Measuring Family Planning Service Delivery

An Assessment of Selected Indicators across Implementing Partners

Janine Barden-O'Fallon, PhD,
and Zahra Reynolds, MPH

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TR-17-194

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MEASURE Evaluation

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-17-194.

ISBN: 978-1-9433-6472-5

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ACKNOWLEDGMENTS

This assessment would not be possible without the generous contributions of our colleagues in the Office of Population and Reproductive Health of the United States Agency for International Development (USAID) and the USAID service delivery implementing partners. We thank our colleagues from Advancing Partners and Communities, at John Snow, Inc.; the Health Communication Capacity Collaborative, at Johns Hopkins University; Evidence to Action, at Pathfinder International; the International Planned Parenthood Federation; the Institute for Reproductive Health, at Georgetown University; Marie Stopes International; the Maternal and Child Survival Program, at Jhpiego; the Post Abortion Care Family Planning Project, at Engender Health; Population Services International; SHOPS Plus (Sustaining Health Outcomes through the Private Sector), at Abt Associates; and the Carolina Population Center, at the University of North Carolina at Chapel Hill. Funding for this assessment was provided by the USAID Office of Population and Reproductive Health.

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ABBREVIATIONS

CPR	contraceptive prevalence rate
DHS	Demographic and Health Survey(s)
FP	family planning
FP/RH	family planning and reproductive health
IP	implementing partner
IRH	Institute for Reproductive Health
M&E	monitoring and evaluation
MCH	maternal and child health
MLE	Measurement, Learning, and Evaluation Project
PAC	postabortion care
PMA2020	Performance Monitoring and Accountability 2020
PPFP	postpartum family planning
SPA	Service Provision Assessment
TBD	to be determined
USAID	U.S. Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Family planning (FP) service delivery is a key component of the global health program of the U.S. Agency for International Development (USAID). There is a long tradition of measuring FP service delivery activities and outcomes through indicators that are internationally standardized and program-specific. Although essential for understanding the content, quantity, and quality of services being provided with U.S. government assistance, the monitoring and evaluation (M&E) of FP service delivery faces many challenges.

USAID technical advisors asked MEASURE Evaluation to assess a set of 16 indicators and five indicator areas that may be used to measure service delivery among USAID's implementing partners (IPs). The indicators and indicator areas selected by USAID represented the types of indicators that IPs collect, but were not representative of the entirety of USAID service delivery measurement. Rather, they posed potential challenges in harmonization, collection, and reporting.

Information and feedback on the use of the selected indicators were collected from eight service delivery IPs and seven technical resources (a combination of projects and published tools). The information was assessed for common trends and reported challenges. Indicator guidance for FP service delivery projects was then developed and applied to the selected indicators.

This assessment provides a summary and analysis of IP feedback and indicator-specific recommendations. A main finding was that many of the service delivery indicators selected by USAID for review were not collected by IPs. USAID partners primarily collect project-specific output-level indicators specific to the scope of their work. This finding indicated that understanding of the application of indicator criteria in the service delivery context is problematic, resulting in some misunderstanding of the measurement needs and capacities of service delivery projects by USAID technical advisors. Another finding was that there were differences in indicator language and definitions: six out of the 16 indicators in the assessment had variations in indicator language, definitions, or how the indicator was operationalized by the various IPs who used them. Finally, it was found that the indicator areas that were being proposed (such as couples' communication, client/provider communication, and provider attitudes) need development to ensure that valid and reliable measures are available for use.

This report offers recommendations and guidance for each of the selected indicators and indicator areas, based on whether a project will be using the information for monitoring/process evaluation only or will also be conducting an outcome/impact evaluation.

This report provides specific criteria to guide USAID and IPs in the selection of FP service delivery indicators. These are standard indicator criteria with an additional focus on practicality and cost efficiency for service delivery IPs. This report includes recommendations for each indicator as to whether it should be collected by service delivery IPs, the language should be harmonized, an alternate indicator should be used, or assessment needs to be completed.

This assessment can be used to inform USAID service delivery measurement among IPs. It should enable the harmonization of data collected by IPs and reported to USAID. It should also aid in the prioritization and selection of indicators for service delivery projects.

INTRODUCTION

Family planning is an essential element of public health services with the potential to dramatically improve lives (Cates, 2010). In fiscal year 2016 alone, U.S. international FP assistance had the potential to reach 27 million women and couples with contraceptive services and supplies, and to prevent 6 million unintended pregnancies, 2.3 million induced abortions, and 11,000 maternal deaths, according to the Guttmacher Institute (Guttmacher, 2016).

Family planning is a key component of USAID's global health program. USAID collaborates with many partner organizations to provide FP programs and achieve significant health impacts.

Monitoring and evaluation of FP service delivery remains essential for understanding the content, quantity, and quality of services being provided with U.S. government assistance. As service delivery has matured over the past 50 years, M&E has also evolved (Montagu & Longfield, 2016). There is a long tradition of measuring FP service-delivery activities and outcomes through internationally-standardized and program-specific indicators. Some of these indicators may be used to measure the introduction and use of high-impact practices that can improve FP access, quality, and related health outcomes (Family Planning High Impact Practices, 2017). Such practices include mobile outreach, integration of community health workers, postabortion care (PAC) FP, and social marketing, among others.

Even though the M&E of FP service delivery continues to be refined, challenges remain in measuring service delivery. Researchers have noted the need for large-scale studies to measure common outcome and impact indicators, the integration of FP with other health and development programs, and an increasing focus on the concept of quality (Cuéllar, Quijada, & Callahan, 2016). Moreover, a renewed focus on ensuring and protecting reproductive rights may require additional indicators at the facility and client levels to assess whether rights-based and client-oriented care is provided (RamaRao & Jain, 2015).

