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Women's Integrated Sexual Health (WISH) Programme for Results: independent verification, evidence and learning

Documentation of how programme data on reaching marginalised and underserved groups informs programme changes

Evidence Brief

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Preface

The UK's Foreign, Commonwealth and Development Office (FDCO) has contracted the e-Pact consortium to undertake Third Party Monitoring (TPM) of Women's Integrated Sexual Health (WISH). Oxford Policy Management (OPM) and Itad are jointly implementing this project in collaboration with Forcier, AEDES and ATR Consulting for in-country support. While TPM is the official name of this project and is used in the contractual documents, in order to better express the nature and dimensions of this work, we refer to this project as the Women's Integrated Sexual Health (WISH) Programme for Results: independent verification, evidence generation, and learning and dissemination for WISH (W4R in short).

This report was drafted by Louise Bury with inputs from Victoria Boydell and Callum Taylor. Catrin Hepworth also assisted in conducting interviews and data analysis. We are grateful to all respondents from MSI, IPPF and IRC at the global / Hub level and all the team members from country partners: Burkina Faso, Nigeria, Pakistan, Senegal, Somalia and Tanzania who participated in the interviews, and members of the WISH technical working groups who took time to complete the online survey.

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Executive summary

This Evidence Brief was produced by the WISH4Results (W4R) team, the third-party monitor for the WISH programme. This brief aimed to document how implementing partners (IP) have used data relating to marginalised and underserved groups in their adaptive programming and learning; and to explore what factors influence the ability to access and use this evidence for the WISH programme.

The study developed a framework to map the evidence utilisation process of programme data for adaptive programming which informed the study design and analysis. The study then used a case study approach to show examples and key lessons from WISH's two lead IPs: MSI Reproductive Choices (MSI) (Lot 1) and International Planned Parenthood Federation (IPPF) (Lot 2). Findings were drawn from 19 interviews with 32 key informants from global / regional and country staff from six WISH partners in Burkina Faso, Nigeria, Pakistan, Senegal, Somalia and Tanzania. In addition, an online survey was conducted through three of WISH programme's Technical Working Groups (TWG) on poverty, disability inclusion and youth and a desk review of WISH programme documentation was undertaken. Data collection was conducted at the end of 2020.

Each IP has their own organisational system for gathering information, assessing progress, identifying learning and adapting programmes. But MSI and IPPF both use similar sources of evidence about underserved populations. The main sources of evidence across both partners are Client Exit Interviews (CEI), service statistics, and external sources (e.g., national health surveys). To collect data on underserved and marginalised populations as part of the WISH programme, IPs have developed or adapted existing data collection tools, such as including additional questions in the CEI to measure capture clients living with a disability and living in extreme poverty, and developed new tools (e.g., Poverty Heat Maps, a Disability Audit Checklist, Routine Poverty Metric, and a Rapid CEI), including an indicator for disability in routine service records.

The two case studies describe how each IPs' structure and approach to evidence utilisation relates to each stage of the evidence utilisation framework. It shows how evidence, based largely on CEI and service data, is accessed and used at the global and country level to better understand needs, to improve services, and to increase access to key population groups. With regard to adaptive programming, evidence concerning underserved groups is mostly used to make decisions and changes in the following programming areas: to improve the reach of services through targeted site selection; increase awareness of FP/SRH services among underserved groups; adapt service delivery approaches to meet the needs of underserved groups; ensure services are inclusive of all client groups; and improve the quality of data on underserved groups.

The key findings about evidence utilisation for WISH programming from the two case studies are as follows:

- **Evidence utilisation is not a singular process that applies to all organisations in the same way**. The markedly different experiences of both IPs in how data is used and adapted depended on an institutional history and culture of using evidence. MSI and IPPF do not have the same structures and are not at the same starting point regarding collecting, analysing and sharing programme data.
- **Evidence use has been largely driven by the payment-related Key Performance Indicators (KPIs), such as for poverty and youth.** Partners have needed to focus their evidence use in programming around increasing performance to deliver against pre-determined programme targets, namely people living in poverty. This has resulted in

country teams using data to hone in on site selection of outreach services for MSI and clusters/ service delivery points (SDP) for IPPF and improving demand creation approaches to ensure services reach the poorest. This can be challenging as switching incurs time and costs within the programme timeframe.

- **'Evidence literacy', or the capacity of the country level teams to handle and analyse data, is an important factor in how IPs manage data and promote evidence use**. MSI and IPPF had different starting points in terms of having systems in place for using evidence. The technical capacity and attitudes of individuals was also a driver for evidence utilisation which is related to the country context, in terms of what opportunities were available to build these skills, what resources were available, the size of organisation and research/ M&E teams, or how established the country partner was and therefore experienced in data systems.
- **Reporting on evidence utilisation lacked detail evidence utilisation to provide important lessons.** While the programme reports for WISH provided valuable contextual background for examples provided in the case study interviews, these were not easily comparable to the evidence utilisation framework. They also lacked detail on the processes, such as how decisions regarding course correction are made or how changes to programming will be monitored, which would provide important lessons. In addition, the more recent reports reviewed contained more information about adaptive programming based on CEIs results highlighting that evidence utilisation takes time, and the importance WISH places upon the CEI results.
- **Partners have experienced changes to evidence utilisation over time as a result of WISH programming**. Partners have had to adapt their systems and approaches to improve the collection and use of programme data, particularly relating to poverty and disability, to meet the needs of WISH. In particular, the increased focus on people living with disabilities has been an area of mutual growth for both IPPF and MSI, whereby both partners endured considerable learning and development around mobilisation and how best to measure disability inclusion.
- **A number of factors were identified that contribute to how WISH stakeholders use evidence.** Certain conditions either enabled or hindered the timeliness, ability and scope to effectively use evidence for adaptive programming among partners, particularly at the country level. Some factors are unique to an IP or the country setting, while other influences were commonly reported. These factors broadly relate to the capacity of country staff to manage data, organisational systems and approaches for data management, consortium composition, and country context.

This study has shown that evidence utilisation is integral to WISH because it informs everything its partners at the global and country level do. With the programme's strong focus on generating evidence, both IPs have dedicated evidence and learning teams who work closely with country level partners to gather quantitative and qualitative data.
The findings have shown that under WISH, evidence utilisation has been largely focused on the programme's KPIs, whereby data about youth and people living in poverty is closely monitored to identify any stagnation or decline in the proportion of clients among these groups. The study has also highlighted some limitations of the data available to IPs in monitoring WISH which ultimately has influenced how responsive IPs are to different data. The limited availability of tools to measure poverty and disability in the context of sub-national programming and health service delivery is a problem that reaches beyond WISH. With few alternative options for reporting on the WISH KPIs, partners have had to balance trade-offs in data quality and value for money, for example using small sample sizes in the CEIs which limits the type of analysis from these surveys, especially for the prevalence of disability.

To help WISH stakeholders improve evidence utilisation for the remaining of the WISH programme and for consideration of future consortium-led programmes, the research

suggestions the following recommendations for the WISH implementing partners, the wider WISH consortium and the Foreign, Commonwealth and Development Office (FCDO):

Recommendations for Implementing Partners

1. IP support offices to provide support that is more tailored for different country teams context and capacity to access and use evidence.
2. Empower country staff to take on aspects of data analysis.
3. Invest in systems to ensure the visibility of data is accessed and used across teams.
4. Increase understanding about how to use different data sources and continue to encourage the triangulation of data to cross-check findings with other sources.
5. Evaluate new tools and / or approaches for monitoring poverty and disability and share learnings across IPs.
6. Ensure country level staff have capacity in specific areas to implement programme adaptations.

Recommendations for wider WISH consortium partners

7. Ensure consistent terminology and reporting around evidence across the WISH consortium.
8. Continue to sustain strong M&E systems with clear roles and responsibilities for data management.
9. Engage with consortium partners to enable better sharing of data and analysis.
10. Increase wider awareness of the limitations of CEIs across the consortium.

Recommendations for FCDO

11. Investigate alternative ways of monitoring progress on poverty reach and disability inclusion.
12. Ensure realistic expectations around the timeline required for adaptive programming, especially for poverty.

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List of abbreviations

CBD	Community-based distribution
CEI	Client Exit Interview
CHW	Community Health Worker
CLIC	Client Information Centre
COVID-19	Corona Virus Disease 2019
CPs	Country programmes
CYP	Couple years protection
DHS	Demographic and Health Surveys
DHIS2	District Health Information Software 2
DMI	Development and Media International
DPO	Disabled people's organisation
DRC	Democratic Republic of the Congo
FCDO	Foreign, Commonwealth and Development Office
FP	Family Planning
FPAP	IPPF in Pakistan
E&I	Evidence and Insights
HI	Humanity and Inclusion
HoR	Heads of Region
HQ	Head Quarter
IDP	Internally displaced populations
IP	Implementing Partner
IPPF	International Planned Parenthood Federation
IRC	International Rescue committee
KII	Key informant interview
M&E	Monitoring and Evaluation
MA	Member Association
MPI	Multidimensional Poverty Index
MSBF	Marie Stopes Burkina Faso
MSI	Marie Stopes International
MSION	Marie stopes Nigeria
OPD	Organisations of people with disabilities
OPM	Oxford Policy Management
PPI	Poverty Probability Index
PSS	Public sector support (for MSI)
PSS	Private sector support (for IPPF)
PWD	People with Disabilities
RME	Research, Monitoring and Evaluation
R-FPAP	Rahnuma-Family Planning Association of Pakistan
SBCC	Social Behaviour Change Communication
SDP	Service delivery point
SGBV	Sexual and gender based violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TPM	Third Party Monitoring
TWG	Technical Working Group
UMATI	IPPF MA in Tanzania (*Chama Cha Uzazi na Malezi Bora* Tanzania)
W2A	WISH2Action
W4R	WISH4Results
WGQ	Washington Group Questions
WHO	World Health Organization
WISH	Women's Integrated Sexual Health
YRC	Youth resources centre

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1 Introduction

1.1 Background

As part of the Leave No One Behind movement, the Women's Integrated Sexual Health (WISH) programme focuses on delivering sexual and reproductive health and rights (SRHR) services to underserved and marginalised populations[1]. Data on reaching underserved groups is collected by WISH implementing partners (IPs) through programme data, particularly Client Exit Interviews (CEIs) and service statistics. This data provides a measure of who is accessing services, which populations they represent, and how these vulnerabilities intersect among this client group.

WISH4Results (W4R)[2] recently prepared an Evidence Brief[3] that captured the experiences of enumerators collecting innovative programme data. This included conducting CEIs and, within that, collecting items on disability (known as the Washington Group Questions) and poverty (using the Multidimensional Poverty Index (MPI) and Poverty Probability Index (PPI) tools). Surveys including questions on disability and poverty have rarely been administered in the context of a sexual and reproductive health and rights (SRHR) programme.

Following this earlier study, W4R conducted a study to look at whether and how programme data on underserved groups informs programming, and explored the following questions:

- Has programme data about underserved populations been used to inform programmatic changes and, if so, how?
- What are the strengths and limitations of using such evidence about underserved and marginalised populations to improve programming practice?
- What factors influence the readiness, willingness and ability to access and use evidence, for example, existing wider organisational systems, performance incentives and the size and presence of different consortium members in WISH countries?

The study showcases examples and key lessons in how IPs have used data relating to underserved and marginalised populations in their adaptive programming and learning. It also takes into consideration how the COVID-19 pandemic and restriction of movement in WISH countries impacted evidence utilisation in terms of the collection, generation and dissemination of evidence, and how IPs at headquarter level have supported country-level teams to use evidence in the context of COVID-19.

1.2 Study objectives

The study objectives are to:

[1] Underserved populations are those with limited or no access to health services. Marginalised populations are those who experience legal, political, social or economic marginalisation that limits their ability to access available care – e.g. adolescents, people living in poverty, people with disabilities, etc.). We generally use "underserved" throughout this report to include both sets of populations.

[2] As part of the WISH Programme, WISH4Results (W4R), the Third Party Monitor (TPM) is mandated with conducting discrete studies and evidence briefs to generate evidence and learning to support programme adaptation for improving WISH outcomes and goals

[3] Evidence Brief #3: *A learning-focused assessment of experiences in collecting poverty and disability measures through client exit interviews*, June 2020.

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1. Understand how programme data (CEI data and service statistics) related to underserved groups are used to reflect on the client groups reached, and programme progress, barriers, and challenges in global and country contexts;
2. Document the ways the programme data have or have not been used to adapt programmes to better serve underserved client groups (compared to adapting programmes to reach clients in general).
3. Provide recommendations on how to support the use of programme data and other sources of evidence to better reach underserved and marginalised clients.

