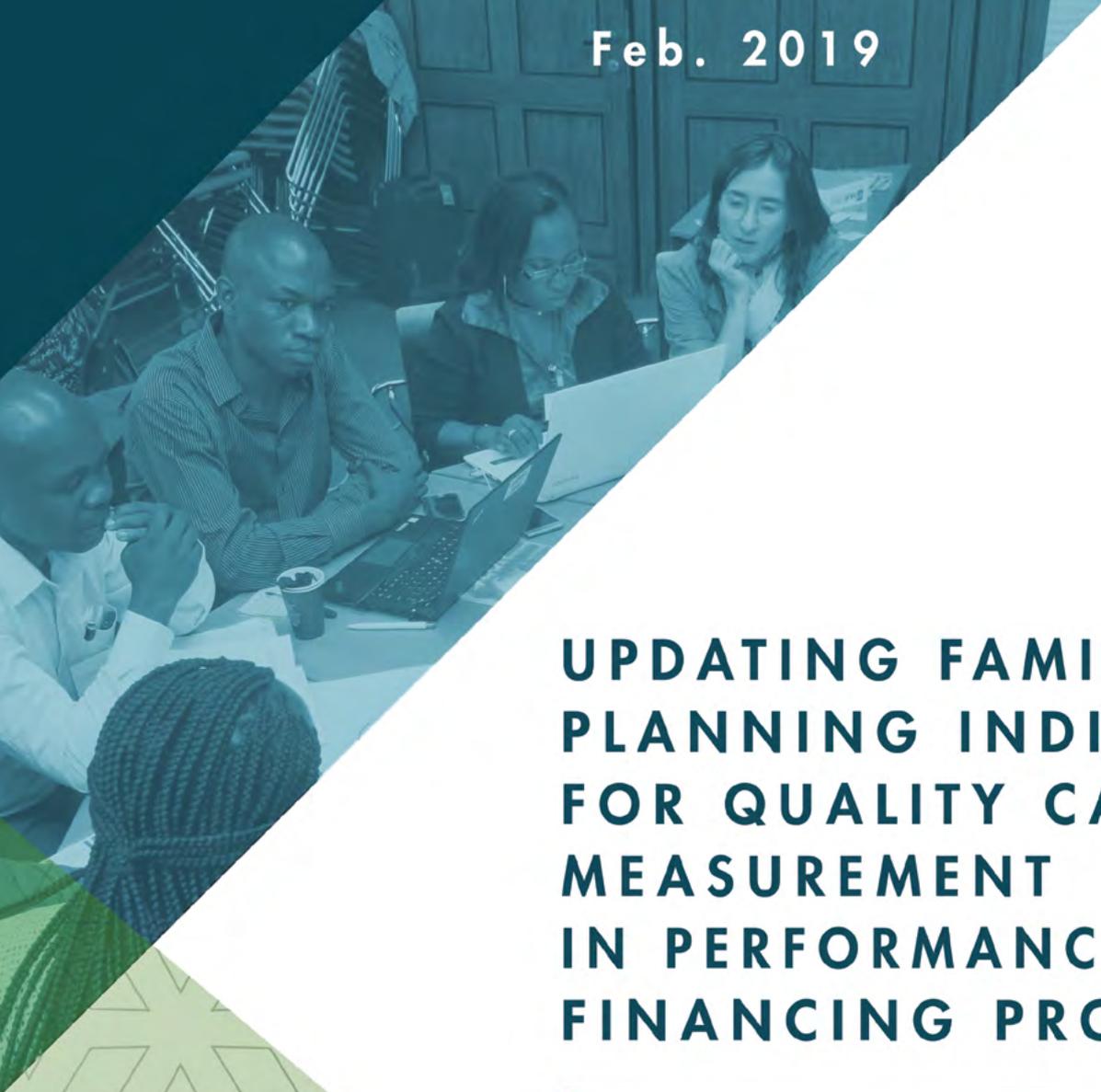


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UPDATING FAMILY PLANNING INDICATORS FOR QUALITY CARE MEASUREMENT IN PERFORMANCE BASED FINANCING PROGRAMS

PERFORMANCE-BASED FINANCING
& FAMILY PLANNING
WORKING GROUP

COLLECTIVITY



CONTRIBUTION

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DISCLAIMER

This report contains the collective views of an international group of experts, and does not necessarily represent the decisions or the stated policy of the World Health Organization.

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Executive summary

On September 14-15th 2017, fifty practitioners, consultants, program managers, policy makers and researchers convened in Antwerp to advance the ambitious agenda of improving how Performance Based Financing (PBF) programs pay for family planning services. The two-day meeting had been prepared by an organizing committee of 26 international experts, under the leadership of Blue Square, the Institute of Tropical Medicine, the Performance Based Financing Community of Practice, Population Council, and the

WHO (Reproductive Health and Research Department). In the follow-up of the meeting, our working group has finalized a new set of priority indicators for FP services in PBF programs.

In this report, we present the background of this collaborative process, summarize key lessons from the encounter between PBF and Family Planning experts in Antwerp and introduce the set of indicators jointly agreed by experts through a consultative process. We also identify ways forward for PBF programs.



Background

Over the past 15 years, PBF has gained prominence in global health; today, it is implemented in around 30 countries. PBF is a mechanism by which health facilities are funded on the basis of their performance, traditionally measured in terms of volume and quality of services. A key feature of PBF is its potential flexibility as a strategic purchasing instrument: on the basis of new knowledge and evidence, it is possible to adapt how performance is measured and rewarded. In an ideal world, such self-reflection would be done regularly by PBF programs. Yet, national program managers have

limited time and support for this undertaking.

The meeting “Improving quality of care measurement of family planning in Performance Based Financing systems” was organised as a first step in making a collective effort to assist countries in the updating of their PBF indicators. The meeting focused on a very specific area: family planning (FP), given the need and opportunity to align performance incentives for FP services in PBF programs with intended health outcomes of beneficiaries.

Objectives, participation and format of the meeting

The objectives of the meeting were:

1. Contribute to the emergence of a collective learning and action agenda on incentivization of quality in family planning services.
2. Define how the measurement of quality of care, including checklists, can be improved. Part of these improvements would lead to greater standardization of measurement within a country, and even across countries, through the dissemination of evidence-based and agreed upon best practices.
3. Define how the tools used for quality of care measurement through patient feedback can be improved.
4. Develop an implementation research and learning agenda to monitor and study the effectiveness of the recommendations.

The meeting built on a fully open peer-to-peer approach organised through the collaborative platform “Collectivity”. Fifty experts participated to the meeting. During the two days, participants generated an updated view on how the quality of FP services could be measured in PBF programs while more systematically aligning contracted performance with a human rights framework.

Main outcomes of the meeting

There was a strong consensus among participants that contracting quantity in FP services is not sufficient – quality of services must be better integrated into payment formulas. The science of quality measurement has advanced rapidly in the last few years, especially in the field of FP, moving from models of health facility assessment and into notions of client-perceived quality of FP counseling particularly the method information index.

There is strong evidence for the need to update PBF strategies for FP objectives. The first step should be to adopt a new perspective. The rights-based approach (RBA) is today well accepted in the FP community and more broadly across large segments of global health. PBF experts should acquaint themselves with it. Bringing PBF programs within an RBA would be beneficial to populations and to PBF programs themselves: one cannot be wrong by linking better PBF with a human rights framework. The RBA will open our eyes on the limitations of some existing strategies. For instance, the current focus of PBF programs on universal health facilities only entails that we fail to reach some specific groups (e.g. adolescents). There

is also a strong need to update indicators in PBF programs. A multi-country review showed that PBF programs are very similar in their measurement and incentivization approach – several important dimensions, especially staff competences, are currently not measured. PBF experts should not assume that the way they address FP needs today is satisfactory. The meeting in Antwerp was also an opportunity to acknowledge that the theory of change of PBF is more complex than what had been taught so far. PBF programs deliver their effects through different routes, given their design features but also systemic and context elements. An even more specific question is how PBF plays as an instrument to quality improvement. Checklists will remain important, but we should avoid believing that they are a panacea. This more comprehensive work program is only mentioned in this report and will have to be continued with specific resources and expertise.

There will be some operational challenges to update indicators in a PBF program. Several have been identified by meeting participants. A prospective implementation research program focused on enablers and barriers



at country level would be welcome. Other implementation research gaps identified by the participants include effects of PBF programs on quality of care, equity and provider bias. As for updating the set of indicators, participants

of the meeting identified six priority dimensions. In Antwerp, we made good progress, but time was too short to finalize lists of indicators or recommendations.

Updating indicators: the priorities

In this report, we present the different indicators recommended by our working group. A general recommendation to countries is to adopt the RBA approach and take equity lenses to critically assess their PBF programs. We recommend program managers to pay more attention to user experience, a critical aspect for FP. The Method Information Index captures a major outcome of quality FP counselling. At least one indicator should be introduced to measure the knowledge and skills of FP providers. We recommend the vignette approach. At least one indicator should correctly capture the availability of the method mix to be delivered by the health facility. In countries

where the interbirth interval is too short, we also recommend the introduction of an extra fee for each woman adopting a FP protection within the six weeks after delivery. This would constitute a relevant outcome indicator for postnatal services. We also recommend a similar extra fee for each FP adoption by a young people or a person from the poorest socio-economic group.

At the end of our report, there is a full list of recommendations targeting the PBF programs, their partners, the research community and CoP facilitators.

General lessons from the whole collaborative process

Collectivity was a powerful tool to convene a highly expert and diverse group. Bringing together two different communities of expertise from PBF and Family Planning led to very interactive discussions. However, two days were too short to finalize the indicators. Any further workshop with a same logic should last at least three days. The organization in subgroups after the

meeting was a nice strategy to continue the work although it required close follow-up. We missed human resources to finalize the report. Time at the level of the general coordinators was a real bottleneck. If we organize any similar process in the future for other health domains, we will have to plan resources and time sufficiently.

Where to find more information on the meeting and this program?

All our process was organized via the Collectivity platform and other collaborative solutions. You can access background materials, power points, list of experts present

in Antwerp [here](#). **This document makes also an extensive use of hyperlinks.** They give access to a rich background material.

