

Indicators currently in use to monitor high impact practices in family planning: Community-focused practices

Brief 2 of 4: January 2022

This brief is part of a series that presents and discusses indicators currently in use to monitor service delivery high impact practices (HIPs) in family planning (FP) in Mozambique, Nepal, and Uganda. It examines **community-focused** practices, including community health workers (CHWs) and mobile outreach.

There is limited information on the types of indicators used to track implementation and scale-up of [High Impact Practices \(HIPs\)](#) for FP. The Research for Scalable Solutions (R4S) project conducted a stakeholder and indicator mapping exercise to generate a comprehensive inventory of indicators regularly collected by ministries of health (MOHs) and implementing partner nongovernmental organizations (NGOs). In this series of briefs, we refer to both the MOH and NGO partners as implementers. Details on our objectives, procedures, and overall recommendations are discussed in our [Overview brief](#).

This brief examines indicators to support monitoring and evaluation (M&E) of **community-focused HIPs—CHWs and mobile outreach**—implemented in Mozambique, Nepal, and Uganda. Community-focused practices aim to increase FP availability by reaching clients closer to where they live and work. These two practices often intersect when CHWs join or support mobile outreach teams to provide services. Insights into the types of indicators collected (see also the full indicator inventory), the level of reporting, and challenges associated with collection are provided. Lessons learned and recommendations for improving M&E of community-focused HIPs are included.

KEY FINDINGS AND RECOMMENDATIONS

- These are well established practices, and many indicators are being used by numerous implementers to monitor them. However, only a few high-level indicators are commonly applied.
- Both CHWs and mobile outreach have national-level FP indicators, but there were concerns about the capacity to report accurate, timely data.
- Programs need to improve the monitoring of inputs like supervision or on-the-job support and supply chain management for CHW programs.
- Training of CHWs should be monitored consistently. Human resources for health databases can be leveraged to track initial and continuous trainings.
- Where multiple mobile outreach models are operating, indicators must be applied carefully to ensure comparable services are being counted.

Community Health Workers

CHW programs have existed for decades and are considered a proven practice for their ability to increase FP access and uptake. The length of training [CHWs](#) require, whether paid or volunteer, and types of services they provide varies, but all are trained in FP service provision and equipped with information, commodities, and reporting tools by implementers. CHWs usually provide community sensitization on FP and offer short-term methods and/or referrals for long-term methods. In total, six partners were reporting indicators for CHWs in Mozambique, six in Nepal, and 10 in Uganda.

Table 1. Frequent Indicators for CHWs*

Indicator	Example definitions
# of people provided with counseling or information	# of people provided FP information by a CHW; # of clients who received FP counseling; # of men who received FP information and services by a CHW
# of clients who received a method	# of clients provided with an FP method # of FP services provided # of FP items distributed or provided
# of CHW trainings	# of CHWs who complete initial training # of CHWs trained in specific FP topics # of providers given refresher or in-service training

*refer to the indicator inventory for the full list of indicators and their variations

Indicators. There were many variations of the most commonly reported indicators, as shown in Table 1. **These indicators focus reaching people in the community with information and FP methods, and the preparation of CHWs through training.** We found that more implementers track FP method provision compared with FP counseling or information provision. Implementers collecting client-level data disaggregate these indicators, at a minimum, by age group and whether users are new or returning. In Uganda, several implementers submitted indicators related to CHW clients who are referred for FP services at a facility.

Less frequently reported indicators included the number of active CHWs, supervision or mentoring of CHWs, and supply chain indicators specific to CHWs (such as number of CHWs experiencing stockouts of FP methods). Implementers sometimes reported method-specific indicators related to project objectives. For example, indicators related to the rollout of self-injection were reported in Uganda, and clients reached with long-acting reversible contraceptives (LARCs) was reported in Nepal (presumably through referrals to a facility-based provider for implant or IUD insertion). Some implementers reported indicators on communities served (Mozambique) as well as services offered to men (Mozambique) or couples (Uganda).

Reporting. CHW FP services are monitored at national level; **all three countries now have national reporting tools and health management information system (HMIS) indicators for FP methods delivered by CHWs.** However, some programs may use additional customized reporting forms. For the HMIS, CHWs usually report data to a local public health facility with which they are affiliated, where it is entered in an electronic report and sometimes also recorded in an FP register.

Procedures describe how CHW method provision is tallied and recorded separately from the facility's FP method provision data. If they are part of a particular project, CHWs also report to the supporting implementing organization. Mozambique recently added CHW indicators to their HMIS; some implementers are still adjusting to the change.

Challenges. For HMIS service statistics, implementers reported **challenges with data quality and late reporting which were attributed to inadequate training on how to record and report data.** In Uganda, implementers acknowledged that the use of paper-based forms by CHWs impeded monitoring. Another challenge reported by implementers in all three countries was that **it is not yet possible to consistently track referrals by CHWs to facilities,** which was considered a missed opportunity for understanding the effect of CHWs on demand creation and how programs are reaching clients in need of facility-based services.

Across countries, **implementers stated they do not know how many total CHWs are actively providing methods** due to turnover and different types of FP trainings being offered at different times. Specifically in Nepal, trainings are not reported in a uniform way by implementers, leading to potential double counting and difficulty assessing the number of CHWs who have been trained to deliver certain methods. Despite the existence of national training databases for health workers, data on trainings are not routinely analyzed at the national level.

➤ Mobile Outreach

[Mobile outreach](#), also a proven practice, involves FP providers traveling to remote communities or health facilities that do not normally have the capacity to provide a wide range of methods, including LARCs. In total, seven implementers used mobile outreach in Mozambique, four in Nepal, and 13 in Uganda.