This study contributes to WISH's documentation of evidence utilisation and of how different types of data are applied to programming. We hope the findings will help WISH stakeholders to understand how to best use evidence about WISH clients to expand reach to marginalised and underserved groups, as well as improve data collection to advance WISH programming activities and outcomes. In combination with the Evidence Brief #3, these findings also provide learnings on the measurement and application of programme data to improve programming for underserved and marginalised populations.

1.3 Evidence utilisation framework

'Evidence' and 'evidence utilisation' mean different things across different organisations. Here we use the following definitions:

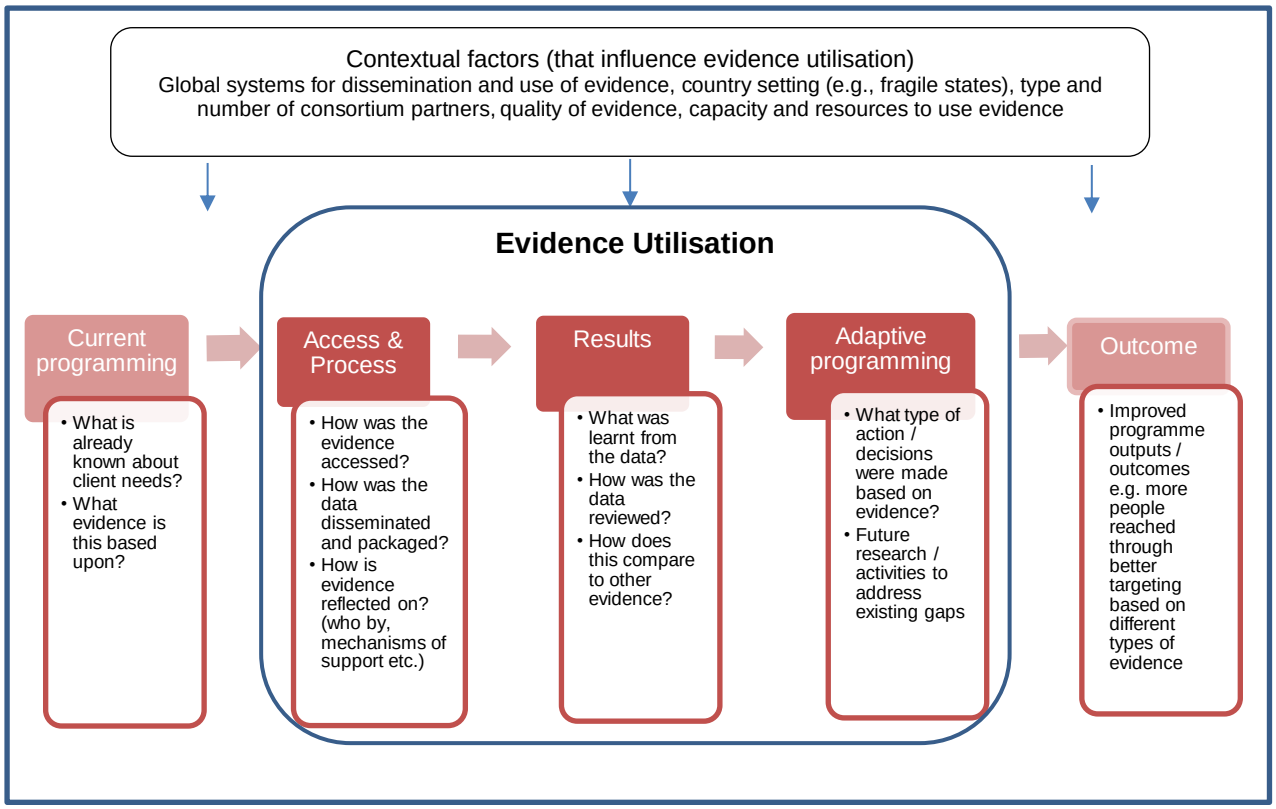
- 'Evidence' is the available facts and information, including research or non-research evidence, that indicates whether a belief or proposition is true or valid (Oxford University Dictionary, 2020). This includes facts and information drawn from service statistics. 'Data', e.g., numbers or text that is tabulated or presented as graphs or figures, is not evidence until it is analysed. Data become information when it is contextualised and processed to make it clear what the data is saying, and packaged in a way to be useful for the intended user.

- 'Evidence utilisation' (or how people access and use information) has been defined by the W4R as *"the process by which a person makes practical, worthwhile and effective use of evidence* (W4R, 2019)." In order for IPs and country teams to utilise evidence, *"it needs to have been made available and accessible to them (generated and disseminated), and they need to incorporate it into their framework of knowledge, beliefs and values (process and reflect on it) (*W4R, 2019)." Evidence can take time to result in action points and programme adaptations after being disseminated.[4]

We developed a framework for this study to map the evidence utilisation process of programme data (CEI data and service statistics), to inform adaptive programming that can then lead to improved outputs and outcomes (Figure 1).[5] Evidence utilisation is often a complex process involving many inputs and taking different directions (Wilson, 1997), but programme data is often used within managed processes. We therefore anticipate that in this context evidence utilisation is more likely to follow a linear process. The framework highlights the stages of evidence utilisation and the relationship between them, and the types of contextual factors that interact with this process. This framework informed our study design, research questions, data collection and analysis at the global and country level. The key questions for each stage are also included in Figure 1.

[4] WISH Evidence Utilisation Report for 2019, W4R.
[5] The theoretical framework for this study was based on the Medical Research Council's useful framework to illustrate the key functions and components of a process evaluation that are informed by the causal assumptions of an intervention and inform the interpretation of outcomes. (See page 11). https://mrc.ukri.org/documents/pdf/mrc-phsrn-process-evaluation-guidance-final/

Figure 1: Framework of the theoretical sequencing for evidence utilisation of programme data



2 Methodology

The study used a case study approach that drew on several data sources and feedback from stakeholders about their experience of evidence utilisation within the WISH programme, triangulated findings and outlined lessons learnt.

The data sources include:

1. **Key Informant Interviews (KIIs)**. A total of 32 key individuals (19 interviews) from Lot 1 and Lot 2 were interviewed to explore in depth the experience of the use of programme data (CEI and service statistics) at the global and country levels of the WISH programme. Six countries were initially selected for the case studies in consultation with the Lot 1 and Lot 2 lead partners (MSI and IPPF respectively). The chosen countries are: Burkina Faso, Nigeria, Pakistan, Senegal, Somalia and Tanzania. These countries were selected to provide a diverse representation of the overall WISH programme in terms of service delivery performance, number of consortium partners, lead agency, types of health systems (e.g. in fragile versus non-fragile contexts), and geography. Suitable respondents for the KIIs were then identified based on the country selections.

   Two groups of respondents were interviewed:
   - At the global level (i.e., Headquarters (HQ) for MSI and Hub for IPPF), eight interviews with 14 respondents were conducted with programme and technical support staff. The focus was on mapping the global 'evidence into practice' system for each organisation and to understand more about how the global level staff interact with and support country teams to use data to inform programming practice.

   At the country level, 11 interviews with 18 respondents across the six countries were conducted with country team members who are closely involved with evidence utilisation for the WISH programme (e.g. the WISH Programme Lead, Research and M&E Manager, Outreach Channel or Clinical Lead). See
   - Table 1 for a breakdown of the sample.

   Two KII questionnaire guides were developed, one for country and one for global, to explore the processes adopted by each IP/country to access and use evidence based on programme data, and what types of programmatic changes or decisions were made based on this information (see Figure 1). The interviews were conducted in English and French (for Burkina Faso and Senegal) via Microsoft Teams over a three-week period during October and November 2020.

Table 1: Summary of KIIs conducted at the global level and country level and the number of interviews and respondents (in brackets)

Level of investigation	Lot 1	Lot 2
Global Level	MSI Head Quarters 4 (4)	WISH Hub 4 (10)
Country level[6]	Burkina Faso 2 (3)	Pakistan 2 (4)
	Nigeria 1 (3)	Somalia 3 (3)
	Senegal 1 (3)	Tanzania 2 (2)

[6] The country partners included in the study were as follows: Lot 1 – Marie Stopes Nigeria (MSION), Marie Stopes Burkina Faso (MSBF), Marie Stopes Senegal, and Lot 2/ W2A – IPPF Member Associations *Chama cha Uzazi na Malezi Bora* Tanzania (UMATI) in Tanzania and Rahnuma- Family Planning Association of Pakistan (FPAP) in Pakistan, and International Rescue Committee in Somalia.

Total interviews	**8 (13)**	**11 (19)**

2. **Online Survey:** A short **online survey** was conducted with three of WISH programme's Technical Working Groups (TWG) on poverty, disability inclusion and youth. The aim of the survey was to provide insights from a wide range of stakeholders about their experiences and gather examples regarding the use of programme data to improve programming for underserved and marginalised populations. In total, 13 respondents responded to the survey.[7]

3. **Desk Review:** A **desk review** of WISH programme documentation was conducted to provide an overview of how IPs are using different data sources, the types of changes or decisions that are being made and where these adaptations are taking place within the WISH programme. In total, 11 reports were reviewed from Lot 1 and Lot 2 (these included the IP's Evidence & Learning plans, Evidence Utilisation reports, and WISH quarterly reports from Q2 2019 – Q2 2020).

Data from both the KIIs and the TWG online survey were combined and analysed using MaxQDA software. Deductive analysis was used to identify key themes based on the Evidence Utilisation Framework (Figure 1) for each IP. Themes related to factors that have enabled or hindered access and use of data were applied to both Lots to highlight lessons to support greater evidence utilisation for the wider WISH programme.

Relevant data from the desk review were coded using an analysis matrix in Excel to systematically assess the examples of programmatic changes by type of underserved or marginalised group per country. The documents for the desk review were mostly quarterly reports, and as these were across Lot 1 or Lot 2, they were fairly broad and lacked sufficient information relevant for the study (e.g., detail regarding the processes for decision making and challenges/ lessons learnt for using evidence, and strengths / limitations of data sources). However, the more recent reports were useful in substantiating the examples provided in the KIIs and included some insights into planned changes. See Appendix 3 for a full list of documents reviewed.

The findings are first presented by Lot, and then cross programme learning is shared. The Lot-specific case studies are informed by the KIIs and provide global (HQ/Hub) and country-level perspectives of how evidence utilisation (under each stage of the framework) happens under WISH. Findings from the survey and desk review have been used to provide more country level examples of how evidence has been used to change programming and contextual information to help triangulate findings from the KIIs.

Limitations

This study has a few limitations.

- Due to time and budget constraints, the study involved a small sample of countries and a small number of key informants from each country team (six countries and two to four key informants per country). The number of survey respondents was also relatively small. As a result, this study could have missed out on capturing other examples of best practice and perspectives from other WISH countries and team

[7] Survey participants were given two weeks to complete the survey and were given email reminders to increase participation. Numbers of TWG members are as follows (note that some people overlap groups): 30 in Reaching young People; 21 in Disability inclusion, and; 31 in Reaching people living in poverty.
There were 13 completed surveys, with 6 further surveys being started but not complete. Note that some individuals were from more than one TWG. So, in total we had feedback from 13 individuals representing: 3 Youth TWG members; 6 Disability TWG members, and; 10 Poverty TWG members.

members regarding how data has been used to adapt programming to inform reaching underserved clients.

- Due to the scope of different activities discussed at the global level and the continuous nature of evidence utilisation it has not been possible to accurately capture the timing or stages of when changes happened at the country level.
- KIIs at the global level involved people with different roles from MSI and IPPF (with the exception of the data analysts) and therefore the information from each organisation is not necessarily comparative.
- All interviews were conducted remotely using Microsoft Teams, due to COVID-19 travel restrictions and to minimise the burden country teams' time. In a small number of cases this affected the quality of the interview due to audio and internet connection problems.
- The impact of the coronavirus pandemic and the associated restrictions on movement resulted in some countries not being able to complete the 2019-2020 round of CEIs, and in-country operations were limited during periods of lockdowns during 2020. This, and some partners having to re-focus on other programme priorities as a result of COVID-19, may have potentially limited the breadth of findings and recommendations for this study.

It is also important to note that due to a combination of factors, IPs may have been limited in their recent use of CEI data in programming. Such factors include: (a) the CEIs being either very staggered or incomplete due to delays with obtaining ethical clearance or the impact of COVID-19 restricting movement for field work during 2020; and, (b) IPs having to refocus on other programme priorities as a result of the pandemic. This may have affected the breadth of findings to reflect upon to inform recommendations for this study.

