

# Indicators currently in use to monitor high impact practices in family planning: a multi-country landscaping assessment

Brief 1 of 4: January 2022

This brief is the first in a series that presents and discusses program indicators currently in use related to service delivery high impact practices (HIPs) in family planning (FP) in Mozambique, Nepal, and Uganda. It provides an overview of the landscaping approach, global findings about the types of indicators and reporting systems used, and implications for monitoring HIP implementation.

## Background and Purpose

**High impact practices** (HIPs) are a set of evidence-based FP practices that have been evaluated by expert groups and determined to be proven or promising to improve FP outcomes in a variety of settings. Country stakeholders and the broader global health community need to assess **how** each practice is being implemented in order to interpret outcomes and make programmatic decisions. The USAID-funded Research for Scalable Solutions (R4S) project has developed a standardized approach to assess the scale, quality, reach, and cost of implementing HIPs, which it will apply in three countries: Mozambique, Nepal, and Uganda. To prepare for this research, the project undertook a landscaping effort in the three countries. Our objectives were to create an inventory of indicators currently in use to monitor different HIPs, and to summarize information about how and when data are collected and challenges shared about the use of existing indicators.

### KEY FINDINGS

- The overall number of indicators submitted by implementers ranged from 18 indicators for monitoring postabortion FP, to 50 indicators for mobile outreach.
- Implementer knowledge of HIPs varies, and program activities do not always align with the specific components of HIP interventions.
- Process and quality indicators are often missing for HIPs. The number of methods distributed is the main outcome indicator captured for most of the practices.
- National HMIS service statistics can indicate where some of the HIPs are taking place, but they do not provide a full picture of the scale of HIP services due to incomplete reporting.

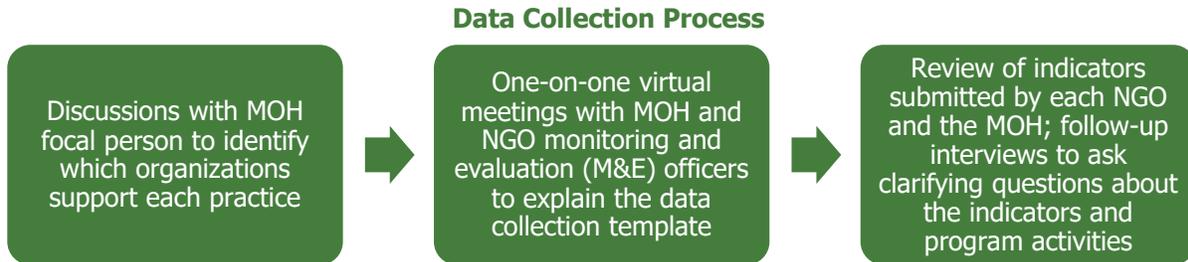
The full indicator inventory and series of briefs is available for download [here](#).

**This suite of tools can help implementers to be aware of HIPs as distinct interventions within their broader FP programs, think critically about monitoring HIPs, and provide illustrative examples of indicators already in use that could be standardized and adopted for targeted tracking of these practices. Future consensus-building activities with country and global stakeholders may result in recommended measurement standards for HIP implementation and scale-up.**

## Process

### Data Collection

In all three countries, the R4S project collected information about program indicators related to the eight service delivery HIPs (see Table 1). There were three main steps in the data collection process.



### Data sources

Information was gathered from both public sector ministries of health and from other implementers who support FP. **In this series of briefs, we refer to both the MOH and NGO partners as implementers.** For practices that take place in the public sector, the MOH is the primary implementer and NGOs play a supporting role; for practices that take place in the private sector, NGOs are often the primary implementer. All implementers were asked to submit indicators and monitoring information that are regularly collected through program activities. This included indicators collected using project-specific forms and information systems. We also asked implementers to indicate whether data points are program-specific or reported into national reporting systems such as health management information systems (HMIS), human resources information systems (HRIS), and any others.

### Synthesis and Interpretation

Researchers first compiled the indicators by country, noting patterns, similarities, and differences. The research team held virtual meetings with M&E officers and national FP stakeholders, including MOH officials, in each country to share preliminary findings and to generate recommendations. The goal was to discuss overall strengths and weaknesses observed based on the indicator definitions and how data are reported, rather than to validate information about individual indicators. After these meetings were held, researchers combined the indicators from the three countries into one inventory file, de-duplicated them, and added interpretive labels. Though the number of implementers varies for each practice, the team determined frequency of use based on whether a version of the indicator was used by multiple partners in multiple countries or not. Indicators were grouped into categories such as “training” and “FP counseling” to facilitate comparisons of the types of measures being used across practices. The full indicator inventory includes a summary of key indicators shared and how they align with recommended indicators from the HIP evidence briefs and the [Family Planning and Reproductive Health Indicators Database](#); the specific program indicators used to regularly report on each practice; and details related to each indicator, including available data disaggregation and levels of reporting.

