Evaluation brief: WISH2ACTION Cluster Model

International Planned Parenthood Federation

1. Purpose

This brief highlights the key findings, insights, learnings and recommendations from an independent evaluation of the "Cluster Model" which was carried out in selected sites in Ethiopia, Pakistan, Tanzania and Uganda in 2021. The primary objective of the evaluation was to determine what has been the contribution of the Cluster Model to the Women's Integrated Sexual Health (WISH2ACTION, or W2A) programme in the four focus countries.

2. Introduction

W2A is IPPF's flagship health programme. It is supported by the UK's Foreign, Commonwealth and Development Office (FCDO) with a total budget of £132 million. It is intended to transform the sexual and reproductive health (SRH) of millions of women and girls, including 2.2m additional users of family planning (FP), in 15 countries in East and Southern Africa and South Asia between 2018 to 2021. The programme has been delivered by a consortium of five internationally recognised organisations and 10 IPPF Member Associations (MAs). The MAs implementing the programme use a service delivery approach known as the "Cluster Model" or "Enhanced Cluster Plus Model" which has been adopted and scaled under W2A, following from the model being shown previously to dramatically increase use of SRH/FP services in a state in Nigeria.[1]

3. The Cluster Model

The Cluster Model is an integrated and comprehensive method of increasing access SRH/FP services for particularly vulnerable people and meeting their needs by delivery of services through a network of coordinated public and private health facilities.[2]

Key features of the Cluster Model

a. Geographically focussed - a cluster is formed by including 5-6 sites operating within a 20km radius from a comprehensive site identified

b. Comprehensive "total market" approach - the model involves the formation of formal partnerships across all service delivery points, including private and public facilities, mobile, static and community-based providers

c. Formal partnerships formed - a partnership agreement is forged to ensure understanding among the IPPF MA and associated health facility

d. Systems strengthening approach – health systems are supported in all cluster sites

e. Comprehensive service provision sites - which enable effective integrated care

f. Single sustainable coordination mechanism -through the establishment of the Cluster Management Committees

g. Variability - the Cluster Model varies according to specific contexts and settings

h. Sustainability focus – which hinges on a health system strengthening approach, comprehensive site to enable efficient integrated care and the single, coordination mechanism

4. The Cluster Model is suitable for multiple settings where coordination is effective and specific resources available

The Cluster Model is a flexible and adaptive approach that can be tailored to suit the different contexts, needs and opportunities between countries.

The Cluster Model is a flexible and adaptive approach that is suited to various contexts and settings, which are supported by effective coordination and resources for key SRH/FP interventions in the public and private sectors. The model has the potential to be applied in humanitarian and some suitability in urban settings. However, the evaluation findings suggest that the model is most suitable and effective in peri-urban and rural contexts – as it enables SRH/FP services to be scaled dramatically, and typically with populations who have less physical and financial access to services, and with a smallerconcentration of service delivery points than in urban areas. The Cluster Model can also have the greatest impact on strengthening health systems and supporting typically under-resourced coordination structures in peri-urban and rural contexts.

---

[1] The pilot was undertaken in Oyo State in Nigeria in two clusters that tested the ClusterPLUS model, with direct service delivery being undertaken April – December 2015. This was funded through a planning grant from the Bill & Melinda Gates Foundation, and with support from IPPF's Africa Regional Office.

[2] An independent evaluation of the model conducted in February 2016 showed that the model led to a significant increase in access to comprehensive quality FP services in that state and that all the project targets were achieved. The expected project target was to reach 20,200 FP users and to provide 60,600 SRH services, although it was able to reach 53,152 FP clients (263% of target) and provided 102,979 services (170% of target). It was also noted that the proportion of clients who adopted long acting and reversible FP methods increased significantly.

The Cluster Model works well in contexts where good coordination exists, and where resources to support coordination are available to support it, including resources for meetings and dedicated staff to communicate and coordinate between cluster stakeholders. Additional resources are also required to support key activities within the clusters, such as quality assurance, supply of commodities and so on.

