FP CAPE

Family Planning
Country Action Process Evaluation

Insights Deck –
The Democratic Republic of the Congo (DRC)

June 2018

UNC
CAROLINA
POPULATION
CENTER

Table of contents

01

Executive summary

DRC findings & insights

Executive summary (1/3)

We asked six questions (5a-5f) to test the portfolio Theory of Change (TOC) and explore collaboratively identified questions from the Annual FP Partner's Meeting.

Question 05a	**Who are the key FP stakeholders in DRC and how are they connected?** **Are there particular individuals or organizations that are connection hubs?**
Key findings *Informs sustainability and scale-up*	Tulane and the Ministry of Health are key current connections for BMGF grantees. Tulane and JHPIEGO are mentioned as desired future connections.

Question 05b	**How are the CTMPs connecting partners to government?**
Key findings *Informs sustainability and scale-up*	CTMPs provide an excellent opportunity for both grantees and government organizations to meet, share data, build capacity, and generate advocacy. In particular, grantees are very active with the Ministry of Health.

Executive summary (2/3)

We asked six questions (5a-5f) to test the portfolio Theory of Change (TOC) and explore collaboratively identified questions from the Annual FP Partner's Meeting.

Question 05c	**Who are the traditional method users? Who are the non-users?**
Key findings *Informs replication*	Use of traditional methods is increasing in many countries, and we see this trend in Kinshasa and KC. More educated, higher parity, married women are more likely to use these methods. Many potential factors such as social norms have been identified as explanations for traditional methods' increase, however qualitative interviews with users are needed to understand reasons.

Question 05d	**What do we know about women getting methods from pharmacies?**
Key findings *Informs replication and sustainability*	There is no significant increase or decrease in either province of women obtaining FP from pharmacies. Pharmacy FP user profiles differ slightly in Kinshasa as compared to Kongo Central, which has implications for program replication.

Executive summary (3/3)

We asked six questions (5a-5f) to test the portfolio Theory of Change (TOC) and explore collaboratively identified questions from the Annual FP Partner's Meeting.

Question 05e	**Who are reached by CHW? How effective is this strategy in increasing mCPR?**
Key findings	Women are significantly more likely to use modern contraception when they are exposed to a FP message from a CHW in both Kinshasa and KC. The profiles of women reached by CHW are different in the two provinces. Coverage of CHWs remains a constraint to population level impact.

Informs replication and sustainability

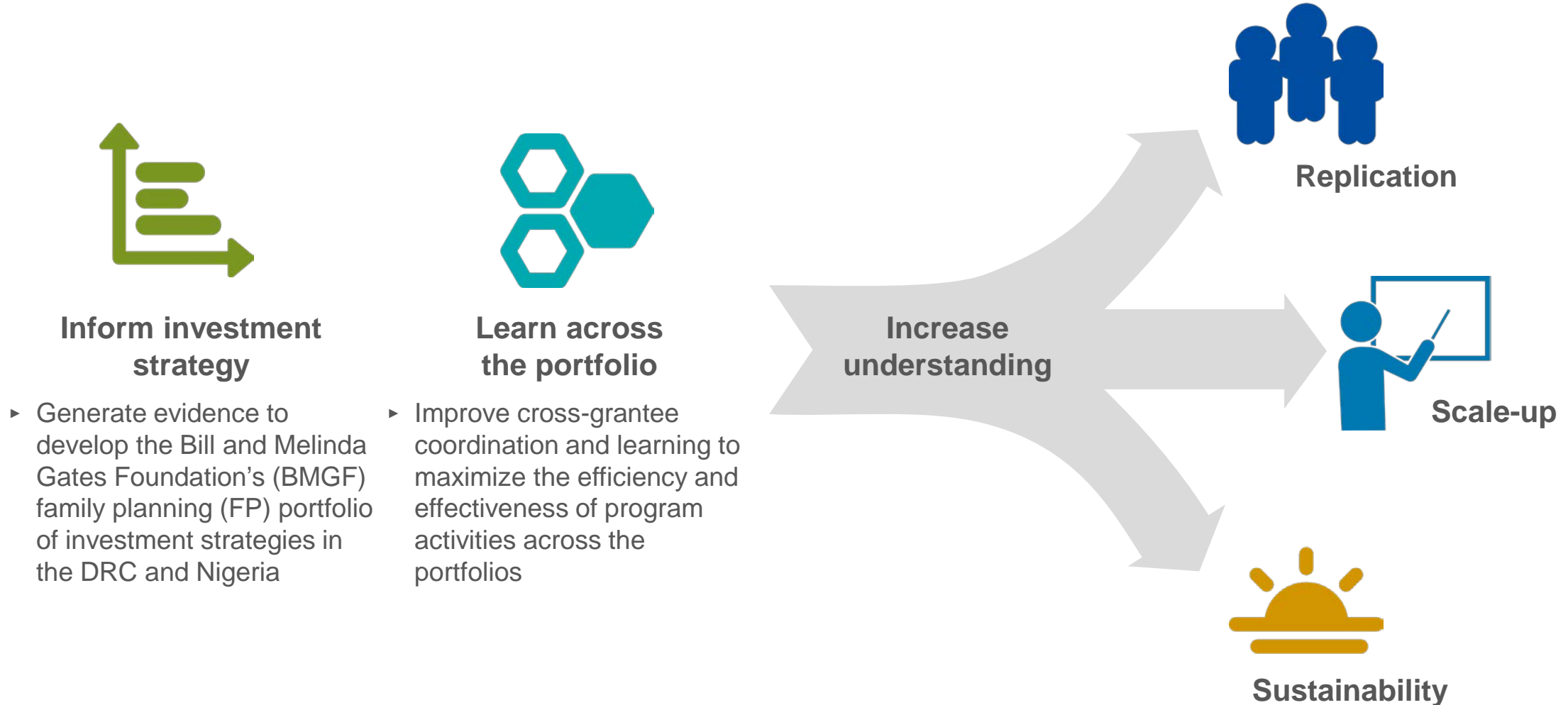|	
Question 05f	**What is the effect of different types of FP messages on mCPR in Kinshasa?**
Key findings	Analyses did not find a significant association between media exposure and mCPR, however, additional rounds of data might make any effect clearer, as the sample size is relatively small for this model.

Informs replication

02

FP CAPE purpose & goals
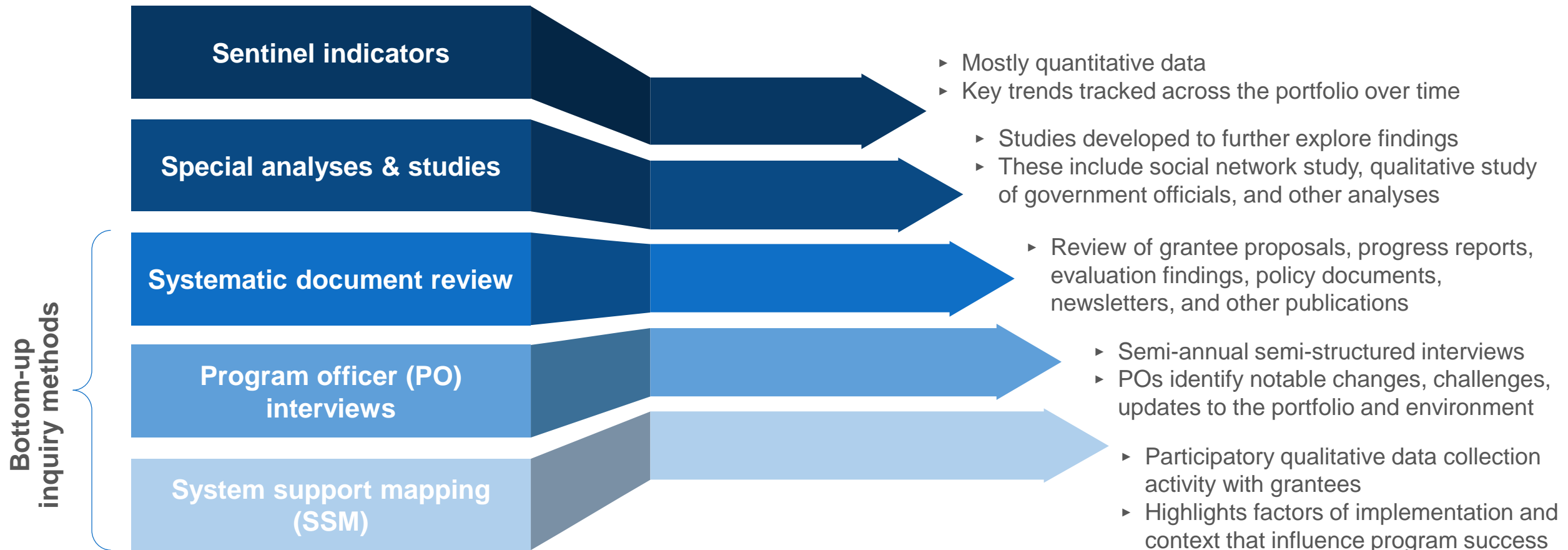
A portfolio evaluation

FP CAPE evaluation objectives

The purpose of FP CAPE is to generate evidence on <u>how</u> and <u>why</u> each portfolio of investments is/is not driving change in key reproductive health outcomes in the DRC and Nigeria.

Inform investment strategy

▸ Generate evidence to develop the Bill and Melinda Gates Foundation's (BMGF) family planning (FP) portfolio of investment strategies in the DRC and Nigeria

Learn across the portfolio

▸ Improve cross-grantee coordination and learning to maximize the efficiency and effectiveness of program activities across the portfolios

Increase understanding

Replication

Scale-up

Sustainability

FP CAPE evaluation toolkit

FP CAPE uses quantitative and qualitative methods to consider the complexity inherent in evaluating diverse program activities across different contexts.
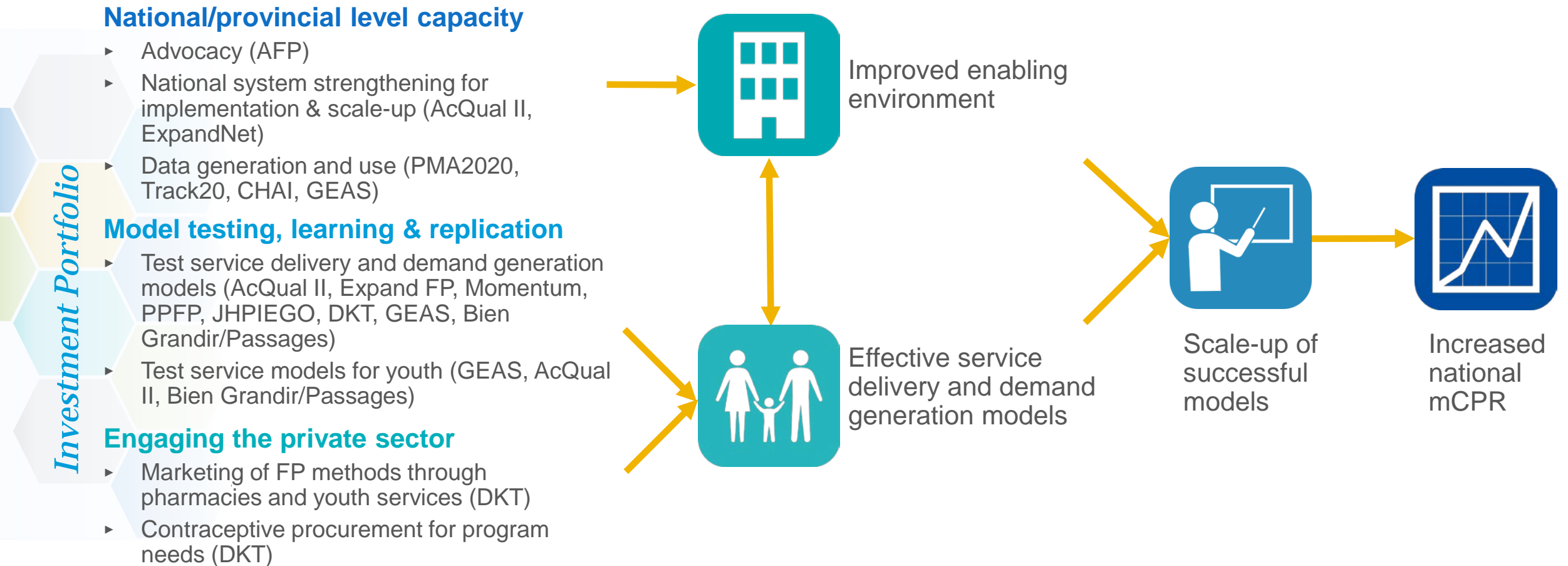

Sentinel indicators
- Mostly quantitative data
- Key trends tracked across the portfolio over time

Special analyses & studies
- Studies developed to further explore findings
- These include social network study, qualitative study of government officials, and other analyses

Systematic document review
- Review of grantee proposals, progress reports, evaluation findings, policy documents, newsletters, and other publications

Program officer (PO) interviews
- Semi-annual semi-structured interviews
- POs identify notable changes, challenges, updates to the portfolio and environment

System support mapping (SSM)
- Participatory qualitative data collection activity with grantees
- Highlights factors of implementation and context that influence program success

Bottom-up inquiry methods

03

Portfolio theory of change (TOC) and critical assumptions

The Democratic Republic of the Congo (DRC)

BMGF FP portfolio theory of change: DRC

FP CAPE's research questions are based on a TOC which defines and monitors causal linkages towards increased national mCPR. BMGF's work is in support of the DRC government's overall National Strategic Plan for Family Planning (2014-2020).