**Table 1: Briefs in this series and the practices they include**

Brief Name	Practices Included
<a href="#">Community-focused practices</a>	Community Health Workers, Mobile Outreach
<a href="#">Facility-based practices</a>	FP-Immunization Integration, Postpartum FP, Postabortion FP
<a href="#">Private sector practices</a>	Drug Shops and Pharmacies, Social Franchising, Social Marketing

## Key Findings

We collected indicators from 9 organizations in Mozambique, 10 in Nepal, and 16 in Uganda. The number of implementers for each practice is shown in Table 2. Some practices have more implementers supporting them compared with other practices. This does not necessarily mean that they are more widespread because implementers may be working on a practice nationwide or in certain regions.

**Table 2: Number of indicators and implementing organizations per practice**

Service delivery high impact practices	Total indicators submitted	# of implementing organizations		
		Mozambique	Nepal	Uganda
Mobile Outreach	52	7	4	13
Community Health Workers	44	6	6	10
Postabortion FP	18	5	3	7
Immediate Postpartum FP	26	3	5	5
FP and Immunization Integration	20	2	3	4
Drug Shops and Pharmacies	29	2	2	5
Social Franchising	36	2	2	3
Social Marketing	19	3	1	3

### Inconsistent Understanding and Implementation of HIPs

One of the chief difficulties in gathering and comparing indicators for the service delivery HIPs was the lack of a common understanding of the practices among FP technical experts and program implementers. Program implementers understood terms like “mobile outreach” and “post-partum FP” to represent broad strategies for reaching clients with FP, rather than defined interventions with specific components. When these practices are comingled in program activities with other services it is difficult to determine what should count as a HIP indicator. Sometimes NGOs that were initially identified as implementing HIPs were not actually implementing any aspect of the practice as described in the HIP brief. Variations and adaptations of each practice were also common, leading to important differences in the quantity and types of program indicators within and across countries. Additionally, we found that FP programs or projects do not always select their indicators in a way that corresponds to the HIPs. Several implementers submitted nonspecific indicators such as “# of health workers trained in FP provision” or “# of supervision visits.” Refer to the other briefs and the indicator inventory file for examples of indicators.

### Indicators Do Not Capture HIP Implementation processes

To evaluate service delivery HIPs, researchers and program managers need data that demonstrates how HIPs are being implemented. However, the most commonly collected and reported indicator is the number of clients provided with an FP method. Many implementers also use this to calculate couple years of protection (CYPs). This focus on monitoring a key output for FP programs reveals missed opportunities to measure the process of implementation. Indicators that describe which providers are offering the services (provider availability and distribution) or how well they are offering the service (adherence to standards and client satisfaction) were often missing. These types of data are sometimes available in implementing organizations’ own program databases but are not easily accessible. In each country,

only one or two organizations reported that they conduct occasional surveys to assess the quality of FP services from the client perspective.

### **Limited HIP-Specific Data in National Data Reporting and Systems**

In general, we found that the only HIP-specific data consistently in each national HMIS was clients provided with a method in the public sector. This was most consistently and reliably reported for two practices—community health workers (CHWs) and mobile outreach. Frequently, postpartum FP also has its own HMIS indicator, though it covers different time periods that do not always align with the immediate postpartum period. Likewise, postabortion FP is an HMIS indicator but it is not clear how this is operationalized, leading to concerns with the quality and completeness of the data. Only one country had an HMIS indicator for integrated FP and immunization services. In contrast, private sector facilities, including drug shops, pharmacies, and social franchise facilities, rarely report service statistics into the HMIS. It was widely acknowledged that FP HMIS data can be challenging to use due to late and incomplete reporting. National HMIS service statistics can indicate where some of the HIPs are taking place, but they do not provide a full picture of the scale of HIP services.

Other national data systems such as human resource information and commodity tracking do not usually link indicators to a particular practice, and the systems are not connected to facilitate cross-checking the availability of methods and health workers with service data. Training indicators for FP providers are sometimes reported into a national system, but whether it is possible to determine the number of trained providers in a certain geographic area or facility and whether they are up to date on training is unclear.

## **Implications for Policy and Practice**

These findings can provide ministries of health and FP stakeholders with an understanding of the limitations of current HIP program indicators. Preliminary findings were shared with country-level FP implementers and have already led to suggestions for short- and long-term improvements in HIP monitoring, such as revising certain reporting tools that were confusing or difficult to use, standardizing some indicator definitions, using technology to ease reporting burdens, and ensuring that reporting of some practices takes place at lower levels for more targeted program monitoring. The findings can also spur country-level and global discussions about how to standardize HIP-specific indicators that can be reasonably incorporated into each national HMIS and/or other feasible data collection efforts. In phase two of this activity, the R4S project seeks to assess the scale, quality, reach, and cost of select HIPs through a combination of data extracted from the HMIS in each country and implementer program databases, interviews, and facility observations. The findings in this phase will help government and partners understand how each practice is being implemented locally and make recommendations for program strengthening, including how to improve monitoring systems to routinely produce this type of data.

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