3 Results

The following section combines the findings from the KIIs, online survey and desk review. This section is divided in two parts: the first describes the sources of evidence used by WISH partners and the second presents two case studies.

The case studies focus on the lead organisation for each Lot, Case study 1: MSI (Lot 1) and Case study 2: IPPF (Lot 2), though each WISH Lot includes a selection of both MSI and IPPF country programmes / Member Associations (MAs), and other consortium partners.[8] We have presented the findings in this way because the organisational structure, history and culture around evidence utilisation is specific to each Lot and influences their respective country partners' use of evidence. Therefore, we reflect on how each IPs' structure and approach to evidence utilisation relates to each stage of the evidence utilisation framework. Through a comparative analysis of the two case studies, we identify the contributing factors that enable or hinder access and use of data, as well as the strengths and limitations of using data experienced by stakeholders for the WISH programme.

SECTION ONE: Sources of evidence used by partners

The following section focuses on the main sources of evidence used by IPs to inform WISH programming, planning, and reporting related to underserved and marginalised populations and it also details the tools developed or adapted by the IPs to help them collect data on underserved and marginalised populations.

Main sources of evidence across both partners

MSI and IPPF both use similar sources of evidence about underserved and marginalised populations.[9] The main sources of evidence across both partners are CEIs, service statistics, and external sources (Box 1).

Box 1: Main sources of evidence used by WISH partners

1. **Service statistics** are collected routinely from all service delivery points or channels and provides client and service information. Service data gives a measure of programme reach in terms of reporting how many clients are adolescents (under 20 years of age) and the number of family planning services and products provided to clients.
2. **Client Exit Interviews** are annual cross-sectional surveys among a sample of clients in different service delivery channels. The CEI used for the WISH programme is based on the tool developed by MSI that was primarily designed to provide client feedback on quality of care, client socio-demographic and use profile and information about marketing preferences. The CEI was adapted for WISH to include additional questions to measure vulnerability in terms of clients with a disability through the Washington Group Questions (WGQ) and clients living in extreme poverty through the Poverty

[8] It should also be noted that while IRC are a consortium partner for W2A they are also an implementing service provider and in this study are included in the case study for W2A.

[9] The term 'evidence' and 'data' are used interchangeably by partners when talking about evidence used to inform decision making and adaptive programming. There were inconsistencies within the two Lots which was not IP-specific, and use of the terms did not always align with the W4R definition of evidence. This depended on the *type* of data and *how* it was presented and how it was shared. Service statistics or routine data that are taken from client and service numbers were commonly referred to as 'data', such as when asking 'what does the data tell us?' (despite the data having been analysed and processed to make sense of it); and CEI evidence was usually called 'results'. 'Evidence' was used more in the context of sharing more in-depth analysis via internal webinars or WISH partner-led meetings, working groups or evidence briefs, and when using external sources of information, such as government data. For the purposes of this report 'sources of evidence' is used to refer to the types of programme and external sources of data that is then processed into useable information for programming.

Probability Index (PPI) and Multi-dimensional Poverty Index (MPI).[10] Measuring clients living in extreme poverty is very important as it informs a WISH payment-based KPI.

3. **External sources of data** such as demographic health surveys (DHS) or other national poverty related / FP surveys are used by all partners to gain understanding of the wider evidence base and any outstanding gaps such as the demographic and geographical distribution of certain groups' unmet need for contraception, to help with planning, informing programme design and comparing internal data. Such data has also been used to develop poverty heat maps, which have become an important tool for WISH adaptive programming.

Each IP has their own organisational system for gathering information, assessing progress, identifying learning and adapting programmes that are discussed in the case studies in the following section. There are some similarities and differences in how the two Lots collect this data.

The partners also use other evidence that they generate themselves to inform their WISH programming. These include: **baseline assessments** in countries where family planning service provision was not a core focus before WISH (such as for IRC in Somalia and South Sudan), **mapping** of organisations of persons with disabilities (OPD) and youth organisations to improve linkages and referrals to WISH services; and qualitative **bespoke studies** and **community dialogues** among target groups to understand more the barriers to accessing services to inform behaviour change strategies.

Data collection tools used by partners

To collect data on underserved and marginalised populations as part of the WISH programme, IPs have developed or adapted existing data collection tools. These new or tailored tools were important to address gaps in data for decision making and improve the IPs' learning and evidence base. For example, MSI's CEI questionnaire was adapted for WISH to include additional questions to measure vulnerability in terms of clients living with a disability through the Washington Group Questions (WGQ) and clients living in extreme poverty through the Poverty Probability Index (PPI) and Multi-dimensional Poverty Index (MPI). Other examples include:

- Under WISH, MSI has scaled up its **routine poverty metric** that is integrated with routine data systems to several new country programmes.[11] The metric uses a simplified version of PPI poverty questions and measures the relative poverty level of a group of clients served at a site in comparison to other sites, to be able to track (and compare across) sites that are likely to be reaching most poor populations. The poverty measurement provides an indicator of relative poverty of sites (not individual). This helps country programmes to optimise site selection by managing the relative performance of sites and teams and test which interventions work in increasing MSI reach to those living in extreme poverty. The routine poverty metric was piloted in 2017-18 and is operational in 9 countries (7 countries involved in WISH: Burkina Faso, Mali, Niger, Nigeria, Senegal, Tanzania, Uganda; and 2 non-WISH countries: Malawi and Kenya).
- **Poverty Heat Maps** that combine wealth data from the DHS and geo-spatial data of service delivery points to identify areas of highest density poor populations to inform selection of sites for outreach services / channel. The Poverty Heat Maps were

[10] See the W4R report for more details: Evidence Brief #3: *A learning-focused assessment of experiences in collecting poverty and disability measures through client exit interviews*, June 2020.

[11] The relative poverty metric was piloted in some country programmes prior to WISH as a means to provide a reliable measure of relative wealth without putting additional strain on service delivery staff, or the clients themselves as part routine data collection.

initially created by MSI prior WISH but have been developed further and become an essential tool for IPs to identify area of unmet need.

- In collaboration with consortium partner Leonard Cheshire, MSI have also adapted their standard **Mystery Client Survey** to include a **Disability Audit Checklist** to evaluate the quality of care and to improve inclusivity of services for different underserved and marginalised populations.
- In efforts to improve measurement of disability inclusion, some of the IPPF MAs (e.g. Pakistan and Tanzania) have adapted their client register to include a **routine disability indicator** to monitor mobilisation activities in the community and record the number of clients who are living with a disability.
- IPPF are trialling a **Rapid CEI**, a simplified version of the original CEI that can be implemented more frequently to help monitor programme changes.
- Since data collection, MSI have been undergoing a re-platforming of their central Client Level Management Information system (CLIC) that will build in additional functionality such as the ability to randomise questions per client or add a standardised set of questions to a random sample of clients. Once operational key questions will be piloted such as the routine poverty metric questions and WGQ for disability, and the data assessed for quality, validity, and the comfort of clients and providers with the approach.

Many of the new tools that have evolved in response to adaptive programming have not yet generated data for evidence utilisation (at the time of this study).

Table 2 illustrates how the main sources of evidence are used for reporting on underserved and marginalised populations and how it relates to programming. Under WISH, evidence is broadly used to plan or design different aspects of programming such as site selection of outreach locations, behaviour change / demand generation interventions and service delivery approaches; to monitor and evaluate the quality of care; performance management (of country, channel and team level); and donor reporting.

Table 2: Sources of evidence and how it is used in programming

Source (tools)	Client group			What the evidence informs?		
	Poverty	Youth	Disability	Strategy/ design	Monitor/ progress	Results/ KPIs
Internal						
Client Exit Interview	✓			✓		✓
Service statistics		✓		✓	✓	✓
Routine poverty metric (MSI)*	✓			✓	✓	
Routine disability data (IPPF)*			✓		✓	
Poverty Heat Maps*	✓			✓		
Baseline assessments / mapping			✓	✓		
Community dialogues (IPPF)		✓	✓	✓		
Bespoke studies			✓	✓		
Mystery client survey (MSI)		✓			✓	
Disability audit checklist (MSI)*			✓	✓	✓	
External						
National poverty related surveys	✓			✓		
Demographic Health surveys	✓	✓		✓		

* Indicates new or modified source of data as apart of adaptive programming.

While evidence about clients living in poverty and youth is based on CEIs and routine data respectively, evidence about clients with disabilities relied more on qualitative data and engagement with OPDs, and therefore generated less formal feedback and insight.

SECTION TWO: Case Studies

The case studies that follow describe how this evidence (largely focussing on data from service statistics and CEIs) is accessed and used to better understand the needs of underserved and marginalised populations to adapt programming by improving services and increasing access where unmet need for these groups is highest.

3.1 Case Study 1: MSI (Lot 1)

3.1.1 Background – Organisational structure and evidence culture

MSI has an established coordinated system using standardised tools and processes for collecting, analysing and using data for performance management and to improve access to service provision. This system is cascaded to MSI country programmes who contributed to this coordinated system. The range of respondents who could respond to this study is indicative of the in-house technical expertise and institutional investment in supporting performance data collection for decision-making.

Fifteen MSI country programmes deliver WISH activities, split across Lot 1 and Lot 2. They are closely supported by an Evidence and Impact (E&I) team based in London (HQ) to carry out their research, monitoring and evaluation (RME) activities, as well as MSI Channel Leads who oversee the performance of their service delivery channels globally. With strong technical capacity and an incentive-based evidence culture, country programmes have been able to quickly adapt to the reporting requirements of WISH. Several of WISH KPIs align with MSI's existing priorities and objectives, such as the focus on serving underserved and marginalised groups, and many of the data collection systems that provide evidence on these groups were already in place. At the start of WISH, MSI built upon its existing structures and processes for evidence utilisation, and as one respondent explained: "Our sources are not different [from data sources that we normally use] but the way we are using them have where we have dived deeper into our data and use it differently." (Global KII: MSI,3). As a result, MSI didn't need to focus on investing so much in their evidence utilisation structures and were instead able to focus on making these systems more efficient at the country level and leveraging them to examine disability inclusion and improve & measure service inclusivity.

3.1.2 Access and use of evidence

The following section detail the processes guiding access and use of evidence from the routine data and CEIs at the country and Global level.

Routine data

Independent of WISH, over the last eight years MSI has rolled out an electronic routine data system, Client Information Centre (CLIC)[12], in its clinics, mobile outreach teams and community-based service delivery programmes. This has increased MSI's access to timely client data for both programmes and the country offices. The programmes that had already implemented CLIC in its outreach teams talked enthusiastically about how this increased their ability to receive data promptly and to then run analyses and return these results to the in-country teams. However, there were some technical problems with the electronic system

[12] CLIC enables teams to capture and visualise a broad range of client-level demographics, services and financial information while working offline to suit the low connectivity environments clinics and outreach teams.

that impacted on the collection and accessibility of the client data. In the case of Burkina Faso, the team reported they did not have sufficient training and autonomy to manage CLIC, having to call upon contractors to address difficulties with the system, and the often-unreliable internet access during outreach prevented uploading the data in real time. There were also incidences of there not being enough laptops to use on outreach visits, notably when the teams split up to maximise coverage.[13] This meant that service numbers could not be entered into CLIC in real time, but instead had to be uploaded later.

It was also observed that the visible presentation of programmes' routine performance in CLIC Dashboards was an important factor for enabling timely access to and reflection of trends in data across multiple teams. Once the data is captured, the system is designed to produce standard tables and graphs (dashboards) for type of services, including FP and SA/PAC and / or service delivery channels to compare monthly trends. For example, the Outreach Performance dashboard includes key indicators such as adolescents served as a percentage of total clients and sites mobilised.

For MSI, data visibility and timely availability of routine data (for youth) through monthly performance dashboards was seen as a key driver for regional and country teams to access and use data to quickly address challenges. The success of reaching more adolescent clients was attributed by one respondent to the "*push towards making routine data visibly accessible to all programme teams to empower them to be able to drive change.*" (Global KII: MSI,2) This was particularly the case for the outreach and PSS channels.

Respondents from Senegal and Burkina Faso explained that a first step to ensure effective evidence utilisation was that each programme team member understood their role in relation to evidence utilisation, particularly around data collection. What had helped these country teams to use evidence was having clear roles and responsibilities for each person throughout the organisation so they understood how to collect accurate and useful information.

The importance of clear roles and responsibilities for quality data collection was also expressed at the Global level, where they spoke about inconsistencies across country teams. For example, due to some country programmes' structures, it was not possible for the Marketing Leads / teams to effectively oversee the quality of reporting on marketing activities in the field, which could lead to gaps or inconsistent data. This was especially the case for mobile Outreach Teams that were tasked to independently collect marketing data, compared to static clinics where Marketing Teams can be more directly involved in monitoring.

