universities, implementing partners, or donors because of limited in-country capacity or funding.

Data Requirements: Concrete evidence of a research or data collection agenda and some sort of consultative process that led to the development of the agenda is required. The research and/or data collection agenda (or an accompanying document, as appropriate) must include a description of secured or pledged funding for all or part of the research and/or data collection detailed in the document.

Data Source(s): Meeting notes; consensus statements; memoranda detailing research/data collection agenda; memorandum or email from a donor; line item in a budget.

Purpose: A research agenda may reflect a country's recognition of and commitment to research and data collection as well as the issues being studied. To avoid unnecessary duplication of effort, remain focused and ensure that all important questions are being studied; research coordination is important.

Issues: The presence of a research agenda is not sufficient to assume that the coordination of research and data collection is country-led. There is a need to collect qualitative information about the process of developing the agenda and the level of country stewardship of the process and the agenda itself. Also, it may not be possible to discern from the research agenda if the identified priorities for FP research represent the country's actual needs or if the research agenda is more a reflection of the predominant donor(s) priorities.

Indicator 4.4: *Evidence of increased in-country technical capacity for the collection, analysis and/or communication of family planning information.*

Definition: Evidence of increased in-country organizational technical capacity for the collection, analysis and/or communication of family planning information.

"Collection" involves an assessment of policy and programmatic questions that decision makers need to address. Researchers and others involved with data collection can then determine the best way to collect the data required to answer the questions that are identified.

"Analysis" is the process of understanding and explaining the data that were collected. The purpose of analysis is to provide answers to questions being asked at a program site, facility or in research questions being studied. The type of analysis required is dependent on the type of questions posed by decision makers. The research approach and analyses required may be simple or complex.

"Communication" can include press-related materials, briefs, dissemination meetings, presentations or publications.

Data Requirements: In the case of training or mentoring in research methods or M&E, this indicator requires periodic follow-up with the individuals or groups trained to document their progress in conducting research or collecting and processing other types of data. This could be accomplished through questionnaires or in-person interviews. In the case of organizations and institutions, program documents or external FP documents must be reviewed for examples of increased capacity or the leadership of FP data generation and review activities by the institutions and organizations that received assistance. All individuals, organizations, and institutions must be identified in advance.

Data Source(s): Key informant interviews, questionnaires, surveys, focus groups, operations research, a routine health information system (RHIS), research publications, presentations, reports of data analysis, data briefs, and other relevant program or government documents.

Purpose: This indicator measures capacity building in research, RHIS, and data demand and use, as well as country ownership of FP. This indicator demonstrates a country's demand for data, information, and accepted best practices for decision making with regard to FP. It is an extension of stewardship and evidence-based decision making when leaders support or fund the development of local capacity in research so that they can ensure availability of information for decision making. In addition, a country's generation of country specific data demonstrates further commitment. The indicator addresses concerns that without strong local capacity and leadership, the country would not continue to promote FP once donor support has shifted to competing priorities.

Issues: Evaluators may face difficulty measuring capacity if a clear program definition and criteria for increased capacity are not established prior to capacity building work. Efforts should be made to establish a baseline measure of capacity before training or technical assistance begins. Clear examples of expected increases in capacity should be outlined prior to work, so that it is evident when trainees, organizations, or institutions demonstrate increased capacity.

Indicator 5

Indicator 5.1: *Evidence of entities provided with donor assistance that demonstrate capacity to independently implement family planning activities.*

Definition: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement family planning activities. Evidence of instances of champions/networks/organizations/institutions provided with donor-funded training or other technical assistance that demonstrate capacity to independently implement activities in one or more of the following repositioning family planning (FP) areas: advocacy, policy dialogue, planning, priority setting, resource allocation, program improvement, and/or data analysis and use. These can be individuals or institutions in the public sector, private sector, or civil society.

Data Requirements: In the case of trainings or mentoring with individual champions, this indicator requires periodic follow-up with individuals or groups trained to document their follow-on activities. This could be accomplished through questionnaires or in-person interviews. In the case of organizations and institutions, program documents or external FP documents must be reviewed for examples of increased capacity or ownership of FP activities. All champions/networks/organizations/ institutions must be identified in advance. Evaluators may wish to disaggregate data by the type of donor assistance provided and/or the area of capacity.

