# TABLE OF CONTENTS

- **BACKGROUND INFORMATION** ......................................................................................................................................... 6
- **FAMILIARITY AND USE OF GLOBAL TOOLS AND GUIDELINES FOR FP/RH** .............................................................. 7
- **WHO Medical Eligibility Criteria Wheel for Contraceptive Use** ..................................................................................... 9
- **Training Resource Package for Family Planning** ........................................................................................................... 10
- **WHO Programming Strategies for Postpartum Family Planning** .................................................................................... 11
- **High Impact Practices in Family Planning** ...................................................................................................................... 12
- **WHO Consolidated Guidelines on SRH and Rights of Women Living with HIV** .......................................................... 13
- **WHO Guidance and Recommendations on Ensuring Human Rights in the Provision of Contraceptive Information and Services** .................................................................................................................. 14
- **WHO Recommendations for Optimizing Health Worker Roles for Maternal and Newborn Health** ............................. 15
- **WHO Guide to Identifying and Documenting Best Practices in Family Planning Programmes** ....................................... 16
- **SCALE UP OF GLOBAL TOOLS AND GUIDELINES FOR FP/RH** ............................................................................ 17
- **PARTNERSHIPS & MEMBERSHIP** ................................................................................................................................. 19
- **CONCLUSION** ............................................................................................................................................................... 23
## ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AYSRH</td>
<td>Adolescent and Youth Sexual and Reproductive Health</td>
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<tr>
<td>CoP</td>
<td>Community of Practice</td>
</tr>
<tr>
<td>DMPA-SC</td>
<td>Depot medroxyprogesterone acetate subcutaneous</td>
</tr>
<tr>
<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<tr>
<td>EDEAN</td>
<td>Emorikinos Daadang Etogogongo Alatanakin Ngidwe</td>
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<tr>
<td>FIGO</td>
<td>International Federation of Gynaecology and Obstetrics</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GREAT</td>
<td>Gender Roles Equality and Transformation</td>
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<tr>
<td>HIP</td>
<td>High Impact Practices</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency virus</td>
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<td>IBP</td>
<td>Implementing Best Practices Initiative</td>
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<td>KG</td>
<td>Knowledge Gateway</td>
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<tr>
<td>LARC</td>
<td>Long-Acting Reversible Contraception</td>
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<tr>
<td>MEC</td>
<td>Medical Eligibility Criteria for Contraceptive Use</td>
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<tr>
<td>MNC</td>
<td>Maternal, newborn and child health</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organizations</td>
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<td>PAC</td>
<td>Post abortion care</td>
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<td>PHE</td>
<td>The Population, Health, and Environment</td>
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<td>PM</td>
<td>Permanent method</td>
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<td>PPD</td>
<td>Partners in Population and Development</td>
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<td>PPFP</td>
<td>Postpartum family planning</td>
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<td>PPIUD</td>
<td>Postpartum intra-uterine devices</td>
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<td>SRH</td>
<td>Sexual Reproductive Health</td>
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<tr>
<td>TEFSA</td>
<td>Economic and Sexual Reproductive Health Outcomes for Adolescent Girls</td>
</tr>
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<td>TJ</td>
<td>Tékponon Jikuagou</td>
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<tr>
<td>TRP</td>
<td>Training Resource Package</td>
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<tr>
<td>WALAN</td>
<td>Wake ki Lago Nywal</td>
</tr>
<tr>
<td>WAHO</td>
<td>West African Health Organisation</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
ORGANIZATION

1. Abt Associates
2. Association of RH Professionals
3. CARE USA
4. Chemonics International
5. ChildFund International
6. East, Central & Southern Africa Health Community
7. EngenderHealth
8. ExpandNet
9. FHI 360
10. International Federation of Gynecology and Obstetrics
11. Institute for RH Georgetown University
12. IntraHealth International
13. Ipas
15. Jhpiego
16. Management Science for Health
17. Marie Stopes International
18. Palladium
19. Partners in Expanding Health Quality and Access
20. Partners in Population and Development
21. PATH
22. Pathfinder International
23. Population Council
24. Population Media Center
25. Promundo-US
26. Population Services International
27. Public Health Institute
28. Save the Children US
29. University of CA Berkeley
30. University Research Co., LLC
31. United States Agency for International Development
32. West African Health Organisation
33. White Ribbon Alliance
Duration of IBP Membership (N=33)

