

Differentiating local government performance in strengthening and scaling family planning programming: A mixed methods comparative case study

Background and Theoretical Focus

Globally, more women want and seek access to contraception than are able to obtain it; particularly in low and middle-income countries (LMICs) (Singh et al. 2014; Cahill et al. 2018; Cleland et al. 2015). Local government expansion of access to contraceptive services is one important way of addressing this, particularly for lower income women (Bongaarts & Hardee 2017). Relatively few studies rigorously examine the factors associated with health system performance and scaling at the local government levels, particularly in low- and middle-income country (LMIC) settings (Bennett et al. 2017). Further, while some ‘pilot’ health initiatives do manage to scale access to services, many do not accomplish this on a sustained basis (Greenhalgh et al. 2004; Barker et al. 2016; Bulthuis et al. 2019). This research draws on the Consolidated Framework on Implementation Research (CFIR) which assembles a set of domains and constructs shown to be associated with effective implementation, including those from Diffusion of Innovations theory and a systematic cross-disciplinary review (Rogers 1952; Greenhalgh et al. 2009). As sustainability, impact, and scale, are central aims of TCI’s model, our entering analytic framework draws on factors identified by several reviews as linked with sustainable (Shelton et al. 2018; Savaya et al. 2008) and scaled (MSI 2016; Rogers 2010; Zamboni et al. 2019) adoption of evidence-based health system innovations.

Between 2016-2021, The Challenge Initiative (TCI) has aimed to sustainably scale women’s access to and use of quality contraceptive services in urban areas through leadership of local governments in partnership with TCI Regional Accelerator Hubs. Local governments in Nigeria, Francophone West Africa, East Africa and India adapt and implement best-practice family planning and adolescent and youth sexual and reproductive health (AYSRH) interventions, drawing on coaching and support from four regional Hub partners: Johns Hopkins Center for Communication Programs (CCP), Population Services International (PSI), IntraHealth International and Jhpiego. TCI is led by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health.

The Challenge Initiative (TCI) coaches sub-national actors to rapidly and sustainably scale best-practice family planning and adolescent and youth sexual and reproductive health (AYSRH) solutions for the urban poor. This demand-driven model is premised on local governments who opt in and lead in partnership with TCI, demonstrating political and financial commitment. After four years, one hundred and nine local governments now partner with TCI, reaching an additional 1.48 million family planning users in 11 countries across sub-Saharan Africa and Asia. Local governments decide on which evidence-based interventions to adopt and receive coaching to increase their capacity to implement and institutionalize these interventions. Over the past four years, TCI has demonstrated proof of scale for its demand-driven model and is active in 109 cities as of March 2021.

This study seeks to describe, whether and how local government processes and TCI interventions are linked with sustained impact at scale. By rigorously examining the experience of high-performing cities to-date and contrasting them with a low performing city in the same region, our intent is to generate insights that are both useful to TCI platform partners as they continue to strengthen TCI’s approach and interventions, but also to the larger communities of governments, of experts on scaling interventions, and of technical assistance providers who seek to sustainably scale social service interventions with broad impact.

Study Questions

This comparative case study aims to address the following questions:

1. What have been the most effective strategies that local governments have used to increase women’s access to family planning programming? How were they put in place?

2. How has TCI support of local governments most contributed to their expansion and strengthening of family planning programming?

The study has particular focus on identifying and understanding the more modifiable factors (i.e., the types and intensity of interventions; internal government practices and policies; etc.), rather than the factors that are fixed (e.g., city size, health system structure), that are associated with higher performance. In particular, the study will focus on understanding local government processes and on TCI intervenors and interventions.

Research Methods

This is a mixed methods comparative case study of the factors associated with successful implementation of the TCI partnership to expand and strengthen implementation of high impact family planning programming. This research was deemed exempt from full review by the Institutional Review Board at Johns Hopkins Bloomberg School of Public Health and is consistent with international standards for the ethical conduct of research. Key informant participation is voluntary and confidential.