With such critical support behind the Cluster Model, and with modifications to suit specific contexts, it arguably could be applied effectively to most settings in many countries, even in humanitarian settings with multiple agencies offering SRH/FP services. The Cluster Model appears to have some suitability to urban settings, as has been evidenced through some of the sampled clusters. However, the application of the model in urban areas is more complex and challenging, specifically due to the large population sizes and densities, multiplicity of stakeholders and other programmes operating in the same locations which can make coordination more difficult. In addition, some of the approaches used under the Cluster Model may be less suitable for urban areas, such as mobile outreach, which is designed to reach more remote populations. In peri-urban and rural areas is perhaps where the Cluster Model is most effective and where the most benefits are felt, especially as the Cluster Model can scale up SRH/FP services dramatically, and this is typically with populations who have less physical and financial access to services, and with a smaller concentration of service delivery points than in urban areas. In addition, in peri-urban and rural areas is where there is often less support from stakeholders and other programme partners and where capacity of the health sector is lower, which provide opportunities for the Cluster Model to have important results.

The Cluster Model is effective and can bring significant benefits to programmes

a. It can significantly expand SRH/FP service provision, including couple years of protection (CYPs) and additional users of FP

b. The model can effectively reach special groups such as young people and people with disabilities (PWDs)

c. The model can help to improve coordination of public and private health stakeholders

d. Referrals and integration under the Cluster Model can increase the number of SRH/FP users in public and private facilities

e. The quality of care in public and private facilitiescan be improved significantly, as can the availability of SRH/FP commodities and supplies

f. The model can improve the availability and use of better quality SRH/FP data, including the reporting of private sector data into national health information systems

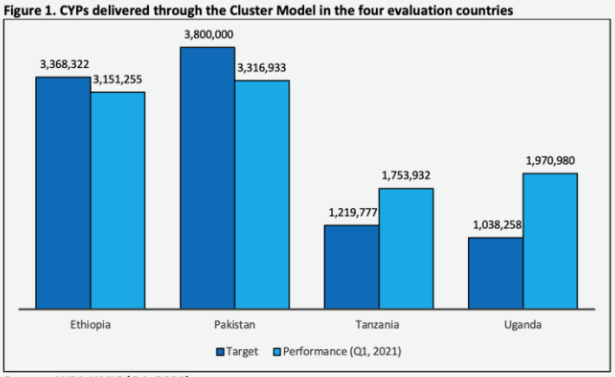
g. Good Value for Money (VfM) can be achieved through the Cluster Model

5. The Cluster Model has significantly expanded SRH/FP service provision

CYPs have been dramatically increased under the Cluster Model. As shown in figure 1, the total target for the four evaluation countries by the end of 2021 was 10.193 million CYPs, and by the end of the first quarter in 2021, 9.556 million CYPs have been delivered – equivalent to almost 94% achieved, which is ahead of schedule and suggests that the end of programme target will be exceeded. In terms of the breakdown of CYPs delivered in the four countries against their targets, evaluated countries have either achieved their CYPs already or are on track to at least achieve their target by the end of the W2A programme.

Trends regarding additional FP users are also significant in the four evaluation countries. The overall target of almost 900,000 additional users was surpassed one year ahead of schedule.

Figure 1. CYPs delivered through the Cluster Model in the four evaluation countries



Source: W2A HMIS (Q4, 2021)

With regards to reaching young people and PWDs, the Cluster Model has been shown to be effective overall.

6. The Cluster Model has made some important contributions to strengthening health systems

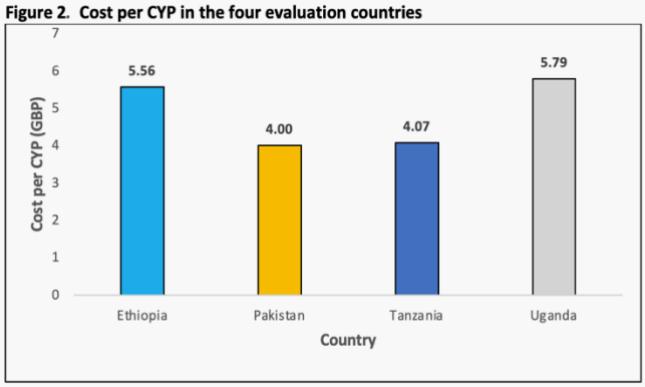
The model has helped to significantly improve coordination of public and private health stakeholders at the sub-national levels where service provision occurs, and in many instances the public and private health sectors are partnering more effectively in clusters than before the W2A began. Referrals and integration have helped to increase the number of SRH/FP users in public and private facilities, and the Cluster Model has improved the quality of care. The availability of FP commodities and supplies in both public and private facilities has increased under the Cluster Model, and better quality SRH/FP data is widely available and used within clusters by both public and private sectors.