- <1 year: 5%
- 1-3 years: 20%
- 4-6 years: 25%
- 7-10 years: 30%
- > 10 years: 40%
- Not sure / Not available: 20%

Type of Participation (N=32)

- Other (please specify): 12%
- Served as IBP Chair: 15%
- Organization was a founding member: 30%
- Participated in IBP Steering Committee: 48%
- Participated in Task Team: 52%
- Attended IBP Regional Meeting: 58%
- Attended IBP Consortium Global Meeting: 76%
- Attended other IBP workshop or meeting: 76%
- Used the Knowledge Gateway: 82%
- Used the IBP website: 85%
- Included on email list-serv: 94%

*Other: worked with the Secretariat on specific activities, contributed to publications, possible chair position, HIP development
BACKGROUND INFORMATION

A survey was administered to Implementing Best Practices Initiative (IBP) members via SurveyMonkey to evaluate the progress of the IBP Initiative’s goals over the past year. The survey captures background information; details on use and scale up of a variety of global tools/guidelines for family planning and reproductive health; and information on partnerships and membership. One survey was completed per organization; each organization was encouraged to seek information from country colleagues and regional colleagues.

A total of 33 participants provided responses to the survey on behalf of their respective organization. The majority of organizations (79%) were based in the USA. Two-thirds of organizations were NGOs. Duration of membership varied; the highest percentage of respondents (about 36%) noted that their organizations have been IBP members for more than ten years. More than 75% of organizations participated with the IBP Initiative in the following ways: participation in IBP meetings or workshops (76%), use of the Knowledge Gateways (82%) and IBP email (85%) as well as inclusion in the listserv (94%).

Countries Represented (N=33)

Primary Affiliations (N=33)
FAMILIARITY AND USE OF GLOBAL TOOLS AND GUIDELINES FOR FP/RH

The figures below illustrate organizations' familiarity with and use of global tools and guidelines for Family Planning/Reproductive Health (FP/RH) promoted by the IBP Initiative. These are described in further detail below. Overall, organizations were most familiar with the High Impact Practices (HIPs) and Medical eligibility criteria for contraceptive use (MEC) tool were most used among those familiar with any of the tools.

Familiarity ranged between 55% and 85% with an average of 74%. Overall, the MEC and HIPs tools were most popular while use of the WHO Recommendations for Optimizing Health Workers Roles for Maternal newborn health (MNH) lagged behind others.

Familiarity with Tools & Guidelines

Use of the tools and guidelines among all organizations for each specific tool ranged between 45% and 85% with an average of 62%. Overall, the HIPs and MEC guides were most popular while use of the WHO Consolidated Guidelines for Sexual Reproductive Health and Rights of Women Living with HIV and the WHO Guide to Identifying and Documenting Best Practices in Family Planning Programmes lagged behind others.
Use of Tools (of all respondents for each tool)

Off those familiar with the tools, the use of the tools ranged between 65% and 100% with an average of 84%. Overall, the WHO Recommendations for Optimizing Health Worker Roles for Maternal and Newborn Health, MEC, WHO Guidance and Recommendations on Ensuring Human Rights in the Provision of Contraceptive Information and Services and HiPs were most popular while use of the WHO Consolidated Guidelines for SRH and Rights of Women Living with HIV lagged behind the most.

Use of Tools (of those familiar with them)
WHO Medical Eligibility Criteria Wheel for Contraceptive Use (MEC)

Familiarity
About 88% (29 of 33) of respondents were familiar with the MEC guideline and wheel. The most common ways that organizations learned about this tool was through the WHO website (57.14%), IBP global or regional meetings (53.57%), and other international conferences or workshops (53.57%). Additional sources of knowledge included participation in the development of the tools (35.71%), colleagues or co-workers (35.71%), IBP website or Knowledge Gateway (35.71%), training within the organization (25%), WHO training (14.29%), and IBP webinar (14.29%).

Use
Of the 29 organizations who reported they had heard of the MEC, 28 (97%) of them used it. The main uses were in-service training for providers (60.71%), internal education within the organization (57.14%), informing policy guidelines (42.86%) and advocacy to other organizations and partners (42.86%). Other uses included developing country strategy for family planning, clinical practice, and pre-service training for providers. The tool was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. The most common countries in which the tool was used are Uganda, India, Ethiopia, Niger and Nigeria. Three organizations (12%) did not use the tool in any countries; a number of managers could not easily identify all of the countries in which their organizations used this tool.