Summary table of indicators

| CATEGORY | INDICATORS |
|------------|---|
| Priority A | <i>Informed choice of contraceptive methods (quality of the counseling) (Client experience)</i> |
| | <i>Theoretical knowledge on contraceptive methods (Staff technical knowledge)</i> |
| | <i>Range of methods available (Structural inputs indicators)</i> |
| | <i>Stock levels ensure availability of FP products (Structural inputs indicators)</i> |
| | <i>Number of women who take a FP method during PNC in the first six weeks post-delivery (Outputs and outcomes)</i> |
| | <i>Reach of FP programs through community health workers (Outputs and outcomes)</i> |
| | <i>Acceptability of the FP services for young people (Rights-based approach)</i> |
| Priority B | <i>Respect for client's physical privacy and privacy of conversation (Client experience)</i> |
| | <i>Provider technical competence in inserting and removing contraceptive devices (IUD and implants) or performing vasectomy (Staff technical knowledge)</i> |
| Priority C | <i>Time to access the FP consultation (Client experience)</i> |
| | <i>Warm and respectful welcome and treatment (Client experience)</i> |
| | <i>Clarity of answers to user's questions (Client experience)</i> |
| | <i>Essential equipment availability for long-acting reversible contraception (LARC) (Structural inputs indicators)</i> |

Explanatory footnote:

- **Priority A** : this indicator is high priority and it is recommended to have it in all PBF programs.
- **Priority B** : it is useful to have these indicators as they will help substantiate the information collected through the priority A indicators.
- **Priority C** : these indicators are also useful to have, but are more context specific and may be used where applicable.

ACRONYMS

ANC: antenatal care

CHW: community health workers

CYP: couple-years of protection

FP: family planning

HMIS: health management information system

HTA: health technology assessment

IUD: intra-uterine device

LARC: long-acting reversible contraception

LICs: low-income countries

LMICs: low- and middle-income countries

LMIS: logistic management information system

MII: method information index

PBF: performance based financing

PBF CoP: performance based financing community of practice

PNC: postnatal care

RBA: rights based approach

RBF: results based financing

WRA: women of reproductive age



|||| PBF & Quality of Care: a long term learning agenda

Over the past 15 years, Performance Based Financing (PBF) has gained prominence in global health. PBF is a mechanism by which health facilities are funded on the basis of their performance, traditionally measured in terms of volume and quality of services.¹ Today, PBF is being implemented in nearly 9,000 facilities serving more than 113 million people in around 30 countries.

One of the primary purposes of PBF is to contribute to the improvement of quality of care provided by health facilities. One of the strategies to achieve that goal is to integrate quality indicators in the payment formula of the health facilities (Fritsche et al. 2014). In

most PBF programs, the measurement tool used to evaluate quality is a comprehensive checklist that covers several topic areas and includes a mix of structural (e.g. service readiness) and process (e.g. clinical care) indicators (see also Box 1). They are often paired with information obtained from patient feedback surveys. Since there is a financial incentive to meet the checklist requirements, health facilities are expected to use the checklist to guide where they prioritize their attention and resources. Health services assessed include family planning, maternal and child health, HIV/ AIDS, immunization, tuberculosis management, nutrition, and more.

Raising questions on how PBF addresses quality of care

There is evidence that health staff respond to these checklist incentives (Bonfrer et al. 2014; Rusa et al. 2009). However, among stakeholders, there are questions emerging about whether the current checklists of indicators sufficiently reflect quality in clinical processes (Josephson et al. 2017). It is also unclear whether the existing approach and measurement tools constitute the best way to trigger quality improvement at health facility level in all settings.²

Answering these questions is strategic. There is clear evidence – across settings – that PBF can contribute to significant improvement in coverage rates for essential services. However, if quality of care is not ensured, these increases in utilization could lead to disappointing results in terms of health outcomes. PBF will not solve all the problems of quality care – the determinants of

the latter are numerous, still we must make sure that PBF brings its best possible contribution to quality improvement in LMICs.

The PBF Community of Practice (PBF CoP) has identified this issue as one of its priority learning agendas.³ Empirical findings produced by the scientific community will of course be key. Yet, evidence will take time to emerge and will probably be very context and experience specific. We believe that there is already enough scientific and experiential knowledge to warrant updating how PBF addresses quality of care in LMICs. This report presents a first step: to develop **a practice of updating PBF quality of care indicators**.

¹ PBF belongs to the family of so-called 'Results-Based Financing' arrangements, which do a cash payment or non-monetary transfer to a government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Under PBF arrangements, the payment goes to the health facility. See also footnote 7.

² Eerens P. 2017. Quality improvement: just another journey. [Health Financing in Africa - Le Blog](#).

³ Meessen B. 2017. Performance Based Financing and Quality of Care: ready for an upgrade? [Health Financing in Africa - Le Blog](#).

IIII Updating indicators in PBF programs: a collective responsibility

The ‘PBF & quality of care’ knowledge agenda will probably keep program managers and researchers busy for many years. Questions abound, among others, at the level of theories of change enacted by the PBF program (Renmans et al. 2017), measurement of quality of care (cf. the variable easiness to capture important dimensions and determinants) (Fritsche & Peabody 2018), ‘dosage’ of the incentivization (e.g. to avoid the crowding-out of intrinsic motivation) and coherence of PBF with other quality improvement strategies (Gergen et al. 2017).

We do not discard the importance of these fundamental questions. Still, for this report,

we assume that the core theory of change of PBF is valid. As a reminder, this theory of change rests on two main tenets: (1) performance of a health facility is, to a fair extent, measurable through indicators of the volume of services delivered (e.g. how many patients have adopted a family planning technique) and quality indicators (e.g. no stock out of contraceptives); (2) paying health facilities according to their performance as measured by these indicators induces their managers and staff to adopt strategies and behaviours better aligned with the desired performance.

Challenges for a frequent update of PBF indicators

A key design feature of PBF is the flexibility in the implementation of this theory of change. At the design stage, it is recommended to adapt the PBF scheme and set of indicators to the country health market (e.g. a strong private sector, staff reservation wage) and health priorities (burden of diseases). This adaptation can also be done across time: by design, PBF programme managers can adapt how performance is measured and rewarded, introduce new indicators or remove redundant ones.

In an ideal world, such adaptation would be done regularly, as new knowledge and evidence emerges. Yet, today, national PBF program managers have limited mandate, information and support for this undertaking. Revision of the instruments at country level (rightly) involves large consultations, where the process sometimes leads to an inflation of requests, as each disease program wants to address its own informational needs. Furthermore, participants

of such country consultations are not always up-to-date on the evidence and emerging practices at global level. They may also misunderstand the type of indicators PBF programs look for.

Without proper management of the revision process, this can reduce the overall coherence and quality of the tool; it can even lead to a lengthy checklist whose logic is not understandable anymore by those expected to address bottlenecks and change their practice: the health staff. This lack of clarity can greatly affect the theory of change underlying the measurement effort. More generally, any lack of updating leads to a waste of resources (as facilities are paid for indicators which became irrelevant) and affects the effectiveness and efficiency of PBF, which may, at country level, even jeopardise the strategy itself.

⁴ In practice, it is unclear whether such contextualisation is done enough: some have replicated tools in neighboring countries, possibly with insufficient tailoring to the health care and public health context.



Our choice: a global collaborative process facilitated by the PBF CoP

Several actions are possible, at country and international level.⁵ However, the scarcity of expertise in Health Technology Assessment (HTA) in most LMICs and the very limited time available to PBF program managers indicate that today, a collaborative effort across countries would be more efficient than each country trying to do it by itself. Furthermore, the knowledge relevant for updating PBF indicators is distributed among a wide array of experts and sources. Given the fact that many countries share the same indicators for their PBF programs (Josephson et al 2017), the relevant level for review of indicators is actually the global level.

It happens that the PBF expert community holds a platform for such a collective endeavour: the PBF Community of Practice (PBF CoP), which gathers more than 2,000 PBF experts on its [online discussion forum](#). The PBF CoP has been coordinating several collaborative research projects and has co-organised several international events. Commitment of its facilitation team to gather researchers and practitioners around co-owned learning programmes is well-

known (Meessen et al. 2011). This provides the PBF CoP some convening power to organise and facilitate a collaborative process around the update of PBF indicators.

This report presents the outcome of an innovative collaborative approach for the updating of PBF indicators. The PBF CoP played an important role in this process, jointly with other partners: the Institute of Tropical Medicine, Antwerp; the Reproductive Health and Research Department, WHO, Geneva; Population Council and Blue Square. The core activity was a consensus meeting, which was followed by six thematic working groups. In the spirit of the CoP approach, all of the process was open; participants had to apply via the platform TheCollectivity.org before participating in the consensus meeting or joining a working group. In the following section, we present the main focus of the meeting: quality of care indicators for family planning services.



⁵ See for instance [this working group](#) looking at how Health Technology Assessment could be better integrated in PBF programs.



IIII Why a focus on family planning services?

PBF programs remunerate health facilities for various services (See Box 1 on how it is done). In nearly all countries, family planning is one of them. One of the triggers for us to review how PBF programs incentivize FP was a meeting at Harvard University in December 2015. The meeting was the final dissemination event of a research program, which consisted in the systematic review of mechanisms for financing family planning (Lissner and Ali 2016), including PBF (Blacklock et al 2016). The research

program was coordinated by the Reproductive Health and Research Department, WHO, Geneva; it involved several research groups, including the ITM and Population Council. Meeting participants acknowledged that this was probably one of the first time that FP experts met health financing experts and engaged into a technical dialogue. The idea to meet again, for instance, to assess how FP was handled in PBF programs was put forward.

The idea came back after a discussion on the online forum of the PBF CoP early 2017. We realized that several groups were working in parallel on the issue of developing appropriate indicators for PBF programs. One starting point was common: the assessment that in most countries, PBF checklists had some major limitations as for family planning services:

- **Checklists ignore some important dimensions of quality of care.** For instance, they do not include expected service availability and readiness indicators. In one country, neither the availability of condoms nor the availability of trained staff and educational materials for family planning are included.
- **Checklists are imbalanced.** They focused on structure, process indicators and less on outputs/outcomes, provider and client perspectives and services received (acceptance and continued use).
- **Checklists are confusing health staff on the actions to take.** In some cases, the use of composite indicators could inhibit a clear understanding of the delivery and availability of the disaggregated services important for measuring quality of care.
- **Checklists are inconsistent across countries.** This lead to inconsistent, incomplete, and incomparable data across different countries and PBF programs. Indicators of quantity and quality are often poorly defined or untested.
- **Checklists are not up-to-date.** Existing checklists ignore for instance recent work on [rights-based programming](#) which has been carried out by the FP community. The rights-based approach has been an important development in reproductive health, rich in new perspectives, dimensions to monitor and indicators to analyze.

