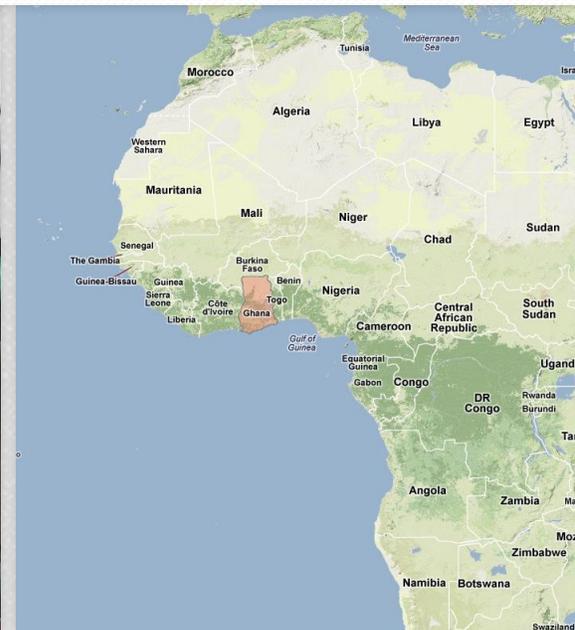


CASE STUDY

Marie Stopes International's Use of the PPI® in Ghana

How the Progress out of Poverty Index® (PPI®) Helps a Global Family Planning Organisation Track and Improve Outreach to the Poor

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The Progress out of Poverty Index® (PPI®) allows poverty-focused organizations and businesses to measure poverty among the households they affect. Each PPI is created by [Mark Schreiner](#) of Microfinance Risk Management, L.L.C.

Cover Photo by Marie Stopes International

For more information on the PPI, visit www.progressoutofpoverty.org.

Introduction

This case study outlines how Marie Stopes International (MSI), a global family planning organisation, uses the Progress out of Poverty Index® (PPI®) to assess the poverty status of its clients. The PPI team promotes and supports the use of the PPI to address the poverty measurement needs of microfinance institutions and pro-poor organisations. As MSI is the first known healthcare service delivery organisation using the PPI, we see MSI as a model in highlighting the successes, challenges and opportunities associated with PPI use within healthcare organisations.

The case study looks specifically at PPI operations within Marie Stopes International's Ghana programme (MSI Ghana) in 2010 and 2011. With its mission of “children by choice, not chance,” MSI Ghana aim to reach women and couples currently underserved by family planning services: the poor, the young, and those with unmet need (i.e. clients who want to prevent a pregnancy but are not currently using family planning). MSI Ghana uses the PPI to understand if its services are reaching poor clients and how those services could be improved to better meet the needs of the poor.

A Commitment to Evidence-Based Decision Making

In all aspects of the organisation, MSI is committed to evidence-based decision making and transparent monitoring and evaluation (M&E) to understand the impact of its programmes, the quality of services, and the degree to which it is reaching its target clients. This includes understanding if the “poorest of the poor” have equitable access to family planning services.

MSI has research and M&E staff based in London, as well as at the regional level and in-country offices. The MSI Research, Monitoring and Evaluation team advises individual country programmes on how best to implement, improve and streamline M&E instruments. The country-level M&E officers manage all data collection, analysis and reporting.



Photo by Marie Stopes International

MARIE STOPES INTERNATIONAL

MSI is a global family planning and reproductive healthcare non-governmental organisation (NGO). Millions of the world's poorest and most vulnerable women trust MSI to provide them with quality sexual and reproductive health care. MSI has been delivering contraception, safe abortion, and mother and baby care for over thirty years and works in 42 countries around the world. In 2011, an estimated 11 million people were using an MSI-supplied method of contraception.

Across its global network, MSI delivers family planning services via 1) *MSI centres*; 2) *mobile outreach services* to low-income urban and peri-urban areas, usually through government facilities; 3) *social franchising* with private clinics; and 4) *social marketing* with private pharmacies/retailers. Through these service delivery channels, MSI adopts numerous approaches including service delivery via community health workers and mid-level providers and various financing schemes. MSI also engages in behaviour change communication (BCC) campaigns and conducts family planning advocacy with host country governments.

Operating as a social enterprise, MSI uses surpluses of income-generating parts of the organisation (often urban MSI centres) to subsidize services for clients who cannot afford to pay (often poor and rural clients accessing MSI's mobile outreach services). MSI reserves, foundations and trusts, and bilateral and multilateral donors make up remaining budget needs for developing country programmes.