Barriers
Respondents were asked what the main barriers were to the use of the tool. The most common response (66.67%) was that there were not enough copies of the tool available. Other barriers mentioned included limited time and/or resources needed to implement the tool, lack of availability in a specific language, not user-friendly or lack of coaching on how to use the tools properly, expensive to distribute widely, not applicable to the organization’s activities, not focused on providing clinical information or support, missing Fertility Awareness Methods, and lack of Ministry support.
Training Resource Package (TRP) for Family Planning

Familiarity
About 84% (27 of 32) of respondents were familiar with the Training Resource Package for Family Planning (TRP). The most common ways that organizations learned about this tool was through IBP global or regional meetings (51.85%) and the WHO website (44.44%). Additional sources of knowledge included IBP website or Knowledge Gateway (40.74%), participation in the development of the tools (37.04%), colleagues or co-workers (25.93%), training within the organization (14.81%), WHO training (14.81%), and IBP webinar (14.81%).

Use
Of the 27 organizations who reported they had heard of the TRP, 21 (78%) of them used it. The main uses were in-service training for providers (57.14%) and internal education within the organization (52.38%) including using it to develop a training needs assessment and to develop and update training curriculums. Other uses included advocacy, informing policy guidelines, developing country strategies for family planning, clinical practice, and pre-service training for providers. The TRP was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. The most common countries in which the TRP was used are Uganda, Tanzania, Kenya and India. About 37% of respondents reported that their organization either did not use the TRP in any countries or were not sure where they have been used.

Barriers
Respondents were asked what the main barriers were to the use of the TRP. The most common barrier indicated by half of the respondents was limited time and/or resources needed to implement the tool. Other barriers mentioned included not enough copies of the tool, lack of availability in a specific language, cultural insensitivity, missing information, not applicable to the organization’s project activities or clinical content, slow and complicated roll-out, requiring a skilled trainer to use it, not enough evidence available on its use and barriers and not disseminated broadly enough.
WHO Programming Strategies for Postpartum Family Planning

Familiarity
About 74% (24 of 32) of respondents were familiar with the WHO Programming Strategies for Postpartum Family Planning. The most common ways that organizations learned about this strategy document was through the WHO website (50%) and other international conferences or workshops (45.83%). Additional sources of knowledge included IBP global or regional meeting (37.50%), participation in the development of the tools (33.33%), IBP website or Knowledge Gateway (33.33%), colleagues or co-workers (29.17%), IBP webinar (29.17%), training within the organization (12.50%), and WHO training (8.33%).

Use
Of the 24 organizations who reported they had heard of the strategy document, 19 (79%) of them used it. The main uses of the strategy document were informing policy guidelines (47.37%); advocacy (47.37%) including recommending it to counterparts, sharing it with missions and encouraging its use and promoting its availability on the organization's website; internal education within the organization (36.84%); and in-service training for providers (36.84%). Other uses included developing country strategy for family planning, clinical practice, and pre-service training for providers. The strategy document was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. Only a small number of countries overlapped in 2-3 organizations. Nearly 30% of organization representatives reported that their organization did not use the strategy tool in any countries.

Barriers
Respondents were asked what the main barriers were to the use of the strategy tool. The most common barrier indicated by nearly 60% of the respondents was limited time and/or resources needed to implement the strategy tool. Other barriers mentioned included not enough copies of the strategy tool, cultural insensitivity, and lack of alignment with the focus and work of the organization.
High Impact Practices (HIPs) in Family Planning

**Familiarity**
About 88% (28 of 32) of respondents were familiar with the High Impact Practices in Family Planning (HIPs) tool. About 46% of respondents reported being familiar with all 14 HIPs. Generally, there was a high recognition rate among all the HIPs; respondents were most familiar with the HIPs on community health workers (84.62%) and mobile outreach service delivery (84.62%) and least familiar with the one on financing (57.69%). The most common ways that organizations learned about this tool was through participation in their development (74.07%), participation in HIP meetings (70.37%) and the HIP website (70.37%). Additional sources of knowledge included IBP global or regional meeting (62.96%), IBP website or Knowledge Gateway (59.26%), IBP webinar (44.44%), and co-workers or colleagues (29.63%).