Investment Portfolio

National/provincial level capacity

▸ Advocacy (AFP)

▸ National system strengthening for implementation & scale-up (AcQual II, ExpandNet)

▸ Data generation and use (PMA2020, Track20, CHAI, GEAS)

Model testing, learning & replication

▸ Test service delivery and demand generation models (AcQual II, Expand FP, Momentum, PPFP, JHPIEGO, DKT, GEAS, Bien Grandir/Passages)

▸ Test service models for youth (GEAS, AcQual II, Bien Grandir/Passages)

Engaging the private sector

▸ Marketing of FP methods through pharmacies and youth services (DKT)

▸ Contraceptive procurement for program needs (DKT)

Improved enabling environment

Effective service delivery and demand generation models

Scale-up of successful models

Increased national mCPR

DRC investment portfolio: critical assumptions

FP CAPE's research agenda is driven by explicit critical assumptions underlying the portfolio TOC.

Project area	Critical assumptions (established & emerging*)
Investment Portfolio	
National/provincial level capacity	▸ PNSR and PNSA coordinate partners in support of national and provincial strategies ▸ Favorable FP policies are enacted ▸ Effective national supply-chain ensures commodity availability and GIBS-MEG contributes to estimating needs.
Model testing, learning & replication	▸ Service delivery models increase quality and access to full range of services ▸ Learning about sexual/RH behaviors improves youth-related outcomes ▸ An enhanced service delivery environment will lead to an increase in modern method use by non-users and traditional method users* ▸ Model program strategies will create demand for modern FP methods*
Engaging the private sector	▸ Private sector models increase access to FP ▸ Adults and youth will purchase socially marketed FP methods
Outcomes	
Scale-up of successful demonstration models	▸ Improved coordination and planning will attract scale-up investments ▸ Strong measurement drives performance, scale-up and donor coordination ▸ Demonstration models seen as relevant and feasible for other provinces and donors
Increased national mCPR	▸ Model programs remain effective when scaled up by others in new contexts

*Emerging/new proposed critical assumption

04

Key questions and themes

Emerging from DRC 2018 Annual FP Partners Meeting and December 2017 portfolio findings

Annual meeting key takeaways & actions

At the 2018 DRC Family Planning Partners Meeting, BMGF grantees worked together to identify key actions across DRC's FP investment portfolio, based on FP CAPE's annual findings.

National/provincial level development

▸ Coordinate advocacy efforts for release of budgeted funds
  ▸ National level: Prime Minister's office
  ▸ Provincial level: Governors

▸ Develop effective strategies for passing the RH/FP law

▸ Focus capacity building on data collection and use
  ▸ Increasing quality of decision-making by FP service providers and data managers
  ▸ In particular, with DHIS2

Model testing, learning & replication

▸ Target demand generation activities to youth aged 10-24 years and men

▸ Strengthen FP messaging for social norms change at individual and institutional levels, e.g., couples/households, schools and churches

▸ Improve quality of FP services, especially in Kongo Central

Scale-up of successful models

▸ Improve coordination among BMGF partners to ensure full coverage of health zones in Kinshasa and Kongo Central
▸ Displace surplus commodities to areas with shortages

▸ Ensure all levels of health facilities and CHWs refer and/or provide FP services

▸ Implement studies to explore FP method and service preferences for specific target groups, such as women accessing FP methods from pharmacies, CHWs

Collaboratively identified questions

At the 2018 DRC Family Planning Partners Meeting, BMGF grantees identified key questions across DRC's FP investment portfolio. Questions in colored bubbles will be addressed in this deck.

National/provincial level development

Model testing, learning & replication

Scale-up of successful models

What are challenges for a smooth release of government funds?

Which additional strategies are needed for advocacy to pass the new RH/FP law?

How do we improve the quality of FP data? How does data flow between organizations or individuals?

What can be done to change social norms around FP (individual & institutions)? How effective are current approaches? (Q5e-Q5f)

Can we understand more about traditional method users, given increases in KC? (Q5c)

Who does what activities, and where?

What do we know about women getting methods from pharmacies? (Q5d)

How do we make interventions sustainable over time?

How do we improve data use for decision-making?

How do we improve coordination efforts? (Q5a, Q5b)

How do we improve product and services availability?

How do we improve financial accessibility for FP services and products?

How do we improve flow of resources?

05

Select questions and findings

DRC June 2018

Questions

We focus our analyses at key questions brought up in the FP Partners Meeting, as well as explore the TOC critical assumptions.

#	Question	Enabling Env.	Model testing	Scale-up
05a	Who are the key FP stakeholders in the DRC and how are they connected? Are there particular individuals or organizations that are connection hubs?	■		■
05b	How are the CTMPs connecting partners to government?	■		■
05c	Who are the traditional method users? Who are the non-users?		■	
05d	What do we know about women getting methods from pharmacies?		■	
05e	Who are reached by CHW? How effective is this strategy in increasing mCPR?		■	■
05f	What is the effect of different types of FP messages on mCPR in Kinshasa?		■	■

How do we improve coordination efforts? (Q5a, Q5b)

Question 05a

Who are the key FP stakeholders in DRC and how are they connected?
Are there particular individuals or organizations that are connection hubs?

Informs sustainability and scale-up

Critical assumption explored	Improved coordination and planning will attract scale-up investments	**Analyses used**	▸ Social network analysis study of FP CAPE stakeholders
		Theory of change	

Key findings	Tulane and the Ministry of Health are key current connections for BMGF grantees. Tulane and JHPIEGO are mentioned as desired future connections.

A note on social network analysis methodology

FP CAPE collected data from 32 BMGF-supported technical staff to assess current FP stakeholder networks and better understand potential/wished for connections/networks.

Technical staff, BMGF grantee

Who are you currently connected to?

Current connection

Who would you like to be connected to?

Wished-for future connection

— Current connections

— Potential connections
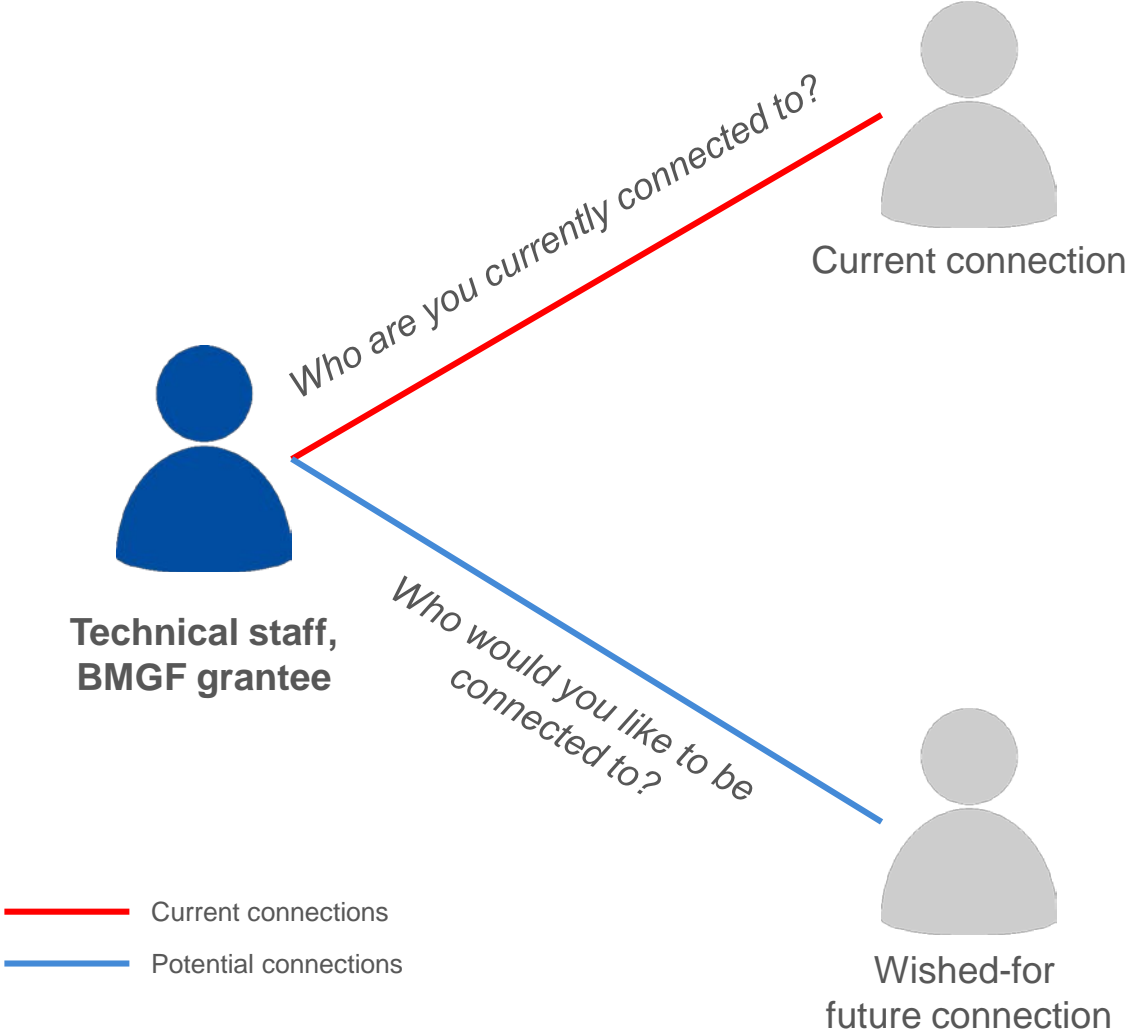
Beyond a connection: Resource sharing

▸ We also asked respondents about specific areas of resource sharing between their connections:

Data/technical	Resources
•Data/findings •Technical knowledge/assistance •Policy info	•Funding •Equipment •Space •Access to key staff/partners

Analysis

▸ Survey responses were transformed into an adjacency matrix, and connections plotted out

▸ Key current and future connections were identified

▸ Initial results, partial network maps, presented here

Future research

▸ Review of the network data ongoing

▸ Future analysis will result in a separate data analysis product, Fall 2018

▸ Additional rounds of data collection are possible in the future. These will identify network change over time and interview named stakeholders

We mapped FP technical staff's self-reported current connections with grantees and external partners

Technical staff have a rich assortment of connections both within the BMGF grantee network and with external stakeholders.

Reading the map

▸ For ease of interpretation, we focus on a small part of the overall network here

▸ Red lines represent current connections

▸ The color of the circle represents which organization the staff is involved with

▸ Circles without names represent individuals who were not interviewed, or only named once

Example interpretation

▸ Here we see A. Aluma is a part of JHU/CCP, and has five current connections (red lines) to other technical staff

▸ One connection is R. Yodi (Ministry of Health), who is currently connected to six other FP technical staff

Legend:
- Ministry of Health
- Tulane
- DKT
- Jhpiego
- Sanru
- EngenderHealth
- IRH
- JHU/CCP
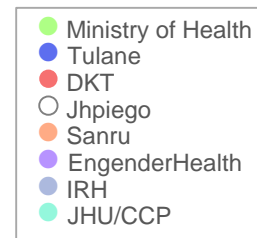
—— Current connections
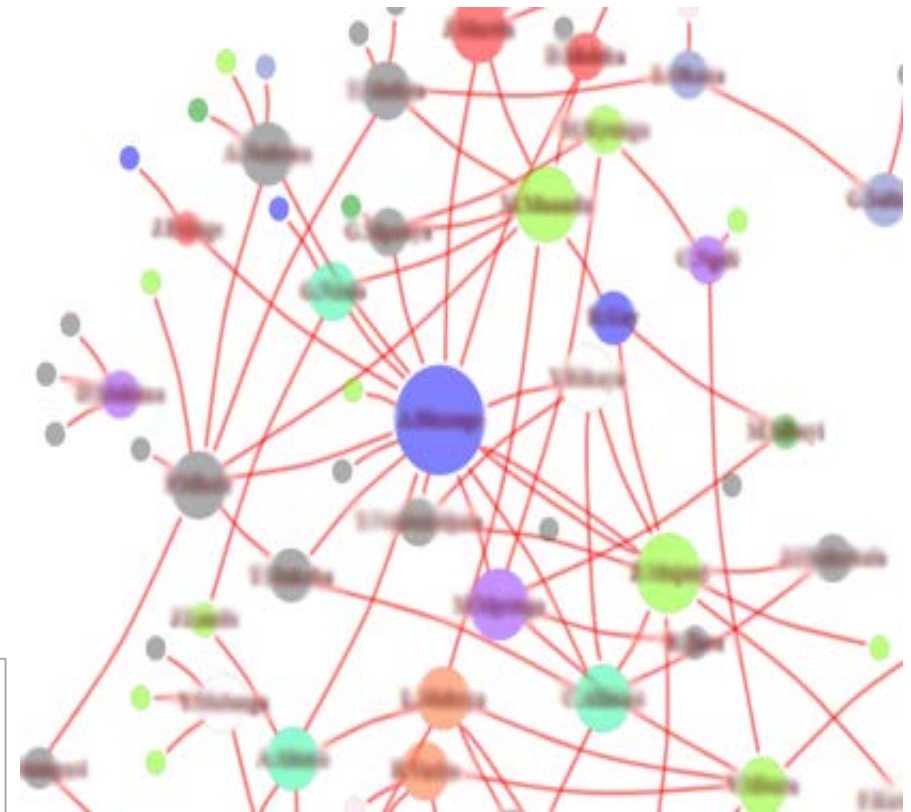
Who do staff most frequently list as connections?