Client Exit Interviews

MSI conduct CEIs across all country programmes on an annual basis and oversees the implementation and analysis of the survey internally. Country programmes are responsible for managing the data collection and additional country-specific analysis and reported a deep sense of ownership over their CEIs. Following data collection, country programmes send their raw data to the London office to be cleaned and analysed by the Global E&I Team, who follow a standard process of verification and presentation of results. A summary set of key indicators by service channel is then sent back to the country to be checked and agreed. The country RME staff are then equipped with standardised tools from the E&I

[13] MSI's recent Accelerated Outreach Model that some countries have started to practice (Zambia, Nigeria and Nigeria) whereby a normal outreach team partners with a public sector provider to assist with the clinical provision, and splits across two zones to serve more clients but use the same allocated team structure and resources.

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Team to independently conduct further analysis and communicate findings across their teams.

The Global Evidence Advisors and Analysts also provide ongoing support to country RME teams for additional analysis and use of CEI data. This was seen as beneficial because it provided a different perspective on interpreting findings and communicating with other teams. To help strengthen the capacity of country staff, the Global E&I team also facilitate Evidence and Learning events for the country RME managers to attend in person[14] to build on skills and learning such as *'how do you use your CEI data, and how do you use your routine data?'*. MSI also hold global awards for 'use of evidence or data' that have encouraged and rewarded good practice within the organisation. Both events have continued to take place during the COVID-19 pandemic, with a shift to online platforms.

Sharing learnings from data analysis

When each country CEI data set is finalised, it is shared with the country team. The country datasets are also then merged into a global dataset for further in-depth analysis. The E&I Team reflect on the data with respective Channel Leads / support office teams and carry out thematic and channel-specific deep dives that combine CEI data alongside other programme data.

The CEI learnings are shared both internally via different platforms such as webinars across MSI's Channel Communities that bring together all the Leads running that channel in each country (such as Outreach, Marketing and Youth), as well as for WISH partners through the TWGs and dissemination of evidence briefs.

The Channel Leads, who oversee the progress and challenges of their channels globally, also highlight lessons to be shared with all MSI country programmes to improve implementation through monthly newsletters. As Outreach is the largest mode of service delivery for MSI under WISH, the lessons learned and shared with all MSI country programmes are often the product of WISH work – providing key insights and suggested adaptations based on what has or as not worked in WISH countries. As such, the positive and often innovative experience of WISH country programming has been useful in strengthening MSI's wider learning and programmes in non-WISH countries. It was also reported by one respondent that these platforms have been a particular focus in the past year versus other platforms used in previous years due to COVID-19, "…*to feed out CEI insights across teams and programmes so we can triangulate with other data sources."* (Global KII:MSI 4).

Building capacity around data

Interviews at the Global level indicated that how country programmes managed data and promoted evidence use within their countries depended on their capacity and 'evidence literacy' at the in-country level. It was also observed that the technical capacity and attitudes of individuals was an important driver of how data was used. Some country RME staff were more comfortable or enthusiastic with data and evidence than others, as reflected by either their showing initiative to access external evidence or adopting a more 'business approach' to looking at data to drive performance. These personal qualities of RME staff were also reported to be correlated to the country context in terms of what external data resources were available, the size of organisation and RME teams, or how established the country programme was and therefore experienced in data systems.

[14] This event was based in London, although some countries did not attend due to problems with obtaining visas to enter the UK.

3.1.3 Results and usefulness of evidence

Processes to reflect upon and use programme data from their routine data and CEIs were not new for the country teams, as the systems and standard procedures were already in place prior to WISH.

The following highlights how the evidence from WISH has provided MSI with new learnings and reflections on the strengths and limitations of the data.

Evidence on Youth
Overall, MSI country programmes have maintained a consistently high performance in reaching young people (with one quarter of client visits being made by young people under 20 years). Having established metrics to capture youth clients through service statistics, the programme was able to capture the changes resulting from expanded youth programming, including demand creation using community-based mobilisers, youth ambassadors as well as using social networks and contact centre.

It was reported in some KIIs that the slight declines some countries experienced in youth reach during the height of the COVID-19 pandemic could have been attributed to school closures or travel restrictions, making it difficult for youth to access services. At the country level, respondents explained that where there are changes in the trends of youth uptake across locations in routine data, these are investigated quickly to understand reasons for discrepancies to be able to adapt service provision accordingly. For example, in Nigeria, Marie Stopes International Organisation Nigeria (MSION) reported that despite seeing a small overall increase in the proportion of young clients accessing outreach services, deeper analysis of the data found there was variation between locations and where reach was lower there are restrictive cultural practices hindering young women to access facilities. (see also Box 3).

Evidence on Poverty
According to the CEI results for 2019, many Lot 1 countries did not meet their poverty targets.[15] The first WISH CEIs were conducted in 2018, although the 2019-2020 round of the surveys was the first time both the PPI and MPI metrics for poverty had been included in the CEI across all WISH country programmes.[16] There are various factors affecting the results in relation to the measures, and more in-depth country-focused analysis and discussion among the consortium partners, FCDO and the TPM in early 2020 were pursued to ensure a deeper understanding of the metrics and performance.

Some respondents noted the lack of effective metrics for tracking clients living in poverty as well as for clients living with a disability as limiting factors for evidence utilisation, particularly when they are linked to be payment-based KPI (i.e. poverty). Not having accurate data and information has caused uncertainty, particularly as it resulted in the appearance of under-performing in an area that is linked to payment.

Evidence on disability
The 2019-20 round of CEIs was the first time for implementing the WGQs to assess disability among clients. While the CEI results across Lot 1 were in line with the global prevalence of people living with *severe* disability, respondents were surprised at the low

[15] In only five out of 11 countries the proportion of WISH clients living in poverty achieved parity with the national poverty headcount. Cameroon, Burkina Faso, Senegal, DRC and Sierra Leone performed well but Chad, Mali, Niger and Nigeria achieved mixed results below the benchmark (WISH Lot 1 Quarterly Report 2020 Q1, page 8).
[16] MSI conducted WISH CEIs in 2018, although IPPF did not conduct CEIs this year. MSI had previously conducted CEIs including the PPI metric only in other programmes.

proportion of clients living with disability.[17] MSI recognise the lack of evidence to effectively monitor country programmes' efforts to address disability inclusion, claiming that it has been (so far) "*frustrating to find a solution to track this work effectively and is still work in progress* (Global KII: MSI3)". Outside of WISH, MSI piloted routine disability measurement (using one question and also the WGQs) but found this was not viable or acceptable to ask these kinds of questions to clients in the context of their clinical visit. On the basis of the study (and corroborated by Lot 1's disability technical partner Leonard Cheshire), MSI made a global recommendation not to capture disability status routinely. Instead MSI advised its country programmes to continue to measure WGQs in the annual CEI and regularly assess how *inclusive* services are (with tools like disability audit tool). MSI's routine data does not capture disability status at the client level.

There were some reservations at the global level about capturing disability as a part of the CEIs. The addition of the poverty questions had substantially increased the length of the questionnaire, resulting in "*more burden for our clients, when they are not directly benefiting from it or findings are improving the client experience* (Global KII: MSI3)." In addition, the WGQs required enumerators to be carefully trained on how to ask these questions in the context of SRH service delivery.

There was also some disappointment in the results from the CEIs, which were seen by some respondents at both the global and country level to not reflect the true extent or nature of services that reach certain client groups. This was particularly evident for countries that were working with OPDs to mobilise clients with disabilities to attend special events for services as well as mobile services which may not take place during the three-week period of CEI data collection.

Limitations of tools and triangulation of data

The inability to capture the true extent of clients living with disability as well as the proportion of youth in some settings[18] was seen as the main limitation of the CEI survey, which MSI had originally designed to provide a snapshot of client feedback among a small sample.[19] As it is conducted once a year it is not possible to capture all the service delivery approaches and thus it was said to be*… "difficult to be sure that we are picking up all the kind of opportunities for the CEI data to be representative of our reach among clients with disabilities"* (Global KII, MSI4). In addition, MSI technical staff highlighted that it is not possible to do sub-group analysis when the prevalence is very low, such as in the case for people with severe disability, as this demands much larger sample sizes than is feasible among client flow on outreach. It is for these reasons the Global E&I Team encouraged countries to triangulate data to investigate further the implications of findings to confirm the reliability of evidence, such as around adolescents or method preferences or counselling trends.

In addition, the strengths and weaknesses of different data was also a reason to draw on different sources to aid decision making. For example, the 2019 CEI results in Nigeria showed a small decline in the proportion of MSION clients living in extreme poverty (12% to 11%)[20]. Further investigation using the Poverty Heat Maps indicated this was associated with

[17] The global prevalence of people with *severe* disability is very low with a range of 0-5% and WISH Lot 1 consortium averaged 2% in 2019/2020 CEI, with very large confidence intervals. The global disability prevalence figure of 15% is based on a much less strict definition of disability compared to WISH.

[18] Similar to mobilising for people living with disabilities, programmes often held special days or events to make services more accessible for young people, which are not necessarily captured in the CEI sample or data collection period.

[19] The sample size also limits the level of analysis whereby the sample cannot be disaggregated by type of underserved/marginalised group per country, although it is possible to look at different underserved/marginalised groups as a whole at the global level and / or by channel. For adolescents, if country programmes want to conduct sub-group analysis they do a booster or extended sample in order to have enough power. Sierra Leone did this in 2019.

[20] This figure represents the MSION total programme average result. (i.e. the average across all MSION activities). The WISH programme figure for MSION was 25%.

the scheduling of outreach teams and selection of sites whereby for some poor communities' clients needed to walk far to access these services.

Further limitations of the CEI were in the context of WISH reporting and the high expectation of a tool that had been adapted beyond its original design to provide important programme data for payment KPIs. In general, the CEI as an approach to inform internal learning about client profile and feedback on the quality of services was still highly valued.

3.1.4 How evidence is used for adaptive programming

This section outlines some examples of how countries have used data to inform programme and service changes based on evidence from service statistics and CEI and other sources that are common to all WISH partners.

Adapting approaches to mobilise youth

Box 2 and Box 3 both illustrate how Marie Stopes Burkina Faso (MSBF) and MSION and used evidence for adaptive programming responding to stagnation or decreases in the proportion of clients aged below 20 years. In addition to using country routine data, evidence from other countries have been used to learn and adapt aspects of youth programming. In November 2019, MSI Youth Leads from Burkina Faso, Senegal, Niger and Mali met at a sharing and exchange workshop in Senegal to promote and disseminate good practices in the SRH of adolescents. As a result of shared learning in the workshop, MSBF trained service providers, including social marketing agents and Marie Stopes Ladies (MS Ladies), in a youth-focused approach to social and behaviour change communication (SBCC) and provided them with youth-focused communication products (Box 2).

Box 2: Adaptive programming: Burkina Faso

Country: Burkina Faso (MSBF)	**Client group:** Youth
Youth: 2019 CEI findings showed that MS Ladies who focus on urban areas were not reaching as many poor clients as mobile outreach services (31% vs. 48% of clients in extreme poverty). They also indicated that young people did not like to mix with older clients at facilities. During 2020, MSBF decided to adapt existing approaches to reach to more young people in and out of school. The opening times of static clinic hours were changed to be more convenient and only available for young people at certain times, and the MS Ladies began to organise dedicated youth days that include a range of activities such as movie debates and radio games to attract young people. To increase its mobilisation efforts MSBF have also strengthened links with school leaders and parent associations and recently obtained permission from the ministry of Education to visits schools. In addition, MSBF have built upon its *'La Famille Idéale'* programme that involves a board game that generates role play and conversation among players and spectators to dispel myths and strengthen communication around family planning at the individual, family and community level.	

Evidence Application in Outreach Channel

As reaching the poorest is a key priority of WISH, approximately 40% of WISH service provision takes place through the Outreach channel. Adaptative programming has thus focused largely on MSI country programmes carefully monitoring outreach data and seeking improvements in the selection of outreach locations. This was seen as key to WISH (and MSI) and an easier approach to increase the uptake of services among poor populations in comparison to reaching the poor through other channels, as captured in the following quote: "*…if you reach more clients on the outreach relative to the other channels than your poverty will go up because outreach's contribution to the poverty score will increase and they get a better public service"* (Global KII: MSI2).

The WISH programme was seen to 'push' MSI to use data differently, and one respondent stated that the focus was on "*the processes of using data, rather than the tools themselves.*

So there are two big processes in the [Outreach] *channel and where MSI really use the data to make decisions: how are you going to review performance, equity etc? and how to select sites?"* (Global KII: MSI2).