**Use**
Of the 28 organizations who reported they had heard of the tool, 26 (93%) of them used it. The main uses of the tool was for informing policy guidelines (65.38%); and advocacy (65.38%) including recommending it to counterparts and partners. Other uses included developing country strategies for family planning including the development of a contraceptive security indicators survey user manual, internal education and its use as a general reference, clinical practice and pre-and in-service training for providers. The tool was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. The most commonly mentioned countries were Uganda (by 7 organizations) and Malawi (by 4 organizations); five organizations mentioned that they use the tool in all of their countries. Only 3 organizations (12%) either did not use the tool in any countries or respondents were not sure where they have been used.

**Barriers**
Respondents were asked what the main barriers were to the use of the tool. The most common barrier indicated by about 42% of the respondents was limited time and/or resources needed to implement the tool. Other barriers mentioned included non-alignment with the focus and work of the organization, not being context specific, lack of wide scale dissemination particularly at the country level, not being in the correct language, and difficulties in gauging the impact of the tool.
WHO Consolidated Guidelines on SRH and Rights of Women Living with HIV

Familiarity
About 68% (21 of 31) of respondents were familiar with the WHO Consolidated Guidelines on Sexual and Reproductive Health and Rights of Women Living with HIV. The most common ways that organizations learned about this tool was through the IBP website or Knowledge Gateway (47.62%) and the WHO website (47.62%). Additional sources of knowledge included other international conference or workshops (23.81%) and co-workers or colleagues (23.81%).

Use
Of the 21 organizations who reported they had heard of the tool, 14 (67%) of them used it. The main uses of the tool were informing policy guidelines (50%); and advocacy (42.86%) including sharing with missions and partners as a technical resource. Other uses included developing country strategy for family planning including the development of a needs assessment for CME/CE provider training and implementing quality improvement programs in developing countries; internal education; clinical practice; and pre-and in-service training for providers. The tool was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. The most commonly mentioned country was Kenya (by 3 organizations). A total of 12 organizations (57%) either did not use the tool in any countries or the respondent was not sure where they have been used.

Barriers
Respondents were asked what the main barriers were to the use of the tool. The most common barrier indicated by two-thirds of the respondents was limited time and/or resources needed to implement the tool. Other barriers mentioned included not having enough copies of the tool, cultural insensitivity, limited dissemination and awareness and lack of relevance to the organization’s programming.
WHO Guidance and Recommendations on Ensuring Human Rights in the Provision of Contraceptive Information and Services

Familiarity
About 58% (18 of 31) of respondents were familiar with the WHO Guidance and Recommendations on Ensuring Human Rights in the Provision of Contraceptive Information and Services. The most common ways that organizations learned about this tool was through co-workers or colleagues (44.44%) and the WHO website (44.44%). Additional sources of knowledge included the IBP website or Knowledge Gateway (33.33%), participating in the development of the tool (27.78%) and other international conferences and workshops (22.22%).

Use
Of the 18 organizations who reported they had heard of the guidance, 17 (94%) of them used it. The main uses of tool were advocacy (52.94%) and informing policy guidelines (47.06%). Other uses included developing country strategies for family planning, internal education including background knowledge for wider maternal health discussions, clinical practice, and pre- and in-service training for providers. The guidance was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. The most commonly mentioned countries were Tanzania (by 4 organizations) and Uganda (by 3 organizations). A total of 4 organizations (22%) either did not use the tool in any countries or were not sure where they have been used.

Barriers
Respondents were asked what the main barriers were to the use of the tool. A total of 8 respondents reported that their organization either did not experience barriers or could not identify them. The most common barrier indicated by 63.64% of the respondents who did experience them was limited time and/or resources needed to implement the tool. Other barriers mentioned included not enough copies of the tool, not being in the correct language, cultural insensitivity, limited opportunities in the area, and lack of awareness of the tool and not enough time to integrate it into programs.
WHO Recommendations for Optimizing Health Worker Roles for Maternal and Newborn Health

Familiarity
About 55% (17 of 31) of respondents were familiar with the WHO Recommendations for Optimizing Health Worker Roles for Maternal and Newborn Health. The most common ways that organizations learned about this guideline was through the WHO website (62.50%) and other international conferences and workshops (50%). Additional sources of knowledge included the co-workers or colleagues (43.75%), the IBP website or Knowledge Gateway (37.50%), and the IBP global or regional meeting (31.25%).