When looking at technical staff's current connections, five individuals were nominated five or more times by other staff members.

Individual	# Nominations	Organization
Arsene Binanga	12	▸ Tulane
Mbadu Muanda	6	▸ Ministry of Health
Rachel Yodi	6	▸ Ministry of Health
Vicky Mbutu	5	▸ Ministry of Health
Zenon Mujani	5	▸ Ministry of Health/Track20

This statistic is also known as in-degree centrality

Grantees also self-reported potential/wished-for connections with other grantees and external partners

Technical staff often noted potential future connections to staff they were peripherally connected to – that is, not directly connected to, but had connections in common.

Reading the map

▸ For ease of interpretation, we focus on a small part of the overall network here

▸ Blue lines represent wished-for future connections

▸ The color of the circle represents which organization the staff is involved with

▸ Circles without names represent individuals who were not interviewed

Example interpretation

▸ A. Aluma (JUH/CCP), has noted two connections they wish to have in the future, one with T. Mukaba and another with T. Nemuandjare

    ▸ Both potential connections have one connection in common with A. Aluma, but no current direct connection (slide 20)

▸ R. Yodi (Ministry of Health), does not note any additional possible future connections

Legend:
- 🟢 Ministry of Health
- 🔵 Tulane
- 🔴 DKT
- ⚪ Jhpiego
- 🟠 Sanru
- 🟣 EngenderHealth
- 🔵 IRH
- 🟢 JHU/CCP

—— Potential connections

22
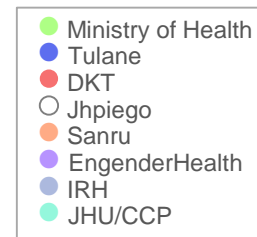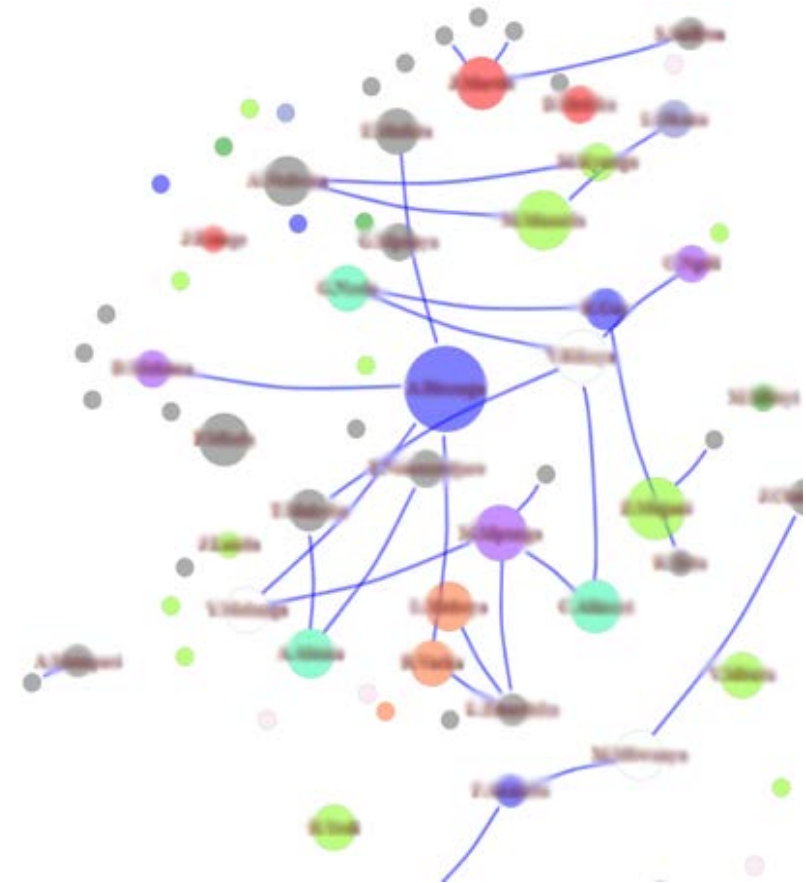
Who are the most wished-for connections for BMGF grantees to achieve their program objectives?

Technical staff nominated fewer connections for the future; the "top five wished-for" list does not mirror the current connection list. These represent opportunities for further connection/exchange.

Individual	# Nominations	Organization
Arsene Binanga	4	‣ Tulane
Virgile Kikaya	3	‣ JHPEIGO
Franck Akamba	2	‣ Tulane
Jean Lambert Chalachala	2	‣ FP CAPE
Lucie Zikuduka	2	‣ JHPIEGO/MCSP

Binanga is the only individual on both the current and potential future connection lists

Discussion: Why are these individuals viewed as key future connections?

23

Future analysis on FP stakeholder network in the DRC

There are many opportunities for increasing our understanding of the stakeholder network; further analysis is ongoing and future data products may include the following.

Topic	Future analysis	Data
Resource flow	‣ Examine the kinds of resources (data, technical, financial) that flow between BMGF grantees and other stakeholders in the network (ongoing)	‣ Current SN data
Strengthening opportunities	‣ Continued review of the FP network for specific strengthening opportunities	‣ Current SN data
Network connectivity	‣ Model shocks on the connectivity of the network ‣ Example: the impact to the network connectivity/ sustainability given withdrawal of central stakeholders	‣ Current SN data
External stakeholders	‣ Expanding further surveys to named external stakeholders ‣ Mapping full universe of current stakeholders to better understand wider context of FP in the DRC	‣ Snowball method, ongoing interviews to conduct
Dynamic changes	‣ Time-series network analysis to assess changes over time, perhaps in relation to a particular intervention	‣ Additional future round(s) of SN data collection

How do we improve coordination efforts? (Q5a, Q5b)

Question 05b

How are the CTMPs connecting partners to government?

Informs sustainability and scale-up

Critical assumption explored	Improved coordination and planning will attract scale-up investments	**Analyses used**	‣ Document review ‣ SSM
	PNSR and PNSA coordinate partners in support of national and provincial strategies	**Theory of change**	
Key findings	CTMPs provide an excellent opportunity for both grantees and government organizations to meet, share data, build capacity, and generate advocacy. In particular, grantees are very active with the Ministry of Health.		

CTMPs connect all BMGF partners to key branches of the DRC government

12 BMGF grantees are members of the national CTMP, connecting to 9 government branches.

How do grantees connect to government?

● ● ● ● ● ● ● ● 8 collaborated on grantee activities

● ● ● ● ● 5 shared data at CTMP meetings

● ● 2 collaborated on advocacy initiatives

● ● 2 shared data outside of CTMP meetings

Insights

▸ All 12 BMGF grantees in the DRC are also national CTMP members
▸ 9 government branches are connected to grantees
  ▸ 4 government branches (Ministry of Health, Ministry of Gender, Family and Children, Ministry of Budget, Ministry of Planning) are members of the national CTMP
▸ Organizations with the most connections:
  ▸ Grantee: AcQual II
  ▸ Governmental: Ministry of Health

DKT also sits on the Kongo Central CTMP

Legend
- ● BMGF Grantee
- ● Government
- — Advocacy
- — Data sharing at CTMP Meeting
- — Data sharing (not at CTMP meeting)
- — Collaboration on grantee activities

26
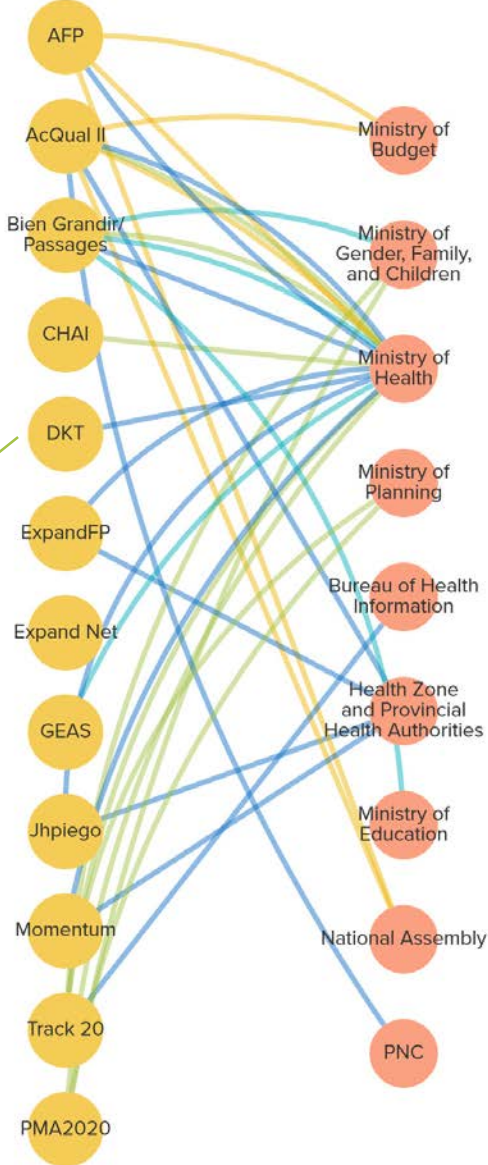
Note: ExpandNet is a member of the CTMP and attends meetings, but did not report other connections to the government Source: Grantee documentation, CTMP documentation, SSM, CTMP website

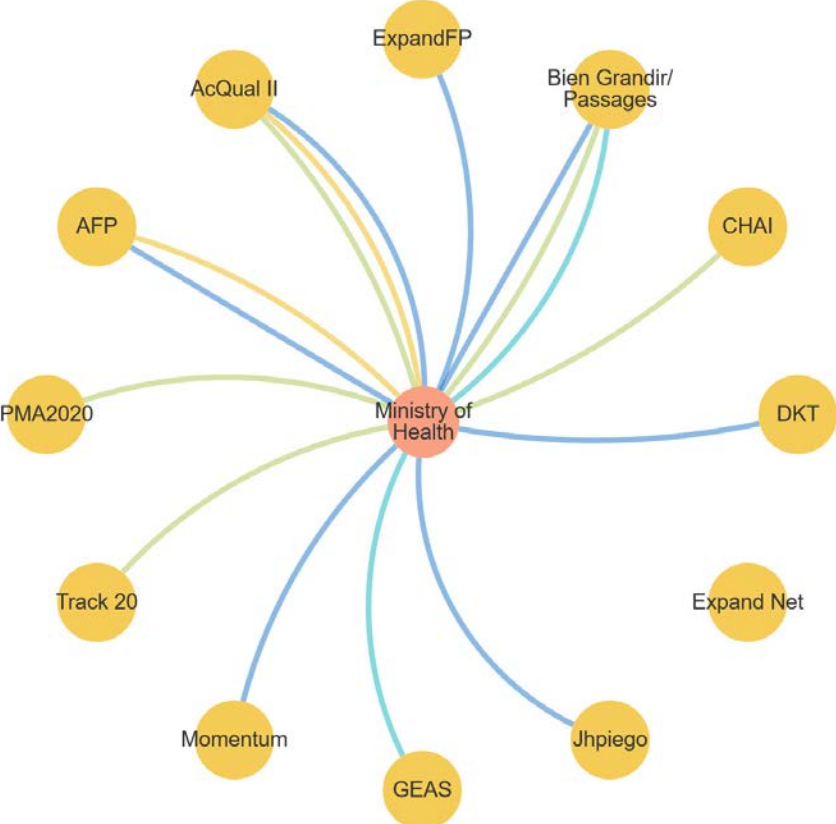# The Ministry of Health is the governmental body most connected to BMGF FP grantees

CTMPs are the dominant vehicle for BMGF grantees to share data with MoH for decision-making.