To learn more, visit www.mariestopes.org.

MSI regularly reports on a number of indicators globally and by country, collected via various data collection instruments. First, MSI's Management Information System (MIS) collects demographic information on all MSI clients, such as age group, type of service, how clients hear about services, client geographic location, and whether or not clients are first-time users of family planning. This information is collected at client check-in via computer or carbon copy ledger book and delivered to the country M&E officers monthly for entry into the MIS. Second, MSI country offices implement annual client surveys to understand satisfaction with services, the quality of service delivery and the poverty status of clients. Third, MSI country offices regularly administer clinical quality assessments of all service delivery channels and some offices administer evaluations of outreach service activities to ensure that client services meet a high level of service quality and medical rigor. Finally, MSI conducts a number of miscellaneous studies on specific topics of interest. For example, MSI underwent a study on why clients discontinued use of Intrauterine Devices (IUDs).

Why the PPI? The Importance of Poverty Measurement to MSI

Poverty measurement is important for MSI. Around the world, there are vast inequities in sexual and reproductive health status between rich and poor. MSI aims to address this by targeting their services at the poorest groups within each country. MSI internal documents indicate that "the focus for many MSI programmes is to ensure that women who cannot afford to pay for family planning will still be able to access those services." In 2011, three in ten MSI clients globally lived below the \$1.25/day international poverty line.

In 2009, MSI began to focus even more on using rigorously-collected evidence to steer its organisation and individual country programmes. As part of this focus, MSI expanded its Research, Monitoring and Evaluation team and began to look for a more methodologically-sound means of measuring and reporting on its outreach to the poor.

MSI learned about poverty measurement tools via on-line research and discussions with microfinance organisations. Through its research, MSI also learned that

WHY IS THE PPI THE BEST TOOL FOR MSI?

- ▶ The PPI *allows for poverty comparisons across most MSI regional and country programmes*, as 1) the PPI is available in most of the countries in which MSI works and 2) the PPI uses an international poverty line, in addition to national poverty line estimates.
- ▶ The PPI *bases poverty status estimates on quality of life indicators rather than income*. Income-based indicators are often inaccurate, are hard for many clients to answer, and elicit high levels of non-response.
- ▶ The PPI is *quick and easy* to administer and interpret for all levels of staff.
- ▶ The PPI is *inexpensive to implement* and can be incorporated into existing M&E processes, such as client surveys and data management systems.
- ▶ Despite its ease of use, the PPI provides a *statistically rigorous* way for MSI to measure and track how well it targets the poor.
- ▶ The PPI *provides the proportion of clients living below a specific poverty line*, which many other poverty measurement tools do not.

most healthcare organisations – even those that were focused on poor populations – were not measuring poverty directly. MSI ultimately chose the PPI based on its rigorous methodology, its ease of implementation and analysis, the countries for which it was available, and its ability to measure poverty against the universally recognized \$1.25/day international poverty line. In 2010, MSI introduced the PPI to seven of its country programmes by incorporating the ten PPI questions into MSI's existing client surveys. Another 15 MSI country programmes began using the PPI in 2011.

PPI results reveal to what extent MSI is reaching poor clients and which service delivery models and regions are reaching the poorest populations. Internally, this information allows MSI leadership to focus on improv-

ing services that are most relevant to and preferred by the poor. Externally, this information allows MSI to share the number of poor clients it serves with service delivery partners, relevant government agencies and national and international donors.

“MSI aims to provide services to the poor and the underserved and has now adopted a tool to test whether or not we are achieving this. This [PPI]... allows us to estimate for the first time the proportion of clients who are ‘poor’. It is a powerful tool to showcase success in reaching the underserved and to steer improvement in programming.”

— MSI's monitoring and evaluation guidelines

Service Delivery Channels at MSI Ghana

► SOCIAL FRANCHISES

One hundred and thirteen (113) BlueStar Ghana social franchise partners deliver an average of 32% of total CYPs*. BlueStar Ghana is a network of existing private providers who offer standardised reproductive health services via operator-owned clinics, pharmacies and chemical shops. These services are aimed at low-income clients in urban and peri-urban areas. MSI's BlueStar Ghana franchise regulates the quality of family planning services offered by these providers via routine supervision, monthly reports and a set of quality standards. In exchange, MSI collects a small annual fee from franchisees and provides the franchisees with branding, training, community demand creation events, clinical and marketing technical assistance, some free and subsidised supplies, and direct sale of some family planning commodities (condoms, IUDs, etc.). Providers may offer additional, non-family planning services not regulated by the BlueStar Ghana franchise.