Use
All 17 organizations who reported that they were familiar with the tool actually used it. The main uses of the tool were informing policy guidelines (52.94%) and advocacy (47%). Other uses included using the tool as background knowledge to develop country strategies for family planning, internal education, clinical practice, and in-service training for providers. The tool was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. A total of 4 organizations (25%) either did not use the tool in any countries or respondents were not sure where the tool has been used.

Barriers
Respondents were asked what the main barriers were to the use of the tool. A total of seven respondents reported that their organizations did not experience any barriers or were not aware of what they were. The most common barrier indicated by two-thirds of the respondents was limited time and/or resources needed to implement the tool. Other barriers mentioned included not enough copies of the tool, cultural insensitivity, conflicting post-abortion guidelines, poor awareness of the tool, lack of accessibility due to limited internet, and limited exposure of country teams to the tool and government resistance.
Familiarity

About 74% (23 of 31) of respondents were familiar with the WHO Guide to Identifying and Documenting Best Practices in Family Planning Programmes. The most common ways that organizations learned about this tool was through the IBP website or Knowledge Gateway (54.55%), IBP global or regional meeting (45.45%) and the WHO website (40.91%). Additional sources of knowledge included co-workers or colleagues (27.27%), participation in development of the tool (18.18%) and other international conferences and workshops (13.64%).

Use

Of the 23 organizations who reported they had heard of the tool, 15 (65%) of them used it. The main uses of the guide were informing policy guidelines (33.33%), developing country strategies for family planning (33.33%) and advocacy (26.67%). Other uses included internal education, in-service training for providers, and program documentation. The guide was used in a variety of countries ranging from none to all countries that the organization covers in a region or globally. A total of 10 organizations (45%) either did not use the guide in any countries or respondents were not sure where they have been used by their organizations.

Barriers

Respondents were asked what the main barriers were to the use of the guide. The most common barrier indicated by 53.85% of the respondents was limited time and/or resources needed to implement the guide. Other barriers mentioned included not enough copies of the tool, difficulty understanding the technical language, cultural insensitivity, missing information, too broad, poor awareness of the tool, lack of accessibility due to limited internet, and lack of guidance on how to apply at country level.
### SCALE UP OF GLOBAL TOOLS AND GUIDELINES FOR FAMILY PLANNING REPRODUCTIVE HEALTH

Of 30 respondents, 25 (83%) reported that their organizations invested resources to scale up family planning interventions at the country level.

#### Interventions for scale up

Twenty-three organization representatives reported specific interventions that their organizations have focused on scaling up over the past year. The number of interventions mentioned ranged from one to eight with an average of three per organization. The specific 33 interventions mentioned include the following categorized into policy and advocacy, partnerships, capacity building, task-shifting, training, service delivery, behavior change, community engagement, task-shifting, family planning and its linkages, social norms behavior change, and various others:

**Policy & Advocacy**
- Annual inter-ministerial conferences for higher level policy dialogue exchange between member countries, advocacy and policy development; including health and population diplomacy
- Network of African Parliamentary Committees of Health to address barriers of uptake
- Policy/advocacy and service delivery approaches
- Development of national guidelines, training manuals, supporting supply chain
- Advocacy for making emergency contraception available to victims of sexual violence
- Advocacy for ending child marriage

**Partnership and Collaboration**
- Promoting south-south cooperation to reduce regulatory barriers and improve commodity security
- Developing partnerships among partner institutions in the 26 Partners in Population and Development (PPD) countries
- Transfer of knowledge and south-south replication of proven practices

**Training and Task-Shifting**
- Training and scholarship programs for capacity development and of new generations of policymakers, managers and leaders and technical cooperation
- Training of providers in Long acting reversible contraceptives (LARCS) permanent methods (PM)
- Task-shifting (FP/LARCs/MNCH)