How do grantees connect to the Ministry of Health?

●●●●●●● 7 collaborated on grantee activities

●●●●● 5 shared data at CTMP meetings

●● 2 collaborated on advocacy initiatives

●● 2 shared data outside of CTMP meetings

Data insights

▸ Grantees are primarily connecting with the MoH through:
  ▸ Collaboration (cited as "facilitators" in the 2017 SSM exercise)
  ▸ Sharing data with partners at CTMP meetings
▸ CTMP meetings appear to act as a vehicle for increased data sharing and coordination between grantees and the MoH

Legend
- ● BMGF Grantee
- ● Government
- — Advocacy
- — Data sharing at CTMP Meeting
- — Data sharing (not at CTMP meeting)
- — Collaboration on grantee activities

Can we understand more about traditional method users, given increases in KC? (Q5c)

Question 05c

Who are the traditional method users? Who are non-users?

Emerging critical assumption explored

An enhanced service delivery environment will lead to an increase in modern method use by non-users and traditional method users.

Analyses used

▸ Multinomial modeling – PMA2020 data
▸ SSM
▸ Document review
▸ Annual meeting discussion

Theory of change

Informs replication

Key findings

Use of traditional methods is increasing in many countries, and we see this trend in Kinshasa and KC. More educated, higher parity, married women are more likely to use these methods. Many potential factors such as social norms have been identified as explanations for traditional methods' increase, however qualitative interviews with users are needed to understand reasons.

A note on interpreting marginal effects

The next few analyses use pooled rounds of PMA2020 data to explore how different characteristics are associated with the probability that different outcomes occur.

Marginal effect calculations show how the probability of different outcomes (e.g., mCPR, traditional method use, use of a pharmacy for FP) change as different background characteristics, x, change.

We calculate marginal effects and their level of significance over different individual characteristics:

Age
Younger than 25 vs. 25 or older

Education
Primary or secondary vs. none

Marriage
Married vs. non-married

Parity
1-2 or 3+ children vs. none

Example outcome: Use of traditional methods (Y)
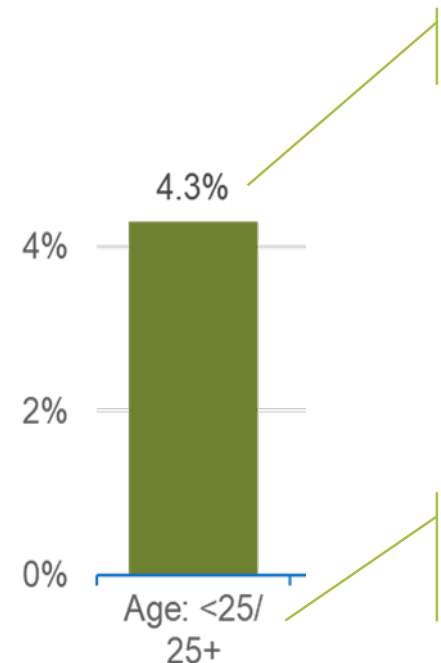
Marginal effect size (a 4.3 percentage point increase in traditional use)

This example shows that in the time period given, **traditional method use increases 4.3 percentage points as the sample goes from old** (25 or older) **to young** (younger than 25), significant at p<0.05.

4.3%

Marginal effect comparison: traditional use of those <25 versus (indicated by "/") those 25+

Age: <25/ 25+
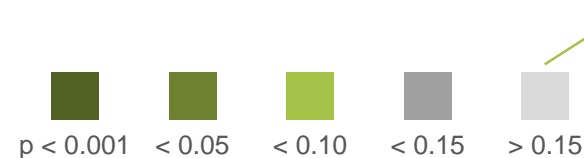
Level of significance identified through color

p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

Traditional method usage is increasing in Kongo Central

After correcting for changing population characteristics, the likelihood of using traditional methods is increasing over time in Kongo Central (KC).
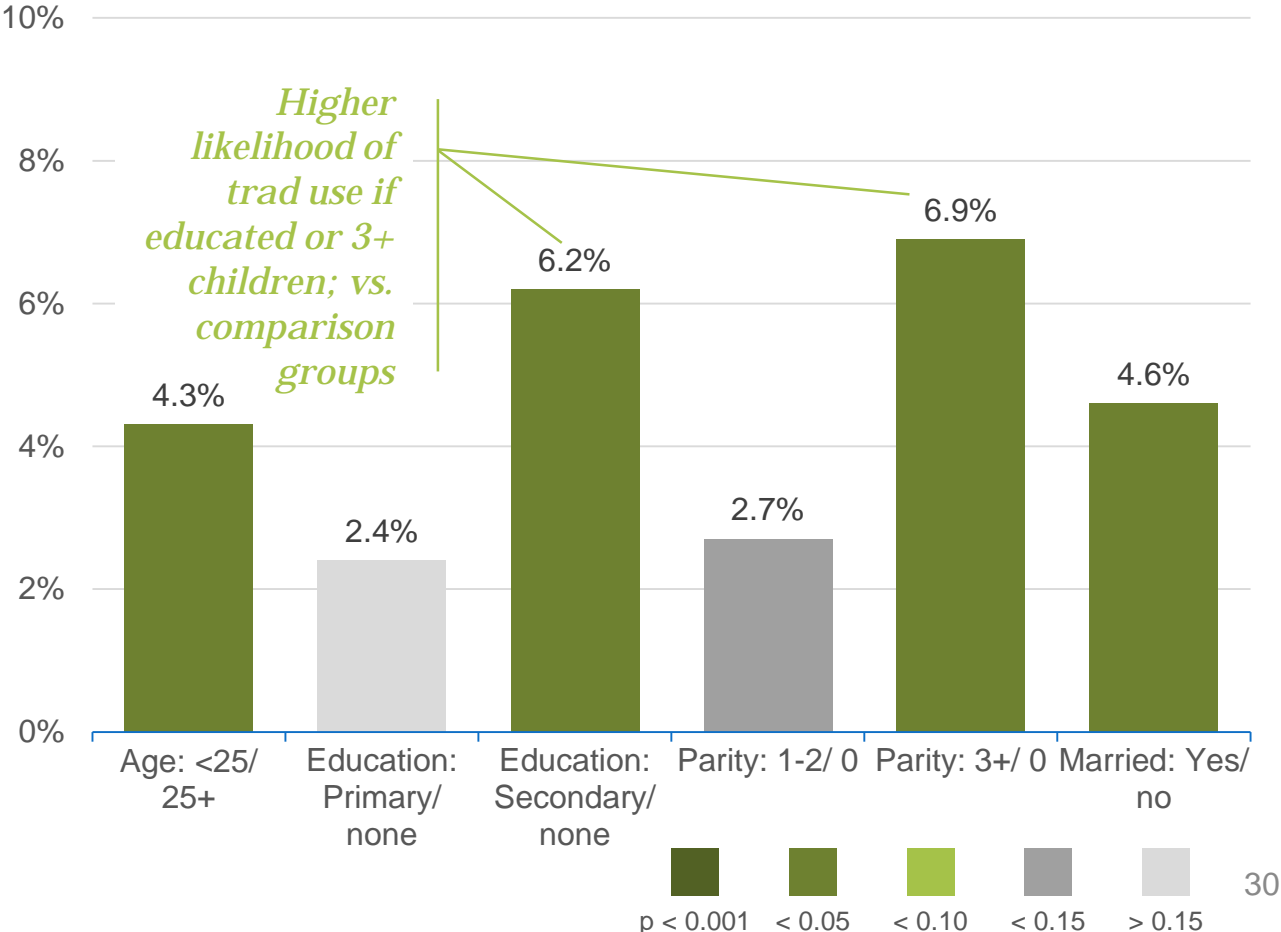
Traditional method usage over time

▲ *5.7%*

p < .05

Significant increased traditional method use over time in Kongo Central, 2015-2016

Traditional methods usage is more likely within the following demographic groups:

- ▸ Age: Those under 25
- ▸ Education: Those with secondary education
- ▸ Parity (living children): Those with three or more living children
- ▸ Marriage: Those who are married

Marginal effects on traditional method use, Kongo Central, 2015-2016

Higher likelihood of trad use if educated or 3+ children; vs. comparison groups

- Age: <25/ 25+ — 4.3%
- Education: Primary/ none — 2.4%
- Education: Secondary/ none — 6.2%
- Parity: 1-2/ 0 — 2.7%
- Parity: 3+/ 0 — 6.9%
- Married: Yes/ no — 4.6%

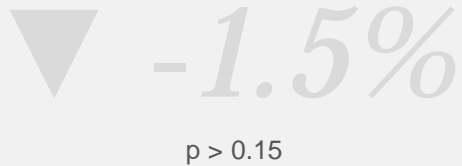p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

N = 3,188
Note: Marginal effects expressed as a percentage point.
Source: PMA2020 Data (R4/R5, KC)

Traditional users in Kinshasa have similar profiles to KC

After correcting for changing population characteristics, we see no significant trend in traditional method usage in Kinshasa. We see similar traditional user profiles compared to KC.

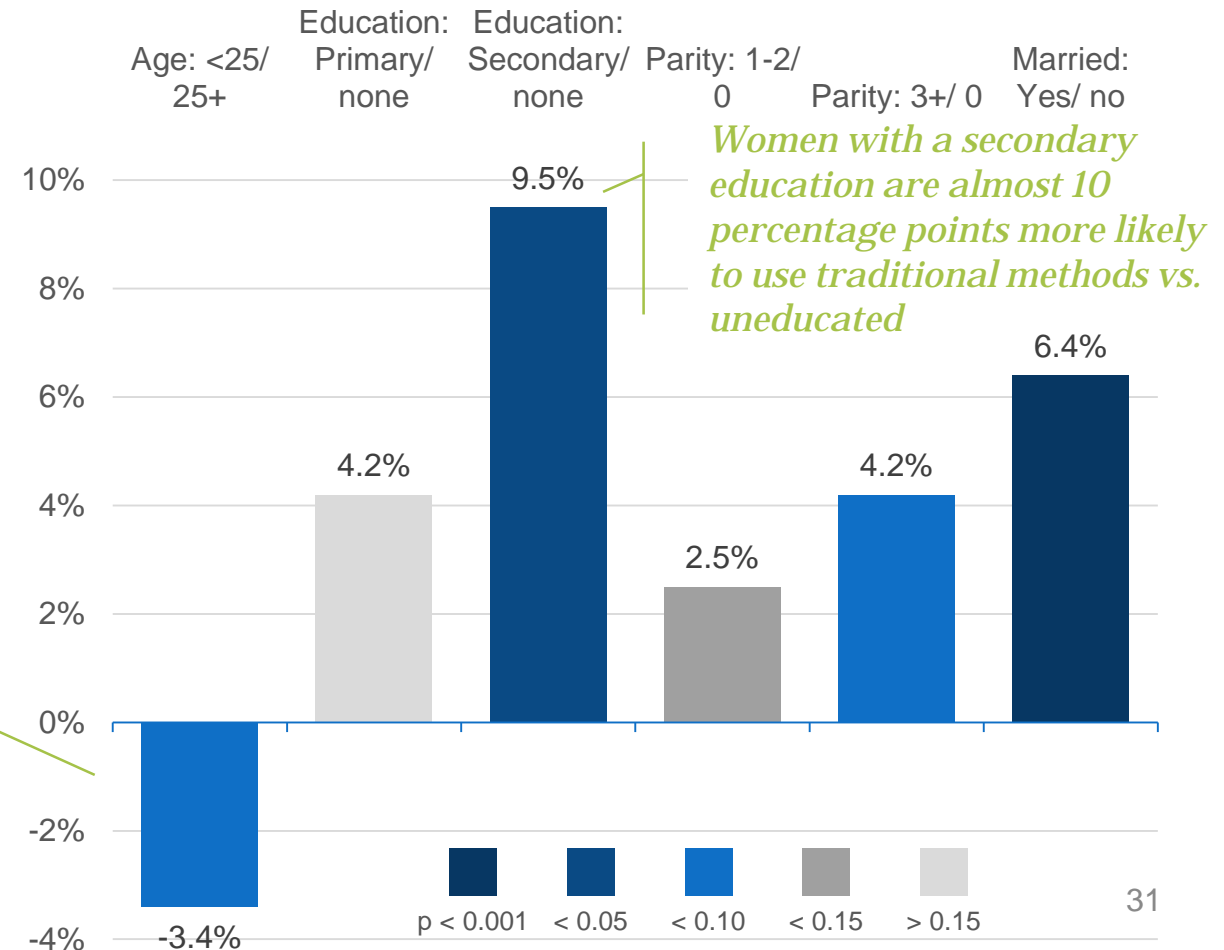## Traditional method usage over time

▼ *-1.5%*

p > 0.15

Insignificant decreased traditional method use over time in Kinshasa, 2015-2016

▸ Generally, traditional method users have a similar profile in Kinshasa as Kongo Central

▸ One exception is age: those under 25 are somewhat less likely to use traditional methods compared to those 25+ (p<0.10)

Younger women are less likely to use traditional methods than those 25+, which may indicate the need for different targeting strategies in Kinshasa for this sub-group.