* MSI quantifies its services by CYPs: One CYP is the equivalent of one year of contraceptive protection for one couple.

► CENTRES

Six urban MSI Ghana centres deliver an average of 45% of total couple years of protection (CYP) services. Centres are static, MSI-run facilities providing a range of family planning services. Centres largely serve the urban poor and some middle-income clients in urban areas but also provide subsidized or free services to clients who cannot afford to pay standard service prices.

► MOBILE OUTREACH SERVICES

Five outreach teams deliver an average of 23% of total CYPs. Outreach teams target poor and rural communities; all services provided by outreach teams are free. Teams currently rotate through 86 rural sites across Ghana – usually visiting about 12 rural sites one day in a month – to provide family planning services, often out of public health facilities run by the Ghanaian Ministry of Health.



Photo by Marie Stopes International / Charlie Shoemaker

MSI Ghana's Client Survey and the PPI

MSI Ghana began use of the PPI in 2010 by incorporating it into existing client surveys within its centres. In 2011, MSI Ghana incorporated the PPI into client surveys across its three service delivery channels: outreach services, social franchisees and centres. The client survey is divided into six sections, of which the PPI is one. These sections include 1) interview and site information; 2) service use; 3) marketing; 4) demographics; 5) client satisfaction and feedback on quality; and 6) the PPI.

The client survey is core to MSI and MSI Ghana's M&E practices. The client survey is administered annually to a sample of clients after they receive family planning services. The client survey is designed to gain detailed information on a client's demographics (more than the standard information collected for all MSI clients at check-in), satisfaction with MSI services, and perceived quality of care experienced.

The client survey data is used for both internal and external audiences. For internal audiences, MSI uses data to produce, what staff state as, "actionable, cost-effective information which helps in reviewing performance, showcasing successes, and making strategic decisions," which can "inform and improve strategic planning, target setting, operational decisions, and reporting." For external audiences, MSI uses data to demonstrate its global impact on health, specifically reproductive health. Further, it fulfils reporting requirements for a number of large-scale MSI donors.

Preparation and Sampling Strategy

MSI Ghana has a dedicated M&E Officer who manages the client survey process, from data collection to analysis and reporting. Prior to administering the client survey, MSI Ghana's M&E Officer first coordinates with the appropriate ethics review process in Ghana. He also determines the translation needs for each of the regional areas in Ghana in which the client survey will be administered and hires local translators to translate the



Photo by Marie Stopes International

Insights from Client Survey Data

Country programmes are encouraged to demonstrate how the client survey data is being used to improve services* by answering the following questions:

- ▶ **Does the programme reach the target population, i.e. the poor and underserved?**
- ▶ **Who are our clients, i.e. what are their socio-demographic characteristics?**
- ▶ **Do our services meet client expectations?**
- ▶ **Do our marketing / behavioural change communication (BCC) strategies work?**

* The client survey is not designed to measure a programme's outcomes or impacts.

client survey questions into the appropriate local language.

The client survey is designed to be a rigorous measure. MSI has created a detailed instructional guide for all global staff on how to most effectively implement the client surveys within their country programmes. It is not feasible to visit all MSI Ghana service delivery sites to conduct the client surveys. Therefore, MSI randomly selects facilities from each service delivery category (outreach services, centres and social franchisees). Interviewers then randomly select clients at each of the selected facilities, depending upon the sampling guidelines. For example, interviewers may be instructed to interview every fourth client until the sample size requirement for that specific service delivery site is fulfilled. In 2011, MSI Ghana conducted client surveys at all five centres, at 24 of the 36 outreach sites, and at 44 of the 89 social franchisees.

Finally, the M&E Officer works with MSI Ghana's clinical outreach services teams, centre managers and social franchise partners to recruit interviewers in each region who have knowledge of the local health sector. These interviewers are typically community health workers or community based volunteers* in the various regions in which MSI Ghana conducts services. After hiring each interviewer, the M&E Officer conducts regional trainings and role-playing exercises, lasting one to two days, to train interviewers on how to administer the client survey.

Administration

Data was collected for the 2011 client survey in September and October 2011. Depending upon the number of clients typically seen within a given facility, the administration of client surveys took approximately one to six days per site.