In the spring of 2016, USAID technical advisors asked MEASURE Evaluation to assess a set of indicators that can be used to measure aspects of FP service delivery. The request stemmed from field observations of service delivery programs using different indicators in their M&E plans, and at times, using different definitions for the same indicator. Based on these observations, USAID's Office of Population and Reproductive Health selected a draft set of 16 indicators and five indicator "areas" for the assessment. These were not necessarily "key" indicators for service delivery organizations, nor did they cover all technical priority areas within the USAID Office of Population and Reproductive Health. Rather, the selected indicators and areas represented a sample of the types of indicators for which there may be differences in definitions and reporting across USAID implementing partners (IPs). The indicators spanned technical areas (social and behavior change communication, PAC, postpartum FP, and healthy timing and spacing of pregnancy) and program levels (national, facility, and community-based). Thirteen of the indicators were already in the FP/RH Indicators Database: an online compendium of more than 400 core indicators across 36 technical areas. These indicators had identified definitions, data requirements, and data sources. USAID proposed eight additional indicators that did not have standard definitions, data requirements, or data sources.

The objective of this work was to investigate the use of the selected 21 indicators and indicator areas, provide guidance on service delivery indicator selection and prioritization, and make recommendations to improve the consistent measurement of the indicators across service delivery IPs.

The selected indicators and areas are:

Indicator #1: Percent of CPR accounted for by LAPMs [long-acting and permanent methods], broken down by method

Indicator #2: Unmet need for family planning

Indicator #3: Number of acceptors new to modern contraceptives

Indicator #4: Percent of women using a modern FP method who obtained their current method from a community-based worker

Indicator #5: Number/percent of trainees competent to provide specific services upon completion of training

Indicator #6: Percent of audience who recall hearing or seeing a specific message disaggregated by channel and number of exposures

Indicator #7: Percent of audience that know of a product, practice or service

Indicator #8: Percent of audience who believe that spouse, friends, relatives, and community approve (or disapprove) of the practice

Indicator #9: Percent of post-abortion care clients who left the facility with a contraceptive method

Indicator #10: Percent of obstetric and gynecological admissions owing to abortion

Indicator #11: Number/percent of target population who can state at least one health benefit of waiting at least two years after last live birth before attempting the next pregnancy

Indicator #12: Number/percent of target population who can state at least one benefit of delaying first pregnancy until after 18 years old

Indicator #13: Percent of target population who can state at least one health benefit of waiting six months after a miscarriage or abortion before attempting the next pregnancy

Indicator #14: Proportion of women who deliver in a facility and leave with a modern contraceptive method

Indicator #15: Proportion of women at routine immunization sessions who leave with a contraceptive method

Indicator #16: Number/percent of target populations who can state at least one health benefit of having less than four live births

Indicator area #17: Couples communication

Indicator area #18: Provider attitudes

Indicator area #19: Client/Provider communication

Indicator area #20: Continuing users of a FP method

Indicator area #21: Switchers of a FP method

The assessment involved the following eight USAID core-funded service-delivery IPs:

1. Advancing Partners and Communities, a project of John Snow, Inc.
2. Evidence to Action, a project of Pathfinder International
3. International Planned Parenthood Federation
4. Marie Stopes International
5. Maternal and Child Survival Program, a project of Jhpiego
6. Population Services International
7. Post Abortion Care-FP, a project of Engender Health
8. SHOPS Plus (Sustaining Health Outcomes through the Private Sector), a project of Abt Associates

METHODS

Monitoring and evaluation points of contact were identified for each of the eight service delivery IPs. These contacts were reached by e-mail, telephone, and Skype, and invited to participate in the activity. All agreed to participate. Information and feedback on the selected indicators were then obtained over the course of a few months. The input came in a variety of ways: some points-of-contact completed and submitted a spreadsheet with indicators or comments; some sent global and/or country-level Performance Monitoring Plans and materials for review and retrieval by MEASURE Evaluation; some gave feedback on the indicators over the phone or through e-mail.

Information on the selected (or similar) indicators was also collected from the following sources: FP2020 Performance, Monitoring, and Evaluation Working Group; Track20 (a project of Avenir Health); the Global Reference List of 100 Core Health Indicators (World Health Organization [WHO]); the Measurement, Learning, and Evaluation Project (MLE) of the Urban Reproductive Health Initiative; the Health Communication Capacity Collaborative (a project at Johns Hopkins University); the Institute for Reproductive Health (IRH) at Georgetown University; and the Service Provision Assessment (SPA) tools.

A spreadsheet of indicators was developed with sections for each indicator name, definition, data requirements, data sources, and notes about possible changes/updates and other commentary. The spreadsheet contained information received from the IPs and additional sources. A status report was submitted to USAID in January 2017 with details about the information collected and a summary of key findings. The review of the status report solicited a request to more fully analyze the information and provide guidance and recommendations on the selected indicators, general indicator selection, and prioritization for service delivery organizations.

Indicator guidance for FP service delivery projects was developed and applied to the 21 indicators and indicator areas selected for this activity. Recommendations were made for each indicator and area based on the application of the indicator guidance.

FINDINGS

Service Delivery IPs Did Not Collect Most of the Selected Indicators

The exercise began by collecting (1) definitions of selected FP service delivery indicators; (2) feedback from IPs on the selected indicators (such as feasibility, quality, and usability); and (3) suggestions from IPs on improvements on indicators selected for the assessment.