Marginal effects on traditional method users, Kinshasa, 2015-2016

Age: <25/ 25+	Education: Primary/ none	Education: Secondary/ none	Parity: 1-2/ 0	Parity: 3+/ 0	Married: Yes/ no

Women with a secondary education are almost 10 percentage points more likely to use traditional methods vs. uneducated

- 9.5%
- 6.4%
- 4.2%
- 4.2%
- 2.5%
- -3.4%

p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

N = 5,302
Note: Marginal effects expressed as a percentage point.
Source: PMA2020 Data (R4/R5, Kinshasa)

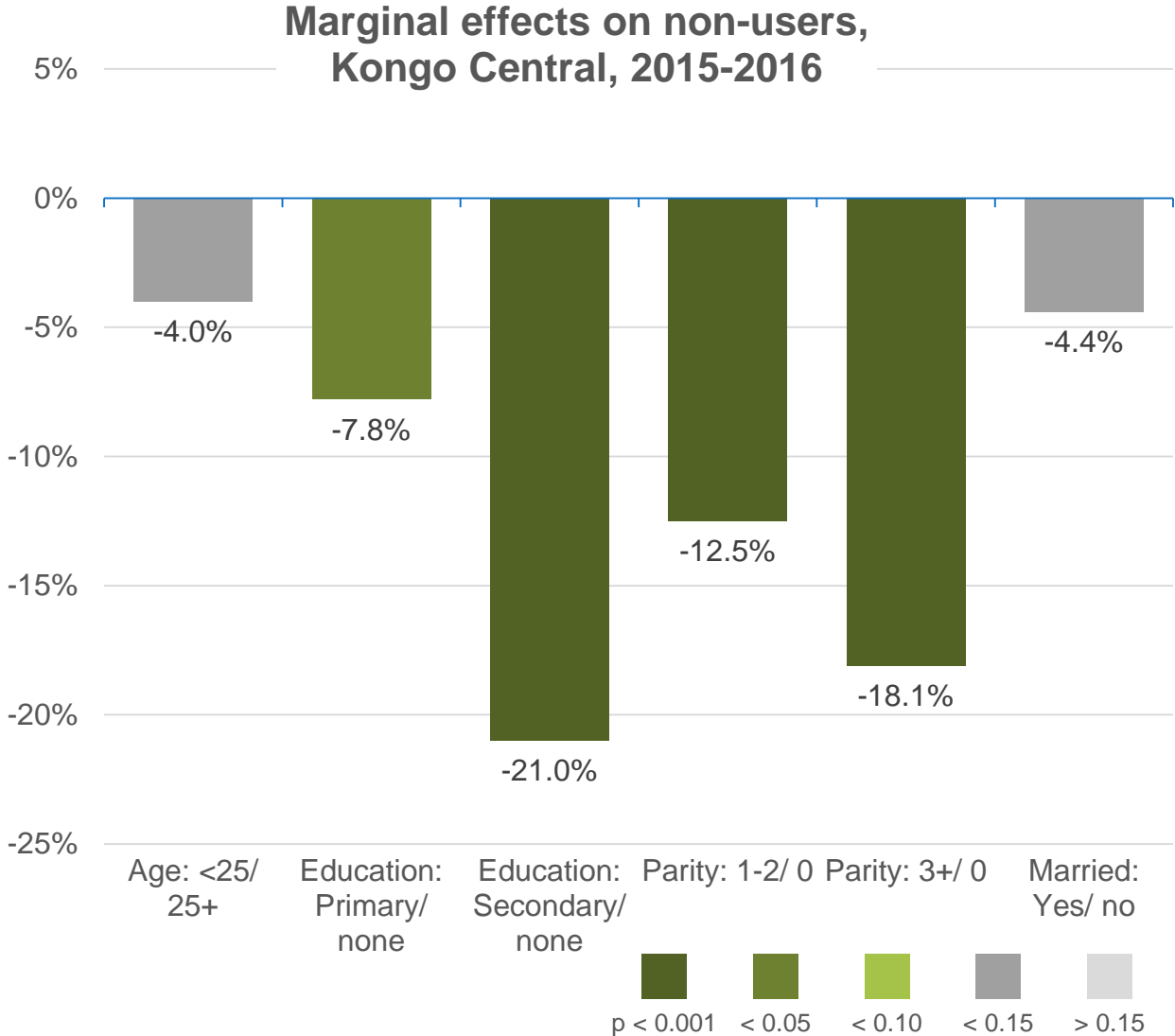# Who are non-users of family planning in Kongo Central?

After correcting for changing population characteristics, the likelihood of being a non-user of family planning is decreasing over time in KC.

Non-usage over time

▼ **-4.8%**

p < 0.10

Borderline insignificant decreased non-use in Kongo Central, 2015-2016

▸ The marginal effects of age and marital status on non-use are not significant

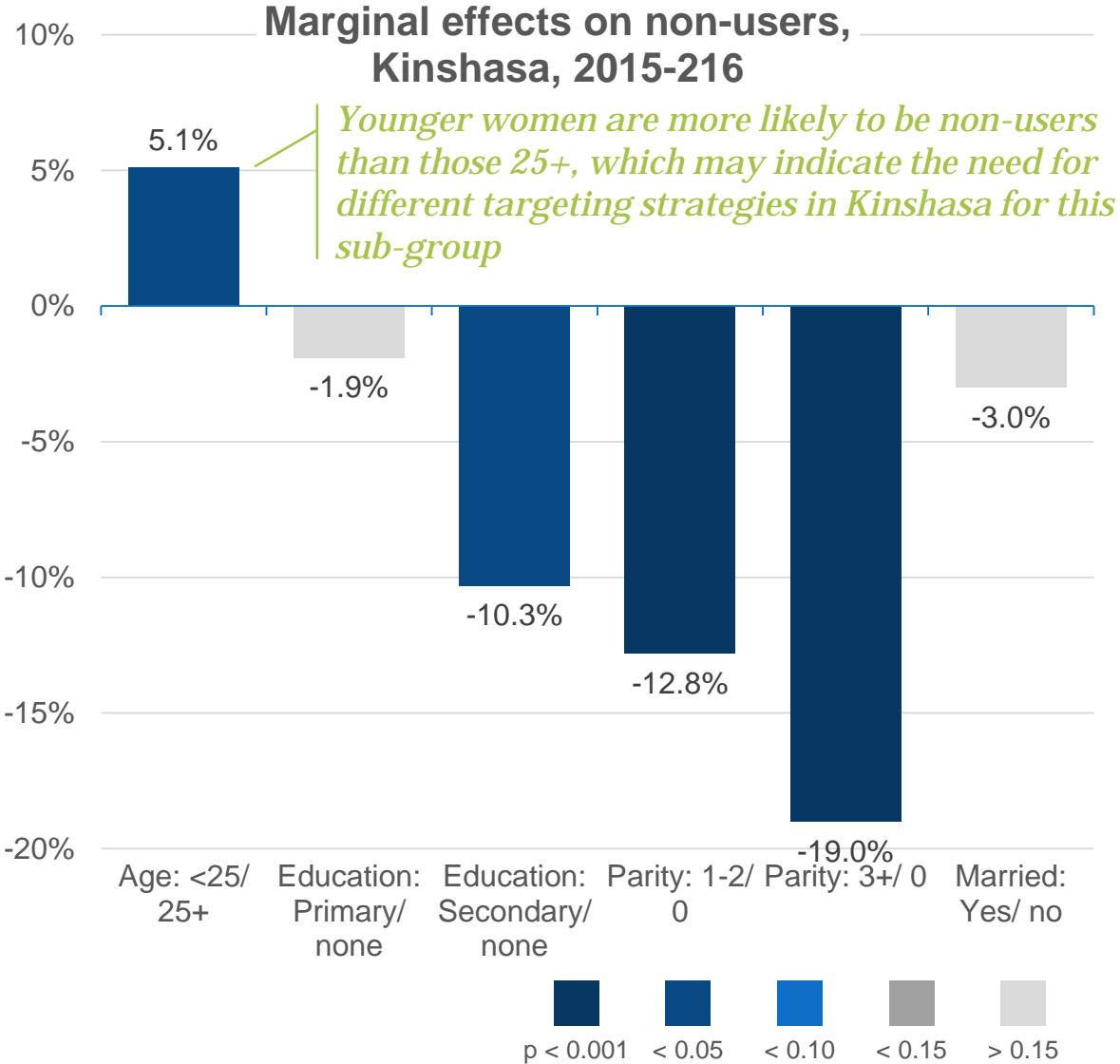▸ Non-use of contraception is less likely among all other demographic groups examined

Marginal effects on non-users, Kongo Central, 2015-2016

Category	Value
Age: <25/ 25+	-4.0%
Education: Primary/ none	-7.8%
Education: Secondary/ none	-21.0%
Parity: 1-2/ 0	-12.5%
Parity: 3+/ 0	-18.1%
Married: Yes/ no	-4.4%

p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

N = 3188
Note: Marginal effects expressed as a percentage point.
Source: PMA2020 Data (R4/R5, KC)

32

Who are non-users of family planning in Kinshasa?

After correcting for changing population characteristics, we see no significant trend in non-use of contraception in Kinshasa.

Non-usage over time

▲ 2.1%

p > 0.15

Insignificant increased non-use in Kinshasa, 2015-2016
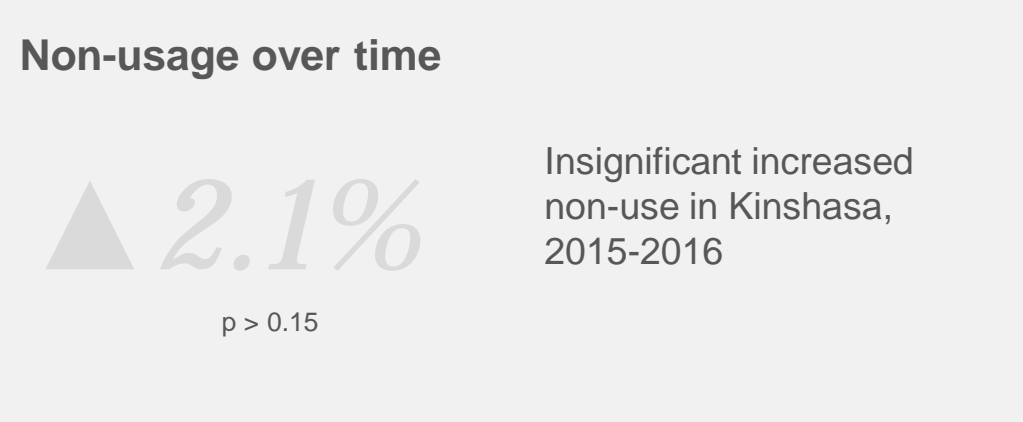
▸ Non-use is less likely among demographic groups illustrated on this graph with the exception of women under 25

▸ The marginal effects of education (primary vs. none) and marital status on non-use are not significant

Marginal effects on non-users, Kinshasa, 2015-216

Younger women are more likely to be non-users than those 25+, which may indicate the need for different targeting strategies in Kinshasa for this sub-group

- Age: <25/ 25+: 5.1%
- Education: Primary/ none: -1.9%
- Education: Secondary/ none: -10.3%
- Parity: 1-2/ 0: -12.8%
- Parity: 3+/ 0: -19.0%
- Married: Yes/ no: -3.0%

p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

Why do we see such high traditional method usage in the DRC?

A document review identified four main factors that underlie increasing traditional method usage, with potential action plans identified by partners at the 2018 meeting.

Factor	Potential reasons	Potential actions
Social norms	▸ Sociocultural barriers exist against modern FP ▸ Gender norms encouraging masculine dominance reduce women's ability to use FP	▸ Create messages addressing social norm changes ▸ Target men
Faith-based organizations	▸ Promotion of natural methods by faith-based organizations	▸ Strategies to involve socializing institutions: couples, churches, and schools
Side effects	▸ Fear of side effects from modern methods	▸ Messages addressing fears of side effects
Sociopolitical unrest	▸ Partners leaving country because of instability ▸ Partners reluctant to work in remote areas (outside of Kinshasa) because of security concerns	▸ n/a

Who are pharmacy users in Kongo Central?