In addition to using poverty data presented in the Poverty Heat Maps to help select the most densely populated poor regions to improve Outreach performance, MSI has started to roll out other innovative approaches to reach the poorest. One such intervention is MSI's Accelerated Outreach Model that aims to serve more clients by splitting outreach teams. The approach was piloted in Zambia (Lot 2) and Nigeria, and findings from the evaluation were shared via a webinar for MSI Outreach Channel and PSS teams in May 2020.

Box 3: Adaptive Programming: Nigeria

Country: Nigeria (MSION)	**Client group:** Poverty and Youth
Poverty: In Q2 2020, to improve poverty reach, MSION adapted the site selection and mapping process of its outreach services using poverty data, as well as by collaborating with government authorities to use local knowledge to ensure only areas that are very poor are selected: "*Our new strategy includes how we conduct our schedule meetings for outreach to include local government staff at different towns and villages, who are able to redirect us to where the hard-to-reach communities are to be reached as well as keep us informed about the security in the local areas*"(Country KII: Nigeria,2). In addition, routine data informed the allocation of resources for outreach, it showed which teams were reaching more poor clients and therefore it would be more productive to split the teams to be able to reach more clients. **Youth:** After learning that the mobility of married adolescents is restricted in some outreach locations due to the religious and cultural practices of *Purdah* preventing women to access facilities, MSION used their routine data to realign their strategy for adolescents through the use of MSI's door-to-door MS Ladies[21] who are trusted in the communities by husbands and mothers-in-law and allow access to these services at home.	

Challenges to Evidence Use

It takes approximately one year to implement CEIs from data collection to presentation and use of findings, with a lot of support required from HQ to manage CEIs across many countries. As such, some respondents felt that CEIs were "*not very accessible for adaptive programming"* (Global KII: MSI3) within the timeframe of the programme.

WISH Outreach work in Nigeria experienced challenges in early 2020, whereby teams were not able to reach all sites due to security issues. To address this, MSION have collaborated with government authorities to use local knowledge about the security situation and begun to mobilise at a broader level to ensure there are back-up sites available (Box 3). Instability in other fragile, conflict afflicted settings has also prevented service provision as well as implementing changes to programmes. In Burkina Faso, following the government's decision to make all family planning services free, MSBF plans to scale up its outreach service in the Internally Displaced People (IDP) camps but was unable to enter the sites due to conflict.

Another barrier to implement programme changes was lack of staff capacity. In some cases, country teams lack the skills to implement programme changes to address the needs of underserved and marginalised populations. For example, in Burkina Faso it was reported service providers lacked training in sexual and gender-based violence (SGBV) and youth programming to target particular segments of the population in new locations.

It was also acknowledged that using evidence to make decisions about where Outreach teams need to visit to increase the coverage of poor communities takes time that is not always conducive for adaptive programming. Making arrangements to send Outreach teams

[21] Marie Stopes Ladies are a part of MSI's outreach channel strategy whereby mobile midwives / nurses from local communities are trained and supported by MSI to provide contraceptive services and advice to women in their own homes.

to new areas involves a lot of work with different stakeholders, and then to stop providing services comes with additional responsibilities.

While COVID-19 was reported to have created challenges for WISH due to the restrictions on movement and fear of exposure to the virus, the pandemic has also presented opportunities to adapt and innovate ways of programming. With a shift in focus to the COVID response, some countries integrated their reproductive health services with COVID-related programmes. For instance, in Senegal, community-based mobilisers have obtained permission from the government to offer contraception as part of their awareness campaigns around COVID-19. While in Nigeria, building on a collaborative relationship with the national and local authorities, the Ministry of Health has allowed mobile teams free movement between states to deliver FP services across the country.

3.1.5 Changes to evidence utilisation

This section outlines how MSI have adapted its processes for evidence utilisation at the global and country level as a result of WISH programming.

Improving processes for evidence utilisation

In general, WISH provided the opportunity and space for MSI to scrutinise its current approaches and improve tools for evidence utilisation. While sharing similar priorities and objectives with WISH, MSI as an organisation was in a good position to build upon its existing structures and methods and enhance evidence utilisation processes.

There has been increased focus on using data to drive performance, such as the launch of the **Outreach Performance dashboard** to all MSI Country Programmes in June 2020, including a 3-day (virtual) workshop for Niger, Mali, Senegal and Burkina Faso. The dashboard offers greater visibility on key indicators, including the percentage of youth reached and sites mobilised. MSI have also produced a new **CEI data visualisation dashboard** to support use of the CEI data for decision-making. While these platforms have been developed for use by MSI, the learnings from the WISH programme have influenced their design and the drive to get them operational for the purposes of WISH.

Rethinking how to define and measure poverty

The discussions around the suitability of the MPI/PPI in the CEIs has resulted in more in-depth analysis of the CEI data and the development of knowledge products to be shared across MSI programmes and WISH. One of these products is the forthcoming **poverty deep-dives**, developed by the Global E&I Team, which includes analysis of CEI data alongside mapping and routine data to explore in more detail the relationship between these sources of evidence and learn more about the reach of poor clients.[22]

MSI have learnt that there could have been a deeper exploration of poverty data sources at the start of the programme. However, one respondent commented that this *"is not always possible at the time of putting a bid together and being a stretched team, I just also think we didn't know* [poverty metrics] *as well as public data sources and they don't always highlight the limitations or risks it might have"* (Global KII:MSI3) At the time of this study (end of 2020), MSI are investigating further poverty metrics and considering other approaches to measure poverty, including building on the Poverty Heat Maps, which use geospatial and external data and thus have the potential to reduce the burden on clients participating in a lengthy CEI.

[22] WISH Lot 1 Quarterly Report 2020 Q2

MSI have also rolled out its '**routine poverty' metric**, whereby adapted PPI poverty questions are integrated into the routine CLIC system in seven of the 11 WISH countries. Two poverty questions are randomly asked of each client, building up a composite site-level relative poverty metric over time, assuming client samples at each site are sufficient to generate an accurate estimate. This metric has been seen more conducive for adaptive programme as it is more readily available (compared to relying on the annual CEI results to learn about how poor clients are reached by service channel) to help monitor the relative wealth status among clients across outreach teams, however it also comes with challenges. For example, relying on live data entry to prompt the 'pop up' poverty questions (which is not always feasible in a busy outreach context, especially during split team days) and the resulting data can be difficult to interpret as it is relative rather than absolute. However, this metric has been built into outreach dashboards in a colour scale to help interpretation and has also been important to verify CEI results and to help confirm site selection based on the poverty heat maps.

Rethinking how to define and measure disability
As part of WISH, and working closely with its consortium partner Leonard Cheshire, MSI developed a **Disability Audit Checklist** in 2020 to assess the quality of services in terms of disability inclusivity. The tool was piloted in Sierra Leone, Zambia and Cambodia. In terms of measuring disability, MSI have realised the limitations of using WGQ in CEI in training and implementation in a health service setting. While MSI piloted the inclusion of WGQ as part of routine data collection, the asking of such questions in the context of a clinical service was found to be problematic, as well as being time-consuming and intrusive for the client (see also section 3.1.3). Measuring disability for WISH has relied more on qualitative data and working with OPDs; its approach to disability measurement is still in progress and a part of a wider focus on service inclusivity to assess readiness to serve clients with disabilities.

3.2 Case Study 2: IPPF (Lot 2 /W2A)

3.2.1 Background - Organisational structure and evidence culture

Eighteen of IPPF's MAs deliver the WISH programme across Lot 1 and Lot 2. The MAs are autonomous organisations and have their own operating structures and different systems for data collection, but they submit a set of standard service statistics to IPPF secretariat on an annual basis. As a result, IPPF's approach to data, evidence and evidence utilisation is very much structured around the MAs, which vary in capacity and resources. Through the WISH programme, IPPF has set up centralised systems and processes, including for programme-wide data management. IPPF established a regional W2A Hub office in Nairobi, Kenya and recruited dedicated staff to provide technical support to its WISH countries, including three Heads of Region (HoR) and a W2A Evidence and Learning (E&L) Team consisting of one Technical Lead for Systems, a Technical Lead for Monitoring and Evaluation, and three Data Analysts who are assigned a selection of W2A countries.[23] IPPF also needed to adapt its data collection away from exclusively service data to also collecting client data. MAs were also required to switch from reporting to IPPF at the channel to service delivery point level and increase the frequency from annual to monthly reporting.

Many of the MAs work closely with national governments and have data systems that feed into the public sectors' data management systems. At the start of WISH, it took time to get

[23] The full Evidence and Learning team came on board in April, 2019.

some governments on board with the programme which delayed the alignment of the various health data management systems the MAs work with. It was also reported that some MAs had to negotiate government approval in the case of making changes to data management or to shift programming in new locations, which could impact on timeliness of executing different aspects of evidence utilisation.

3.2.2 Access and use of evidence

The following section details the processes guiding access to and use of evidence from the service statistics and CEIs at the country and Hub level.

Service Statistics

At the start of the programme, it took additional time[24] for the regional Hub Data Analysts to set up standard reporting systems and to get all MAs on board to adhere to the WISH reporting requirements. The setting up of an integrated W2A data system to align with IPPF global data systems also required consistent human resources to manage the process and the country and Hub level. As one respondent explained about setting up data management systems: "*At the start it wasn't business as usual and the project was going to have to run differently from the traditional way that IPPF was managing things... it was until Q2 in 2019 that we were ready to go."* (Hub KII: IPPF2, respondent 4).

In addition, as many MAs work in partnership with the public sector and use the public sectors' data management systems, it was also necessary to adapt local systems in some countries to ensure consistent data was collected across partners (e.g., the different age categories recorded for youth service data). This required the regional advisors to understand the data system for each of the 18 MAs and then develop a standardized template and work with each MA to align the different data systems.

The Hub level staff highlighted the capacity of their MAs was key to how teams managed data and promoted evidence use. Given the diversity of data collection systems, it was observed how the organisations with stronger M&E systems and experience of working on other donor projects found it easier to adapt to the WISH reporting requirements.

It is only recently (Q2 2020) that MAs and the W2A Hub staff have transitioned to the new reporting requirements via the online District Health Information Software (DHIS2) reporting platform, which has augmented WISH data strategies via on-demand data collection.[25] For the first time, the MAs now also have access to performance dashboards that show results in real time. W2A data analysts' role is to oversee the processing of programme data for donor reporting and to prepare slide decks for programme and management teams, including adaptation plans to inform of any necessary changes to programme activities. These outputs are then reviewed at monthly meetings with the MAs, chaired by the HoR, to discuss programmatic issues arising from the data and inform necessary adaptation. Quarterly review meetings are held with all service delivery partners under W2A (IPPF, IRC and MSI).

Client Exit Interviews

In 2019-2020, IPPF conducted standardised CEIs across its WISH MAs for the first time as an organisation and project. This endeavour involved a lot of time, coordination and learning

[24] The development work took 4 months in total from August-December 2019, including two pilots in Uganda and Tanzania. The first roll out was in February 2020 in the two pilot countries and then full rollout to all WISH MAs in Q2 2020.

[25] It was reported in the W2AQuarterly report 2020 (Q2) that following training in DHIS2 data systems in Q1, the very applications, including data collection and quality of care assessment, *"is currently* [Q2] *in use by WISH MAs and W2A HUB staff.* W2A has plans to on-board IRC with a capacity building training planned for 3 August 2020. The next action point is to fully transition MAs and partners to DHIS2 reporting.

from both the Hub and country teams. IPPF benefitted from MSI's history in conducting CEIs and consultative relationship to inform the developing of tools and global CEI protocol, as well as the sampling strategy, to ensure the CEI methodology was aligned across both Lots. Two external research agencies (Kantar and Genesis) were hired to work with IPPF on submitting country specific protocols to local institutional review boards (IRB), develop training materials and conduct data collection training, and manage the implementation and data analysis across different regions. MAs regard this survey as an external research activity, although MA staff were involved in sampling and the logistics for data collection.

The W2A E&L Team received all CEI data and results from the data collection agencies and, after verifying the analysis, disseminated the findings through multiple webinars for specific audiences, such as country teams, W2A partners, Hub staff, IPPF Global and with FCDO. Presentations at the country level was more focused on sharing and reflecting of findings tailored for each MA. The M&E or RME teams for each MA then cascaded the CEI findings to their respective country teams. The Data Analysts and HoRs continue to support each country in the development of Programme Action Plans that outline strategic changes to programme activities based on the CEI findings.