In order to improve on the existing measurement tools, it was agreed that it was necessary to hold a meeting which would bring together experts from the different relevant silos of knowledge: FP, PBF, other Results-Based Financing schemes (vouchers, social franchising) with the main common assignment to evaluate the existing tools and approaches to consider how they could be improved.

Box 1: Key rules for PBF 'indicators'

As indicated by the name, PBF is about paying for performance. This raises the key issue of defining what performance is. Everyone agrees that performance of any health facility is multidimensional. Experts traditionally (and rather improperly) use the term of 'indicators' to refer to the measures used to document the many dimensions and sub-dimensions to be rewarded. The rules guiding the development of PBF 'indicators' are a bit different from those adopted for standard program monitoring or evaluation. Still the SMART principles (a good indicator is specific, measurable, achievable, realistic/relevant and time-bound) provide a good benchmark to understand what matters for a PBF indicator.

Specific: a good indicator captures in a circumscribed manner the reality it tries to measure – any indicator is indeed a communication tool stating what is important. The message sent by 'number of days of absence of stock-outs' is clear. Yet, as there is a reward directly linked to the satisfaction of the indicator, an extra issue with PBF is to develop an indicator which is not amenable to (too much) manipulation or gaming by the rewarded provider. We must define clearly what a 'stock-out' is : stopping prescribing a FP technique and keeping one last box on the shelf for the verifier is also a stock-out.

Measurable: a good indicator can be measured in an objective manner. The PBF payment formula relies on the observation and counting of phenomena. Phenomena can be of various kinds: inputs available at the facility (e.g. no stock out of contraceptives), adopted processes (e.g. correct completion of a register), delivered outputs (e.g. number of inserted IUD) and achieved outcomes (duration of protection due to a family planning technique, absence of side-effects). Most PBF programs have a payment formula distinguishing the payment for the outputs (the quantity component) and the payment for the inputs, processes and outcomes (the quality of care component), with various possible links between the two components. For outputs, most PBF programs have opted for a simple counting, without any denominator or target: for instance, each new FP subscriber brings an extra revenue

to the facility. For quality of care aspects, most PBF programs have adopted a checklist approach. A set of conditions required for ensuring quality of care are measured. For some conditions, the score is based on a 'yes or no' (e.g. for availability of a key input); for others, proportions are used (e.g. the verifier checks 10 consultations in the register and calculate the proportion satisfying a condition). Because of the payment relationship, the measurement effort has to be well-thought under a PBF program. The third party verifier must have no conflict of interest and be trustworthy. Extra effort has also to be put into checking the reality of the information reported by the health facility (e.g. with the organization of home visits). Conversely, one must not forget that some important dimensions of quality of care (e.g. those which require direct observation) might fall out of the attention because they are, in the current stage of the technology and medical practices, not verifiable by a third party.

Achievable: a good indicator relates to something the health facility can achieve. PBF indicators are tailored to each level of care and respect packages of services as defined by the national policy. The payment of health facilities per unit delivered evacuates the difficult issue to set targets. For ethical reasons, the PBF program must sometimes check whether some prerequisites are satisfied (e.g. were the providers trained to deliver this service?). The health facility must also feel that it is not powerless in front of bottlenecks. A consequence of this principle is that health facilities must have enough decision rights on their resources (autonomy).

Relevant: collecting indicators has an opportunity cost. A good indicator or set of indicators focuses on what really matters. The main purpose of this collaborative project was to improve the relevance of indicators used in PBF programs as for FP.

Time bound: most PBF programs opt for a payment formula which does not require to pre-determine a period to achieve the objective. For instance, the health facility will be paid for each new adopter of a contraceptive technique.



IIII The consensus meeting in Antwerp

Format and objectives

The meeting was convened jointly by the Institute of Tropical Medicine, the Reproductive Health and Research Department of WHO, Geneva, Population Council, Blue Square and the PBF Performance Based Financing

Community of Practice. Its programme was developed in a participatory manner by a group of 26 international experts identified through the collaborative platform Collectivity (see [here](#)).

The objectives of the meeting were:

1. Contribute to the emergence of a collective learning and action agenda on incentivization of quality services in family planning.
2. Define how the quality of care checklists can be improved. Part of these improvements would lead to greater standardization of measurement within a country, and even across countries, through the dissemination of evidence - based and agreed upon best practices.
3. Define how the tools used for quality of care measurement through patient feedback can be improved.
4. Develop an implementation research and learning agenda to monitor and study the effectiveness of the recommendations.

The meeting built on an open selection approach. It gathered 50 experts (list of participants [here](#)) selected from around 80 applications. Half of the participants were senior experts from LMICs directly involved in the management or study of PBF or Family Planning (FP) programmes at country level. The other half were experts supporting PBF or FP

programs through their agency (WHO, USAID, World Bank, Bill & Melinda Gates Foundation, Mary Stopes International) or their capacity of advisers to countries or agencies. During two days, participants interacted and generated an updated view on how PBF should address quality of services for family planning (see program [here](#)).

Key lessons

In Antwerp, there was a strong consensus that contracting quantity in FP services is not sufficient – quality of services must be better integrated into payment formulas. The science

of quality measurement has advanced rapidly in the last few years, especially in the field of FP. There is knowledge to tap.

1. There is strong evidence for the need to update indicators. On day 1, we had the opportunity to learn from different countries and agencies on how they address quality in family planning services in their results-based financing (RBF)¹ programs. A multi-country review showed that PBF programs are very similar in their measurement and incentivization approach – several important dimensions, especially staff competences, are currently not measured. [A case study in Cameroon](#) gave us some evidence on how the availability of qualified personnel is a programmatic bottleneck today. This case also showed that PBF programs, by limiting their support to health centres used by the general population, were missing adolescents, whom are probably reluctant to use the same health centres than parents and



siblings. Actors implementing other RBF strategies such as franchising or vouchers have more experience of working with more specialized providers. The findings from qualitative research presented in the Cameroon case also reminded us the many cultural barriers affecting the use of FP services. This review of the evidence confirmed that the PBF experts should not assume that the way they address FP needs is satisfactory.

2. The **need to embrace a right-based approach** (RBA) is today well accepted in the FP community. For PBF experts, the concept is new (see Box 2). In Antwerp, we heard a very helpful [presentation](#) explaining the content of the RBA. Its application to other RBF schemes (vouchers and franchising) made things clear and concrete. At the end of the meeting, there was a strong consensus that bringing PBF programs within a RBA would be beneficial to populations and to PBF programs themselves: one cannot be wrong by linking better PBF with human rights.
3. In the PBF community, there is growing recognition that the **theory of change of PBF is more complex** than what had been taught so far. In Antwerp, participants acknowledged the need for an update at that level as well (see [here](#)). PBF programs deliver their effects through different routes, given their design features but also systemic and context elements. An even more specific question is how PBF plays as an instrument to quality improvement. Checklists will remain important, but we should avoid the pitfall to believe that they are a panacea. The theories of change of PBF is a work program to be continued.
4. On the afternoon of day 1, we had a rich brainstorming session on the operational challenges to update indicators in a PBF program. The summary of the brainstorming is provided in Box 3. This list must be kept in mind by program managers willing to introduce some of the new indicators provided in this report.
5. Just after that session, we were asked to identify key priority issues for us to work on. We came to a list of six areas where some work by all of us could probably help to improve how PBF addresses quality services in family planning: staff knowledge & competencies, structural inputs, patient experience, outcome, equity and human rights (see further).
6. The morning of day 2 was dedicated to work on the six priority dimensions. This activity was organized as group works. We made good progress, but time was too short to finalize lists of indicators or recommendations. At least, we kicked off the process. This work was finalized after the meeting (see next chapter).

All these important lessons have shaped the general recommendations of this report and **our work on FP indicators which should be brought into PBF programs.**

⁷ RBF is an umbrella term for instruments that link reward to results. As far as family planning is concerned, two strategies dominate: vouchers and PBF. A PBF scheme focuses on supply-side only: it rewards health facilities for volume and quality of services provided to the population. A voucher scheme is both a demand and a supply-side mechanism: it grants some target users (e.g. adolescents) a coupon entitling them a discount or free access to specific services. The providers (a health facility, a transporter) are compensated by the voucher program according to the volume of services delivered.



Box 2: the rights-based approach

Rights-based family planning is an approach to developing and implementing programs that aims to fulfill the rights of all individuals to choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence. A RBA involves the application of key human rights principles to how programs are

planned, implemented, monitored, and evaluated. Policies, plans, and programs can only be considered rights-based if they are designed and implemented to respect, protect, and fulfill the following principles for all people: accessibility, acceptability, accountability, agency, availability, informed choice, non-discrimination, and quality.

Sources : Hardee et al 2014,
[Family Planning 2020](#).

Need for a follow-up

The meeting was a very rich moment of interaction, but two days were not enough to achieve our objectives. We therefore decided to split in smaller working groups to finalize indicators. Each group was entrusted with one of the priority action areas identified in Antwerp.

Box 3: the many challenges which could constrain the updating of PBF indicators at country level

1. There could be a lack of ownership of this agenda at high level of the Ministry of Health; there can also be quite some inertia within the government system; ownership by the national Family Planning program will be key.
2. To progress fast, it will be key to have a national expert advocating for the implementation of the new measures/indicators; countries without such a champion will move slowly.
3. Even if there is ownership and technical leadership, this agenda could enter in competition with other priority issues or other frameworks. This may delay the revision.
4. In some countries, there could be a lack of technical capacity to implement the new measures/indicators (e.g. chose the right indicators for the local context).
5. Introducing a new system will require change. There could be resistance to change, for instance because the new indicators change the incentive structure; this resistance can be at all levels, including technical and financial partners.
6. Changes will have to be well identified, explained and discussed with national stakeholders. Particular attention will have to be granted to: (i) design issues (the characteristics of the new indicators, their relative strengths in comparison with existing ones, their added value given the country needs, priorities, specific bottlenecks and organization, the appropriate number of indicators and their complexity; (ii) resource allocation issues (e.g. if there is a shift of budget towards FP indicators, who will cover the implementation costs); (iii) implementation issues (update of the manual, training, work burden induced by their verification and analysis, introduction of new assessment methods such as vignettes or mannequins; (iv) possible conflicts between stakeholders.
7. The cost of changes will have to be covered. It could include: a seminar to validate the indicators, the development of new tools and manuals, the (re)training of health workers, possibly some additional costs for verifications, database management and updating.
8. A training plan may be required. If the changes are substantial, it will be necessary to build capacities at many levels (providers, verifiers, civil society organisations , central level...). In some countries, there is quite high staff turnover at some positions; this may require to repeat the capacity building effort later on.
9. The introduction of the new indicators aims at greater impact; this may have some spillover effects on the system (e.g. need to procure more contraceptives); some of the systemic effects might disrupt the health system organization. This will require close monitoring.
10. There will be a need to ensure that the new indicators are compatible with the PBF routine data system, the national program data system and the broader health monitoring information system.



