Indicators currently in use to monitor high impact practices in family planning: Facility-based practices

Brief 3 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 **facility-based** HIPs, including FP and immunization (FP/IZ) integration, immediate postpartum FP (IPPFP), and postabortion FP.

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 **facility-based HIPs** implemented in Mozambique, Nepal, and Uganda. These practices are focused on providing FP counseling and services at opportune times when women are already seeking other health services at facilities. It provides insights into the types of indicators collected (see also the full indicator inventory), the level of reporting, and challenges associated with collection. Lessons learned and recommendations for improving M&E of facility-based HIPs are included.

KEY FINDINGS AND RECOMMENDATIONS

- Indicators for facility-based practices are regularly reported into national HMIS for postabortion FP and IPPFP but not for FP/IZ integration.
- Indicators are often collected from multiple data sources, leading to concerns about data quality and whether indicators are HIP-specific.
- Indicators do not clearly capture if the practice is being implemented as defined in global guidance. Indicators for IPPFP and postabortion care should capture whether services were provided pre-discharge; indicators for FP/IZ integration should capture the deliberate integration of services.
- To measure service coverage, implementers should include an indicator for the number of clients receiving FP counseling.
- Implementers can streamline data collection by recording integrated services in the register used at the point of service delivery, eliminating the need for cross-checking multiple data sources.

Family planning and immunization integration

As a promising practice, FP/IZ integration involves delivering FP information and services to women in the extended postpartum period (through one year after birth) in coordination with routine immunization contacts for children. The integration of services should be deliberate, rather than simply having both services available at the same location. In total, two implementers were reporting indicators for FP/IZ integration in Mozambique, three in Nepal, and four in Uganda.

Table 1. Frequent Indicators for FP/IZ Integration*

Indicator	Example definitions
# clients receiving FP counseling during immunization	# of clients who received FP counseling during immunization # of women attending Expanded Programme on Immunization Clinic who are provided counseling on FP # of women who received FP counseling during ANC
# clients receiving FP services during immunization	# of clients who received FP services during immunization # of clients that received FP during immunization days # of women attending a Healthy Child Consultation or vaccination program who accept or continue FP

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

Indicators. In general, few indicators for FP/IZ integration were reported in Uganda and Mozambique; variations of the most frequently used across countries are in Table 1. **Overall, there was an emphasis on the number of clients receiving FP services during immunization.** However, some indicators used to assess FP/IZ referred to FP services that were integrated with ANC or well child visits. These visits often, but not always, include immunization services. Although indicators on FP counseling were reported by one implementer each in Uganda and Nepal, it was unclear how and when FP counseling is recorded for women who attend infant immunization clinics.

Less frequently shared indicators included number of providers trained on the provision of FP/IZ integration (Nepal only); number of facilities supported to provide FP services during immunization days and conduct FP/IZ without support; and number of referrals for long-acting reversible contraceptives (LARCs) during immunization (Mozambique only). No associated indicator existed for follow-up of referred clients. One implementer in Uganda included the number of babies immunized, which may be compared against the number of women reached with FP services. However, this does not measure the integration of the two services.

Reporting. Across countries, **only Mozambique had an established national reporting mechanism for FP/IZ.** An indicator for FP/IZ integration is beginning to be routinely collected in the country's health management information system (HMIS). However, the MOH defines this indicator broadly as the number of women attending healthy child consultations and the child vaccination program who received an FP method. Additionally, the indicator does not limit the period for FP/IZ integration to 12 months. In Uganda and Nepal, indicators for FP/IZ integration are not in any national reporting system, and the practice is only monitored at facility levels with specialized reporting forms provided by implementing partners. Some implementers in Uganda and Nepal indicated supporting activities related to the practice but did not have any relevant indicators to report.

Challenges. Challenges in collecting FP/IZ indicators varied based on the context of implementation. The key challenge encountered among implementers in Uganda was delays in facilities reporting relevant information. In Mozambique, although the indicator for clients receiving the FP/IZ service is now in the HMIS, not all health facilities report on it yet. No notable challenges were reported by implementers in Nepal.

Immediate postpartum family planning

IPPFP is a proven practice that includes offering contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the facility. In total, three implementers were reporting indicators for IPPFP integration in Mozambique, five in Nepal, and five in Uganda.

Table 2. Frequent Indicators for Immediate postpartum family planning*

Indicator	Example definitions
# postpartum clients who received FP counseling during postpartum care	# of mothers who received FP counseling in postpartum # of clients counseled on PPFP in antenatal and postnatal care # of PPFP counseling services
# postpartum clients who received a method	# of mothers choosing an FP method # of FP clients in the postpartum period (immediate and extended postpartum period) # of women of reproductive age who received PPFP

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

Indicators. Indicators frequently used across countries for monitoring IPPFP are in Table 2. As with FP/IZ, **there was a focus on the number of clients receiving FP counseling and methods during the postpartum period.** However, despite the definition of this HIP specifying that the practice should occur prior to discharge from the facility, implementers in all three countries were tracking indicators across several time intervals up to 12 months after delivery. Only one implementer in Nepal specifically monitored the proportion of clients who received FP after delivery and prior to discharge from the health facility, using project-specific data collection tools.