**Specific Interventions / Projects**
- Depot-medroxyprogesterone acetate subcutaneous (DMPA-SC)
- Malaria programming
- TRP
- Several reproductive and maternal health interventions in Bihar, India have been taken to scale across the state of Bihar and the country (with Government Support)
- Focused on scaling the TESFA model (working with married adolescent girls) in Ethiopia and other countries
- HIPs
- Looking into how to scale CARE’s Community Score Card - used in various countries scaled to several areas but not nationally
- EDEAN
- WALAN
- PPIUD
- PHE
- NCH
- Sayana Press
- Contraceptive security at the last mile
- Postpartum family planning

**Topic Areas**
- Newborn health
- Adolescent & Youth Sexual Reproductive Health (AYSRH) (general, Francophone Africa, including youth leadership)
- Family planning (general, urban, community based, increased access and coverage; and integration with Post Abortion Care (PAC), Zika, fistula care, immunization and HIV)
- Social franchising
- Education
- Environmental conservation

**Engagement**

- GREAT approach (social norms change intervention)
- TJ social networking (social norms change intervention)
- Community Support System model has been taken to scale nationally in Bangladesh after CARE developed and tested it

**Service Delivery**

- Continued scale-up of our services through our channels: centers, mobile outreach, social franchising, and social marketing.
- LARC service delivery
- Community based distribution
- Mobile reach out services
- Under our current strategy, MSI has committed to reach 12 million additional users by 2020 as part of FP2020. We also aim to double the number of MSI contraceptive users to 40m.

**Tools for scale up**

Respondents reported various different tools that their organizations have used to support a scale up strategy. The most common tool, used by 68% of respondents, was the WHO ExpandNet 9 Steps Guide. Another commonly used tool was the IBP Fostering Change Guide, used by nearly 30% of organizations. Various respondents mentioned that their organization used a range of strategies adapted from various tools, frameworks and consultations based on the partner.

**Support for scale up**

When asked what support would be valuable to help organizations’ future scale up efforts, more than 70% of respondents indicated funding. More than 50% of respondents also indicated the following respectively — monitoring and evaluation, documentation and advocacy for scale up. Other support mentioned included training on scale up strategies, identifying priority interventions for scale up based on needs and priorities, co-implementation of workshops and training sessions, case-studies capturing what works and what doesn’t and webinars on the WHO Guide to Identifying and Documenting Best Practices in Family Planning Programmes.
PARTNERSHIPS & MEMBERSHIP

Partnership vision, organizational leadership, communication and impact

Vision & Mission
Nearly 90% of organizations reported that they agreed or strongly agreed that their vision and mission align well with that of the IBP Initiative; the rest of respondents replied that they were neutral suggesting that they may not be aware of IBP's vision and mission.

Contribution to Shared Goals & Objectives
Over half of organizations reported that they agreed or strongly agreed that their organization understands how their contribution as part of IBP is being measured against the shared goals and objectives of the 2016-2020 IBP strategic plan. About 17% disagreed with this statement and the rest were neutral.

Organizational Structure
Nearly 75% of organizations reported that they agreed or strongly agreed that the organizational structure of IBP works well to achieve IBP goals; the rest were neutral.

Member Responsibilities
A total of 60% of organizations reported that they agreed or strongly agreed that their organization has a clear understanding of their organization's responsibilities as IBP members and how they can contribute to shared goals. Disagreements were voiced by 10% of respondents while 30% were neutral.

Representation of Member Organizations
Only 37% of respondents agreed or strongly agreed that there is an equal representation of member organizations within IBP activities; 50% were neutral and over 13% disagreed.

Communication with Members
Over 80% of respondents reported that they agreed or strongly agreed that there was a mechanism in place to communicate with IBP members about their organization's work. Most others (13%) were neutral with only 3% disagreeing.

Communication on Activities & Events
Nearly all (97%) respondents reported that IBP meetings, webinars, and other activities are clearly communicated to facilitate participation by their organizations.

Communication on Work Towards Achievements
About 75% of member organizations reported that their organization receives regular communication on how IBP is meeting their shared objectives. Most others (17%) were neutral with only 7% disagreeing.

Collaboration
Over 80% of respondents reported that they agreed or strongly agreed that their organization has used resources and tools developed by other member organizations to strengthen their work at country/regional levels. Most others (13%) were neutral with only 3% disagreeing.