One of the main findings is that IPs did not collect data for most of the indicators selected for this assessment. In our review of the materials submitted by IPs, we found that the projects (and/or their subgrantees) collected mainly project-specific, output-level indicators. Therefore, few IPs had comments about higher-level indicators, indicators outside their specific scope, or indicators requiring expensive data collection (such as household surveys). As a result, some of the indicators in the list did not receive any comments, while others received comments from only a few of the IPs.

Understanding of Indicator Criteria Applied to Service Delivery Context Was Problematic

Technical advisors at USAID selected some indicators that are not used by, or useful to, currently awarded service delivery programs. This suggests there may have been a misunderstanding around programmatic information needs and data availability. It also suggests a need for refined criteria that can be used to prioritize and select service delivery indicators.

The conventional criteria for "strong" indicators are outlined below. Strong indicators are defined as:

- Valid (accurate measures of behaviors, practices, or tasks)
- Reliable (consistently measurable in the same way by different observers)
- Operational (defined in unambiguous terms)
- Measurable (quantifiable using available tools and methods)
- Nondirectional (allowed to vary in either direction)
- Timely (provide measurement at relevant and appropriate intervals)
- Programmatically important (linked to program activities, outputs, outcomes, or impacts)

Two standard criteria stood out as being problematic for the indicators selected for this assessment.

- **Measurable.** Technically, all indicators chosen for this assessment are measurable, in that they are quantifiable, and tools and methods are available, or can be made available, to collect the appropriate data. Most are widely used for monitoring and evaluating FP programs; in fact, many have been validated and standardized and are available in indicator resources and compendiums. However, the issue is whether they are measurable for service delivery programs, which are often implemented at the facility and/or service provider level. At this level of operation, the main data sources are typically program records, facility registers, other routine sources of information, and routine and nonroutine surveys of clients and providers. Indicators that require data sources not typically used by service delivery programs (such as large, population-based surveys) are not captured through regular program monitoring. The extra resources needed to collect such data may far outstrip what programs are able to afford, making the indicators "unmeasurable." When prioritizing and selecting indicators for service delivery programs, it is important to consider the available data sources and planned data collection activities, because these will help determine which indicators are measurable.

- **Programmatically important.** Many of the selected indicators are relevant for FP programming and are widely used. However, they have debatable programmatic relevance for service delivery programs, especially those that are not working at a national level. It is not reasonable to expect service delivery projects to collect information on indicators that are not directly related to project work or immediate outcomes. Information that the program does not need should not be collected.

There Are Differences in How Some Indicators Are Defined and Operationalized

Six indicators among the list of 16 had variations in indicator language or definitions or how the indicator was operationalized. In such cases, indicator harmonization would ensure that all IPs are collecting the same information in the same way. One example involves Indicator #3: "Number of acceptors new to modern contraception." A recently published paper (Dasgupta, Weinberg, Bellows, & Brown, 2017) discussed the issue of terminology around who uses contraception and recommended the use of "first-time users" and "adopters" rather than "new users" or "acceptors." Another indicator that could benefit from harmonization is in measuring competency to provide services after training (Indicator #5). Although IPs assessed this issue in several ways, none of the IPs collected the exact indicator as it was proposed for this activity.

The Five Indicator Areas Proposed for the Assessment Need Development

Only a few measures for couples' communication were being used by service delivery IPs. These indicators assess discussion of FP with the partner, partner approval, and partner support of FP use, and the information can come from client exit interviews or (if needed for evaluation) population-based surveys. Additional measures of couples' communication are being tested through evaluation and survey research, such as measures of the level of difficulty of having FP discussions with the partner, whether consent is required for FP use, who takes the initiative to start FP use, the level of partner participation in FP, and the level of comfort discussing FP with the partner. Such measures may provide important information on couples' communication, but will need to be tested.

Another new indicator area is the measurement of provider attitudes. Only one IP collects information on this issue, using "Percent of providers who demonstrate positive attitudes toward providing contraception to youth in specific interventions." Evaluation and survey research groups have assessed provider attitudes in different ways, such as by measuring the level of comfort that providers feel when offering FP services to different client populations (such as adolescents, people with HIV, and people with disabilities) and whether providers restrict clients' access to each offered FP method based on age, parity, partner consent, or marital status. One research organization has assessed provider attitudes by how they respond to client scenarios. This important area needs validation and development of agreed upon measures both at the service delivery and population levels.

We see a similar pattern for measures in the areas of provider-client communication, continuing users, and method switching. Most IPs do not collect information on these issues; however, if there is a desire to monitor these behaviors, indicators should be standardized across the service delivery IPs. As with couple communication and provider attitudes discussed above, innovative measures at the population level are currently being used in evaluation and survey research.

GUIDANCE AND RECOMMENDATIONS

The selection and prioritization of indicators should always follow the seven standard criteria (valid, reliable, operational, measurable, nondirectional, timely, and programmatically important). Service delivery programs will need to apply these criteria to the service delivery context, which may mean some refinements will be needed. For example, service delivery programs that will not have a large evaluation component should extend the definition of "measurable" to include whether the indicator data need to be collected at the facility, provider, or client levels (and do not require large national population-based surveys). Only programs with plans to conduct outcome or impact evaluation should consider collecting data at the population level.

In addition, the following two criteria can be used to help prioritize and select FP service delivery indicators:

- **Practical.** Program resources are available to collect, analyze, and use information obtained by the indicator.
- **Cost-efficient.** Cost of collecting information needed to calculate the indicator or a group of indicators does not outweigh the benefit of the information to the program.

Refinements to the seven current indicator criteria and two recommended criteria do not conflict with USAID policies for indicator criteria, found in ADS 201.3.5.7 (USAID, 2017). The refinements provide more explicit guidance for the FP service delivery context.