Data Source(s): Key informant interviews, questionnaires, policies, budgets, copy of action plans, campaign plans, newspaper articles, published statements, speeches, and other relevant program or government documents.

Purpose: This indicator measures frequency of capacity building successes in FP as a result of donor assistance. In repositioning FP efforts, forms of capacity may include leadership, management, monitoring and evaluation, advocacy, policy development, program content, etc. The indicator addresses concerns that without strong local capacity and leadership, the repositioning initiative would not continue to promote FP once donor support has shifted to competing priorities.

Issues: Evaluators may face difficulty measuring capacity if a clear program definition and criteria for capacity are not established prior to capacity building work. Efforts should be made to establish a baseline measure of capacity before training or technical assistance begins. Clear examples of expected increases in capacity should be outlined prior to work, so that it is evident when trainees, champions, organizations or institutions demonstrate increased capacity.

Indicator 5.2: *Evidence of government bodies or other entities established or strengthened to support the family planning agenda.*

Definition: Evidence of government bodies, civil society groups, associations, networks, coalitions, etc. formed, expanded and/or strengthened to support the family planning agenda (i.e. through advocacy, oversight, identifying health systems solutions). Examples include reproductive health (RH)/FP-focused department in ministries or other existing government agencies or the development of a network or coalition of nongovernmental organizations. The group must be formally established.

Evidence of "strengthened" involves having baseline information about the capacity of the institution, coalition or organization, information about the types of support the organization received to expand or strengthen their efforts, and endline information about the expansion or strengthening of the organization.

Data Requirements: Program documents or external FP documents must be reviewed for examples of increased capacity or ownership of FP activities. All civil society groups/networks/organizations/institutions must be identified in advance. Evaluators may wish to disaggregate data by the type of donor assistance provided and/or the area of capacity. Baseline required for claiming "strengthened" and "expanded."

Data Source(s): Key informant interviews, questionnaires, policies, budgets, copy of action plans, campaign plans, newspaper articles, published statements, speeches, and other relevant program or government documents, group records, meeting minutes, invitations, protocols; registration records for entity; vision statement, charter, membership over time.

Purpose: This indicator measures capacity building successes in FP as well as country stewardship of FP. Establishment of government offices for FP/RH or organizations to address FP signals a long term commitment on the part of the country to focus on FP. The expansion or strengthening of these groups reflects increases in capacity. In repositioning FP efforts, forms of capacity may include leadership, management, monitoring and evaluation, advocacy, policy development, program content, etc. The indicator addresses concerns that without strong local capacity and leadership, FP efforts will not continue when donor support shifts.

Issues: The terms "strengthen" and "expand" are subjective. Where a structure exists, it is important to capture evidence of initial weaknesses and the subsequent improvements made.

Evaluators may face difficulty measuring capacity if a clear program definition and criteria for increased capacity are not established prior to capacity building work. Efforts should be made to establish a baseline measure of capacity before training or technical assistance begins. Clear examples of expected increases in capacity should be outlined prior to work, so that it is evident when organizations or institutions demonstrate increased capacity — i.e., are expanded or strengthened.

Indicator 5.3: *Evidence of targeted public and private sector officials, FBOs, or community leaders publicly demonstrating new or increased commitment to FP.*

Definition: Evidence of targeted public and private sector officials, FBOs, or community leaders publicly demonstrating new or increased commitment to family planning (FP). Instances in which a leader in government, an organization, or the community, publicly demonstrates their new or additional support for FP. For example, providing financial or material support for an activity for the first time; delegating staff to work on an issue; or taking concrete action.

For donor or project reporting, this indicator requires that there be a clear link between the leader and repositioning efforts by a donor, project, program or initiative. This is not required for the assessment of a country's overall efforts to reposition family planning.

New commitment may be a one-time occurrence but should be reflective of ongoing or continuing support. Increased commitment is an observable change in the frequency, consistency, and/or depth of attention to an issue.

Data Requirements: To track this indicator, the project needs to establish in advance which officials it is trying to reach with activities. Evidence is needed to verify the nature of the new or increased commitment.

Data Source(s): Newspapers, workshop agendas, published statements, speeches, media reports, political party platforms, clipping service; key informant interviews.