Value of Membership
Nearly 90% of respondents reported that they being an IBP Member has added value to their organization and the work they do. Most others (13%) were neutral with only 3% disagreeing.
### IBP Initiative Member Survey Results

#### Collaboration with other members

Out of 30 respondents, 87% (26) reported collaborating with other member organizations in some way. The most common mechanisms were participation as a panelist, moderator or presenter at the IBP Consortium Meeting (69.23%) or IBP Regional Meeting (50%). Other mechanisms for collaboration included participation as a speaker in an IBP webinar (46.15%); documented scale-up or implementation of a best practice (42.31%); co-developed tools (42.31%); participated in the regional Ethiopia IBP Meeting (38.46%) and others. Two respondents commented that they did not use the IBP platform for collaboration but have collaborated with partners directly.

Respondents were then asked how collaboration with other IBP members reduced duplication in their work. Sixteen respondents contributed the following ideas:

- Synergies and complementary activities
- Networking and partnership built on knowledge of what others are doing
- Creation of shared tools
- Using international standard tools
- Information, knowledge and resource sharing
- Collaborating on webinars
- Communities of practice (CoPs) and working groups

Respondents, particularly those who have not yet collaborated with other IBP members, were asked what kind of collaboration with other IBP members would be useful to reduce duplication in their work. The following ideas were shared by 14 respondents:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organization's vision and mission align well with the vision and mission of IBP</td>
<td>15 (50%)</td>
<td>11 (36.67%)</td>
<td>4 (13.33%)</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>My organization understands how our contribution as part of IBP is being measured against the shared goals and objectives of the 2016-2020 IBP strategic plan</td>
<td>5 (16.67%)</td>
<td>11 (36.67%)</td>
<td>9 (30%)</td>
<td>5 (16.67%)</td>
<td>0.00%</td>
</tr>
<tr>
<td>The organizational structure of IBP (secretariat, chair organization, steering committee and member organizations) works well to achieve IBP goals</td>
<td>4 (13.33%)</td>
<td>18 (60%)</td>
<td>8 (26.67%)</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>My organization has a clear understanding of our responsibilities as an IBP member and how we can contribute to shared goals</td>
<td>6 (20%)</td>
<td>12 (40%)</td>
<td>9 (30%)</td>
<td>3 (10%)</td>
<td>0.00%</td>
</tr>
<tr>
<td>There is equal representation of member organizations within IBP activities</td>
<td>2 (6.67%)</td>
<td>9 (30%)</td>
<td>15 (50%)</td>
<td>4 (13.33%)</td>
<td>0.00%</td>
</tr>
<tr>
<td>There are mechanisms in place to communicate with IBP members about my organization's work</td>
<td>9 (30%)</td>
<td>16 (53.33%)</td>
<td>4 (13.33%)</td>
<td>1 (3.33%)</td>
<td>0.00%</td>
</tr>
<tr>
<td>IBP Meetings, webinars, and other activities are clearly communicated to facilitate participation by my organization</td>
<td>16 (53.33%)</td>
<td>13 (43.33%)</td>
<td>1 (3.33%)</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>My organization receives regular communication on how IBP is meeting our shared objectives</td>
<td>8 (26.67%)</td>
<td>15 (50%)</td>
<td>5 (16.67%)</td>
<td>2 (6.67%)</td>
<td>0.00%</td>
</tr>
<tr>
<td>My organization has used resources and tools developed by other member organizations to strengthen our work at country/ regional levels</td>
<td>8 (26.67%)</td>
<td>17 (56.67%)</td>
<td>4 (13.33%)</td>
<td>1 (3.33%)</td>
<td>0.00%</td>
</tr>
<tr>
<td>Being an IBP Member has added value to our organization and the work we do</td>
<td>12 (40%)</td>
<td>14 (46.67%)</td>
<td>4 (13.33%)</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>
- Identify common criteria for selecting best practices
- Country by country assessment of best practices
- South-to-south perspectives, collaboration and exchange
- Involvement from more IBP members beyond the usual suspects to replicated ExpandNet type tools
- Opportunities to connect at country level – sharing workplans to avoid technical and geographical overlaps
- Moving towards open access model
- Establishing more tasks teams focused on specific tool development
- Partnering on programs based on partners’ areas of expertise
- Sharing tools, strategies and coordinating plans on the ground
- Mapping work, areas expertise and successes in scaling up
- Joint sessions at meetings and planning meeting together
- Networking