The primary unit of analysis for this research is the local government (state or city). We selected sites using a two-stage process. We first identified pools of higher (~10) and lower (~5) performing local governments in each of the three regions, on the basis of local government Health Management Information Systems (HMIS) data modeling change in modern contraceptive prevalence rates. Next, from these pools, through review of health systems strength criteria, researchers from each hub and the Gates Institute selected the two highest and the lowest performing cities for a sample of 8 local governments (Nigeria (3), Uttar Pradesh, India (3), Francophone West Africa (2)). First round inclusion criteria were local governments having at least eighteen (18) full months of active implementation with TCI (as of December 2019) and being among those local governments with the highest (or lowest) modeled modern contraceptive prevalence rates. Second stage inclusion criteria were that local governments had received substantive TCI Hub effort and investment at comparable levels to other TCI partners, and met a subset of geography graduation criteria.

We developed interview guides and a codebook based on CFIR domains and constructs and TCI strategies, as well as on codes developed during coding. As the TCI model was designed to accelerate uptake and sustainability of best practices, many of its core elements align with CFIR constructs. TCI hub research partners then further developed and refined the interview guides and codebook ensuring they reflected respective TCI partnership strategies and illustrative examples from their contexts.

Hub research teams identified a purposive sample of local government leaders and managers, external informants, and TCI Hub staff in each region. Key informants selected are involved or familiar with local government leadership and management of work to expand and strengthen family planning programming. All interviews were conducted and recorded virtually over Zoom or Microsoft Teams. Immediately after each interview, the interviewer or notetaker prepared a two-page memo covering key interview contextual features and points. All interviews were transcribed verbatim. Interviews in India and in FWA conducted in Hindi and French were concurrently translated and transcribed verbatim. Transcripts were reviewed twice for completeness and accuracy and then exported into Dedoose 12.6 for coding and analysis.

The Consolidated Framework on Implementation Research (CFIR) offers a tested framework for identifying factors shown to be associated with successful implementation. Our analysis maps TCI strategies for supporting local government implementation to the tested constructs in CFIR's PROCESS domain. We use CFIR constructs as well as TCI model-specific codes to reduce and organize the data to support cross-case analysis of patterns of barriers and facilitators relating to different aspects of implementing the TCI model. A first analytic step is, within each region, to review whether each prioritized CFIR construct is a facilitator or a barrier to local government (higher & lower performing) implementation of TCI interventions introduced by TCI. We next review jointly coded excerpts (CFIR PROCESS constructs and TCI strategies) to identify actionable findings for strengthening TCI strategy components. We then triangulate findings with

project indicators on health systems strengthening. We will map the presence and valence of constructs in the CFIR Process domain to those of TCI partnership strategies.

Table 1: Consolidated Framework of Implementation Research 'PROCESS' domain mapped to TCI Platform strategies

<u>PROCESS domain</u>	<u>TCI Partnership Strategies</u>
<u>A. Planning</u>	<u>Planning & guidance</u> (Program Design; High Impact Interventions/Approaches)
<u>B. Engaging</u>	<u>Spread/Uptake Strategies</u>
<u>Opinion Leaders</u>	<i>(consolidated with Internal Champions)</i>
<u>Formally Appointed Internal Implementation Leaders</u>	Government Point People
<u>Champions</u>	Internal (Government) Champions
<u>External Change Agents</u>	External Champions
<u>C. Executing</u>	<u>Execution/Implementation:</u> Coaching; Management and Systems Strengthening (Coordination; Improvement of Data Quality and Use); Institutionalization; Integration
<u>D. Reflecting and Evaluating</u>	<u>Adaptive management practices</u>

Data

Case study data sources will include 86 semi-structured interviews on local government performance with local government leaders and managers, external, and Hub key informants, triangulated with TCI project records and routine (HMIS and other) government statistics. The primary study data source is semi-structured interviews with informants in three States in Nigeria (Bauchi and Plateau as contrasted with Delta State), three cities in India (Faizabad and Saharanpur as contrasted with Allahabad) and two cities in Senegal and Benin (Ziguinchor, UCOZ) (see table below).