Priority indicators for FP in PBF programs

Introduction

There are a number of reasons why PBF programs are today not optimally designed for FP services. FP is made up of many types of services, from information to commodity distribution to clinical procedures. The PBF tools have often been delineated by teams working on health care financing with limited time and expertise in FP, rights-based programming and quality of care measurement. The clinic level data is also not further used as feedback to improve clinical or structural quality of care, or as information to stakeholders to improve policy or programmatic systems.

At Antwerp, participants identified six priority dimensions on which PBF systems should focus, as for family planning services: client experience, outcomes, staff technical knowledge, structural indicators, patient rights

and equity. In the follow-up of the meeting, we agreed to split in small groups to finalize indicators for each of these six dimensions. Each group was tasked with the mandate to finalize a list of recommendations and propose up to 7 indicators for their specific dimension. A template was given to them to structure their deliberations. It stresses some of the important points raised at the meeting: status of the evidence, theory of change, data collection, etc.

The work by the six groups has been very rich. In this chapter, we present a shorter selection of indicators. Several times, different groups have proposed similar indicators. Some other indicators have been discarded because after second analysis, we considered them as not adapted to PBF programs.

We have decided to organize the indicators in three priority classes:

- **Priority A:** this indicator is high priority and it is recommended to have it in all PBF programs.
- **Priority B:** it is useful to have these indicators as they will help substantiate the information collected through the priority A indicators.
- **Priority C:** these indicators are also useful to have, but are more context specific and may be used where applicable.

Client experience

This sub-group was led by Eric Bigirimana and Sarah Fox. It involved the following experts: Ben Bellows, Bernard Bitouga, Vicky Boydell, Anne Coolen, Rebecca Koladycz, Craig Lissner and Moazzam Ali (see also [here](#)).

Their focus was on the 'client experience' dimension. By 'client experience', we refer to the human interaction between the family planning user and the health provider. The quality of this interaction is a key component of quality family planning services. A specific issue is the information transferred to the users. In many societies, there are indeed misconceptions on FP; it is crucial that clients are able to ask all the questions and make

the right choice. We believe that PBF can contribute to this objective.

The group proposed five new indicators which captures different moments in the interaction between the client and the provider: the waiting time, the welcome, the consultation, the information transfer and the response to client's questions. All these aspects are important for a good experience; still, the PBF & FP working group has identified the transfer of information as the most important indicator. It is the 'SMARTest' indicator among the five and it is also an outcome indicator (whilst most of the others capture mainly processes). We see it as a 'must have' in any RBF program

with ambition on FP. This indicator requires to interview directly the client herself. As the main cost for the program will be to retrieve the client, it makes sense to collect some of the other indicators during the interview. This will generate a rich measurement of the client experience. This option is certainly the

one to pick if the whole verification is carried out through a phone survey. Two dimensions (physical privacy and waiting time) can also be measured objectively by facility supervisors. We have identified three cross-cutting issues for all client experience indicators.

Cross cutting issue 1 : data collection

Only the user themselves can provide reliable and complete information on her experience. In most PBF programs, the best opportunity to collect extensive information on the user experience is during **the home visit verification** by the grassroots organizations.

For all these indicators related to client experience, we thus recommend to collect information during these home visits or via

a phone call. We recommend a sample of at least **20 users per quarter per health centre.** The shorter the recall period the better; it should not be more than 3 months. The data collection for these indicators does not request a specific professional education; yet, a basic training to ensure standardisation and compliance with ethical rules is required (see also next point). Digitalization can be done through tablets or SMS surveys.⁸

Cross-cutting issue 2 : informed consent

Collecting information on the experience with family planning services at home raises confidentiality issues if the user is not alone when she is interviewed. In some PBF programs, FP services are therefore excluded from the verification investigation at community level. This is a major constraint for collection of data to improve performance of FP services.

Instead of this extreme option, we recommend to integrate the collection of an informed consent during the health facility visit and to exclude from a home visit only those who have not signed the consent. This could be integrated in the normal tasks of the provider. For instance, with such a question :

We want to improve the quality of the services we provide to our clients. We participate in a program managed by the Ministry of Health, a team independent from this health facility gives a phone call to some of our users to know how the visit to the facility was. If you are ok with answering questions about this visit, could you give me your phone number? If it is not your own phone and if you have not disclosed this visit to your partner, we recommend you not to give your number.

Or

We want to improve the quality of the services we provide to our clients. We participate in a program managed by the Ministry of Health, a lady from your community will visit some of our users to know how the visit to the facility was. Are you ok to be visited by this lady? Are you ok with disclosing your use of FP services to managers of the quality program and this surveyor? She will come to your house without talking to neighbours about the purpose of the visit. It will be up to you to request other persons to leave the place of the interview.

⁸ In some countries where internet is widespread, online surveys might be an option in a close future.

Cross cutting issue 3 : relevance for programmatic use as well

Beside the use of these indicators in the remuneration formula of the health facility, we recommend a system allowing some extra analysis at district or national level. We

should aim at assessing the extent to which any woman has positive user experience, regardless of her age, education or socio-economic background.

Interesting disaggregation include:

- Gender
- Age
- Marital status
- Service delivery point (health facility level)
- Service delivery channel (e.g. outreach versus fixed site)
- Service delivery sector (private, public; non-profit, for-profit)
- Family planning method/service
- Poverty status (where appropriate to collect using standard measures such as the Poverty Probability Index)

If information on user experience is collected via a phone survey, such profile information can also be part of the survey. If analyses are shared

with the public, patient anonymity should be guaranteed. Communication of provider data should not be stigmatizing.



Indicator C.E.1. Waiting time

Rating: Priority C

| Quality of Care dimension | Time to access the FP consultation |
|---|--|
| Rationale | <p>A factor limiting use of family planning services is women’s experience at a local health facility. Some conditions are particularly challenging for accessing services, such as crowded clinics, settings that make privacy difficult, limited staff and time, and long waiting lines. A focus on waiting time captures both the opportunity costs perceived by women for attending the service as well as the sense of priority they are given.</p> |
| Measurement | <p>Two options can be considered : (1) an objective measurement of waiting time done by the verifiers during their visit to the facility; (2) an indicator based on the subjective perception of users.</p> |
| Data collection | <p>Actual measurement needs to be strictly protocolled to ensure comparability across facilities. The subjective perception is to be collected during the patient satisfaction survey (see also cross-cutting issues 1 and 2). This is a question easy to raise during a phone survey.</p> |
| Analysis and main target users beside the PBF program | <p>An actual measure of waiting time is relevant to feedback to both the facility and district manager, especially if some benchmarking (across services or across facilities) is provided: it is a measure which can inspire action (e.g. reallocation of personnel).The perception measure is mainly relevant for the facility manager: it informs about a possible ‘pain point’ for the users.</p> |
| Priority and payment rule | <p>If the number of indicators for FP is limited, we recommend prioritizing others. In the negotiation with other programs and stakeholders, you may try to get a waiting time indicator adopted for the general PBF checklist: a short waiting time has relevance beyond FP. We anyway recommend a low monetary value for this indicator for two reasons: (1) both measurements have measurability limits (the actual measure may be affected by a factor not under the control of the facility – for instance, if the measurement is done the day of the local market; the perception measure is subjective and may say more on the users than the facility itself); (2) with the payment for quantity, the staff already have an incentive to improve user experience. Most health staff understand, by themselves, that higher volume comes from more satisfied users.</p> |

Indicator C.E.2. Respectful welcome and treatment

Rating: Priority C

| Quality of Care dimension | Warm and respectful welcome and treatment |
|---|---|
| Rationale | <p><i>Client experience is strongly influenced by the way they are made to feel when they enter the health facility (Bruce 1990). The more the client feels at ease, the more the client dares to ask questions; the more the client asks questions, the better the counselling; the better the counselling, the more appropriate the decision on FP method. Warm and respectful welcome will improve the probability that he/she will not regret the choice made, leading to lower discontinuation rates and better FP outcomes. The behavior of the health staff is key to have positive client experience, hence our recommendation to incentivize it.</i></p> |
| Measurement | <p><i>Several options are possible – they would deserve to be piloted. A first issue is to measure the respectfulness of the welcome and treatment. A grading scale (perhaps 1-5) is one option. Another issue is to aggregate the results on several users. One option is to calculate a proportion of users above a given threshold (for example, 3). Another one is to calculate an average score.</i></p> |
| Data collection | <p><i>This indicator can be collected through the patient satisfaction survey, see cross cutting issues 1 and 2. It can easily be integrated in a phone survey.</i></p> |
| Analysis and main target users beside the PBF program | <p><i>This is an indicator which is meaningful at facility level: it can be used by the health facility manager to motivate the team to focus on improving the users' experience. It is therefore a good pick if one has a digital feedback system to health facility managers. It has limited relevance at higher level, although disaggregation by age group could still be interesting.</i></p> |
| Priority and payment rule | <p><i>If the number of indicators for FP is limited, we recommend prioritizing others. In the negotiation with other programs and stakeholders, you may try to get this indicator adopted for the general PBF checklist: a positive experience for clients has relevance beyond FP. We recommend a low monetary value for two reasons: (1) it is a rather subjective measurement; (2) with the payment for quantity, the staff already have an incentive to improve user experience; most health staff understand, by themselves, that higher user satisfaction leads to greater use.</i></p> |