Table 1 provides a guide for selecting proposed indicators, using nine criteria and applicability to service delivery. Strong indicators will have a "Yes" checked for each criterion. Caution should be used if selecting indicators with a "No" checked for any one of the criteria. Indicators with multiple "Nos" have many weaknesses and service delivery programs should not select them for use.

Table 1. Guide for selecting FP service delivery indicators

Criteria	Applicability to service delivery indicators	Yes	No
Valid	The indicator measures what it is supposed to measure, either directly or by proxy. If available, the standard indicator is used.	✓	
Reliable	The indicator provides the same information, with as little bias as possible, each time it is used.	✓	
Operational	The indicator is defined in clear, unambiguous terms.	✓	
Measurable at facility, provider, or client level	The data for the indicator can be collected by the program using data sources that are available and accessible. Indicators do not require large or national population-based surveys, except in the case of outcome or impact evaluation.	✓	
Nondirectional	The indicator can vary in either/any direction.	✓	
Timely	The indicator provides information when needed, at the appropriate intervals.	✓	
Programmatically important	The indicator is directly linked to a programmatic action, output, or outcome. If the program will have an impact evaluation, the indicator links to a specific health impact.	✓	
Practical	The process of collecting the indicator data, analyzing the information, and using the results is feasible for the program. The technical and financial resources are available.	✓	
Cost-efficient	The cost of collecting data for the indicator is proportionate to the usefulness of the indicator. Duplication of effort should be avoided; outcome indicators at the national and regional levels are often available through Demographic and Health Surveys (DHS) and other similar surveys.	✓	

Ideally, indicators should have appropriate levels of disaggregation to enhance the richness of information. For example, if an indicator collects information on FP methods, it is often useful to disaggregate by method type, modern versus traditional, or short acting versus long acting or permanent.

Application of Indicator Criteria to Selected Indicators

These indicator criteria have been used to assess the 21 indicators and areas selected for this study. Table 2 presents each indicator and shows whether the indicator is assessed with routine or nonroutine data collection systems, the main indicator criteria concerns that arise for service delivery programs, and recommendations on use of the indicator for program monitoring or process evaluation, and outcome or impact evaluation. Detailed information on each indicator begins on page 20.

Table 2. Summary of results of indicator criteria applied to selected indicators and recommendations for use

Indicator	Routine or nonroutine	Main criteria concerns for service delivery programs	Recommendation for program monitoring or process evaluation	Recommendation for outcome or impact evaluation
1. Percent of CPR accounted for by LAPMS broken down by each method	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Collect only if DHS data are unavailable; reconsider indicator language (example: Percent of CPR accounted for by each method)
2. Unmet need for FP	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Collect only if DHS data are unavailable
3. Number of acceptors new to modern contraception	Routine	•Reliability: indicator language is nonstandard across service delivery providers	Harmonize indicator language (example: Number of first- time users of modern contraception)	Harmonize indicator language (example: Number of first-time users of modern contraception)
4. Percent of women using a modern FP method who obtained their current method from a community-based worker	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Use alternate indicator (example: Number/percent of FP clients referred by community-based worker)	Reconsider indicator language (example: Percent of women who received FP from a community-based worker in the past year)
5. Number/percent of trainees competent to provide specific services upon completion of training	Routine	•Not operational: indicator definition is not clear; measures of training competency vary across service delivery providers	Agree on measure(s) of training competency (example: number/percent of trainees who passed the post-training assessment; number/percent of trainees who perform to established guidelines/standards)	Agree on measure(s) of training competency (example: Number/percent of trainees who passed the post-training assessment; number/percent of trainees who perform to established guidelines/standards)

6. Percent of audience who recall hearing or seeing a specific message disaggregated by channel and number of exposures	Nonroutine	•Reliability: indicator language is nonstandard across service delivery providers •Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Reconsider indicator language (example: Percent of audience reporting exposure to FP messages on radio, television, or in print in past 12 months)
7. Percent of audience that know of a product, practice or service	Nonroutine	•Validity: indicator does not assess whether knowledge is correct •Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Reconsider indicator language (example: Percent of audience who recall hearing or seeing a specific product, practice or service)
8. Percent of audience who believe that spouse, friends, relatives, and community approve (or disapprove) of the practice	Nonroutine	•Reliability: too many groups of people specified in the measure •Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Reconsider indicator (example: Percent of audience who believe people in their community generally approve (or disapprove) of the practice)
9. Percent of postabortion care clients who left the facility with a contraceptive method	Routine	•Reliability: indicator language and definition is nonstandard across service delivery providers	Standardize indicator definition	Standardize indicator definition

10. Percent of obstetric and gynecological admissions owing to abortion	Routine	•Validity: not yet shown to accurately capture PAC admissions •Not measurable: data may not be available	Agree on indicator language and definition (example: Number/percent of PAC clients provided services in (1) the operating theater, (2) OB-GYN ward, and (3) outpatient clinic). Test for validity.	Agree on indicator language and definition (example: Number/percent of PAC clients provided services in (1) the operating theater, (2) OB-GYN ward, and 3) outpatient clinic). Test for validity.
11. Number/percent of target population who can state at least one health benefit of waiting at least two years after last live birth before attempting the next pregnancy	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Acceptable
12. Number/percent of target population who can state at least one benefit of delaying first pregnancy until after 18 years old	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Acceptable
13. Percent of target population who can state at least one health benefit of waiting 6 months after a miscarriage or abortion before attempting the next pregnancy	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Acceptable
14. Proportion of women who deliver in a facility and leave with a modern contraceptive method	Routine	•Reliability: indicator language and definition is nonstandard across service delivery providers	Standardize language and definitions	Standardize language and definitions