After correcting for changing population characteristics, we see no significant trend in pharmacy as a source for an FP method in KC.
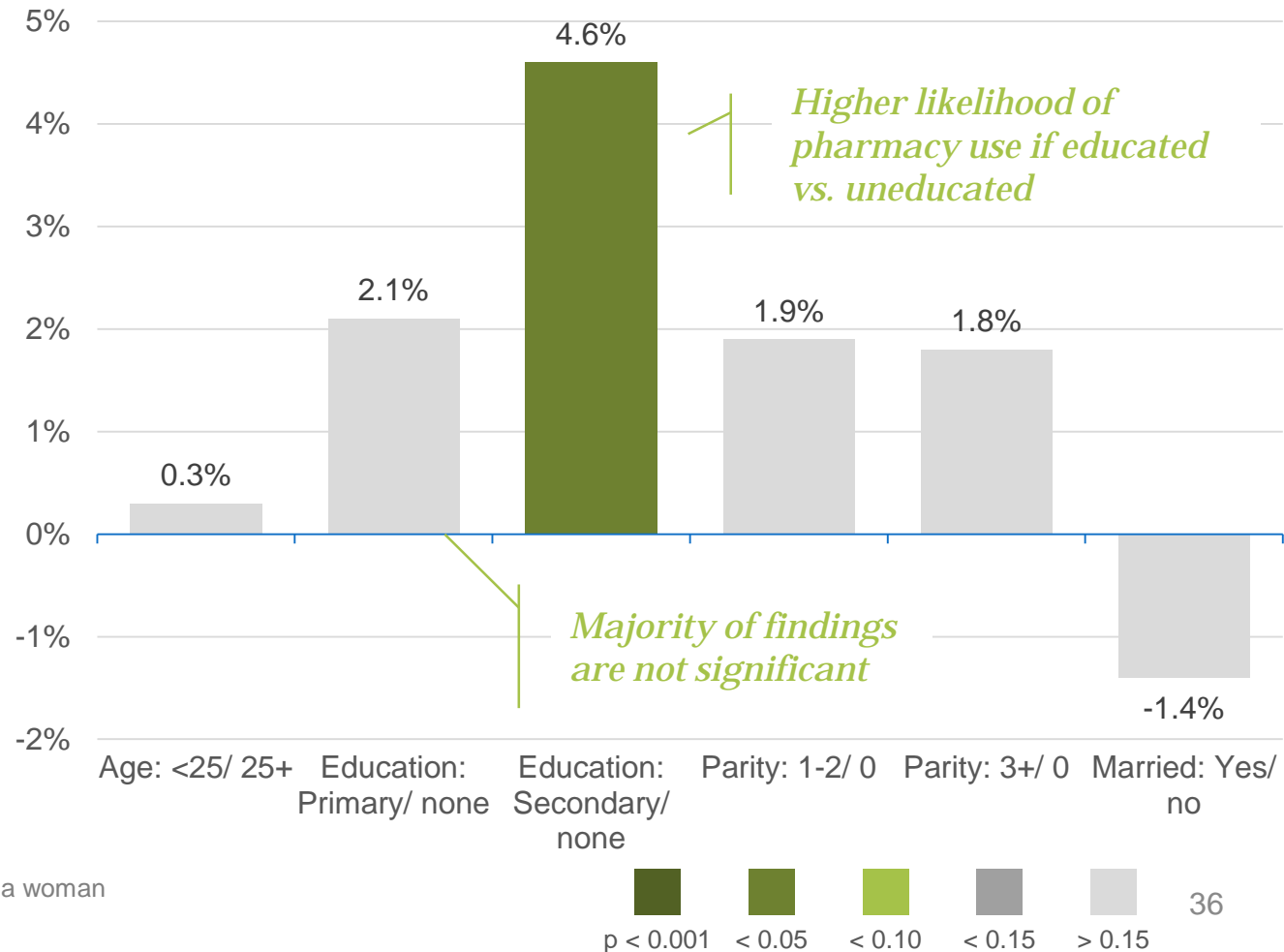
Obtaining methods from a pharmacy over time

▼ *-0.5%*

p > 0.15

Insignificant decreased likelihood of obtaining method(s) from pharmacy Kongo Central, 2015-2016

▸ Educated women are more likely than uneducated women to obtain their current/recent FP method from a pharmacy in Kongo Central

▸ This differs from findings in Kinshasa (next slide)

Marginal effects on obtaining method(s) from pharmacy, Kongo Central, 2015-2016

Higher likelihood of pharmacy use if educated vs. uneducated

Majority of findings are not significant

Category	Value
Age: <25/ 25+	0.3%
Education: Primary/ none	2.1%
Education: Secondary/ none	4.6%
Parity: 1-2/ 0	1.9%
Parity: 3+/ 0	1.8%
Married: Yes/ no	-1.4%

p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

N=3,185
Note: Marginal effects expressed as a percentage point; outcome presented shows the probability of a woman obtaining from a pharmacy a method available at pharmacies.
Source: PMA2020 Data (R4/R5, KC)

Who are pharmacy users in Kinshasa?

After correcting for changing population characteristics, we see no significant trend in pharmacy as a source for an FP method in Kinshasa.
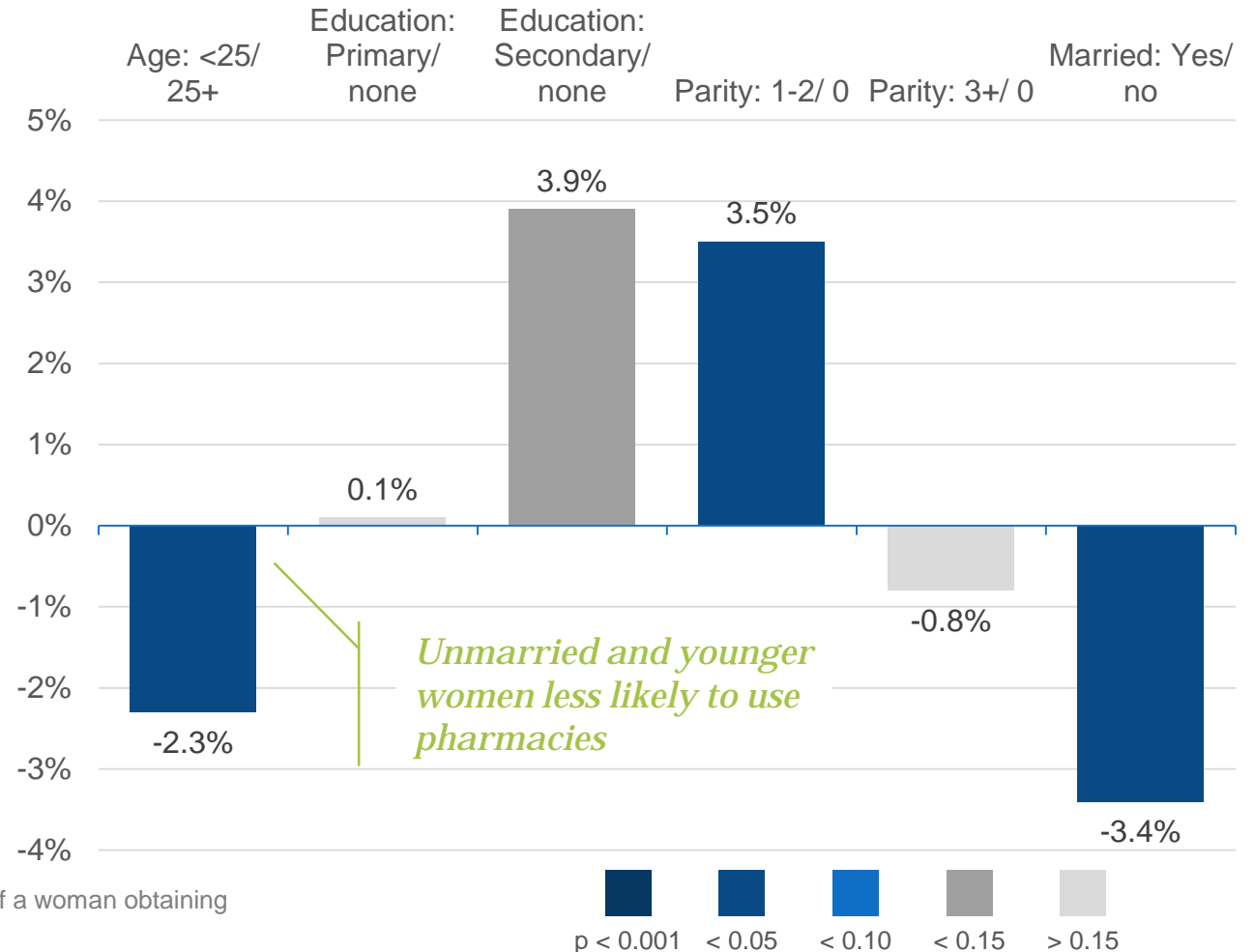
Obtaining methods from a pharmacy over time

▼ *-1.1%*

p > 0.15

Insignificant decreased likelihood of obtaining method(s) from pharmacy in Kinshasa, 2015-2016

‣ In Kinshasa, younger (<25) and married women are less likely to obtain their method from a pharmacy

‣ This is a slightly different profile as compared to Kongo Central. This may have implications for program replication in roll-out in the two provinces

Marginal effects on obtaining method(s) from pharmacy, Kinshasa, 2015-2016

Unmarried and younger women less likely to use pharmacies

N=5,293
Note: Marginal effects expressed as a percentage point; Outcome presented shows the probability of a woman obtaining from a pharmacy a method available at pharmacies.
Source: PMA2020 Data (R4/R5, Kinshasa)

What can be done to change social norms around FP (individual & institutions)? How effective are current approaches? (Q5e-Q5f)

Question 05e

Who are reached by CHW? How effective is this strategy in increasing mCPR?

Informs replication and sustainability

Emerging critical assumption explored	Effective program strategies will create increased demand for modern FP methods	**Analyses used**	▸ Causal fixed effects modeling – PMA2020 data ▸ Tulane AcQual II mid-term evaluation ▸ Annual meeting discussion
		Theory of change	
Key findings	Women are significantly more likely to use modern contraception when they are exposed to a FP message from a CHW in both Kinshasa and KC. The profiles of women reached by CHW are different in the two provinces. Coverage of CHWs is a constraint to population level impact.		

Who are reached by CHWs in Kinshasa? How effective is this strategy in increasing mCPR?
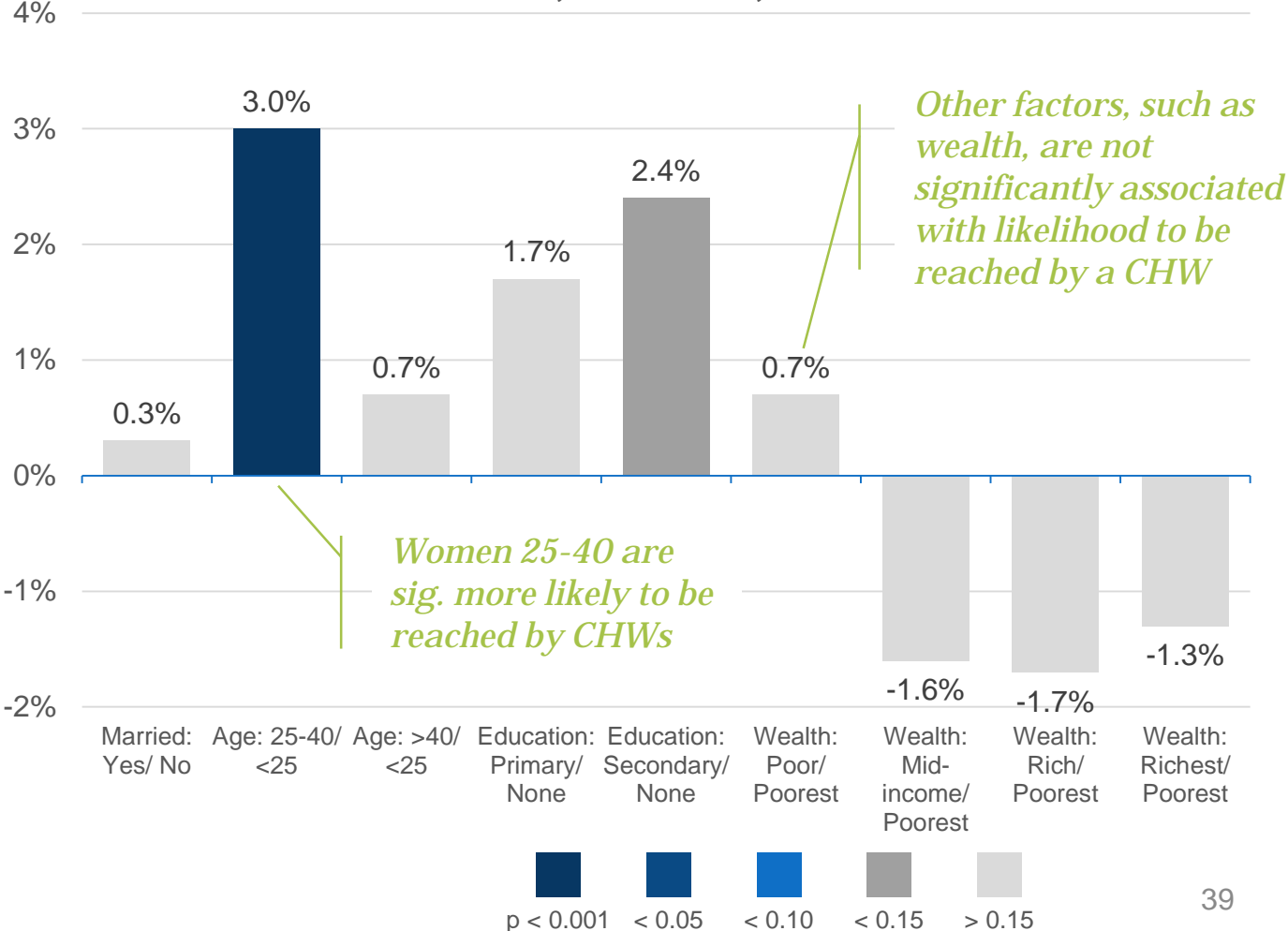
mCPR when reached by CHW

▲ **6.6%**
p < 0.05

Hearing an FP message from a CHW increased likelihood to use a modern method in Kinshasa, 2015-2016

Who is more likely to be reached by a CHW?