For donors or projects wishing to assess their efforts to increase commitment to family planning, a list of targeted officials/champions is required. Additionally, the donor or project would collect baseline information to assess the initial level of commitment or support of targeted leaders. A follow-up assessment will provide evidence of increased support. In addition to monitoring speeches and other signs of increased commitment, it may be necessary to administer a short questionnaire to both targeted leaders and key informants to document this indicator.

Purpose: This indicator tracks increases in public commitment to FP, and can be used by programs working to influence public opinion and support through community leaders. Leaders control resources and affect public opinion. This indicator can also reflect the level of social acceptability of FP within a community/country. Demand for FP is a key factor in repositioning FP, but activities to increase demand are often outside the scope of repositioning efforts. This indicator measures one aspect of demand (social acceptability) that typically falls within the scope of most repositioning efforts.

Issues: Although defined above, commitment is a somewhat subjective term. Simple statements of support by a leader without further evidence of commitment to FP may be better tracked by a modified version of the MEASURE Evaluation Compendium Indicator, "Political and popular support for reproductive health".

Indicator 5.4: *Evidence of regional/national centers or collaboratives for shared education and research in family planning.*

Definition: Evidence of regional or national-level centers, partnerships or collaboratives established for the purpose of expanding the knowledge-base of family planning (FP). "Centers" can include organizations or universities with a specific department or area of specialty in FP, reproductive health, or demography whose key purpose is to promote FP through research, capacity building, and education.

"Collaboratives" are temporary partnerships formed for a common purpose — in this case, education and research in FP. An example could include a group of implementing partners who work together on a specific research or education project for FP, but do not exist as a long term organization.

Data Requirements: List of regional/national centers or collaboratives for education and research in FP.

Data Source(s): Key informant interviews; Web searches; examples of published research and/or research conferences; memoranda of understanding (MOUs) signed by center/collaborative members; description of a mission or purpose of the center.

Purpose: This indicator measures the degree to which a government or region values a local/regional evidence base for FP programming/policies/planning etc. It reflects a country's recognition of and commitment to best practices in FP. It also reflects efforts to provide efficient, effective and high-quality FP care, as well as a reliance on evidence and data in decision making.

Issues: Achievement of this indicator requires substantial financial investment and may not be feasible for resource constrained countries. In addition, a program may have little influence on whether or not a government/university chooses to allocate resources to an institutional endeavor. Furthermore, the existence of a regional institution does not guarantee a country's involvement in FP activities or the use of data and information generated by the institution.

List of Interviewees

USAID Mission Interviews

Barbara Hughes

USAID/Madagascar

Benja Andriamitantsoa

USAID/Madagascar

Tim Manchester

USAID/Tanzania

Thibaut Mukaba

USAID/Democratic Republic of the Congo

Akua Kwateng-Addo

USAID/Senegal

Sheila Nyawira Macharia

USAID/Kenya

Lilly Banda-Maliro

USAID/Malawi

Karla Fossand

USAID/Namibia

Megan Rhodes

USAID/Uganda

Janet Mabel Kabarangira

USAID/Uganda

Andrew Namonyo

USAID/Uganda

Sharon Epstein

USAID/Nigeria

John Quinley

USAID/Nigeria

Interviews with Implementing Organizations

Katie Cook, Leanne Dougherty

AIM Global Health

Milka Dinev

Extending Service Delivery Project, Pathfinder International

Joseph Dwyer, Erin Nilon, Sarah Johnson, Cary Perry

Leadership, Management, Stability Program, Management Sciences for Health

Lynn Bakamjian

RESPOND, EngenderHealth

Duff Gillespie

The Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health

Suneeta Sharma

Health Policy Initiative Project, Futures Group Global

Barbara Seligman

Health Systems 2020, Abt Associates

Jay Gribble, Rhonda Smith

Population Reference Bureau

Ruth Berg

PSP-One and DELIVER Project, Abt Associates

Paul Dowling and Suzy Sacher

DELIVER Project, John Snow, Inc.

Karen Hardee, Craig Lasher, Wendy Turnbull

Population Action International

Suzanne Reier

Implementing Best Practices Initiative, WHO

John Stover and Emily Sonneveldt

Urban Health Initiative Advocacy, Futures Institute

Ilene Speizer, Lisa Basalla, Anna Schurman

Monitoring, Learning, and Evaluation (MLE) Project, Carolina Population Center

Bridgit Adamou

MEASURE Evaluation Population and Reproductive Health, Carolina Population Center

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