15. Proportion of women at routine immunization sessions who leave with a contraceptive method	Routine	•Validity: indicator may not be a good measure of postpartum family planning (PPFP) •Measurability: data may not be available	Agree on indicator language and definition for use as measure of PPFP uptake at integrated FP/maternal and child health (MCH) sites	Agree on indicator language and definition for use as measure of PPFP uptake at integrated FP/MCH sites
16. Number/percent of target populations who can state at least one health benefit of having less than 4 live births	Nonroutine	•Not measurable at the facility, provider, or client level •Practicality •Cost efficiency	Not recommended	Acceptable
17. New indicators: couples' communication	--	TBD. Potential examples: Percent of clients with partners supportive of their use; percent of clients who need partner consent to use FP methods; percent of clients who report discussing contraceptive use with partner is very or somewhat difficult	--	--
18. New indicators: provider attitudes	--	TBD. Potential examples: Percent of providers who demonstrate positive attitudes toward providing contraception to youth; percent of providers who feel comfortable providing contraceptive information and services to adolescents; percent of providers who restrict access to each offered FP method based on age, parity, partner consent, or marital status	--	--

19. New indicators: client/provider communication	--	TBD. Potential examples: Percent of clients reporting provider asked whether they were having (or had had) a problem with the method; percent of clients reporting provider treated them with respect at last visit; percent of clients who felt provider responded to their questions	--	--
20. Continuing users of a FP method	--	TBD. Potential examples: Median duration of use, by main method; percent of short-term FP method clients who renew a method; percent of short-term FP method clients due to return who actually did return; and the contraceptive continuation rates based on DHS reproductive calendar	--	--
21. Switchers of a FP method		TBD. Potential examples: Proportion of clients who switch from a short-term to a long-acting or permanent method of FP; percent of FP users who are switchers	--	--

Many of the selected indicators with nonroutine data collection require large, population-based surveys; as a result, they are not recommended for use in regular program monitoring. However, service delivery programs should always aim to include indicators that require nonroutine data for outcome monitoring and, in some cases, outcome and impact evaluation. Such data sources could be client surveys, provider surveys, or provider-client observations. Some of the indicators presented in Table 2 can be adapted for measurement through routine data systems and/or for facility- or client-level data collection (examples are provided in Table 2).

The assessments of IP feedback and recommendations for each of the 21 indicators and indicator areas are presented below, with recommendations and guidance about indicator use, language, definition, and/or work needed to improve the strength of the indicator.

Indicator 1. Percent of CPR accounted for by LAPMs, broken down by method

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

"Percent of CPR accounted for by each method"

Assessment of Implementing Partner Feedback

Neither current nor suggested indicator is collected by implementing partners. Most implementing partners rely on Demographic and Health Surveys (DHS) for estimates of CPR and CPR by method. Others use service statistics to estimate the number of users, but CPR is not calculated from such data. Examples of related outcome indicators collected by implementing partners are "Percent of CPR accounted for by the project" (not disaggregated by method), "Number of current users," and "Percent of women of reproductive age who are using a modern contraceptive method at a particular point in time" (estimated from nationally-representative surveys and couple-years of protection).

Recommendation

This population-level indicator is not recommended for service delivery program monitoring or process evaluation. In the case of outcome or impact evaluation, it should only be collected when DHS estimates are not already available.

USAID-suggested wording can be applied to the indicator in the FP/RH Indicators Database.[1]

Suggested Wording

"Percent of CPR accounted for by each method"

[1] Once consensus is reached, changes to this and all other indicators will be made in the FP/RH Indicators Database.

Indicator 2. Unmet need for family planning

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

Most IPs do not collect this indicator. One organization collects "Met need among clients," which can be converted to the reverse (defined as "Women who have expressed a desire to space or limit childbearing but are not discharged with a method"). Another organization conducts a household survey in several countries to collect "Percent of mothers of children under 5 who (1) are pregnant and want to either postpone or avoid their next pregnancy, or (2) are fecund and want to either postpone or avoid their next child but are not using a contraceptive method."

The definition of this indicator differs among FP leaders. The FP2020 indicator includes all fecund women of reproductive age, and considers the use of traditional methods as an unmet need. In contrast, the WHO (2015) definition is restricted to fecund women of reproductive age who are married or in union, and considers use of traditional methods as a met need.

Recommendation

This indicator is not recommended for service delivery program monitoring or process evaluation. It is a national-level indicator for which data are found in the DHS. Demographic and Health Survey estimates of unmet need should be used for outcome or impact evaluation, unless they are not available. It is recommended that the FP2020 definition be used to calculate unmet need, because this definition represents the most recent thinking on this issue.

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

About half of the IPs collected some version of this indicator. IPs used different wording, such as "Number of new FP users," "Number of acceptors new to modern contraceptives," and "Number of acceptors of FP method." Others use the term "first-time users." Several IPs expressed an interest in aligning definitions and language around "acceptors," "new users," and "first-time users." The following proposed definitions are based on the recently published paper by Dasgupta, Weinberg, Bellows, & Brown (2017):

Acceptor. A person who adopts any form of contraceptive method

Adopter. A person who accepts a method of contraception and who was not currently using modern contraception at the time of the visit. Adopters are people who have a period of nonuse, for any reason, before the resumption of contraceptive use. A person could be an adopter more than once.

New user. A person who accepts contraception for the first time from a provider/program or who is an acceptor of a method never before used. A person could be a new user each time a method of contraception never used before is begun for the first time.

First-time user. A person who accepts a modern contraceptive method for the first time in his or her life. One can be a first-time user only once.