Advantages of being an IBP member

Thirty-one respondents shared various advantages or benefits of being an IBP member. The most common one (shared by 17 respondents) was networking, visibility and keeping up with what other organizations are doing (e.g. at regional and global levels). Thirteen respondents shared that another advantage was the existence of platform for sharing work, information and knowledge (e.g. through emails, meetings, webinars, listserv and communities of practice). Nine respondents mentioned learning about new strategies, initiatives, best practices and new evidence; and seven respondents mentioned access to guidelines, tools and resources (e.g. Knowledge Gateway and WHO tools). Other reported advantages included: opportunities to explore collaboration in a neutral meeting environment (e.g. working with organizations that are not traditional partners); co-developing international standard practices (e.g. contribution and participation in HIPs taskforce and review of HIPs briefs); stronger familiarity with WHO experts; opportunity for technical discussion; technical and financial support from Secretariat and IBP members for the design of regional meetings; and development of a mapping of IBP regional partners.

Recommendation for the IBP Initiative Moving Forward

Respondents provided the following recommendations to the IBP Initiative on how it can improve its platform and function over the next year:

- Creating case studies on the impact IBP has made, what has worked and what is its value (e.g. demonstrating its value to country programs)
- Facilitating more involvement from low income partners and the Global South
- Creating more task teams focused on tool development and adaptation
- Creating regional meeting for a specific organization (e.g. PPD country offices)
- Proactively linking IBP members with each other or on new initiatives (e.g. alerting members regarding upcoming solicitations from funders; facilitating partnerships with similar agencies doing similar work to avoid duplication and/or pool resources; and formalizing ways to collaborate with IBP members and other organizations interested in similar work)
- Creating formal partnerships between IBP and a partner with roles, responsibilities and expected outputs including guidance on how to optimize the benefit of being an IBP member (e.g. Partners in Population and Development)
- Setting standards/measures for success for each member to contribute to IBP strategic plan
- Clarifying the governance structure of IBP - who is running the initiative, how are selected and how does it work?
- Rebooting what IBP is and how we can use the services it offers
- Assisting members in using the tools to document a best practice or scale-up an initiative/intervention at country level.
- Strengthening communication and joint planning initiatives
- Creating more links with European conferences
- Increasing dissemination of the latest research and lessons learned to the Global South
- Offering concrete opportunities for members to lead various areas of IBP work
- Clarifying IBP’s role with and compared to other initiatives (e.g. HIPs and FP2020)
- Beginning to use language for global SRH that encompasses US domestic work
- Sharing how other organizations use the tools to scale FP practices
- Making the partnership less about IBP and more about global goals around IBP (e.g. alignment with FP2020)
- Finding a way to ensure that IBP work can be incorporated into the work that partners are doing with funding from various donors
- Continuing to disseminate evidence based practices, operationalize more thought leadership in FP
- Supporting resource mobilization in order to better support country programs
- Fairly treating all members’ missions without undue restrictions on areas such as abortion
- Continuing collaboration at the technical and financial level in the organization of the next WAHO fora on good health practices.
- Updating the mapping of IBP partners and doing it dynamically
- Strengthening synergy between IBP partners at the level of each of the WAHO African countries, in order to minimize the verticality of the projects
- Strengthening mechanisms and approaches that promote ownership of projects by recipient countries through the implementation of the Paris Declaration
- Providing technical and financial support to Economic Community of West African States (ECOWAS) countries in scaling up good practices. This must be done through the synergy of action between the IBP partners working within the same country.
CONCLUSION

Overall, survey results indicate varied use of IBP supported resources. Common barriers included the lack of alignment between guidelines and programmatic priorities.

Efforts to better link WHO guidelines and programmatic interventions may help facilitate use of guidelines by IBP member organizations. Most IBP members are investing in scale up efforts but challenges around M&E and documentation remain.

Efforts to strengthen the IBP Initiative moving forward include better coordination with other FP platforms, expanding the partnership to more diverse organizations, supporting more documenting through case studies or other mechanisms, creating more regional opportunities for partners to share experiences and increased thought leadership in FP, particularly around implementation and scale up.

While some organizational challenges remain including ensuring clearer roles and improving representation of all member organizations, participation and communication through the IBP network was high and the majority of IBP member organizations reported IBP membership as valuable to their work in family planning and reproductive health.