Notices are placed at the service delivery site to inform clients that a client survey is taking place and that some clients will be asked to take the client survey; the MSI Ghana healthcare professionals also mention the client survey to clients. The interviewer adheres to client sampling guidelines and continues interviewing clients until reaching the required number of clients for that site. As clients exit their service delivery site, the interviewer asks if they would like to take part in a client survey. If the client is willing, the interviewer reviews the informed consent and finds a private space within the service delivery site to conduct the client's survey, which takes approximately 15 minutes to complete. The interviewer records the client's responses on a hard copy survey sheet.

The M&E Officer works hard to maintain quality assurance throughout client survey administration. First, he visits interviewing sites to observe interviewers in action and to correct any issues. He also distributes cell phone credits to each interviewer so they can contact the M&E Officer if questions about the client survey arise. Finally, the M&E Officer reviews completed client surveys as they come in to identify interviewers who

appear to be having problems with administering the client surveys, such as interviewers who are consistently not completing the client survey or skipping a particular section. He works with interviewers to correct any potential problems as they arise.

Data Entry

Upon completion of the client surveys, the M&E Officer collects all hard copy client survey sheets from interviewers. He closely reviews a sample of the client survey sheets to ensure that they have been done correctly. The M&E Officer finalises the data entry template, using IBM's SPSS programme, and outsources data entry of the client surveys to a local contractor. The M&E Officer then checks data by looking for outliers, running frequencies to detect errors and cleaning the data where necessary. Once entered, data is reviewed alongside client information collected in MSI's internal MIS.

Analysis, Reporting & Decision Making

The M&E Officer compiles the data into a report template, standardized across MSI globally. The M&E Officer presents the aggregate data, trends and key findings to Ghana's Senior Management Team. This team is comprised of the Ghana Country Director and the heads of MSI Ghana's clinical, marketing, operations, social franchise and human resources departments. The M&E Officer also sends the aggregate report to MSI's global headquarters to be incorporated into MSI's annual Global Impact Report and for global analysis of the proportion of poor clients served.

The M&E Officer then works with each individual member of the Senior Management Team to determine the client survey data most relevant to their department. Using this information, the M&E Officer creates a more detailed presentation specific to each manager's data needs and delivers the presentation to them individually. The managers discuss the findings with their respective teams and determine necessary programme changes. While this process usually occurs annually, the M&E Officer is called upon throughout the year if managers need specific data.

* A health volunteer programme coordinated by the Ghanaian government, which often works with social franchises.

MSI encourages all country programmes to develop an action plan based upon annual client survey information. This action plan dictates how leadership will use the data to improve service delivery, social marketing campaigns and the targeting of underserved clients. However, the action plan has not yet been implemented at MSI Ghana.

MSI Ghana analyses the data to understand the proportion of clients – in total and by service delivery channel – living below the \$1.25/day global poverty line and the Ghanaian national poverty line. They then compare this to the proportion of Ghanaian citizens living below the national poverty line to understand how their client demographics match. Further, MSI has begun to look at



KEY LESSONS

Internal Understanding & Awareness

- ▶ MSI demonstrates that in large, global organisations, it may be necessary to *begin use of the PPI in a subset of service delivery channels* to ensure 1) staff understand how to administer the tool, 2) alignment with existing processes and 3) identification of necessary tweaks before full roll-out of the PPI.
- ▶ MSI demonstrates that in large global organisations, even in those with a focus on data-driven decision making like MSI, *it may take a few years for management to understand how the PPI data can best be leveraged* to truly impact programming decisions.
- ▶ MSI demonstrates the *value of leadership and management buy-in* on PPI uptake.

Incorporation into Existing Systems

- ▶ MSI demonstrates that the *PPI can be incorporated into existing M&E and administrative processes*. MSI incorporated PPI questions into its existing annual client survey, reducing financial and human costs and easing implementation and training.
- ▶ MSI demonstrates that it is necessary for the organisation to *explicitly detail how the PPI will fit into their existing processes* to ensure that the rigor and statistical accuracy of the PPI is maintained. For example, MSI developed a client survey protocol document detailing how to administer the client survey and PPI in a format understandable by all levels of staff.

Administration

- ▶ MSI demonstrates the *feasibility of PPI administration in a clinical setting** (versus a client's home). This may be essential to use of the PPI by healthcare organisations where the type of service delivery often makes in-home PPI administration unfeasible.
- ▶ MSI demonstrates that the *PPI can be administered by non-staff community health workers* if they receive in-person training and support prior to client survey administration.