In terms of using CEI data within the timeframe for WISH, many interviewees cited several challenges with this first round of CEIs. They felt that the process took longer than planned, namely due to delays with obtaining IRB approvals and COVID-19 restricting field work operations. Four countries (Malawi, Mozambique, Uganda and Sudan) did not complete CEIs within the timeframe, and so the results were not ready in time for annual WISH reporting. Many respondents felt it would have been more beneficial to have conducted CEIs at the start of the programme to provide baseline indicators and inform activities design, such as SBCC interventions.

Benefiting from the consortium

Among the Hub staff, it was observed how the presence of different consortium partners had an influence on accessing other data sources, in that the type and number of consortium partners in-country contributed positively to the collation and use of evidence as the workload was shared. This was particularly notable for the work around disability. For example, in W2A countries where Humanity & Inclusion (HI) was not present to focus on work around disability inclusion, it was reported that MAs took on additional work (to their normal service delivery) in order to complete mapping and baseline assessment of OPDs. While the presence of HI in some countries may have reduced the burden on MAs to implement these activities around understanding people with disability, it was also highlighted by the Hub staff that the absence of HI did not necessarily mean that this impacted on the quality of collation and use of evidence. On the contrary, it could be argued that MAs may have engaged more with the data due to their closer involvement in collecting it.

The number of consortium partners present in a country was also reported to influence the efficiency of sharing data and discussing the implications of the results. In addition, with more partners to draw upon for technical input and networking to benefit other areas of programming "*..the more people there are to potentially know of another organisation who's done another study or can link to another organisation to help out further.* (Hub KII: IPPF4) This was not just appreciated for the extra resources, but also specific to work around disability which was a new focus for some countries. Having HI as a consortium partner in country was also regarded as *added value* by some MAs, who were grateful for their reflection of CEI results and expertise to provide suggestions for programme and service improvements. They also provided training to services providers on inclusive service provision for clients who have disability.

3.2.3 Results and usefulness of evidence

Findings from both the KIIs and desk review focus on the results from the CEIs, which were seen by many respondents as the most important source of evidence due to *"CEIs directly related to what the project* [WISH] *does*" in terms of *"…assessing how the project is progressing and to inform its strategy and KPIs"* (Hub KII: IPPF3,2). This section highlights how the type of evidence generated from the CEIs provided W2A with new learnings about underserved clients upon which to base plans for adaptive programming.

Appreciation of the added value of CEIs
The first round of WISH CEIs required substantial time and support to implement. However, informants from both global and country KIIs and online survey expressed how helpful the process and results were. They were seen as *"a real eye opener"* (Hub KII: IPPF4) to understanding more about their clients and to improve certain aspects of programming that were either taken for granted or not seen as a priority focus previously. In some cases, this meant rethinking strategies for WISH, such as location of clusters and SBCC approaches. Upon seeing the CEI results on clients living in extreme poverty, MAs and IRC found they were not meeting the set poverty targets in some countries.

Evidence on underserved and / or marginalised groups
Many W2A countries found they were not reaching their poverty targets;[26] as a payment related indicator, there was great impetus to improve reach to underserved poor communities. The CEI data showed that the poverty results varied between countries, but also between partners in the same country. For example, in Ethiopia, the proportion of W2A clients who are living in extreme poverty for MSI sites was 15%, while this was 17% for IPPF sites and 39% for IRC sites. This could partly be due to the locations of sites and types of channels used by the different partners. But in-country variations and lower-than-expected performance does still highlight the importance of site selection for service delivery and SBCC activities in reaching poverty targets.

With regard to the disability inclusivity, the proportion of clients who reported having a disability varied greatly by country, and there was some disparity between service data and the CEI results concerning young clients. While some facilities had already modified their infrastructure to accommodate for people with disabilities prior to WISH the CEI data, as well as observation by country teams, showed this was insufficient to improve access for clients with disabilities. Aside from periodic CEI data and prior to CEI data collection, MAs were not routinely collecting data on disability nor service inclusivity; the evidence was more formative to understand the barriers people with disabilities experienced in accessing services. This resulted in a concerted effort to adapt service registers and start recording the number of clients who had a disability to be able to monitor targeted strategies to reach to this underserved group.

The CEI results also provided new insights about SBCC activities. In some Lot 2 countries, the results showed the importance of community engagement and outreach services (e.g. community based mobilisers (CBM) and CHW) as an important link between underserved populations and the WISH services. In addition, there was also new learning that showed that not as many people were accessing SRH information via mass media sources as previously believed, compared to CHW referrals. This has prompted IPPF and MAs to strengthen their community work, including their stakeholder relationships (e.g. government).

[26] Overall, 33% of countries achieved parity with the poverty benchmark (WISH Quarterly Report, 2020 (Q2), IPPF)

Triangulation of data and additional research

Respondents from three MAs reported using different data sources to cross-check some of the results from the CEIs and using routine service data to investigate further the implications of CEI findings. In Tanzania, UMATI explained how the triangulation of evidence was important to understand gaps and identify opportunities whereby findings from routine service data showed that young people were not accessing facilities despite the MA having integrated youth-friendly services. The CEI data provided insights concerning preferred sources of information about SRH and found that young people did not have access to radio or mobile phones and therefore lacked information about services. UMATI decided to conduct community dialogue sessions with young people to understand the barriers to accessing services and learnt they wanted a comfortable environment, a service tailored for young peoples' needs, and convenient opening times to fit around schooling and separate to adult clients.

3.2.4 How evidence is used for adaptive programming

For MAs, a lot of adaptive programming has focussed on poverty and how to best support underserved and marginalised populations to uptake FP services. Increasing efforts have also been made to improve disability inclusion into programmes, as this has been a new focus for many partners. Based on CEI results, some MAs also needed to rethink approaches for youth programming.

Findings from the KIIs and desk review suggest that much of the W2A's adaptive programming related to poverty is largely based on evidence from the CEIs.[27] Following dissemination and reflection of the results, all the W2A partners were requested to *"consider whether they are working in the poorest places and how W2A can do better, in terms of demand creation approaches via SBCC activities and channelling resources to reach the poorest"* (Hub KII: IPPF3). Country teams developed Adaptation Plans to ensure they are working in the poorest places, which has involved the input of all consortium partners and was a valuable opportunity to strengthen cross-consortium collaboration. These plans have largely been put into action since Q3 2020. Some of the country-level examples of adaptive programming based on data from service statistics and CEIs and other sources that are common to all WISH partners are illustrated in Box 4, Box 5, and Box 6.

Box 4: Adaptive Programming: Tanzania

Country: Tanzania (UMATI)	**Client group:** Youth and Disability Inclusion
Youth: In response to learning about the barriers young people experienced in accessing services, UMATI adapted and scaled up its Youth Weekend Clinic approach from two to five regions under WISH. Focused youth FP services operate on a dedicated day for both in- and out-of-school youth and uses entertainment to attract young people to the facility. Service providers were also trained on youth-friendly counselling for FP. Limited radio coverage and phone access made CHWs key to reaching young people. **Disability Inclusion:** At the start of WISH, UMATI conducted community dialogues with people with disabilities in the community to learn more about their awareness of the project and services. Two gaps were identified: 1) a lack of training and sensitisation of CHWs towards people living with disability and 2) a need for peer-friendly community-based mobilisers to reach out and talk to disabled people in the community. To improve disability inclusivity, UMATI partnered with a DPOs in each district to recruit and train local people with disabilities to be community mobilisers and improve the integration of people with disability service provision.	

[27] Before CEI data was available towards the end of 2020, W2A partners used service statistics, quarterly reports, and country visits to flag areas that needed attention and change programming accordingly. This is particularly true in other programme areas. For example, in Pakistan and Uganda the upward trend in youth data was achieved before CEI data was available.

They also provided sensitisation training to all 218 CHWs to address the needs of people with disability in the community. UMATI also adapted its client register to record if a client has a disability, which is based on observation and self-reporting.

Box 5: Adaptive Programming: Pakistan

Country: Pakistan (Rahnuma Family Planning Association of Pakistan)	**Client group:** Youth, Poverty and Disability Inclusion
Based on performance data early into the WISH programme, Rahnuma-Family Planning Association of Pakistan (R-FPAP) found that youth uptake of services was below the WISH 5% target, and through a W2A data review meeting established that new service providers had not been accurately capturing the age of clients. To improve its youth programming, R-FPAP provided training with new service providers on how to capture and correctly report age, and introduced more youth-friendly initiatives, such as staff trained in providing youth-friendly services and a male doctor at its youth centres. They also identified Youth Ambassadors in the community to raise awareness and refer young clients for SRH/FP. R-FPAP adapted its cluster model, and in agreement with the government they extended the cluster area from 25km to 35/45 km to expand the community-based distributors' (CBD) outreach coverage. In addition, R-FPAP mapped and enrolled OPD and youth organisations to create more community ownership within the clusters for the WISH project and to help closer engagement with these target client groups. The consortium partner Humanity & Inclusion trained providers to raise awareness of inclusive service provision and needs of people with disabilities as well as in the use of assessing clients using the WGQs, so the recording of clients with disabilities could be included in the services register.	

Box 6: Adaptive Programming: Somalia

Country: Somalia (IRC)	**Client group:** Poverty
IRC Somalia experienced many challenges at the start of WISH: with a more direct focus on provision of FP that was new and contentious in the context of Somalia, a lack of FP and community referral policy, as well as resistance from the community due to negative beliefs about contraception. The CEI results were thus very important to IRC to provide feedback about the acceptance and quality of its FP services. As the CHWs were the main link between the services and the population IRC decided to modify their approach to outreach. This also coincided with the COVID-19 pandemic, whereby women stopped visiting the facilities for FP due to fear of catching the virus from health workers. The frequency of community outreach changed from quarterly to monthly visits and CHWs started to actively refer women to IRC clinics. To address clients' need for more privacy while accessing FP services at the facility, IRC have begun to rearrange the layout of services so these services can be offered in an area separate from other maternal and child health (MCH) services. The CEI findings also showed there was more demand to switch from short- to long-term methods, and service providers were given more training to improve counselling and demonstration of these methods. Willing 'early adopters' of implants in the community have also been identified to act as Ambassadors and participate in sessions to discuss the benefits of FP to other women in the community. Other changes include creating a Youth Working Group in different facilities to increase focus and reach youth for during outreach visits, and to increase the visibility of IRC by using its logo more widely in the community and to track new clients awareness of IRC.	

IPPF introduced an adapted version of MSI's Poverty Heat Maps in early 2020[28] and this was seen as a "*real game changer*" (Hub KII: IPPF3) for IPPF because it could realign its cluster model strategy to increase service provision, community-based outreach and SBCC activities in high poverty areas. In Tanzania, Poverty Heat Maps have been used in conjunction with CEI results and indicated that mobile outreach and CHW were effective strategies in offering services in areas with high incidence of poverty. The increased use of

[28] W2A started to develop Poverty Heat Maps for 8 countries in Q3 2019 and completed collecting geolocation data (GPS coordinates) for WISH SDPs in Uganda and Tanzania in Q4. The scale up use of maps was planned for Q1 2020. (W2A Quarterly Report, 2019 Q4)

the Poverty Heat Maps has contributed to rethinking approaches to target poor clients and how poverty is dictated by geospatial data in terms of where to deliver services for very poor populations.

MAs have also been changing programming to improve disability inclusion. MAs have increasingly partnered with OPDs in the community and recruited people with disabilities to be community mobilisers or engage with other demand generation activities. The consortium partner Humanity Inclusion have been training service providers to raise awareness of inclusive service provision and needs of people with disabilities as well as in the use of assessing clients using the WGQs, so the recording of clients with disabilities could be included in the services register.

3.2.5 Changes to evidence utilisation

Increased awareness and capacity for evidence utilisation
In terms of evidence utilisation, the Hub staff see the WISH programme as being a positive process that has built the capacity of country staff "*in terms of their systems and processes, in terms of data collection and data quality and management"* (Hub KII: IPPF1). Having gained new skills and learnt different approaches for planning and measuring service inclusivity for underserved and marginalised populations, MAs are better equipped to improve future programming beyond WISH.

Adaptation and development of new tools / approaches
In addition to the annual CEI, moving forward IPPF have developed a **Rapid CEI,** which is a simplified version of the original CEI that takes only 15 minutes to complete and can be implemented twice a year to provide "*more regular information on how MAs are performing in responding to the CEI results"* (Hub KII: IPPF2). Interestingly, poverty indicators are included in the rapid CEI but not disability items. The purpose of the rapid CEI is to have a 'sneak preview' prior to the annual CEI to check progress towards the poverty targets and to make more timely adjustments. Some IPPF MAs have also developed a **disability indicator** to include in the client registers in order to monitor the uptake of services among clients with a disability. The indicator is based on the WGQ and recorded by the service provider.