▸ Women age 25-40 are more likely to be reached by a CHW in Kinshasa; No other characteristics are significantly associated with being reached by a CHW

▸ CBD work covers 33 out of 35 health zones (HZ) in Kinshasa

▸ Coverage of a HZ does not mean full coverage of all health areas, however. Within a covered HZ in DRC, many health areas are not covered

Marginal effects for select characteristics on CHW reach, Kinshasa, 2015-2016

- Married: Yes/No — 0.3%
- Age: 25-40/<25 — 3.0%
- Age: >40/<25 — 0.7%
- Education: Primary/None — 1.7%
- Education: Secondary/None — 2.4%
- Wealth: Poor/Poorest — 0.7%
- Wealth: Mid-income/Poorest — -1.6%
- Wealth: Rich/Poorest — -1.7%
- Wealth: Richest/Poorest — -1.3%

Other factors, such as wealth, are not significantly associated with likelihood to be reached by a CHW

Women 25-40 are sig. more likely to be reached by CHWs

Legend: p < 0.001 | < 0.05 | < 0.10 | < 0.15 | > 0.15

Who are reached by CHWs in Kongo Central? How effective is this strategy in a replication site?
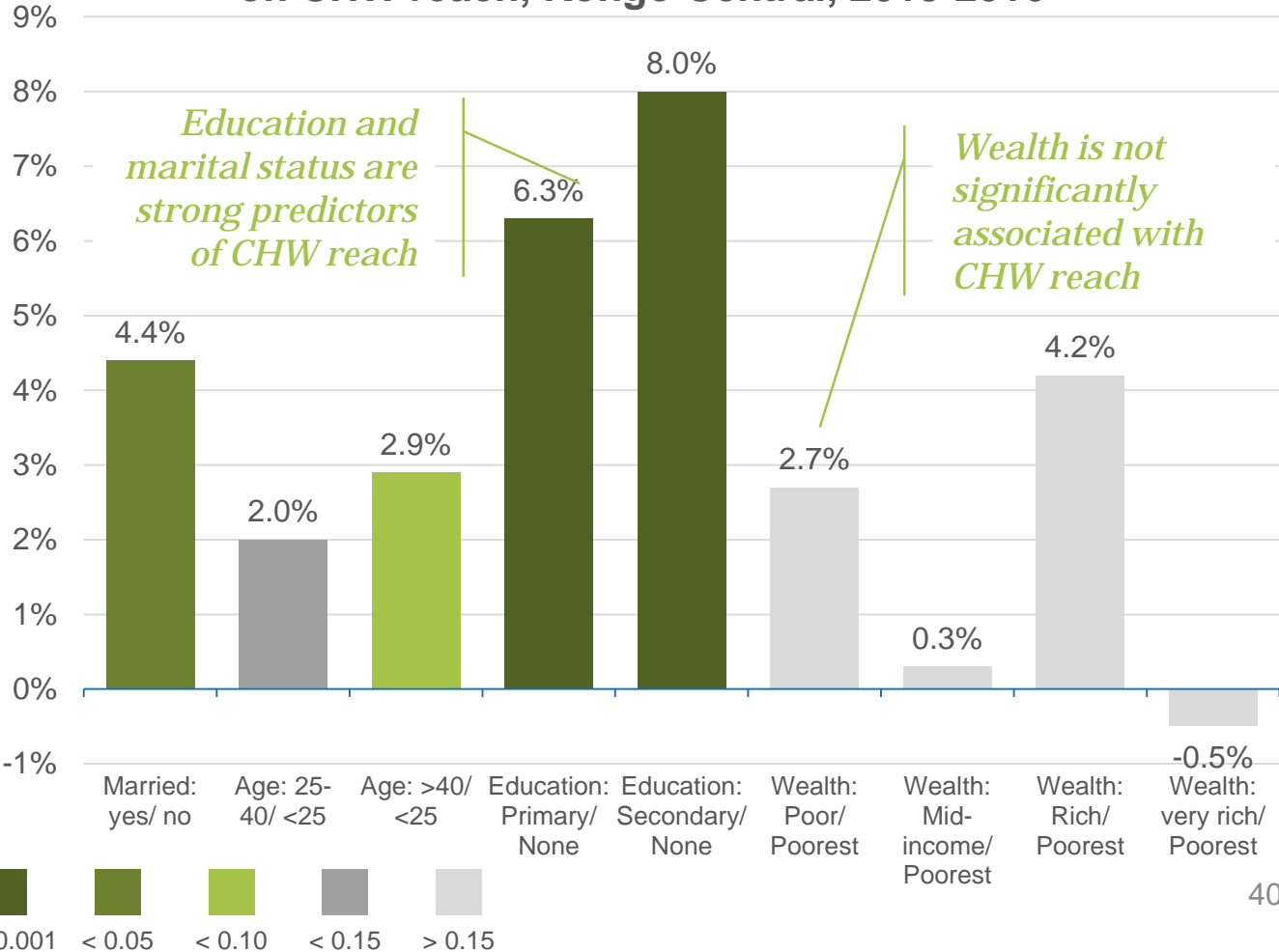
Overall mCPR when reached by CHW

▲ *11.8%*

p < 0.10

Hearing an FP message from a CHW increased likelihood to use a modern method in Kongo Central, 2015-2016, but borderline insignificant

Who is more likely to be reached by a CHW?

▸ Being reached by a CHW in Kongo Central becomes more likely if women (see chart to right):

  ▸ are married

  ▸ more educated (primary or higher)

▸ CBD work covers 12 out of 31 HZ in Kongo Central

▸ Coverage of a HZ does not mean full coverage of all health areas, however. Within a covered HZ in DRC, many health areas are not covered

N=3,214
Note: Marginal effects expressed as a percentage point.
Source: PMA2020 Data (R4/R5, KC)

Marginal effects for select covariates on CHW reach, Kongo Central, 2015-2016

Education and marital status are strong predictors of CHW reach

Wealth is not significantly associated with CHW reach

Category	Value
Married: yes/ no	4.4%
Age: 25-40/ <25	2.0%
Age: >40/ <25	2.9%
Education: Primary/ None	6.3%
Education: Secondary/ None	8.0%
Wealth: Poor/ Poorest	2.7%
Wealth: Mid-income/ Poorest	0.3%
Wealth: Rich/ Poorest	4.2%
Wealth: very rich/ Poorest	-0.5%

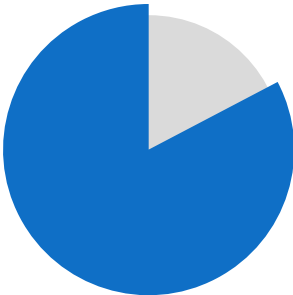p < 0.001   < 0.05   < 0.10   < 0.15   > 0.15

40

Who are CHWs in the DRC?

Community Health Workers (CHWs) are generally older, married, and with children. A check of CHWs showed that most were not carrying FP communication materials.
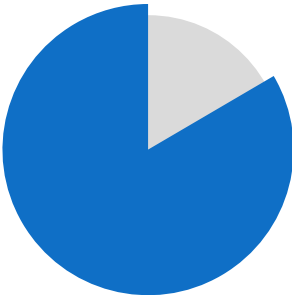
CHW profile	CHW materials
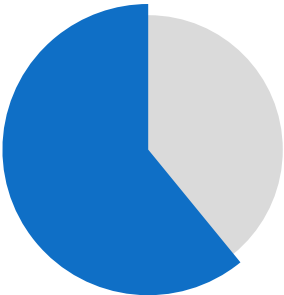
60%
of CHWs are
married

85%
of CHWs are
older than 35

86%
of CHWs
have children

41%
of CHWs had a
counseling card

39%
of CHWs had
a FP image

Exposure to FP through community health workers

In Kinshasa we see low but stable exposure of women to FP messages through CHW. In Kongo Central, exposure has declined slightly.

Percent of women exposed to FP messages through CHW, Kinshasa, 2013-2016

- R1/2013: 1.7%
- R2/2014: 6.6%
- R3/2015: 6.9%
- R4/2015: 5.4%
- R5/2016: 6.3%

Legend: ■ R1/2013 ■ R2/2014 ■ R3/2015 ■ R4/2015 ■ R5/2016
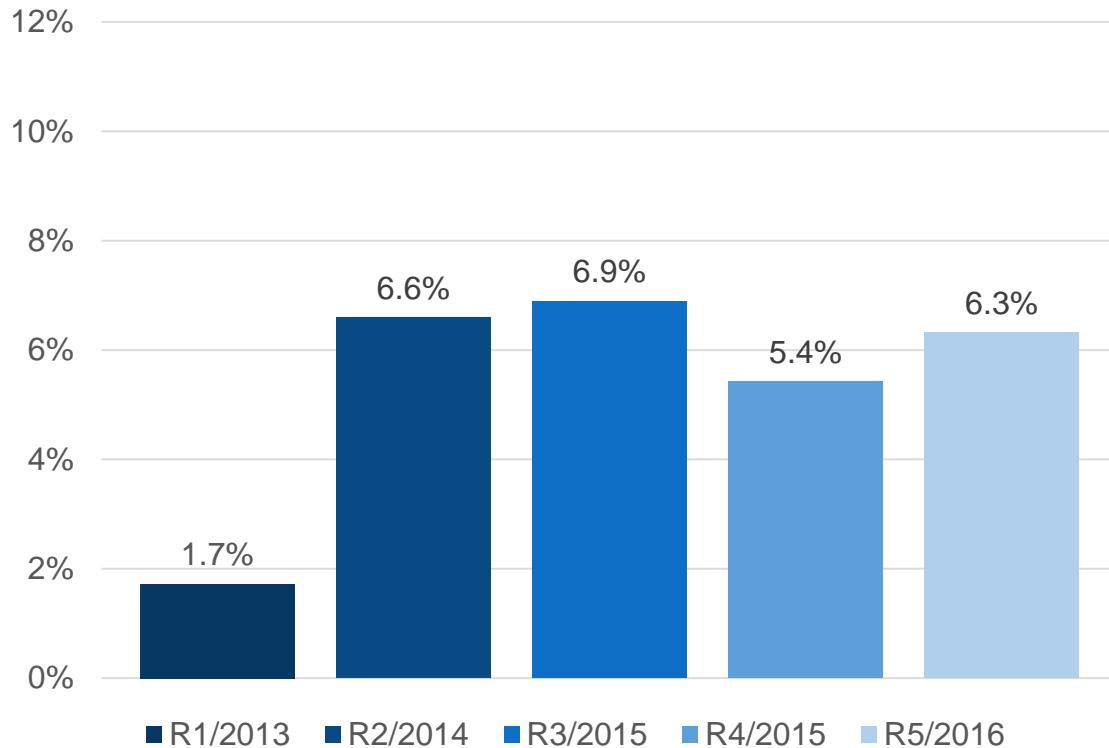
Percent of women exposed to FP messages through CHW, Kongo Central, 2015-2016