Less commonly used indicators from Nepal included the number of trainings on the provision of IPPFP and those on service quality, such as proportion of sites with commodity stock to provide IPPFP, number and proportion of IPPFP users followed up, and number of clients satisfied with services. Other less frequently used indicators were number of service delivery points providing IPPFP (Uganda only) and the proportion of clients who received FP in the postpartum period (i.e., coverage, Mozambique only).

Reporting. Across all countries, **only the number of PPFP clients per facility is reported into the HMIS and the indicator does not always capture immediate postpartum FP**. In Uganda and Nepal, IPPFP data is obtained from the maternal and postnatal register, copied into the FP register, then finally reported in the HMIS. In Mozambique, information on postpartum FP clients is now collected in the maternity logbooks but does not include all the disaggregates available for other FP services (age, methods).

Challenges. The main challenges reported centered on data quality issues. In Uganda and Mozambique, implementers highlighted incomplete and poor-quality data encountered in the collection and use of

IPPFP indicators. In Nepal, some indicators were being collected using tools developed by NGOs for a specific project, but they noted that reporting was likely to stop after project closure.

Postabortion family planning

Postabortion FP is a proven practice in which women are offered contraceptive counseling and services at the same time and location where they receive facility-based postabortion care. In total, five implementers were reporting indicators for postabortion FP in Mozambique, three in Nepal, and seven in Uganda.

Table 3. Frequent Indicators for Postabortion family planning*

Indicator	Example definitions
# clients who received postabortion FP counseling	# of clients who received postabortion care counseling # of clients who received safe abortion counseling # of clients who received postabortion FP counseling
# of clients who accepted a FP method during postabortion care	# of postabortion clients who received a FP method # of postabortion FP users # of clients who received postabortion FP services, by method received # of abortion clients who got an FP method through mobile outreach # of women receiving FP services during the postabortion period
# providers trained in postabortion care	# franchise facilities trained in health care ethics, harm reduction counseling, and provision of comprehensive of postabortion care services # of trainers trained on comprehensive abortion care # of health workers who received in-service training on postabortion family planning # of providers trained on comprehensive abortion care (initial training and refresher training)

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

Indicators. Indicators frequently used across countries to monitor postabortion FP are in Table 3. **Overall, these indicators emphasize clients' receipt of care as well as training of providers to deliver the practice.** Postabortion FP counseling is often counted as part of the indicator for comprehensive abortion care. In terms of less frequently used indicators, some implementers in Nepal reported the number of abortion sites with FP commodity stock, proportion of postabortion clients who are satisfied with the FP services, and proportion of facilities meeting standards for postabortion services.

Reporting. **There is an indicator for postabortion FP in the HMIS for all three countries.** Despite this, not all the NGOs supporting this practice in Uganda and Nepal submit this data in the HMIS. In Mozambique, there is no disaggregation of postabortion FP clients by age, making it difficult to identify adolescent girls and young women receiving this service.

Challenges. In Uganda, NGOs presumed a likely under-reporting of this practice due to stigma related to abortion. In addition, Ugandan and Mozambican implementers also experienced challenges related to incompleteness and quality of data. No significant challenges were reported in Nepal.

Key Findings and Recommendations

Across facility-based HIPs and across countries, the key findings and recommendations are similar. Overall, there was frequent monitoring of the number of clients receiving either FP counseling or methods, and to some extent, the number of providers trained in these practices. We also found that indicators for clients who received a method through these practices are being reported into national HMIS except for FP/IZ, which has been recently added to the HMIS in Mozambique but does not align with the HIP as described in the evidence brief. For example, some implementers were not deliberately integrating these services or were reporting women receiving methods at well-child visits, not necessarily during immunization visits. To improve monitoring, **we recommend that implementers of facility-based practices at least include an indicator for the number of clients receiving FP counseling,** as this provides an indication of the coverage of the HIP. However, expanding this to include indicators on the number of clients receiving methods, number of referrals, and follow-up for referrals will provide comprehensive monitoring of each practice.

We also found that current indicators could be more aligned with the definition of each HIP. For example, in the case of **IPPFP**, implementers often reported clients receiving FP counseling or services in the post-partum period, but several different post-partum time periods were used. Most implementers did not capture whether FP counseling or services were provided *after delivery but prior to discharge*. As such, the indicators reported into the HMIS do not adhere to the HIP as defined by global guidance. **We recommend that indicators for IPPFP and postabortion care more clearly capture whether services were provided post-delivery/pre-discharge and indicators for FP/IZ integration capture the deliberate integration of services.**

Although indicators for clients of FP/IZ integration, IPPFP, and postabortion FP are regularly reported, the process for collecting this information often involved triangulating multiple data sources. For example, particularly in Uganda and Nepal, indicators for the number of clients receiving FP counseling needed to be checked against immunization records for FP/IZ integration or against maternity registers for IPPFP, at which point indicators could be compiled and sometimes submitted to the HMIS. The multi-step process poses challenges for data quality, completeness, and ability to monitor specific HIPs. **We recommend that implementers streamline data collection by updating registers to ensure that indicators can be clearly tagged to specific HIPs.**

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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