Analysis & Reporting

- ▶ MSI demonstrates that *the rigor of the PPI adds credibility in external reporting* of poverty data.
- ▶ MSI demonstrates the *PPI's ability to validate service delivery assumptions and models*. For example, MSI's outreach services were believed to target poor, rural communities and thus services are free. The PPI is able to validate this hypothesis for internal and external stakeholders.

* However, the accuracy of non-home administration is currently untested.

its targeting of poor clients (living on less than \$1.25/day) over time to highlight increases or decreases in reaching the poor.

CHALLENGES

Internal Understanding & Awareness

- ▶ MSI staff understand the importance of targeting and tracking service delivery to poor clients, yet *awareness on the details of PPI data and its potential to inform programme decisions is low*, even among leadership.

Incorporation into Existing Systems

- ▶ *Incorporating the PPI into its existing client survey process limits MSI's use of the PPI data*, as the client survey is conducted only on a sample of MSI clients annually. Additionally, MSI's MIS system is not currently able to track clients over time. Thus, MSI cannot track the poverty status of individual clients over time or determine the proportion of poor clients served by a particular service delivery site (it can only provide the proportion of poor clients served by all sites in its centre, outreach service or social franchise service delivery channels).

Administration

- ▶ While MSI demonstrates that it is possible to administer the PPI outside of a client's home, the PPI was originally designed to be administered in a client's home to verify responses. Privacy issues related to healthcare delivery, specifically family planning services, and the logistics of MSI's operations prevent this from being a realistic option. However, *non-home administration may limit the ability of the interviewer to validate responses to PPI questions*.

PPI Analysis & Reporting

- ▶ *The PPI is not available in all countries in which MSI operates*; this prevents procedural standardization across MSI globally and cross-country comparisons of all MSI country programmes.
- ▶ MSI M&E staff *required some initial assistance in interpreting the poverty likelihood results*.

Using Data in Decision Making

- ▶ *MSI's target clients are multi-faceted*; they include the poor, the young and those with unmet need. This makes client targeting goals difficult to quantify. Without a clear definition of success in client targeting, it is difficult for MSI leadership to use the PPI to measure success and inform necessary programme changes.
- ▶ Organisations delivering health services often require a host of different solutions and thus the *measurement needs of healthcare organisations are extensive*. This is true, even for poverty-focused organisations like MSI, with a specific healthcare focus like family planning services. For example, indicators used as proxies for MSI's target clients include poverty status, age and whether or not clients are first-time family planning users. Thus, poverty metrics alone are not a clear measure of success.

Looking Forward

As with all organisations that care deeply about using data to improve their programmes, MSI constantly reflects on opportunities for improvement. The key learnings and challenges cited above may present MSI Ghana with opportunities to improve upon its use of the PPI; these include:

- ▶ Host a *brainstorming session with MSI Ghana leadership and operations staff* to determine concrete ways of using the PPI data to inform programmatic decision making. Ideas might include:
 - Collect PPI data on all clients at client intake to allow for individual client poverty status tracking, which might help in determining clients who require subsidised or free services at MSI centres and aid staff in determining the feasibility of specific family planning services and follow-up care options.
 - Set targets for the percentage of poor clients served via each service delivery channel or site; consider leveraging 2011 PPI data or the percentage of Ghanaian citizens currently living below the poverty line in Ghana to set initial targets.
- ▶ Conduct an *MSI Ghana-wide meeting* to discuss the rationale for MSI Ghana's use of the PPI and provide specific examples of how MSI Ghana might use PPI data to improve its programmes, client targeting and service delivery.

- ▶ During the 2012 client survey / PPI reporting process, encourage the M&E Officer to *present tailored PPI data in the individualized presentations he already gives to each member of the Senior Management Team*. In this presentation, provide suggestions on what the PPI data may be telling each member of the Senior Management Team about their programme; offer to work with managers to create an action plan detailing how they are going to use the PPI data to plan for future programme improvements.

For example, when asking what the head of marketing is interested in learning, the M&E Officer may learn that the head of marketing wants to know the effects of a particular social marketing campaign. In addition to other client survey data, the M&E Officer might provide the percentages of poor MSI clients served before and after the campaign launched in a particular region. This data would help the head of marketing understand the effects of this campaign on attracting poor clients to MSI-provided services and thus provide information for future campaign decisions.

- ▶ *Use the PPI when conducting needs assessments* for new programme sites or regions; work with leadership to decide in advance how poverty levels will impact decisions between regions or sites. ■