- R4/2015: 10.7%
- R5/2016: 6.4%

Legend: ■ R4/2015 ■ R5/2016
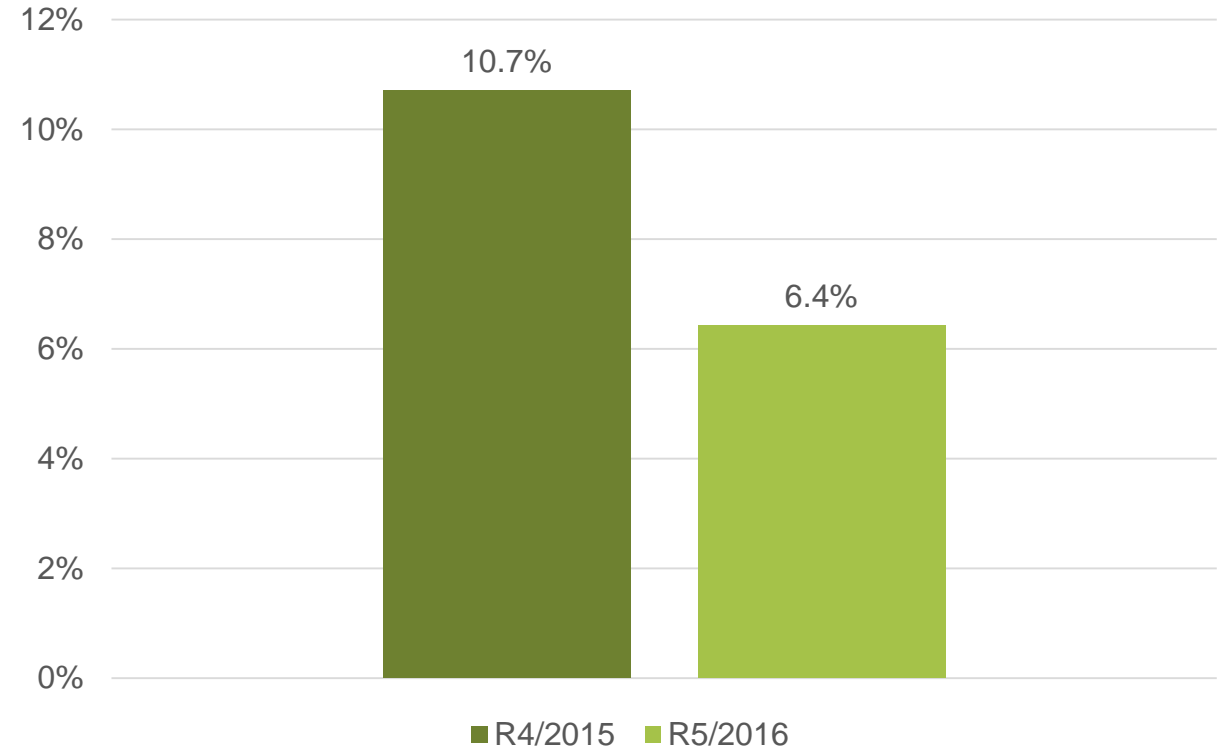
Barriers to CHW reach

As CHW impact is by its nature one-to-one, access and preparation issues must be addressed to make CHW reach consistently impactful.

Factor	Potential reasons	Potential actions
Preparation	‣ Some CHWs are unpaid, reducing motivation to reach clients ‣ Less than half of CHWs had necessary communication materials	‣ Payment schemes for CHWs need to be coordinated among partners to incentivize workers* ‣ Standardize/coordinate CHW training and access to materials
Access	‣ Distance and cost limit reach by CHWs ‣ Uneven reach by CHWs in health zones due to unbalanced coverage of activities by FP partners ‣ CHW profile may be a barrier for unmarried youth	‣ Advocate for task shifting policy for CHWs*
Client preference	‣ Women prefer methods not offered by CHWs ‣ 69% of CHW clients preferred implants	‣ Targeted, youth-appropriate FP interventions by CHWs should be developed to avoid stigma of being seen talking to a CHW*

What is the effect of media messages on mCPR in Kinshasa?

Causal instrumental variables model did not find a significant effect of media exposure on the likelihood to use a modern method in Kinshasa.

Marginal effects for TV and radio exposure on mCPR, Kinshasa, 2015-2016

Kinshasa Radio: -1.0%

Kinshasa TV: -18.1%

Neither result was found to be statistically significant
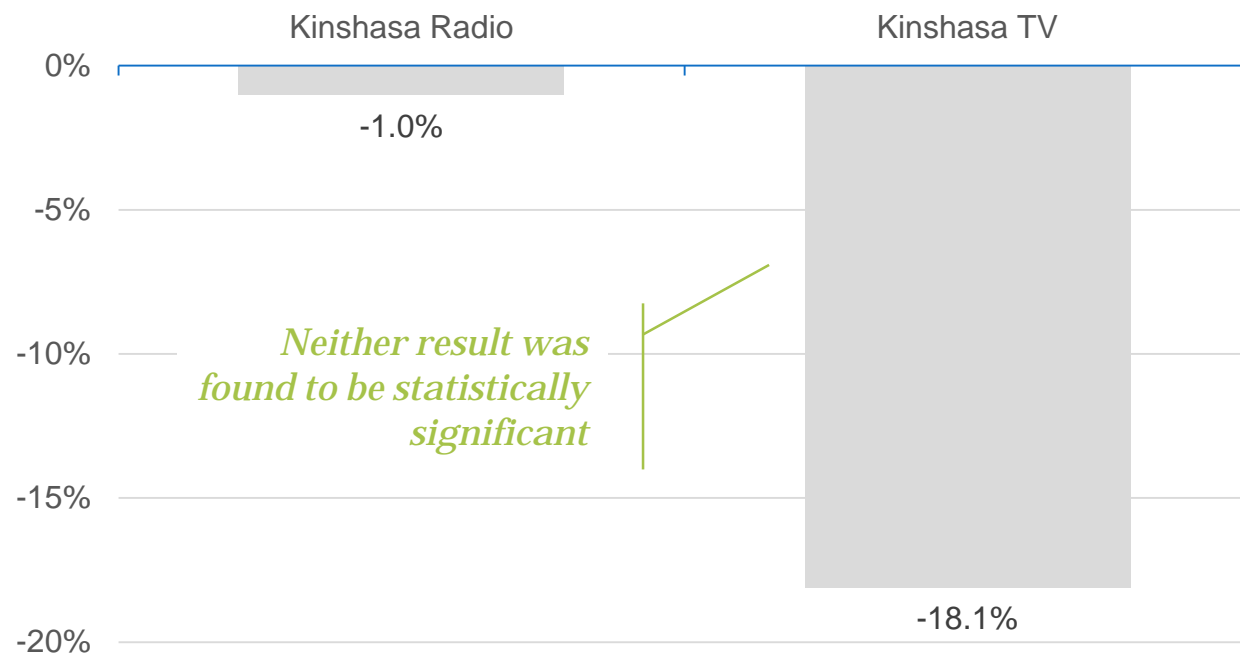
Data

▸ Kinshasa data are over 3 periods (R3-R5), 2015-16

▸ All estimated marginal effects are not statistically significant ($p \geq 0.4$). A larger sample size in future evaluations may make any effects clearer

Media reach

▸ In general, at least 1 of 5 women in the sample recalled hearing about FP from media sources

▸ For Kinshasa, by 2016
  ▸ 57.8% of women recalled TV FP messages
  ▸ 34.5% of women recalled radio FP messages

Kongo Central

▸ We did not have enough rounds of data to fit this model for Kongo Central

Kin.: Radio N= 7,955; TV N=7,958

Note: Marginal effects expressed as a percentage point; an instrumental variables causal model was used to estimate individual-level effects

Source: PMA2020 Data (R3-R5, Kinshasa)

$p < 0.001$ < 0.05 < 0.10 < 0.15 > 0.15

Appendix

The purpose of FP CAPE

FP CAPE takes a complex systems look at BMGF family planning investment portfolios in the Democratic Republic of the Congo and Nigeria towards achieving national mCPR goals.

Mechanisms of action

A clear **theory of change** identifies critical assumptions on drivers of family planning use.

By testing theorized processes, FP CAPE generates evidence on how and why each mechanism can achieve sustained change.

Context & interaction

A **portfolio-level evaluation** independently assesses family planning investments in the DRC and Nigeria.

By observing how multiple activities work together, rather than focusing on individual grants, FP CAPE detects interactions and synergies between programs.

Design features

A **prospective design** documents change, issues, and learning concurrently with implementation. This allows FP CAPE to test critical assumptions in real time.

Realist, theory-based models define and test theoretical assumptions, use realist evaluation techniques, to adapt portfolio theories of change (TOC) in response to FP CAPE findings.

FP CAPE evaluation toolkit

FP CAPE uses quantitative, qualitative and mixed-methods approaches to consider the complexity inherent in evaluating diverse program activities across different socio-political contexts.

Sentinel indicators

Indicators are used to monitor whether expected changes are happening within the FP portfolio.

Primarily quantitative data

Indicators are tracked over time, in order to give an understanding of changes while FP portfolio programming is occurring.

Updates
- ‣ Occur every 6 months
- ‣ Or as frequently as indicator is updated/new data are available
- ‣ Indicators are tracked over time

Bottom-Up Inquiry

Bottom-Up Inquiry is used to qualitatively understand the portfolio of programs related to FP.
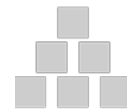
System support mapping

BMGF Program Officer & Grantee interviews

Systematic document review

By identifying themes of inquiry, the information identified is used to validate or adjust the Theory of Change (TOC).

Themes of inquiry
- ‣ Activities
- ‣ Facilitating factors
- ‣ Desired changes
- ‣ Proximate indicators
- ‣ Needs
- ‣ Barriers/challenges
- ‣ Cross-grantee coordination
- ‣ Sentinel indicators

Validate or adjust critical assumptions and potentially change our TOC

Bottom-up inquiry methodology

FP CAPE synthesizes four separate streams of data that make up the bottom-up inquiry.

System support mapping (SSM)

- Participatory qualitative data collection activity
- Collect data on factors of implementation and context that influence program success
- Includes physical map of themes, audio and video recordings of SSM facilitation sessions

Program officer (PO) interviews

- Conducted semi-annually using a structured interview guide
- POs identify notable changes and updates to the FP portfolio and environment in their home countries
- POs are also in a unique position to identify work with private sector entities and innovations in FP

Systematic document review

- Review of grantee documentation allows for understanding of established FP infrastructure and policies
- Looked at grantees documents, including grantee proposals, annual/quarterly progress reports, findings reports, concept notes, newsletters, and other publication on the grantees' websites

Grantee interviews

- Annual structured interviews with grantees to identify facilitators and barriers to their FP work in the DRC
- Allowed for analysis of how and why expected changes happened

Tulane evaluation of AcQual II, community-based distribution (CBD) project, April-July 2017

▸ Between April and July 2017, Tulane conducted a mid-term evaluation of their community-based distribution of contraceptives project, AcQual, in 33 health zones in Kinshasa.

▸ The main objectives of the evaluation were to examine if the project's implementation was in line with the project agenda as well as to identify its strengths and weaknesses, in order to improve its performance and increase its impact moving forward. This evaluation consisted of three parts:

1. Systematic interviews with resident (non-medical) community health workers (700) and nurses (73) trained by ABEF and SANRU
   ▸ The AcQual team created a directory of all CHWs recruited and trained by AcQual partners (ABEF – ND and SANRU).
   ▸ This directory was used to contact CHWs and conduct systematic interviews with CHWs who consented to participate in the study (April – May 2017).

2. Systematic interviews at the health zone level, with Chief Medical Doctors of health zones (MCZ) and community workers "Animateurs Communautaires" (66 total)
   ▸ Asked questions pertaining to partners supporting their HZs, the role of FP activities in their programmatic priorities, knowledge and support of their personnel toward CHWs' work, integration of community-based distribution in the operationalization of their FP programs, and their appreciation and level of appropriation of AcQual project.
   ▸ Review of service reports and input reports from community health workers.

3. Qualitative interviews with AcQual partners from ABEF, SANRU, Tulane, the Ministry of Health, UNFPA and DKT (10 total)

List of abbreviations

AcQual	"Accès" et "Qualité"
AFP	Advance Family Planning
BMGF	Bill & Melinda Gates Foundation
CBD	Community-based distribution
CCP	Center for Communication Programs
CHAI	Clinton Health Access Initiative
CHW	Community health worker
CPR	Contraceptive prevalence rate
CTMP	Comité Technique Multisectoriel Permanent
DHIS2	District Health Information System 2
DKT	DKT International
DRC	The Democratic Republic of the Congo
FP	Family planning
FP CAPE	Family Planning Country Action Process Evaluation
GEAS	Global Early Adolescent Study
GIBS-MEG	Groupe Inter-Bailleur pour la Santé-Médicaments Essentiels Génériques
HZ	Health zone
IRH	Institute for Reproductive Health
JHU	John Hopkins University

KC	Kongo Central
mCPR	Modern contraceptive prevalence rate
MCSP	Maternal and Child Survival Program
PMA2020	Performance Monitoring and Accountability 2020
PNC	Police Nationale Congolaise
PNSA	Programme National de la Santé de l'Adolescent
PNSR	Programme National da Santé de la Reproduction
PO	Program Officer
PPFP	Post-partum family planning
R	Round
RH	Reproductive health
SANRU	Santé Rurale
SN	Social Network
SSM	System support mapping
TOC	Theory of change
UNC	University of North Carolina
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development