Indicator C.E.3. Privacy during the counselling

Rating: Priority B

| Quality of Care dimension | Respect for client's physical privacy and privacy of conversation |
|---|--|
| Rationale | <p>The precautions taken by the health facility to ensure physical privacy and privacy of conversation of the women during the FP consultation is a very important determinant for method continuation, as women will keep returning to the health facility for a new method or for management of side effects. They must feel comfortable to be examined and looked after in that health facility. Users from higher socio-economic groups are probably more demanding on this aspect. Integrating it in the PBF program will remind that this privacy needs to be protected even in poor/ rural/ lowly educated areas. This will trigger the incorporation of new norms and standards related to infrastructures. With a health facility preserving the privacy, all the social categories of women will feel respected and cared for.</p> |
| Measurement | <p>This indicator may be difficult to define, as privacy can have different meanings across culture. Facility surveyors administrating the checklist could check the premises and look for the availability in the health facility of a room with auditory and visual privacy for FP procedures (door can close, curtains at the windows...). As for users, it is probable that most of them will mainly remember confidentiality breaches which made them really uneased. Otherwise, a grading scale (see C.E.2) is one option.</p> |
| Data collection | <p>The privacy of consultation must be collected through the patient satisfaction survey, see cross cutting issues 1 and 2. This can be easily done in a phone survey. Physical privacy can be integrated in the facility survey checklist completed by the facility verifiers.</p> |
| Analysis and main target users beside the PBF program | <p>The physical privacy could be observed once a year. It is probably a quite static indicator (the health facility has the dedicated room or it has not). Comparison across districts may reveal inappropriate infrastructure in some areas. District managers should be able to access this information and to compare their facilities with those of other districts. As for privacy of conversation, reports of incidents are a useful information for district managers, as they are the authority who can sanction.</p> |
| Priority and payment rule | <p>This indicator can be identified as a transformative one: it is about introducing and enforcing new cultural norms. Yet, we do not recommend a too high payment: many facilities may get a good score – not so much because the privacy is perfect, but because problems remain unidentified. It could be an indicator playing negatively: it would lead to a limited gain if satisfied and to a major loss if an incident is reported. This would suggest some changes in PBF programs (creation of 'negative indicators').</p> |

Indicator C.E.4. Quality Information

Rating: Priority A

| Quality of Care dimension | Informed choice of contraceptive methods (quality of the counseling) |
|---|---|
| Rationale | <p><i>Proper counseling provides women and girls with medically accurate information about their bodies and contraceptive options, enables them to explore and choose among a range of methods as their sexual and reproductive health needs evolve over time, and helps them understand potential side effects. This can result in declines in contraceptive discontinuation and increases in contraceptive use. Furthermore, informed choice and decision making is a core component of a rights-based approach to family planning. All women have the right to quality information – the Method Information Index (MII) measures the extent to which this right is realized. The inclusion of the MII (an outcome measure) in the RBF incentivization structure will encourage health workers to provide complete information during the consultation. Since the change measured by this indicator relates to behavioral change and does not require additional resources (beyond the initial training), it is well suited as an RBF indicator.</i></p> |
| Measurement | <p><i>We propose to use the MII promoted by FP2020 (see here). This index measures the extent to which women are given specific information when they received FP services. The index is composed of three questions (Were you informed about other methods? Were you informed about side effects? Were you told what to do if you experienced side effects?).</i></p> |
| Data collection | <p><i>The MII can be collected through the patient satisfaction survey, see cross-cutting issues 1 and 2. It is important to keep the granularity of the answers to the three questions (see below). This question is easy to integrate in a phone survey.</i></p> |
| Analysis and main target users beside the PBF program | <p><i>The indicator to be used for RBF is the composite indicator that combines the responses of three questions. Other users will be interested to analyze the responses to the three questions separately in order to get a better understanding of strengths and challenges. This is indeed an indicator meaningful beyond the PBF program. The fact that this indicator is one of the core indicators of FP2020 will allow to compare the national performance with the 69 FP2020 countries. The PBF program will also offer the national programs a way to routinely monitor progress on this important right. At district level, answers to the three questions will allow the supervisor to compare across individual providers and prioritize its coaching and supervision.</i></p> |
| Priority and payment rule | <p><i>We see this as the top priority indicator for the client experience. We recommend this indicator to weigh heavily in the payment formula: the signal to the staff is clear and the indicator is easy to verify.</i></p> |

Indicator C.E.5. Answers to question

Rating: Priority C

| Quality of Care dimension | Clarity of answers to user's questions |
|---|--|
| Rationale | <i>A client who feels that her FP information needs have not been met may not want to return to the service. It is essential that the provider be evaluated on its ability to fill the client's need for FP information.</i> |
| Measurement | <i>We propose to measure the proportion of clients whose questions were answered to their satisfaction using a 1 to 3 scale for the question "How satisfied are you that all of your questions were answered?" - Scaled response: 1 – Not satisfied; 2 – satisfied; 3 – very satisfied</i> |
| Data collection | <i>This indicator can be collected through the patient satisfaction survey, see cross-cutting issues 1 and 2. This question is easy to integrate in a phone survey.</i> |
| Analysis and main target users beside the PBF program | <i>This is an indicator which is also meaningful at district level: it can be used by the FP district supervisor to identify providers paying too little attention to answering users' questions. It is a good pick if there is a digital feedback system to the FP district supervisor.</i> |
| Priority and payment rule | <i>We see this as a low priority indicator: it probably requires a large number of answers to be informative.</i> |

Recommendations by this group

- If only one indicator must be taken, we recommend the MII indicator on the quality of the information to the user.
- Most indicators can nicely fit into a phone survey (which could also be a nice way to collect profile data on the users, a key information for equity analyses).
- Several issues go beyond FP services only and can be integrated in a more general investigation of the quality of the services to the users.
- If data system allows it, granular results should be shared beyond the PBF program, for instance with district health management teams.



Staff technical knowledge

This group was led by Stephan Brenner. It involved the following experts: Jeannette Afounde, Moazzam Ali, Rena Eichler, Cosmas Kamango, Catherine Korachais and Serge Mayaka (see also [here](#)).

By 'staff technical knowledge', we refer to the theoretical knowledge and practical skills that FP providers can mobilize in the delivery of services to the users. Knowledge is a major determinant of quality of care. Today, this determinant is not

addressed in most PBF programs. The group recommends a major step in this direction.

The group produced 15 indicators. In this report, we focus on two indicators which (1) are the best adapted to PBF programs as they are implemented today in LICs; (2) have the greatest transformative potential; (3) can consolidate the RBA approach. Our preference clearly goes to the development of assessment tools such as vignettes.

Cross-cutting issue 4: integration of the assessment

Because of measurability constraints, many PBF quality checklists have most of their focus on the availability of physical inputs (e.g. drugs, equipment). There is a consensus today that this leads to overlooking some major determinants of quality of care, including staff competences. The development of new measurement techniques like the vignettes or mannequins is therefore welcome: it will allow PBF programs to address this structural weakness. Yet, these techniques are not magic bullets. The evaluation of some skills (e.g. interpersonal interactions) requires direct observation. A tubal ligation can only be assessed by a qualified staff. For a consultation, one needs a qualified surveyor or at least a trained investigator (e.g. mystery patient). In the stage of current technology⁹, these techniques are deemed not scalable under PBF programs. Another issue is the initial education in FP (Muganyizi et al 2014). This reminds us that professional knowledge requires a holistic approach and PBF can only be part of the solution.

This suggests that any action developed under a PBF program must be well integrated within the whole set of strategies tackling staff competences. This also applies as for the relationship to be built with trusted supervisors. There is no need to request staff consent before an examination (it is part of continuous training), but one must ensure some basic security (e.g. the score on an exam has no consequence for the employment, data is anonymized once it is shared with persons not directly involved in personal supervision).

Integration can also be searched with non-FP related competences. For instance, if a program decides to go for vignettes, it would make sense to rapidly expand the vignettes to other health problems (and create a situation where every clinical staff member is susceptible to be assessed by this system). This would be efficient and fair.

⁹ Smart glasses could create new possibilities.

Indicator STK.1. Theoretical knowledge on contraceptive methods

Rating: Priority A

| Quality of Care dimension | Theoretical knowledge on contraceptive methods |
|---------------------------|---|
| Rationale | <p>Knowledge of the FP providers is a major determinant of quality of care. Today, this determinant is not addressed in PBF programs. The proposition is to incentivize health facilities to ensure that knowledge gain on FP methods is a continuous process actively and regularly pursued by the individual providers, beyond trainings. The more knowledgeable and up-to-date are the providers, the more personalized the counseling to FP clients will be, which will improve satisfaction of clients and thus their compliance to follow-up or readiness to come back to the facility for a shift to a more adequate FP method (Assaf et al 2017). One area of assessment will be the RBA: this will contribute to promote and get internalized knowledge on the RBA. It is proposed that the incentive structure affects the whole team. This will stimulate everyone in the facility or team to encourage each other to be clear about guidelines.</p> |
| Measurement | <p>The main indicator will be the score in a written exam taken by the FP providers (see below). A minimal mark would have to be obtained (ex. 50%). Content would focus on the following aspects: indications, contraindications, side effects, protection methods, correct use, follow-up for all / commonly available contraceptive methods, but also theoretical aspects of practices in relation to a rights-based approach. To enhance effectiveness and equity, specific focus on sub-populations (post-partum women, adolescents, postpartum women, HIV positive women, etc.) would also be integrated.</p> |
| Data collection | <p>This indicator requires to develop new data instruments. Two options could be feasible: a) Knowledge assessment based on multiple-choice questions (wide range of topics): Idea would be to create a pool of knowledge questions (about 100-150 simple yes/no questions) based on guidelines applicable to the context (e.g. the WHO Global Handbook). Only a small subset (purposefully or randomly drawn from question pool) of questions would be run in each testing cycle. General topics tested will be communicated to test-takers, but specific aspects tested in each cycle will remain unknown prior to testing; b) Knowledge assessment based on vignettes (case-specific topics): Vignettes are structured written or online case simulations. The assessed clinician has to respond to a short description of a person situation; the case is built on precise references to what are thought to be the most important factors in the clinical decision-making (Fritsche and Peabody 2018). Research in a number of countries suggests that knowledge as demonstrated by performance on a clinical vignette is correlated with actual practice.</p> <p>The exam would be administered by the survey team in charge of the quality checklist or the health district team. The exam should be taken by any (new) staff member taking a role in FP. The test could be on paper, but ideally it should be on a digital format (e.g. tablet, phone): this would indeed facilitate broad access to the score (possibly anonymized for some data users). Ideally, there should be a system to monitor the person taking the test (to prevent major frauds).</p> <p>The theoretical knowledge assessment could be part of a broader effort to assess clinical knowledge at health facility level. The assessment would be organised on a quarterly basis.</p> |