Table 2: Key Informant Interviews

Hub	Higher-performing states/cities	Lower-performing states/cities	Local government leaders and managers	External key informants	TCI Hub Coaches	Total
Nigeria (State & Local Government Area)	2	1	21	3	8	32
India (City and District)	2	1	19	3	8	30
Francophone West Africa (municipality & health system)	1	1	14	2	7	24
						86

Expected Findings

To-date, preliminary analysis has been conducted on Nigeria interview data, without yet triangulating with project records. Analysis and triangulation of India and Francophone West Africa data will be included in the final paper.

In our preliminary analysis, we've found that:

- CFIR framework, when applied beyond health service delivery systems, requires substantial contextualization in close coordination with TCI hub staff
- Complexity of TCI platform made iterative review and revision of codebook with hub team members essential.
- The CFIR implementation PROCESS domain appears particularly helpful for those interested in making mid-course improvements.

Illustrative finding on presence and valence of CFIR constructs/TCI strategies – External Champions

As noted in Table 1, the presence of effective 'external champions' is a key construct identified by CFIR as associated with successful implementation and uptake of interventions and is also key TCI strategy components. Related illustrative findings from Nigeria on the presence of external champions indicate that in all three states, external champions are perceived to have helped improve the enabling environment for family planning. Informants uniformly called out the transformative benefits of FP champions, particularly of religious leaders who they see as encouraging both greater community receptiveness to FP use, but also of Advocacy Core Group members who push for greater government commitment and funding for FP.

The successful working linkages between external FP champions and state government creates a strong platform to elevate family planning as a social norm among both citizens and government decision-makers. External champions' influence was seen as setting up a permission structure for users.

One of the champions is an Emir in the state. If he calls and speaks, people listen to him, especially when you call them to speak at the local government level. They will say, "the Emir has said so, the Emir has agreed with it," and you see them accepting it. We have stakeholders at the local government, we have religious leaders who we have made FP champions. They talk about how religion agrees with child birth spacing through television and radio. I told you even on radio we have from both faiths: they came up and spoke how religion has helped family planning. In fact, people have been amazing. When we have meetings with religious leaders in our communities, if you hear their contribution, it is impressive. They talk about it in churches and mosques, because they have heard it from their religious leaders that are FP champions, so they accept it and agree with it and that is what is impressive and encouraging, and that is one of the reasons we have high flow of women (to facilities). (NIG26)

Further, TCI has been able to help states to channel external family planning champions' public-spiritedness to strengthen local service delivery, particularly in the higher performing states:

The difference is coming together at the grassroots level with these groups of people that I mentioned to you. Let me give you an example with a specific area where TCI is working in my area. There is one influential person in a facility that did great work. There was no light in that facility. When they are working at night and the place is dark, they cannot perform their procedures but to my greatest surprise, there was a time we went for a Quality Improvement Team (QIT) meeting, and out of his pockets, he brought NEPA (National Electric Power Authority) to that facility.... He even bought lanterns and put it for them inside their various wards so that when there is any case either in the night or not, they can use it. (NIG13)

Finally, external champions have worked to ensure accountability in state budget processes.

Because honestly, despite the fact that we have the political commitment and the demonstrated willingness to do the needful, we need a third eye to also put pressure, yes to put pressure, on the Government to ensure that they don't play politics with it. Sometimes for us, the experience here is that as the English say, 'familiarity breeds contempt'. If you are too familiar with somebody, it sometimes gets to a point that they decided to turn a blind eye towards your issue - not because it is not important to them but because they think that their priority is now shifted to other areas. But when you have somebody at the background, an independent person, also putting some external pressure for some of these things to be done, it helps a lot in putting the Government's or this political commitment into focus. (NIG28)

The public advocacy success of external family planning champions at state levels was seen as linked with:

- The social prominence and high caliber of the champions selected (including stature to engage with senior executive and legislative leaders)
- An upfront investment in training of FP champions
- The government's comfort with the role of Advocacy Core Group (ACG) members, which was less in the lower performing state.

(To be triangulated with data on government financial commitments made and disbursed.)

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