Recommendation

This indicator should be used both for program monitoring and evaluation, but harmonization of the language is needed, particularly around "acceptors," "adopters," "new users," and "first-time users." The indicator would meet the remaining indicator criteria if reworded for clarity. Note that more than one indicator may be required to capture the characteristics of women adopting and receiving FP.

Suggested Wording

"Number of first-time users of modern contraceptives"

"Proportion of FP clients who are FP adopters"

Indicator 4. Percent of women using a modern FP method who obtained their current method from a community-based worker

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

This indicator is not collected by IPs. One reason is that the data for the indicator require a population-based survey, which few of the IPs use as a source for M&E data. Also, when collected, alternate indicators are used. For example, a country program of one project collects an output indicator defined as "Number of new FP users reached through mobile outreach." Another IP has done occasional household surveys that include "Percent of mothers of children under 5 who received their modern contraceptive method from a community health worker."

Recommendation

Service delivery IPs should use an alternate indicator for monitoring, such as "Number/percent of FP clients referred by a community-based worker" and/or "Number/percent of first-time users reached by community-based workers." Either of these indicators could be collected through program records or client interviews. As currently worded, the indicator would be best suited for outcome or impact evaluation requiring population-based surveys. In such cases, indicator language should be harmonized. One suggestion for a more precise indicator comes from the MLE Project: "Percent of women who received FP from a community health worker in the past year."

Suggested Wording

"Number/percent of FP clients referred by a community-based worker"

"Number/percent of first-time users reached by community-based workers"

"Percent of women using a modern FP method who obtained their current method from a community-based worker"

"Percent of women who received FP from a community-based worker in the past year"

Indicator 5. Number/percent of trainees competent to provide specific services upon completion of training

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

This indicator is not collected by IPs as currently worded. While many IPs collect data on the number of people trained by their projects, they do not have assessments of competency. Others collect this data using "Percent of providers that passed their post-training knowledge exams and competency exams (by type of training)" and "Number of trained health workers who achieved competency to provide RH/FP information and services by place of service (facility or outreach), sex, and method type." Two IPs provided suggestions for rewording this indicator even if they do not currently collect it. These include:

"Proportion of trainees who passed the post-training assessment"

"Number of service providers trained in FP in line with government standards/international best practice"

"Number of providers trained who are certified competent to provide services according to national standards"

Other potential indicators in the FP/RH Indicator Database are "Number/percent of trainees who have mastered relevant knowledge" and "Number/percent of trainees who perform to established guidelines/standards."

Recommendation

It is difficult to operationalize the indicator as it is currently written, because it lacks specificity around the concept of competency. Agreement needs to be reached on how to reliably assess training competency. The term "mastered," which is used in a related indicator in the FP/RH Indicator Database, also suffers from a lack of specificity. Some suggestions for alternate indicators were provided by IPs; there may be others worth considering. Once determined, the indicator should be standardized for IPs and serve as an outcome indicator for training activities.

Suggested Wording

"Number/percent of trainees who perform to established guidelines/standards"

"Number/percent of trainees who passed the post-training assessment"

Indicator 6. Percent of audience who recall hearing or seeing a specific message disaggregated by channel and number of exposures

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

IPs have modified this indicator to suit their specific programs. Often the indicators do not account for "channel" or "number of exposures" and rarely use percent as a metric. As expected, the indicator is only collected by IPs with a focus on behavior change communication. Some examples of modifications to the indicator are:

"Number of community members reached with family planning messages (disaggregated by type of provider)"

"Number of targeted audience accessing FP information, products or services, disaggregated by age and gender"

Recommendation

This indicator is useful for programs that have a mass-media or behavior-change communication component; it would likely be used as one of a set of indicators to fully measure exposure to communication messages. However, it is currently applied in different ways by service delivery IPs. Indicator language needs to be harmonized for more standardized application. The suggested wording below comes from the Performance Monitoring and Accountability 2020 (PMA2020) indicator "Recent exposure to mass media FP messages." Harmonization may be needed for other social behavior-change indicators.

Suggested Wording

"Percent of audience reporting exposure to family planning messages via radio, television, or print in past 12 months"

Indicator 7. Percent of audience that know of a product, practice or service

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

This indicator is not collected by IPs in any iteration. One IP noted that "know of" is a vague term and should be clarified. The definition of the indicator in the FP/RH Indicators Database contains guidance on operationalizing the term "know of" as whether audience members can "spontaneously name" or "recognize when the name is mentioned" a product, practice, or service. However, the indicator does not capture whether the "knowledge" is correct.

Recommendation

The indicator is not recommended for service delivery program monitoring. Audience awareness of products, practices, and services is a potentially useful indicator for outcome or impact evaluation, especially for behavior-change and communication programs, but there is not an identified need for this indicator among the service delivery IPs. If used for impact evaluation, it is recommended that the phrase "know of" be replaced with "can recall hearing about" and that the indicator be considered low priority.

Suggested Wording

"Percent of audience who recall hearing about or seeing a specific product, practice, or service"

Indicator 8. Percent of audience who believe that spouse, friends, relatives and community approve (or disapprove) of the practice

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

No changes

Assessment of Implementing Partner Feedback

This indicator is not collected by service delivery IPs. It requires data from a large population-based survey and is difficult to operationalize and interpret. For example, with so many types of people included in the indicator, it is not clear how one would account for differences in approval or disapproval among them.

Similar information on the social norms around FP acceptability has been captured through evaluation and research surveys using questions such as, "Do you approve or disapprove of couples using modern contraceptive methods to space births or avoid pregnancy?" One IP suggested the following wording to improve the indicator: "Percent of audience who believe people in their community approve of the practice" or "Percent of audience who believe people in their community use modern contraception."