| Quality of Care dimension | Theoretical knowledge on contraceptive methods |
|--|---|
| <p>Analysis and main target users beside the PBF program</p> | <p><i>The assessed provider, the health facility manager and the district supervisor would be informed about the individual score, but also about the detailed marks: this information could indeed inform them on possible needs for extra supervision and coaching. A system allowing direct feedback to evaluated staff and anonymized benchmarking could also help. The anonymized aggregated information will also have value for the national sexual reproductive health program, especially if characteristics of providers (e.g. sex, age, years of service, professional degree, etc.) have been collected. This will allow the program to craft additional training or materials for provider groups that appear to need more support or by question content/item (e.g. FP methods, relevance given to single items, etc.). Training should be guaranteed for any provider asking for support – the evaluation should not be perceived as a threat for the individual. For instance, the large pool of questions or vignettes could be available online to allow the health staff to learn by themselves.</i></p> |
| <p>Priority and payment rule</p> | <p><i>This indicator will open the eyes of the health facility manager on the actual knowledge of the staff in charge of FP. The score could be used every quarter (with rotation of questions, see data collection above). It should have a significant monetary value. An alternative approach would be to use it as an indicator playing negatively: if the score is too low, the health facility is not paid for its FP services for the next three months (volume) or the facility is paid, but suffered from a penalty. This would suggest some changes in some PBF programs (creation of ‘negative indicators’). The FP staff who failed the test would be allowed to be examined again three months later. It could be strategic to integrate this evaluation in a broader effort of evaluating staff knowledge (beyond FP). This would allow a rotation for the clinical issues under evaluation. Frequency of the assessment of a specific domain would depend on the height of the score. Alternatively, the indicator could be related to a provider accreditation or qualification system. Such an approach would require to actively involved responsible authorities (professional groups, accreditation agencies, etc.) in the development of the assessment tool from early on. Their active use of the assessment tool could eventually make the use under the PBF program redundant.</i></p> |

Indicator STK.2. Practical skills

Rating: Priority B

| Quality of Care dimension | Provider technical competence in inserting and removing contraceptive devices (IUD and implants) or performing vasectomy |
|---|--|
| Rationale | <i>Theoretical knowledge is not enough. Practice is key for tasks such as insertion and removal of implants and IUD or surgical interventions</i> |
| Measurement | <i>This dimension requires direct observation by a qualified supervisor, either on an actual patient or on a mannequin simulator. Observation on an actual patient is not scalable (difficult to gather at the same time the three participants: the patient, the assessed personnel and the supervisor) and therefore not appropriate for PBF programs. However, several acts can be observed on a mannequin.</i> |
| Data collection | <i>The easiest option would probably be to integrate this assessment in a few relevant vignettes.</i> |
| Analysis and main target users beside the PBF program | <i>Similar to STK1. In case of negative result, the staff member would be directly retrained on the mannequin by the examiner or a qualified supervisor.</i> |
| Priority and payment rule | <i>We recommend to integrate this assessment under the theoretical knowledge assessment.</i> |

Recommendations by this group

- In many countries, PBF programs must develop strategies to stimulate health facilities to act upon staff knowledge and skills; they are key determinants of the quality of health services. FP could serve as a pilot area.
- If only one indicator must be taken, we recommend the theoretical knowledge indicator. There is a role for international actors to develop the related assessment tools. Our preferences goes to the development of a set of vignettes. Experts will have to be hired to develop the FP vignettes.
- Ideally, these assessment tools should be available in a digital format (as well).
- If data system allows it, granular results should be shared beyond the PBF program, for instance with district health management teams and the national sexual and reproductive health program. Results could indeed inform human resource strategies (training programs, recruitment, supervision...).
- It is important to remember that the evaluation of some skills required direct observation. This suggests that quality improvement strategies should not exclusively rely on PBF programs.

Structural inputs indicators

This group was led by Tamara Goldschmidt. It involved Tarisai Manjengwa, Aloys Zongo, Moazzam Ali, Joël Arthur Kiendrébéogo, Serge Mayaka and Nirali Chakraborty (see here).

By 'structural inputs', we refer to the consumables, equipment, transport means and infrastructure required to perform high quality FP services. The observation prior the international meeting was that this aspect is considered by many PBF programs, but rarely in an optimal way as far FP is concerned. Our indicator SI1 is the most comprehensive: it tries to capture the status of the availability

of methods from the perspective of the user. We offer two ways to measure it. The second one is actually our SI2 indicator, which focuses exclusively on the physical availability of the contraceptives. Availability of contraceptives is key to ensure contraceptive choice and continuity of care. These indicators are fully in line with the RBA approach. SI3 is a more specific indicator. It certainly makes sense for a PBF scheme tailored to health facilities specialized in FP services.

As for infrastructure, we refer the readers to our indicator C.E.3.



Indicator SI.1. Range of methods available

Rating: Priority A

| Quality of Care dimension | Range of methods available |
|---|--|
| Rationale | <p>A key determinant of uptake and continued utilization of family planning services is overall availability of methods that clients are offered. Studies of contraceptive discontinuation rates, for example, have indicated that clients who are given the method of their choice tends to continue using the method for longer duration of time (Ross et al 2002). Integrating this indicator will generate routine measurement of the methods available in health facilities and incentivize maintaining a variety of methods available. Method availability is determined by four main factors: (1) the national or health facility policy; (2) the technical platform (operation theatre or not); (3) staff qualification; (4) availability of contraceptives.</p> |
| Measurement | <p>The indicator must measure the availability of modern contraceptive methods for a given period or on the day of the assessment. Ideally, it should capture more than one factor of availability. For health centers, the target should be “at least three modern contraceptive methods”; for higher levels, the target should be at least five modern methods. In both cases, there should always be at least 1 long acting method, 1 short acting method, and 1 barrier method available.</p> <p>There are mainly two ways to define this availability. The first approach is to do it retrospectively with actual prescriptions registered in the patient registries. For instance, the availability would be confirmed if at least the three/five types of methods have been prescribed over the last quarter. The strength of this approach is that it captures the availability from the user perspective (output measure). For instance, a faith-based health facility which does not deliver modern techniques is reported as not meeting the standard (even if it holds some stocks in its medical store).</p> <p>The drawback of the method is that one has to trust data self-reported by the FP provider and to assume that the contraceptives were delivered. It may also be a bit redundant with the indicators used for the monthly quantitative payment (the only difference is the obligation to report patients in at least each of the three categories). The second approach is to do it at a point of time, with the observation of the availability of the required inputs: qualified staff (see STK1) and contraceptives (see SI2).</p> |
| Data collection | <p>If one adopts the retrospective approach, one option is to rely on data self-reported by the health facility in the Health Management Information System (HMIS). This is an interesting option if there is a high volume of services and if data systems are well integrated (possibility to extract data from the HMIS for the quality checklist). The other option would be to entrust the data collection to the PBF quantity verifiers (quarterly visit). They would review patients registries and evidence the prescriptions of methods from the different categories.</p> <p>If one adopts the cross-sectional approach, again, one can either rely on the logistics management information system (LMIS) (if it exists and is reliable), or on a physical inspection by the PBF quantity verifiers (see S2). The easiest approach would be to include all the FP products in the existing tracer checklists and check whether the 3/5 methods are secured.</p> |
| Analysis and main target users beside the PBF program | <p>The score will be available to the health facility manager and verifiers. District health management teams should be informed so that regular supervisions can be carried out to ensure method mix. If the data system captures units in stock, analyses can confirm gaming (keeping a few units for the surveyors) or under-use (a product not used may indicate a lack of skills to use it). This is an indicator which has also relevance in terms of accountability (security of the entitlement) and equity. The national sexual and reproductive health program and its partners will be interested in disaggregating it by location or by level of care for instance. If it is collected regularly, it will provide a surveillance system at a low cost.</p> |
| Priority and payment rule | <p>This is a very important determinant of quality of care for FP services and should have a significant monetary value. If data is extracted from routine information systems, the payment can be a monthly lumpsum as a top up of FP services (an algorithm will easy calculate that). If data is collected by the PBF verifiers, the payment is part of the quarterly quality payment.</p> |

Indicator SI.2. Availability of equipment for LARC

Rating: Priority C

| Quality of Care dimension | Essential equipment availability for long-acting reversible contraception (LARC) |
|---|---|
| Rationale | <p><i>Affording a woman an increased range of contraceptive choices will improve contraceptive uptake, couple-years of protection (CYP), and method continuation. IUD and implants provide higher CYP than other reversible methods. It matters that health facilities can physically provide IUD and Implant insertion and removal thanks to the presence of essential equipment.</i></p> <p><i>By ensuring and incentivizing the presence of the needed equipment, there is a greater likelihood that women will actually be able to receive the full range of contraceptive options.</i></p> |
| Measurement | <p><i>We propose the following tracer list of essential equipment (not all needed equipment listed) for insertion and removal of IUD and implant: Graves speculum, Medium; Tenaculum (also known as Volsellum forceps); Uterine sound; Mosquito forceps (curved); Scalpel with blade; Local anesthetic (such as 1% or 2% lidocaine).</i></p> |
| Data collection | <p><i>This tracer list should be integrated in the checklist of the PBF quality verifiers. A yearly check might be enough. Data collection through smartphones or tablets with data entry programs would help. The data collector could be equipped with visual aids of the items included in this tracer list.</i></p> |
| Analysis and main target users beside the PBF program | <p><i>Combined with the indicators on contraceptive method availability and availability of trained providers, it will provide a rich and detailed information on bottlenecks at facility level, both for the district team and the national program.</i></p> |
| Priority and payment rule | <p><i>This indicator could be particularly welcome in countries lagging behind as for the rollout of LARC. Women who want long-acting reversible contraception (LARC) methods could receive them closer to home, rather than having to travel to district hospitals, if the methods were fully available. This indicator does not require a high frequency of verification. Removal from the checklist could be considered if a very high proportion of facilities (>85%?) report having commodity, qualified provider and equipment for the full method choice)</i></p> |

Recommendations by this group

- PBF programs must try to optimize their structural input indicators as far FP is concerned.
- Countries could establish smart links between HMIS, LMIS and PBF routine systems. They could generate smart indicators, but also coherence checks (e.g. is the consumption of products in line with reported activities).



Outputs and outcomes

This group was led by Solome Kirribakka Bakeera and Corinne Grainger. It involved the following experts: Olivier Basenya, Ben Bellows, Serge Mayaka and Denise Tamga (see also [here](#)).