4 Key Findings

This section highlights the cross-cutting findings about evidence utilisation from both case studies.

- The markedly different experiences of both IPs indicates that **evidence utilisation is not a singular process that applies to all organisations in the same way**. Rather, how programme data is used and adapted depends on an institutional history and culture of using evidence. MSI and IPPF do not have the same structures and are not at the same starting point regarding collecting, analysing and sharing programme data.

- In relation to evidence utilisation under WISH, there has been a strong focus around programme data related to people living in poverty. **Evidence use (so far) has been largely driven by the payment related KPIs, such as for poverty and youth,** and this has meant partners need to focus their evidence use in programming around increasing performance to deliver upon set targets. This has resulted in countries honing on site selection of Outreach services for MSI and clusters/ SDPs for IPPF and improving demand creation approaches to ensure services reach the poorest, which can be challenging as switching incurs time and costs within the programme timeframe.

- **The evidence literacy, or capacity to handle and analyse data, at the country level is an important factor in how IPs manage data and promote evidence use**. This was relative to the starting point of MSI and IPPF in terms of having systems in place for using evidence for WISH. Evidence utilisation was also related not only to the strength of partners' M&E systems, and experience of working on other donor projects to adapt to the reporting requirements of WISH, but also the technical capacity and attitudes of individuals. These qualities were related to the country context, in terms of what opportunities were available to build these skills, in terms of what resources were available, the size of organisation and RME teams, or how established the country programme/MA was and therefore experienced in data systems.

- The reporting from IPs on evidence utilisation for WISH provided valuable contextual background for examples provided in the interviews, yet they were not easily comparable to the evidence utilisation framework. Acknowledging that the reports are presented for the two Lots and not the lead organisations, they lacked detail on the processes, such as how decisions regarding course correction are made or how changes to programming will be monitored which would provide important lessons. The more recent reports reviewed contained more information about adaptive programming based on CEIs results (available in Q3-4 2020) highlighting that evidence utilisation takes time, and for WISH relies heavily upon CEI results. The forthcoming collection of Stories of Change (as part of the Evidence Utilisation Report) is likely to showcase some good examples.

- **Partners have experienced changes to evidence utilisation over time as a result of WISH programming**. Partners have had to adapt their systems and approaches to improve the collection and use of programme data, particularly relating to poverty and disability, to meet the needs of WISH. In particular, the increased focus on people living with disabilities has been an area of mutual growth

for both IPPF and MSI, whereby both partners undertook considerable learning and development around mobilisation and how best to measure disability inclusion.

- A number of factors were identified that contribute to how WISH stakeholders use evidence. We have referred to these **factors as enabling or hindering the timeliness, ability and scope to effectively use evidence for adaptive programming**. Some factors are unique to an IP or the country setting, while other influences were commonly reported. Table 3 presents these findings according to the stages of the evidence utilisation framework. (The source of the findings is indicated in brackets).

Table 3: Enabling or hindering factors for evidence use

Stages of evidence utilisation	Enabling factors	Hindering factors
Access & process	• Strong M&E systems and clear roles and responsibilities for data collection and processing (MSI) • Country staff capacity to handle and analyse data (MSI/IPPF) • Country staff empowered to take on aspects of data analysis (MSI) • Type of consortium partner in country helps with specific data collection, e.g. mapping of OPDs (IPPF)	• Technical problems to manage routine data, e.g. internet or sufficient resources for electronic tools on outreach (MSI) • Problems with data that is collected on outreach whereby central teams can't easily supervise / control data collection (e.g. Client data collected on behalf of Marketing Team can be inconsistent or incomplete) • Lack of consortium partners in a given country results in more data collection for IPs (IPPF) • Delay in executing CEIs within WISH timeframe, e.g. ethics approval (IPPF)
Results	• More consortium partners in country enables better sharing of data and reflection of results (IPPF) • Aspects of WISH KPIs (e.g., youth) well-aligned with organisational priorities (MSI) • Visibility of data aids timely access by different teams and drives performance (MSI/IPPF) • Capacity and attitude of individuals to communicate and lead on evidence utilisation (MSI/IPPF) • Triangulation of data to cross check with other sources to understand implications of findings (IPPF/MSI)	• Length of time to make decisions and changes for organisations working within government health systems (IPPF) • Lack of effective measures of poverty and disability for subnational programmes and in health service delivery setting to provide sufficient data for monitoring WISH (MSI)
Adaptive programming	• Direct input and training from consortium partners e.g. disability inclusion sensitisation training for providers (IPPF/MSI) • Inter-organisation sharing of approaches to enable wider impact e.g. poverty heat maps (IPPF)	• CEI process requires significant investment of time and resources • Security in regions prevent accessing new areas to increase reach of very poor populations, e.g. IDPs in Burkina Faso, Nigeria (MSI) • Lack of staff capacity in specific areas, e.g. GBV, disability, youth (MSI) • Impact of COVID-19 on access and service delivery • Adaptive programming for poverty takes time

5 Conclusion and recommendations

This study to investigate how IPs have used data relating to underserved and marginalised populations in their adaptive programming and learning shows that evidence utilisation is integral to WISH because it informs everything its partners at the global and country level do. With the programme's strong focus on learning and building evidence both IPs have dedicated evidence and learning teams who work closely with country level partners to gather quantitative and qualitative data. This enables the IPs to better understand the needs of underserved and marginalised clients, to improve services and to increase access where unmet need for these groups is highest.

The two case studies documenting the experiences of MSI and IPPF show that while the two organisations share common objectives and sources of data for WISH, how data is accessed and used to identify new learnings and changes for programming differs widely across the WISH programme. The use of evidence is therefore indicative of different institutional structures and history of evidence utilisation. There are also various factors that both enable or hinder the readiness, willingness and ability to access and use evidence which broadly relate to the capacity of country staff to manage data, organisational systems and approaches for data management, consortium composition, and country context.

WISH countries use evidence to make programmatic changes that aim to improve access to SRH information and services for the most underserved and to increase the efficiency, effectiveness and sustainability of implementation. Findings from this study highlight that under WISH, evidence utilisation has been strongly driven by the programme's KPIs, whereby data about youth and people living in poverty is closely monitored to identify any stagnation or decline in the proportion of clients among these groups. This study has also highlighted some limitations of the data available to IPs in monitoring WISH which ultimately has influenced how responsive IPs are to different data. The limited availability of tools to measure poverty and disability in the context of sub-national programming and health service delivery is a problem beyond WISH and an area for creators of these measures to provide more guidance. With few alternative options for reporting on the WISH KPIs, partners have had to balance trade-offs in data quality and value for money, for example using small sample sizes in the CEIs which limits the type of analysis from these surveys, especially for the prevalence of disability. The development of poverty heat maps and introduction to this tool by all partners has been revolutionary to enable easier identification of the densest, poorest locations in order to reach poverty targets. The focus on people with disabilities has also pushed partners to explore new ways to mobilise and address service inclusivity and to effectively measure the uptake of services among this target group.

With regard to adaptive programming under WISH, evidence concerning underserved and marginalised groups is mostly used to make decisions and changes to address the following programming needs: to improve the reach of services through targeted site selection; to increase awareness of FP/SRH services among underserved groups; to adapt service delivery approaches to meet the needs of underserved groups; to ensure services are inclusive of all client groups; and to improve the quality of data on underserved and marginalised groups. While adaptive programming for reaching youth is relatively straightforward and reveals quick results through routine service data, making changes to programming for poverty, such as using outreach teams need to increase the coverage of poor communities, is more complex. Making arrangements to send outreach teams to new areas involves coordinating with many different stakeholders, from fostering and maintaining relationships with the community to obtaining permission from the government, and then to stop providing services comes with additional responsibilities. In terms of moving forward and applying lessons learnt from WISH to similar programmes reaching the poorest

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populations, organisations are encouraged to invest in the development and use of tools that utilise geospatial data (e.g., Poverty Heat Maps), as well as consult with local authorities, to ensure accurate selection of locations for outreach services. In addition, a lot of adaptive programming is a behaviour change process, for example, changing the attitudes and practices of service providers or CBM / CHWs, and so important to understand that behaviour change always takes time with positive results beyond short project timescales.

It is hoped the findings from this study will help WISH stakeholders to understand the challenges of using evidence, including the limitations of using different types of evidence in different contexts, so these can be addressed; to learn how to best use evidence about WISH clients to expand reach to underserved and marginalised groups; and to improve data collection to improve WISH programming activities and outcomes.

Recommendations

Based on these findings, we have identified the following recommendations for different audiences. It is hoped these will help WISH Implementing Partners improve evidence utilisation for the remainder of the WISH programme, and the FCDO and other organisations can take these learnings into consideration for their work and/ or the design of future consortium-led programmes:

Recommendations for Implementing Partners

1. **IP support offices to provide support that is more tailored for different country teams context and capacity to access and use evidence.** It is important that in recognition of different country partners' settings, support offices also consider how these circumstances affect teams' ability to access and use evidence, in order to address these needs accordingly and to tailor expectations to local capacity/ resource. Such factors may include types of data resources available (or not available) in country, the size of organisations and RME teams, how established the country programme/MA are and their experience in data systems, consortium composition, as well as communication and internet challenges for online data collection/ reporting.

2. **Empower country staff to take on aspects of data analysis.** The technical capacity and attitudes of individuals is an important driver of how data is accessed and used. Country level individuals are also experts in their context and can interpret findings better. To ensure evidence utilisation is efficient for WISH and carried out in a sustainable way, it is important for support staff to take time to strengthen and equip local RME teams with the skills/resources to conduct analysis and presentation of evidence to ensure a sense of ownership of the data and to be able to readily share findings among their country teams (e.g., via inter-country webinar sessions and/or templates and learning briefs).

3. **Invest in systems to ensure the visibility of data is accessed and used across teams.** The visible presentation and timely availability of routine data was found to be a key driver for regional and country teams to access and use data to quickly address challenges. Moving forwards, efforts need to be made to ensure all team members / levels can access relevant data and understand what to look for and how to use evidence to inform decision making.

4. **Increase understanding about how to use different data sources and continue to encourage the triangulation of data to cross-check findings with other sources.** Users of WISH evidence could benefit from understanding more about the methodology of different data sources, including how they measure an issue and why data might differ in their results (e.g., CEIs versus service statistics on youth) so that evidence can be used appropriately without doubting data quality of these tools. In addition, IPs need

to continue to encourage the use of different data sources to compare results or investigate further the implications of findings and help confirm the reliability of evidence. For example, CEI results only provide a snapshot of client feedback, and therefore it may be of interest to follow up on specific findings through routine data or targeted focus group discussions, e.g., around adolescents or method or service preferences.

5. **Evaluate new tools and / or approaches for monitoring poverty and disability and share learnings across IPs.** Many countries using the CEI for the first time appreciated the depth of data and client feedback generated per service delivery channel and reported that they would have liked to have had this data as a baseline to inform programme design / strategy (e.g., for SBCC activities and site selection). IPPF's Rapid CEI is a promising addition to efficient means of monitoring changes to programming, and it would be of value to ensure there is time to review the feasibility (time and resources) and effectiveness of the tool to contribute to WISH learning. In addition, it would be beneficial for WISH partners to invest in the evaluation of new measures introduced or developed during implementation, such as IPPFs disability indicator in their service registers and MSI's routine poverty data. This would contribute to the wider evidence base for measuring reach to underserved and marginalised groups.

6. **Ensure country level staff have capacity in specific areas to implement programme adaptations.** In some cases, country teams lacked the necessary skills to implement programme changes to address the needs of underserved or marginalised populations (e.g., youth programming and SGBV training). This was particularly noted in fragile, conflict afflicted countries where teams need to quickly adapt their targeted services in response insecurity and the displacement of people and available staff requiring additional skills to address to the needs of certain populations. It is therefore important steps are put in place for the right staff, including non-service providers to receive training and be equipped to deal with these issues.

Recommendations for wider WISH consortium partners

7. **Ensure consistent terminology and reporting around evidence across the WISH consortium.** While appreciating organisations use different terms and definitions regarding data and evidence, as a consortium it is important to have clear definitions to ensure that partners and staff at all levels understand expectations and use evidence in a systematic manner to contribute towards the objectives of WISH. Programme reports documenting examples of adaptive programming could also benefit from more detail and guidance on how to capture lessons learnt at the different stages of evidence utilisation, including the monitoring of the changes to programming.

8. **Continue to sustain strong M&E systems with clear roles and responsibilities for data management**. Effective and efficient use of evidence relies on quality data. This includes clear roles and responsibilities set out in guidance or manuals for all stakeholders to understand the data collection and processing at all levels of country programmes and partners, especially in cases where data is collected by different team members from the end user. In addition, for programmes like WISH that requires one integrated data system, it is important that sufficient time and human resources is allocated to developing and embedding this system at global and country levels very early on in the programme.