Recommendation

This indicator may not be programmatically relevant for many FP service delivery programs. It is not recommended for service delivery program monitoring. If useful for evaluation purposes, rewording of the indicator should be considered.

Suggested Wording

"Percent of audience who believe people in their community generally approve (or disapprove) of the practice"

Indicator 9. Percent of postabortion care clients who left the facility with a contraceptive method

Current indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

Total number of PAC clients who receive a FP method prior to discharge from the facility

Assessment of Implementing Partner Feedback

Few service delivery projects collect this indicator. Of those that do, the following versions are in use:

> "Number/Percent of PAC clients who accept a contraceptive method prior to discharge from the facility"
>
> "Number of postpartum/post-abortion women receiving a contraceptive method at program-support health facilities"
>
> "Number/Percent of safe abortion/PAC clients who adopted a modern contraceptive method during the same visit" (known as "Same-day PAC FP" and "Number/Percent of safe abortion/PAC clients who adopted a modern contraceptive method within 14 days of the safe abortion/PAC procedure" (only collected when client is not referred to other clinics for FP)

IP feedback on the indicator included a concern for specifying that the method needs to be delivered on the same day, because this potentially biases behavior toward uptake of short-term methods. This is because, as noted by the program M&E team, "the same-day requirement makes it more likely that clients will accept condoms or oral pills as a way of making a quick and commitment-free decision, and also that clinics will offer these methods immediately rather than (depending on time pressures, for example) asking a client to return the next day for an IUD or implant."

Recommendation

This indicator only applies to service delivery IPs offering PAC services; it would not be programmatically important to other IPs. Nevertheless, this is a key indicator for monitoring and evaluating PAC services, and therefore should be standardized across service delivery IPs. Agreement needs to be reached on indicator language and definition. For example, the USAID-suggested wording changes the indicator from a coverage estimate to a count. It is recommended that coverage be estimated when possible.

Suggested Wording

"Number/percent of PAC clients who accept an FP method prior to discharge from the facility"

Indicator 10. Percent of obstetric and gynecological admissions owing to abortion

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

"The total number of obstetrical admissions ≤ 20 weeks gestation due to bleeding or infection"

Assessment of Implementing Partner Feedback

The current indicator is not collected by IPs. One IP is considering collecting data on the type of treatment (such as sharp curettage, Manual Vacuum Aspiration, and misoprostol) found in clinic registers that include PAC, operating theater, and obstetrics/gynecology wards. This work requires checking for double-counting across registers, which would also be a concern for calculating the number/percent of PAC clients seen in more than one ward.

Another concern expressed by the IPs is that this indicator is likely to miss PAC clients receiving outpatient services; therefore, it would skew results toward women with complications. Owing to the availability and use of misoprostol, the incidence of serious complications may be declining, while the need for PAC services at the outpatient level may be increasing. Additionally, the USAID-suggested wording may capture women admitted for complications related to pregnancy rather than abortion.

Recommendation

An indicator is needed that could assess the degree to which PAC clients are not captured in PAC registers. However, the current indicator has not been validated or used by service delivery IPs. Concerns about data quality involve double counting, missing PAC clients seen in outpatient services, and capturing women who are admitted for pregnancy complications and not safe for abortion or PAC. A potential indicator is, "Number/percent of PAC cases admitted and provided in (1) the operating theater, (2) obstetrics/gynecology ward, and (3) outpatient clinic"; however, consensus needs to be reached about the indicator language and definition. Any agreed-upon indicators should be validated in the field. It will be important to ensure that this indicator does not double count cases that are also recorded in a PAC registry.

Suggested Wording

"Number/percent of PAC cases admitted and provided in (1) the operating theater, (2) obstetrics/gynecology ward, and (3) outpatient clinic"

Indicator 11. Number/percent of target population who can state at least one health benefit of waiting at least two years after last live birth before attempting the next pregnancy

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

Same as above

Assessment of Implementing Partner Feedback

This is not a global indicator for any IPs. It is only collected by one IP for a selection of its programs, and is worded as "Percent of mothers of children age 0-–23 months who know one or more benefits of waiting at least 24 months after giving birth before attempting to become pregnant again." It is collected through a standardized household survey.

Recommendation

The wording of this indicator should be harmonized with that of the FP/RH Indicators Database, which one IP uses. Overall, this indicator is not recommended for monitoring service delivery programs. It could potentially be useful for program evaluation, but may not have program relevance for most service delivery programs. It should be considered low priority for most service delivery IPs.

Suggested Wording

Same as FP/RH Indicators Database

Indicator 12. Number/percent of target population who can state at least one benefit of delaying first pregnancy until after 18 years old

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

Same as above

Assessment of Implementing Partner Feedback

This is not a global indicator for any IPs. It is only collected by one IP for a selection of its programs, and is worded as "Percent of mothers of children age 0–23 months who know at least one benefit of a woman delaying a pregnancy until the age of 18 years."

Recommendation

The wording of this indicator should be harmonized with that of the FP/RH Indicators Database, which one IP uses (for example, "Percent of mothers of children ages 0–23 months who can state at least one benefit of delaying first pregnancy until after the age of 18 years"). Overall, this indicator is not recommended for monitoring service delivery programs. It could potentially be useful for program evaluation, but may not have program relevance for most service delivery programs. It should be considered low priority for most service delivery IPs.