The group identified two new indicators which could significantly contribute to the greater effectiveness

of FP programs. Both are context specific. The first one is recommended in LICs where interbirth intervals are too short. The second one applies to countries where large segments of the population live far from health centres but can be accessed by community health workers (CHWs).

Indicator O.1. Women adopting a FP method within the first six weeks post-delivery

Rating: Priority A

| Quality of Care dimension | Number of women who take a FP method during PNC in the first six weeks post-delivery |
|---|--|
| Rationale | <p><i>Up to two-thirds of women would like to avoid pregnancy in the first year after a delivery but are not using contraception (Ross and Winfrey 2001; Rossier et al. 2015). There is strong evidence of health risks for both mothers and infants associated with short birth intervals, yet about one fourth of births in many low-income countries occur with intervals less than two years (USAID, 2008). Many women are unaware that they are at risk of pregnancy postpartum and may wait until the return of menses to seek FP. Meeting unmet need for FP has multiple positive outcomes, including reducing unsafe abortion, lower maternal and infant mortality and improved maternal and child health. Providing access to good quality FP counselling and methods post-delivery would contribute to a reduction in unmet need for both birth spacing and family size limitation. In most African countries, unlike other regions, unmet need for birth spacing exceeds that for family-size limitation (Cleland et al. 2006). "...about 1 million of the 11 million deaths per year of children younger than 5 years could be averted by elimination of interbirth intervals of less than 2 years. Effective use of postpartum (and post-abortion) family planning is the most obvious way in which progress towards this ideal could be achieved" (Cleland et al. 2006, 4).</i></p> <p><i>It is hoped that paying for this specific indicator will incentivize health staff to be much more proactive towards this group. It will also encourage them to better integrate their services (ANC, delivery, PNC and FP), as counselling can already start during the ANC.</i></p> |
| Measurement | <i>Number of women who take a FP method within the first six weeks post-delivery.</i> |
| Data collection | <i>The information should normally be captured by PNC and FP registries. In some countries, it might already be self-reported by the health facility in the monthly HMIS report. It can be verified by the monthly PBF verification.</i> |
| Analysis and main target users beside the PBF program | <i>This indicator has relevance at district and national level as well. The data can also be disaggregated by whether the women were postpartum (or post-abortion if included in the indicator), age, the type of facility or program (public, private, non-governmental, community-based), and by other relevant factors such as districts and urban/rural location.</i> |
| Priority and payment rule | <i>This is a high priority indicator, especially in countries where interbirth intervals is too short. Most PBF programs already have a quantitative indicator for WRA taking a FP technique. An option is to keep this indicator, but add a top up when the WRA fits the criteria.</i> |



Indicator O.2. Women who adopted FP after referral by CHW

Rating: Priority A

| Quality of Care dimension | Reach of FP programs through community health workers |
|---|--|
| Rationale | <i>In many settings, community based FP programs have the closest reach to those being served; they show potential for scaling up coverage. In countries where there is a PBF program focused on CHWs, we propose to integrate at least one indicator focused on FP. The objective is to incentivize CHW and health facilities to work together to the greater benefits of women of reproductive age (WRA).</i> |
| Measurement | <i>Number of women of WRA accepting a modern FP method referred by community health workers. This indicator is a synthetic indicator combining at least three actions: (1) the CHW visited the WRA; (2) the WRA availed to the health center; (3) the FP counsellor persuaded her to accept a modern FP method. This indicator could also be modified to include a sub-set of WRA (e.g. Adolescents 15-19 years; post-partum mothers during a given period) if some priority groups are overlooked.</i> |
| Data collection | <i>The indicator will be self-reported by the health center manager. It will be verified during the monthly PBF quantity verification. The verifiers will check the existence of a referral form (or voucher, see below) issued by the CHW and the listing of the WRA in the FP registries.</i> |
| Analysis and main target users beside the PBF program | <i>This indicator captures the volume of activities by CHWs in FP. Besides the PBF program, it will also interest the district team, the national community health program and the sexual and reproductive health program. No personal data about the WRA should circulate.</i> |
| Priority and payment rule | <i>This is a high priority indicator in countries where there is a PBF program for CHWs. Different payment formula can be imagined. It is crucial that part of the reward goes to the CHWs (in Rwanda and Burundi, they are, for administrative ease, locally organized as a collective). The payment to the HC is normally captured by a standard quantitative FP indicator (new adopter). It is also possible to integrate a voucher handed by the CHW to incentivize the WRA to visit the health center.</i> |

Recommendations by this group

- Go beyond input or process indicators. Consider to have some outcome indicators in your PBF programs.
- Acknowledge that FP also contributes to reducing maternal and child mortality in countries where the interbirth interval is too short. In your country, it may be a top priority.
- Consider to extend your PBF program to CHWs. Carefully assess the relevance and feasibility of this option in your country, in close interaction with key stakeholders, including the Ministry of Finance, the Community Health Department of the Ministry of Health and international partners.



Rights-based approach

This group was led by Aida Bayou, Ben Bellows, Victoria Boydell. It involved the following experts: Anna Gorter, Karen Hardee, Beverly Johnson, Patron Titsha Mafaune, Mattew Nvirii, Frank van de Looij (see also [here](#)).

It was anticipated that the other groups would

promote indicators already aligned with the RBA (e.g. availability of the method mix, full information to FP adopters...). The group focuses its attention on groups with specific needs. Young people are overlooked today in most PBF programs.

Indicator RBA.1.

Rating: Priority A

| Quality of Care dimension | Acceptability of the FP services for young people |
|---|--|
| Rationale | <p><i>In many LMICs, there is under-utilisation of health services by young people (WHO, 2007). There are several reasons for this pattern, but some could probably be addressed by health staff. We propose a quantitative indicator rewarding the number of young people seeking FP services. Contraception is particularly key at early sexual age, as pregnancy can have major social, educational, economic and life consequences. The objective is to incentivize the facility to create a youth-friendly environment and the providers to overcome their own biases and develop skills to serve young people. We therefore propose to focus on the age group 10-20, as unwanted pregnancy has major impact at that age. A quantitative indicator will create a responsibility upon the whole team, including staff that welcome and intake clients as well as clinical counselors and providers of health services. The purchasing of this indicator will enhance equity, as it will benefit a group often marginalized from health services because of their age and income level.</i></p> |
| Measurement | <p><i>Number of young people aged 10-20 using a family planning service during the last month (possibly disaggregated by service received).</i></p> |
| Data collection | <p><i>This indicator can easily be added to the list of the FP quantitative indicators. Information would be self-reported, every month, by the health facility and verified from patient registries by the verification team. Age would be an extra information to be reported for the specific payment. For privacy reasons, we do not recommend home visits to verify the reality of this use. Phone calls could be an option if the phone is owned by the young person and informed consent has been collected (see “user experience” section). Local law/policy may require parental consent – an issue to be managed with great care.</i></p> |
| Analysis and main target users beside the PBF program | <p><i>Any information in the data system will be aggregated (no personal data). It will also interest district supervisors, the national program for sexual and reproductive health and possibly the Ministry of Youth. These users may request this data to be disaggregated by gender, age groups (10-14, 15-19, 20-24), in or out of school, marital status or (urban/rural) location. This granularity may not be crucial in universal health facilities. It has more relevance in health facilities specialized in family planning or adolescent health. In any case, it should be generated only if it does burden the health facility.</i></p> |
| Priority and payment rule | <p><i>This indicator will be easy to introduce. In many LICs, we anticipate low volumes at the beginning, as most health facilities providing universal services pay little attention to young persons. For the payment, we propose to set a specific fee for this category of users. In order to incentivize the health facilities to develop original strategies towards young persons, the fee will have to be superior to the fee practiced for adults (or come as a top up). We anticipate that this new indicator will be particularly relevant in health facilities specifically targeting young persons.</i></p> |



Recommendations by this group

- Assess your PBF programs through the lenses of the RBA.
- Acknowledge that some groups do not use the facilities subsidized by your PBF program. Consider to include other providers which are availed by target groups.
- Benchmark each new indicator or strategy against the RBA framework.

Equity

This group was led by Khullat Munir. Other collaborators were : Paula Quigley, Abiy Hiruye and François Staco (see [here](#)).

Their general assessment is that equity issues are insufficiently addressed in most existing PBF programs, including for FP services. There is a lack of guidance in key PBF documents. One of the reasons for the dearth of widely used indicators and measurement approaches

for equity in the context of FP and PBF could be that equity is a complex issue to address; furthermore, it is not easily integrated into a typical PBF monitoring framework, as it requires to collect extra personal data on the users (gender, location, socio-economic group, impairments...) – a step not taken in most PBF programs. They do not propose any specific indicator, but a general reflection on how inequities are addressed by the PBF program.

Cross-cutting issue 5: disaggregated analysis to instruct tailored strategies

When discussing equity, there are a number of lenses for analysis, including: poverty, geography, affordability, access to information and services, access to related services (i.e. clean water, safe housing, sanitation, etc.), gender, social exclusion, and empowerment. Several of these factors are inter-related (e.g. access to quality services and related amenities in remote areas can be limited relative to urban areas).

Addressing inequity is firstly about gathering information on the many barriers faced by different groups. Many sources can be used. For FP services, the Demographic & Health Surveys (DHS) are an obvious one. They can help the PBF program managers to understand well the specific situation of different groups in the country. Although the evidence base is still limited¹⁰, one can expect any national PBF policy to be, at best, equity neutral. As seen in the case of Rwanda, a PBF program that does not include specific provisions for targeting

poorer/marginalized households in its incentive structure is not likely to influence service use differentially by wealth or residence (Skiles et al. 2013).

There are different strategies to target the most vulnerable groups. Their pros and cons must be well understood.

A first strategy is to identify the FP services which are under-utilized by the poor (thanks to the DHS) and then introduce a higher fee for these services. However, incentivizing blanket service provision, even when focused on specific services, can also result in increased service uptake by those who need the services least (Gwatkin 2009). In addition, this targeting through specific services can inadvertently create perverse incentives that further undermine equity. For instance, linking payment to delivery of specific under-utilized services or methods might reduce promotion of choice and the availability of a broad mix of

¹⁰ An unpublished multi-country study of the World Bank indicates that PBF is often equity neutral.

methods and services (Hartmann 2011). To avoid this, this strategy should probably be combined with other targeted measures (e.g., the Method Information Index and Range of Methods Available).