Table 2. Frequent Indicators for Mobile Outreach*

Indicator	Example definitions
# of people reached	#/% of clients who received FP counseling during mobile outreaches; # of people in the community reached with messaging on FP services; # of people accessing interactive voice response messages about health camps and FP
# of clients provided with FP services through outreach	# of clients provided with an FP method or service during outreach # FP clients of mobile community provision clinics # of FP items distributed or provided
# and type of outreach	# of mobile outreaches conducted (by day and nighttime) # of communities in the target district where community-based FP is provided to young people at least once per month

*refer to the indicator inventory for the full list of indicators and their variations

Indicators. Indicators frequently used across countries for monitoring mobile outreach had many variations (Table 2). **Overall, frequently used indicators focused on the reach and scale of outreach programs.** As with CHWs, some implementers tracked FP client counseling or information

provision, though this was not universal. Although many implementers reported the number of outreach visits, it was not always clear how these were disaggregated or analyzed by geographic area.

Implementers sometimes reported indicators to monitor youth FP service uptake and LARC services through mobile outreach. Examples include the number of adolescents/young girls reached (Mozambique) and number of adolescents among new FP users reached by visiting service providers (Nepal). A few implementers were monitoring LARC insertions and removals. One implementer in Uganda also reported an indicator on client follow-up for those on LARCs. Usually, trainings specifically for mobile outreach did not occur since the practice relies on already trained health workers. However, Nepal used the indicator: “health workers trained on LARC to expand facility and health camp services.” Because CHWs may support mobile outreach, a few partners in all three countries reported training and mentoring for CHWs under mobile outreach. Very few implementers had indicators for referrals or linkage to follow-up care after a mobile outreach; however, implementers stated that this happens informally, and it is understood that clients will seek follow-up at their local facility.

Reporting. In all three countries, FP mobile outreach has dedicated HMIS indicators for methods distributed at outreaches, and sometimes LARC removals. Service statistics are usually reported through the public health facility supporting the mobile outreach, or sometimes through the district or regional health office. Other indicators are stored in program-specific databases, and a few implementers only keep paper-based records of their program-specific indicators.

Challenges. All three countries expressed concerns about data recording errors, and data not being reported electronically after paper-based records are collected. One implementer said paper records are sometimes lost. In Uganda, where an extensive amount of data is generated on mobile outreach, there are backlogs in data entry. Implementers in all three countries also noted problems with mobile outreach data potentially being conflated with facility-level data in the HMIS, which would result in an undercount of FP methods provided during mobile outreach and an overcount of methods provided through routine facility-based services.

Key Findings and Recommendations

Monitoring systems are in place to account for FP methods delivered through these practices; however, implementers suggested that capacity strengthening efforts may be needed to ensure service delivery indicators are both collected and reported correctly. M&E could be improved by having more specific indicators that monitor which health workers provide each service, health worker availability for the service, and show how these community-focused services are linked to the broader health system.

Both CHWs and mobile outreach have national-level FP indicators, but there were concerns about the capacity to report accurate, timely data. Implementers suggested that CHWs need more guidance and support on how to maintain client records and fill and submit summary reports. For mobile outreach, procedures for compiling and entering data into the HMIS may need to be clarified. Some implementers suggested that moving toward the use of mobile applications for reporting data could help improve timely submission of reports.

CHW implementers predominantly shared measures that quantify service provision outputs. **There were comparatively fewer indicators related to inputs or technical support for CHW programs,** such as monitoring supplies distributed to CHWs or stockouts of FP methods among CHWs; providing



supervision; activities that promote or measure service quality among CHWs; and tracking active CHWs by geography to ensure program coverage. The direct link of indicators to the HIP should be ensured; sometimes technical support indicators were measured at the facility level but it was not clear how they related to CHWs affiliated with that facility.

Monitoring the training of CHWs should be emphasized, as they have less formal education than other types of health workers. Implementers recommended that attention be given to the continuum of training and ongoing support through supervision and mentorship for CHWs. This requires a set of harmonized indicators to measure and assess the completion of initial training programs and on-the-job continuing professional development. All three countries have a human resources for health database that can be used to improve the collection and monitoring of training indicators.

Additionally, the level of professionalization of the CHW cadre, including training and compensation, can vary. To evaluate CHW programs, it's important to understand policies that describe which services each type of health worker or volunteer provides and how this works in practice. Additionally, FP programs may assign different activities or tasks to CHWs. In Nepal and Mozambique several types of health workers are involved in community-level activities. Some indicators lump these types of health workers together while others count their services, training, etc., separately. The R4S assessment of the scale, quality, reach, and cost of implementing HIPs includes analysis of policies, programmatic guidance, and how CHWs say they are prepared to provide FP through hiring, training, and supervision.

Where multiple mobile outreach models are operating, indicators must be applied carefully to ensure comparable services are being counted. The practice of mobile outreach has many adaptations, some of which are described in the HIP brief. Indicators reflected outreaches that involved one or more service providers visiting a remote health facility to provide long-acting methods, mobile vans or camps that travel to underserved communities to provide FP services, and integrated health events that offer other health services in addition to FP. Each model is expected to have different indicators and targets. However, this makes it challenging to determine which indicators are comparable and can be used to evaluate the practice overall. There was also a concern that FP client data from integrated health outreaches may not be reported in the HMIS.

This is one of several briefs in a series focused on indicators currently in use to monitor HIPs. This suite of resources 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.

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