9. **Engage with consortium partners to enable better sharing of data and analysis.** While the presence of consortium partners in-country provided more resources and expertise to input into programming, the number and type of consortium partners was

also reported to influence not only the sharing of data and analysis but also the efficiency of this process. For countries where there are fewer consortium partners (especially disability partners), mechanisms need to be put in place as early as possible for these countries to be able to draw upon and learn from this area of expertise and / or seek local partners to fill this gap (e.g., to reduce the burden of service partners to conduct additional data collection).

10. **Increase wider awareness of the limitations of CEIs across the consortium.** While the CEIs are an important source of data for WISH, partners at the country level who were new to the CEI process could have benefitted from more consideration given at the start of the programme regarding the time and investment required to set up and implement the surveys across multiple countries and contexts. The availability of the CEI data once a year is also a challenge for adaptive programming within the timeframe of the WISH programme. In addition, it is important that partners are aware of the limitations of the CEIs which could be addressed with some guidance notes around the dos and don'ts of how to use the data during analysis.

Recommendations for FCDO

11. **Investigate alternative ways of monitoring progress on poverty reach and disability inclusion.** The lack of effective metrics for tracking clients living in poverty or with a disability was seen as a major limiting factor for evidence utilisation, especially when linked to a payment KPI (i.e., poverty). The absence of approaches that provide accurate information right from the start of the programme has caused uncertainty, despite the up-side of constantly learning and trialling new approaches, especially concerning under-performance for attaining KPI targets. Moving forward, it would be an opportune time to work with the developers of these tools used by WISH to measure poverty and disability[29] to: a) request more guidance for using the tools in programme evaluation outside of national household surveys, and b) to explore ways to improve these metrics in the context of health service delivery, such as removing the reporting burden of the clients in measuring inclusiveness of services or sites or programming.

12. **Ensure realistic expectations around the timeline required for adaptive programming, especially for poverty.** It is important to understand that adaptative programming can take time, especially when it involves changing the behaviour of providers or CHWs, and to therefore be realistic in the management of expectations of implementing partners. Furthermore, using evidence to make decisions about where outreach teams need to visit to increase the coverage of poor communities takes time that is not always conducive for adaptive programming. Making arrangements to send outreach teams to new areas involves a lot resources and time to foster and maintain relationships with local government authorities and the communities, and to stop providing services comes with additional responsibilities.

[29] Such as The Oxford Poverty and Human Development Initiative (OPHI) for the Multidimensional Poverty Index (MPI tool), Innovations for Poverty Action (IPA) for the Poverty Probability Index and Washington Group for the WGQ for disability measurement.

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Appendix 1: Study KII question guides

1. Global Level KII Question Guide

INTRODUCTION

1. Could you please introduce yourself and your role within your organisation for WISH?
2. To help us understand how people use terminology, what does your organisation / colleagues mean when they use the term 'evidence'?
3. Can I briefly check, how would you describe your role in relation to / how you are involved in supporting WISH programmes using evidence?

Just to ensure we are on the same page with the terminology in the questions that follow I will use the term evidence to include all sources of data unless I specify the type of data.

SECTION 1: CURRENT PROGRAMMING & EVIDENCE BASE

4. In your organisation, what is the main source of evidence (data) that country programmes use to understand about the needs of their clients, particularly vulnerable clients who are living in poverty, or with disability and / or adolescents?
   Probe: What activities do they do to understand the reach, uptake, preferences of vulnerable clients?

SECTION 2: PROCESSES FOR USING EVIDENCE

5. What types of data sources (internal and/or external) does your organisation encourage to use for the WISH programme? *[Explain why?]*
6. How does your organisation support country teams to use evidence to inform their programming to meet the needs of vulnerable populations for the WISH programme?
   Probe: Is there a systematic approach / process that your organisation has developed to support country teams access and use evidence?
7. How do country teams access different types of data? [*specify CEI data or service statistics]*
   Probe: a) How is data processed to become evidence for your country teams to access? e.g. who, how packaged, time this takes?
   b) How is evidence disseminated and to who is this directed / made available to?
   c) What types of challenges or barriers do country teams experience in accessing or using this data?
   d) How are these barriers currently being addressed? What types of techniques do you use to help make the process of using data more efficient and effective ways?
8. How do you use the evidence (from CEI data / service statistics) to inform and guide your own support function?
   Probe: What types of challenges/ or barriers did you experience to use the evidence? *[explain]*

SECTION 3: RESULTS AND USEFULNESS OF CEI DATA

I would now like to ask you more about the results of the (most recent round of) CEI data for WISH.

9. In general, has the CEI data under the WISH programme been *useful* in identifying gaps or strengths in your organisation's programmes/ services with regard to reaching the needs of vulnerable clients? *[explain why/why not, how and what client group/s]*
   Probe: a) Has the data provided new or different findings from what you / countries knew about their vulnerable clients already? *[any examples from global perspective or from country level]*
   b) How much do you / your team trust the CEI data in terms of its accuracy and reliability?
   c) What would help strengthen this or make the evidence more useful for your organisation and/or country programmes?
10. Has any further work / research been done to understand more about vulnerable client groups and their preferences?
11. What factors or conditions influence or affect country teams' ability to utilise this type of evidence? (such as the situation of COVID19, or in fragile versus non-fragile contexts, the presence of different consortium partners etc.?

SECTION 4: ADAPTIVE PROGRAMMING

I now have some questions about 'adaptive programming', which is a term used to describe the process of making changes to a programme based on evidence. This process can include how people reflect, analyse and learn from particular types of data to then make changes / or not.

12. Can you explain to me how your organisation's country teams are going about using evidence to improve programme outcomes with a particular focus on improving reach to vulnerable groups?
    Probe: a) What evidence are they using to do this?
    b) How has the CEI data been used by countries, in comparison to how other sources of evidence is

normally used, e.g. service data that is available on a more routine basis?

13. In your opinion, how have performance incentives for the WISH programme influenced or affected evidence utilisation?
    Probe: a) At the global organisational level *[explain]*
    b) At country programme level *[explain]*
14. Why do you think some countries in your organisation have been more able or efficient than others to utilise this evidence (make changes to their programme)?
    Probe: a) What kind of challenges have any countries experienced with regards to implementing these changes? (e.g. resources, reaching vulnerable groups, COVID 19 situation affected service delivery etc.)
    b) How have these difficulties been addressed?
15. How does your organisation monitor or measure adaptive programming in terms of a) effectively targeting their specific client groups and b) meeting the needs of specific client groups??
    Probe: a) at the global level and programme level ?
16. Is there anything that you could be done differently or improved with regard to the process of evidence utilisation within WISH? *[If so, explain how?]*

2. Country Level KII Question Guide

INTRODUCTION

1. Could you please introduce yourself and your role within your organisation for the WISH programme?
2. To help us understand how people use terminology, what does your organisation / colleagues mean when they use the term 'evidence'?
3. Can I briefly check, how would you describe your role in relation to / how you are involved in using evidence for your programme / organisation?

Just to ensure we are on the same page with the terminology in the questions that follow I will use the term evidence to include all sources of data unless I specify the type of data.

SECTION 1: CURRENT PROGRAMMING & EVIDENCE BASE

I want to start by asking you about the usual types of evidence or programme data your programmes uses before the WISH programme.

4. What activities or type of evidence do you normally use to understand the reach, uptake, preferences of vulnerable clients, that is clients who are living in poverty, or with disability and / or adolescents?
   Probe: In your opinion how satisfactory are these sources of data to inform your organisation's on-going learning about vulnerable clients
5. *If not mentioned above:* How do you use routine service data to understand about vulnerable clients? e.g. adolescents?

SECTION 2: PROCESSES FOR USING EVIDENCE

I would now like to ask you about how your programme goes about *accessing* and *using* evidence based on the Client Exit Interviews data / service statistics. Can I first confirm if your country has completed a Client Exit interview survey as part of WISH? *(if not, then no need to ask about CEI data)*

Access & dissemination

Ask about CEI and service statistics separately. Suggest asking Q6-10 for CEI and then for Service Statistics

6. When was the most recent Client Exit Interview data / services statistics made available?
   Probe: How timely was this evidence for your programme needs?
7. How was the evidence based on this data made available to you?
   Probe: How was it disseminated to your country programme? E.g. how was it packaged, presented, online resource etc.?
8. Did you experience any difficulties accessing this evidence? *[explain]*
   Probe: How were these barriers addressed?

Reflection & action

9. Can you explain how you/your colleagues went about reflecting upon or making sense of what the results from the most recent CEI/SS meant for your programme? [*explain*]
   Probe: a) Did you receive or require support from the global / regional office to analyse or interpret the data?
   b) What types of techniques or approaches were used to help reading the evidence more efficient or easy?
10. Did you compare the CEI data / service statistics to other data sources? And if so, what reflections did you make?

Probe: [For CEI data] How does this differ to your normal use of data, for example, service data that is available on a more routine basis?

SECTION 3: RESULTS AND USEFULNESS OF CEI /SS DATA

I would now like to ask about the type of results and usefulness of these types of data, but first can you tell me
What type of data has been used by your programme / organization to make changes to programming as part of the WISH programme? *(E.g. CEI/ Service Statistics/ poverty heat maps etc)*

Depending on type of data go to A or B (or if more than one ask both)

A: For country case study showing use of evidence from CEI data

11. What did the data from the (most recent round of) CEI tell you about your clients who are living in poverty, or with disability and / or adolescents?
    Probe: a) Did the CEI data provide any new or different findings from what you knew about your clients already? *[explain]*
12. Was the evidence *useful* in identifying gaps or strengths in your programme/ services with regard to reaching the needs of vulnerable clients? *[explain why/why not, how and what client group/s]*
    Probe: What could make the evidence more useful for you/ your programme? (e.g. other things would like to know about your clients?)
13. How much do you / your team trust the CEI data in terms of its accuracy and reliability?
    Probe: What would help strengthen this?

B: For country case study showing use of evidence from SERVICE data

11. What did the data from your service statistics tell you about your clients who are adolescents?
12. Was the evidence useful in identifying gaps or strengths in your programme/ services with regard to reaching the needs of vulnerable clients? *[explain how and what client group/s]*
    Probe: What could make the evidence more useful for you/ your programme? (e.g. other things would like to know about your clients?)
13. How does routine service data compare to the data produced by the Client Exit Interviews in terms of understating about the needs of these clients living in poverty or disability and / or who are adolescent?

SECTION 4: ADAPTIVE PROGRAMMING

I would now like to ask about the changes that your programme has made based upon the data from the CEI / service statistics, or other types of evidence to improve reaching vulnerable populations.

14. What did your programme decide to do differently based on the findings from the CEI / service data? [*explain]*
    Probe: What further actions were determined to be necessary to reach vulnerable groups?
15. What stage is your programme at with making these changes? E.g. Generated action plans or put plans into action?
16. Have you experienced any challenges with regard to implementing these changes? (e.g. resources, reaching vulnerable groups, COVID 19 situation affected service delivery etc.)
    Probe: How have these difficulties been addressed?
17. In your opinion, how have performance incentives (i.e. payment for performance) for the WISH programme influenced or affected evidence utilisation?
    Probe: a) At the global organisational level *[explain]*
    b) At country programme level *[explain]*
18. Lastly, is there anything that could have been done differently with regard to the *process* of using evidence within WISH? *[If so, explain how?*]
    Probe: What could be done to improve the use of CEI data by the programme?
19. What advice would you give to other WISH programmers on how to access and use evidence to inform adaptive programming?
    Probe: Do you think MSI/IPPF should keep doing CEIs? *[why/why not?]*

Appendix 2: Desk review documentation

W4R, (2019) WISH Evidence Utilisation Report for 2019
IPPF, (2019) Evidence utilisation report Lot 2 (Q2, 2019)
MSI, (2019) WISH Lot 1: Evidence utilisation form (Q2, 2019)

Quarterly reports for Lot 1 and Lot 2(W2A):

MSI, (2019) WISH quarterly report 2019 (Q3)
MSI, (2019) WISH quarterly report 2019 (Q4)
MSI, (2020) WISH quarterly report 2020 (Q1)
MSI, (2020) WISH quarterly report 2020 (Q2)
W2A (2019) W2A quarterly report 2019 (Q3)
W2A (2019) W2A quarterly report 2019 (Q4)
W2A (2020) W2A quarterly report 2020 (Q1)
W2A (2020) W2A quarterly report 2020 (Q2)

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