A second, and probably superior strategy for PBF programs, is **to pay more for FP services provided to the poor or other vulnerable groups**. This is the proposition made under the RBA section for the group of young people. The challenge in this strategy is the accurate identification of the target group. It will not be a major issue with age groups (especially if they have identification documents), but it is much more complex with poor users, as a socio-economic classification is required. In some countries, the Ministry of Social Affairs identifies poor households and provides them with some specific entitlements through the handout of an official document. It will be up to the health facility to report this information (ex. identification number) in its patient registries to be able to claim for the higher reimbursement fee. An issue will be to create an incentive for the poor users to give this information to the health facility. If the services are already for free, they may have not incentive to disclose their poor status (as they may fear services of lower quality). If there is no social program routinely identifying poor households, an option could be to organize such a screening for health benefits only. Different options are possible. One is to delegate responsibility for selecting beneficiaries to local bodies. This has been successful in countries where governments can trust community leaders to be socially responsible and knowledgeable about their communities. Once the target group has been identified, demand-side initiatives have been used to encourage increased utilization of health services (i.e. vouchers, conditional cash transfers, etc.).

A third option is to adopt a **geographical targeting approach**. This requires to identify deprived geographic areas (remote provinces, slums) and to pay higher PBF fees to health facilities based in those areas. This approach is administratively straightforward, though it

comes at the cost of accuracy (not everyone living in a generally poor area is poor, and not all those who are poor live in areas of high poverty). Gwatkin (2009) suggests incorporating a geographic approach to focus the PBF program to make them pro-poor, while at the same time implementing other pro-poor approaches relevant to the local context. Additionally, he recommends using a phased-in approach to launch new initiatives, where implementation would start in poor geographic areas as a way to increase the proportion of benefits that initially go to the poor.

A fourth strategy could be to **remove user fees** (if any) for the poor/marginalized for FP services or even introduced a negative price (i.e. the health facility reimburses the transportation cost). Again, identification of the poor/marginalized is central to this strategy (see related recommendations under strategy 2 above). With this approach, it is crucial that the health facility is compensated for any income loss. The risk of over-provision of unnecessary services has also to be monitored. Free FP services for all is also an option, but one must keep in mind that without proactive measures, it will benefit first to the richer groups.

A fifth strategy would be to **incentivize community health workers (CHWs)** to raise awareness and referral for FP services. This can be effective in increasing reach to previously under-served populations. On the other hand, the stronger the incentive for health workers to serve greater numbers, the less likely the poor/marginalized are to benefit. To avoid this, this strategy might be best combined with other targeted measures that would increase the likelihood of benefits for the poor/marginalized.

A sixth strategy is **to add complementary demand-side incentives** related to FP services. Such incentives might include vouchers for FP services or transportation to health facilities. Demand-side programs require careful monitoring to ensure that the process of increasing incentives is rights-based, non-coercive, and reaching the target population. In a combination of strategies 4 and 5, Iqbal et al (2009) found that skilled birth attendants who

distributed vouchers to women from identified poor households in rural areas resulted in increased ANC, PNC and delivery service utilization in Bangladesh. Alternately, a PBF program can take advantage of established channels of reaching the poor. In countries with high ANC rates across the general population, giving vouchers for payment for an institutional delivery to women from identified poor households at the time of ANC could be a way of increasing institutional delivery rates among the poor/marginalized. Such initiatives could be combined with additional vouchers for post-partum FP services.

The strategies recommended above can be implemented in various combinations. Most importantly, they should be tailored to the

context of the country. Strategies 1 and 3 are retrospective and thus, will not necessarily proactively incentivize equity (but strategy 3 may encourage staff to work in deprived areas), whereas strategies 2, 4, 5 and 6 are more likely to actively encourage staff in health facilities to reach out to under-serviced communities and population groups.

Equity is a long term commitment. It is important to note that most PBF programs' routine data systems are not tailored to monitor distribution of program benefits. It is therefore crucial to carefully analyze existing household surveys (e.g. from impact evaluation). There is an important literature on equity measures which can be tapped.¹¹

Recommendations by this group

- In many countries, PBF programs have to pay more attention to equity issues. The first step is to read reports (e.g. DHS) and analyze data in order to have a good overview of main inequities as for FP services.
- Equity requires a mix of strategies – there is no quick fix. RBF programs can contribute through at least six strategies – context will matter. Paying higher fees for vulnerable groups is easy, but it requires an easy identification of people belonging to these groups.
- Ideally, the PBF program should ensure that its own data system contribute to the collective effort in favour of equity.

¹⁰ One could for instance calculate the concentration index for FP services or FP-related outcomes. The concentration index is a measure that quantifies the degree of socio-economic related inequality in a health variable (O'Donnell, et al. 2008). Its value ranges from -1 to +1, where a negative concentration index suggests the existence of unfavorable conditions among the poor wealth strata, while a positive concentration index suggests a favorable condition (e.g. greater use of contraception) among the poorer quintiles (Creanga, et al. 2011).

||| General lessons from this collaborative process

Collectivity was a powerful tool to gather the expertise required for the production of this document. The format of the meeting was very powerful. Bringing together two different communities of expertise (here PBF and Family Planning) led to very interactive discussions. However, two days were too short to finalize the indicators. Any further workshop with a same logic should last at least three days.

The organization in subgroups after the meeting was a nice strategy to continue the work. It worked out, even if it required close follow-up. However, we missed human resources to finalize the report. Time availability at the level of the general coordinators was a real bottleneck. If we organize any similar

process in the future for other health domains, we will have to foresee financial resources for some assistance and plan time sufficiently. This will allow to deliver the final report more rapidly. Ideally, the global collaborative process (preparation of the meeting + meeting + group work) should be followed with some follow-up at country level (e.g. assistance to organize a meeting to revise the indicators).

We believe that this approach could be applied to other domains (e.g. maternal health, non-communicable diseases, malnutrition, HIV/AIDS etc.) of importance for RBF programs. We recommend the PBF CoP and international agencies to consider the re-edition of this approach in the future.



||| General recommendations for updating FP indicators

To PBF program managers

- Assess critically how your PBF program addresses FP challenges. Get familiar with the RBA and consider updating your indicators.
- At country level, involve relevant stakeholders from the start in your revision, including the Sexual & Reproductive Health National Program, its international partners and relevant national civil society groups. Ask them to present you evidence on the FP needs in the country, major inequities and the most effective channels to reach target groups.
- Use ideas presented in this report to structure your revision. At your revision meeting, do not hesitate to re-use some of the power points prepared for the Antwerp meeting.
- For the development of the new indicators, value granularity. If you aggregate too much your PBF FP indicators, you will lose some nuance. For instance, you will not be able to assess the availability and delivery of the method mix – a crucial aspect of the RBA.
- Make sure that the price signals sent by your PBF program are right: if there are major problems with quality (not a good level of knowledge, major stockouts), the impact on the health facility revenue should be significant.
- Explain well to FP providers the objectives pursued by the new indicators and their specific theories of change. Some indicators (e.g. women adopting a FP method within the first six weeks post-delivery) may require a significant change in provider behaviours – tap their intrinsic motivation as well.
- Think about the right frequency of the data collection for your indicators. Some can be collected monthly, through the HMIS. Some require a visit by professional supervisors: a quarterly collection makes sense. Some (e.g. privacy of the consultation room) could actually be assessed once a year.
- Seriously consider phone surveys for your verification. They could be less intrusive, more responsive and more informing than home visits. They could also be particularly helpful for disaggregated equity analyses (though, most vulnerable groups may not have their own phones) Ensure that health facilities collect informed consent from FP users. Create value for FP providers by providing them a clear feedback from user reports. Pilot this approach first before scale up.
- Most PBF programs do not address knowledge and skills of providers. Use FP as an opportunity to test whether vignettes could be a strategy integrated into your PBF program. Connect with actors with some experience in this field.
- The FP data collected for your PBF program has programmatic value. Digitalize it. Ensure anonymity and share it in through user friendly interfaces or formats with relevant stakeholders. Always ensure that FP providers access the information in such a way that they are empowered to improve their practice.
- Monitor impact of your updated program through equity lenses, especially as for the geographical, age and socio-economic distribution.
- Maximize learning from this whole process. Monitor your program and analyse your routine data. Adapt indicators and their prices accordingly.

- Value the fact that some of the practices produced in this report have value beyond FP only. Use any development with your FP indicators for informing your broader RBF strategy.
- Make sure to stay up-to-date with developments outside your country. Share lessons drawn from your experience with other countries.

To partners

- Participate to processes at country level to update and upgrade the RBF strategy relative to FP.
- Support the PBF program in piloting most innovative components of the new strategy.
- Support interoperability of routine database systems. Promote the use of routine information systems as information sources for PBF programs.
- At global level, there is a need for some assistance in the development of FP vignettes. Try to collaborate at an early stage with digital companies for their possible administration through phones or tablets. Financially support some pilot experiments. Involve researchers in their evaluation.

To researchers

- Accelerate the research program on the theories of change of RBF programs.
- Carry out prospective implementation research on the challenges of updating measurement frameworks and indicators under RBF programs.
- Contribute to the broader research agenda on strategies for quality FP services, by generating evidence on the effectiveness of RBF programs, their checklists and other quality of care tools to improve key quality dimensions.
- Document whether and how provider bias in FP services provision is affected by PBF programs.
- Do action research to explore the potential for RBF programs to increase community acceptance and utilization of FP.
- Pay more attention to equity outcomes of PBF programs, including for FP target groups.
- Continue to document country experiences with scaling up and institutionalizing their RBF programs.
- Ensure that your findings are converted into policy briefs and shared with the operational community

To CoP facilitators

- Organize other collaborative projects as this one. Foresee enough financial and human resources for the follow-up of the consensus meeting (coordination of group work and writing of the report).



OTHER USEFUL MATERIALS

- [Medical eligibility criteria for contraceptive use](#) -- 5th ed. World Health Organization 2015.
- [Sexual and reproductive health. Core competencies in primary care.](#) World Health Organization 2011.
- [Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations.](#) World Health Organization, 2014.
- [Ensuring human rights within contraceptive programmes: a human rights analysis of existing quantitative indicators.](#) World Health Organization, 2014.
- [Ensuring human rights within contraceptive service delivery: implementation guide.](#) UNFPA and World Health Organization 2015.
- [Quality of care in contraceptive information and services, based on human rights standards: a checklist for health care providers.](#) World Health Organization 2017.
- [Family Planning. A global handbook for providers.](#) 2018.
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