A store in a public facility in a sampled cluster in Uganda illustrates the ongoing commodity storage and distribution challenges that most clusters and MAs face.

7. Value for Money is good under the Cluster Model

Between 2019 to 2021, the average cost per CYP in the four sampled countries has been £4.85, which can be considered good VfM. The cost per CYP varies to a small degree between the four evaluation countries. Pakistan offers the lowest cost per CYP at £4 and Uganda the highest at £5.79. However, even the highest cost per CYP still offers good VfM compared to other benchmarks internationally and in similar country contexts.

Figure 2. Cost per CYP in the four evaluation countries



Source: W2A programme data

8. Feedback from government partners and other key stakeholders is positive

The Cluster Model is perceived to have broadly improved the situation for SRH/FP in the countries where it has been implemented. It is also perceived positively because the model has provided many benefits to government partners and other stakeholders, which include increased SRH/FP services; facility renovations and improvements; improved skills of health providers; facilitated information exchange between partners, and; the model's focus on reaching marginalised groups.

"Utilization of the long-term family planning method showed improvement in the 16 woredas of operation... capacity of our professionals is increasing; we are observing improvement in counselling services provision."
Public Health Director, Hawassa Zuriya Cluster, Ethiopia

9. Challenges

The time available to support the development and roll-out of the Cluster Model has been limited and,as a result, some of the most significant impacts from the model are yet to be witnessed at full scale. Implementation time has been curtailed and strained due to COVID-19, although the sampled clusters have demonstrated a resilient come-back in 2021.

While contributions to some improvements to localised health systems are noticeable, there are some examples where the most critical priorities of the W2A programme, such as increasing SRH/FP services, may have inadvertently undermined the health system. For example, in some clusters in. Ethiopia, cluster coordination meetings may have been slightly duplicative of existing government health sector meetings. In Pakistan and Ethiopia, free supplies given to private providers have enabled them to scale up service provision in the short-term but without any clear plans for shifting to more sustainable solutions.

Given the limited implementation time, the ownership and buy-in of government stakeholders remains in question, as does the effective transition and sustainability of the model once the W2A programme ends in the coming months.

10. Lessons learned

It is very evident that the Cluster Model can be effective in scaling up health services – as seen in all sampled clusters and all counties. Further, the Cluster Model is a flexible and adaptive approach that can be tailored to suit the different contexts, needs and opportunities between countries, and therefore offers significant potential for replication and scale in other geographies

The Cluster Model is effective in supporting the public and private sectors to work together effectively as partners within a "mixed health system" approach. However, it is critical that a long-term approach is taken to embed the Cluster Model into national and sub-national systems.

Relatedly, government ownership and related issues of transitioning activities and handover for improved sustainability should be put in the centre of all future applications of the Cluster Model.

1.4 Recommendations

For countries that are currently implementing the Cluster Model, the primary recommendation is to focus efforts on an effective transition as possible to local stakeholders, including government counterparts, in order to increase the potential for some aspects of the model's sustainability. It is important for MAs to continue to engage with key stakeholders – and increase the focus on their capacity and ownership as much as possible within the remaining time under the W2A programme.

Should additional funding and time be available that would enable the Cluster Model to continue in the sampled countries, it is recommended that MAs maintain an increased focus on transitioning and augmenting local buy-in and ownership of the model. It will be important to enhance knowledge management and communication regarding the effectiveness of the Cluster Model to government stakeholders and development partners, including strengthening the integration of private sector data and interventions into national systems.

For any new country interested in rolling out the Cluster Model for the first time, it is recommended that the focus on longer-term systems strengthening interventions should be prioritised, alongside rapid start-up. It will be critical to increase the focus on ownership and buy-in over the long-term and from the start of implementation, and to scale-up the integration of Cluster Model components into government systems. it is recommended that the many benefits and results of the Cluster Model be promoted widely to increase understanding and support for the model. It is anticipated that this evaluation will be used to support the promotion and advancement of the Cluster Model in the future.

The Cluster Model evaluation was conducted by Halcyon Consulting Ltd.

HALCYON CONSULTING

www.halcyonconsultancy.com