Suggested Wording

Same as FP/RH Indicators Database

Indicator 13. Percent of target population who can state at least one health benefit of waiting 6 months after a miscarriage or abortion before attempting the next pregnancy

Current Indicator

Included in the FP/RH Indicators Database

USAID-Suggested Wording

Same as above

Assessment of Implementing Partner Feedback

This is not a global indicator for any IPs. It is only collected by one IP for a selection of its programs, and is worded as "Percent of mothers of children age 0–23 months who know one or more benefits of waiting at least 6 months after a miscarriage or abortion before attempting to become pregnant again."

Recommendation

The wording of this indicator should be harmonized with that of the FP/RH Indicators Database, which one IP uses. Overall, this indicator is not recommended for monitoring service delivery programs. It could potentially be useful for program evaluation, but may not have program relevance for most service delivery programs. It should be considered low priority for most service delivery IPs.

Suggested Wording

Same as FP/RH Indicators Database

Indicator 14. Proportion of women who deliver in a facility and leave with a modern contraceptive method

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

Proportion of women who deliver in a facility and leave with a modern contraceptive method

Assessment of Implementing Partner Feedback

Several IPs collect a version of this indicator, such as:

"Proportion of clients who receive a FP method after delivering at a program facility" (using a 6-week cut-off for PPFP)

"Percent of women delivering in program-supported health facilities who accept a method of family planning prior to discharge"

"Number and percent of postpartum women who accept a FP method immediately after delivery (by age, method, and type of user—new or continuing)"

WHO (2015) recommends "Proportion of all postpartum women in the health facility who received contraceptive counselling on birth spacing and family planning before discharge."

Recommendation

This is an important outcome indicator for monitoring and evaluating PPFP. While already commonly used by service delivery IPs, the language and definitions should be harmonized to improve reliability.

Suggested Wording

"Number/percent of women who delivered in a facility and accepted a modern contraception method prior to discharge"

"Number/percent of women who delivered in a facility and initiated a postpartum FP method (except the lactational amenorrhea method) prior to discharge"

Indicator 15. Proportion of women at routine immunization sessions who leave with a contraceptive method

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

"Proportion of women at routine immunization sessions who leave with a contraceptive method"

Assessment of Implementing Partner Feedback

This indicator is not currently collected by IPs. Some concern was expressed about the utility of the indicator, suggesting that it assesses method accessibility rather than PPFP. Also, it is unclear how this indicator would account for referrals.

Recommendation

This indicator should be reconsidered. As it is currently worded, it may not be a good measure of PPFP. However, it may have some utility as a measure of FP/MCH integration, though guidance would be needed on how to account for referrals. The suggested wording for the indicator below assumes the indicator is measuring the extent of PPFP uptake at FP/MCH-integrated sites.

Suggested Wording

"Number/percent of women at routine immunization visits within her child's first year of life who leave with a contraceptive method"

Indicator 16. Number/percent of target populations who can state at least one health benefit of having less than four live births

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

Number/percent of target populations who can state at least one health benefit of having less than four live births

Assessment of Implementing Partner Feedback

This is not a global indicator for any IPs. There was no feedback on the utility or feasibility of this indicator.

Recommendation

The USAID-suggested wording of this indicator is acceptable. Overall, this indicator is not recommended for monitoring service delivery programs. It could potentially be useful for program evaluation, but may not have program relevance for most service delivery programs. It should be considered low priority for most service delivery IPs.

Indicator 17. New Indicator: Couples' communication

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

No specific indicators suggested

Assessment of Implementing Partner Feedback

Most of the service delivery IPs do not collect quantitative information about couples' communication, because that usually requires large population-based surveys. One exception is a program that assesses "Percent of women of reproductive age who report their spouse approves of modern family planning methods in specific interventions"; this is more a measure of acceptability than communication. Another IP collects "Percent of FP clients who have informed/discussed FP choices with their partners."

Several research and evaluation projects collect information on couples' communication, covering topics such as the decision to use FP alone or jointly with their husbands/partners (PMA2020); how often they talked about the number of children desired/use of FP method in the past six months (MLE); who usually starts the discussion about FP/how difficult it is to start a discussion about FP (MLE); whether consent to use FP is required by the spouse (MLE); and how important decisions about FP use are made together (IRH).

Recommendation

Work in this area is needed to identify indicators appropriate for service delivery monitoring and evaluation. Service delivery programs should focus on indicators that can be collected from clients, while evaluation and research projects are best positioned to collect information at the population level. Elements of couples' communication that could be explored are:

- Frequency of communication
- Timing of communication
- Quality of communication
- Content of communication
- Who initiates communication
- Difficulty of/comfort with FP discussions
- FP decision making/consent
- FP approval/acceptability by partner

Many of these elements can be measured with indicators that are acceptable for monitoring service delivery programs. See Suggested Wording.

Suggested Wording

"Percent of clients who have discussed FP with their partner within the past 6 months"

"Percent of clients who feel comfortable discussing FP with their partner"

"Percent of clients who need partner consent to use FP methods"

"Percent of clients who report discussing contraceptive use with partner is very or somewhat difficult"

"Percent of users with partners supportive of their use"

Indicator 18. New indicator: Provider attitudes

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

No specific wording was suggested

Assessment of Implementing Partner Feedback

Most of the service delivery IPs do not collect quantitative information about providers' attitudes. One exception is a program that measures "Percent of providers who demonstrate positive attitudes toward providing contraception to youth in specific interventions." It was also suggested that clients could be asked about whether certain counseling techniques were provided during the last appointment as a way to indirectly assess provider attitudes.

In contrast, research and evaluation projects have used many measures of provider attitudes to assess the level of comfort in providing contraceptive information and services to an array of populations such as (1) adolescents (married and unmarried), (2) people with HIV, (3) sex workers, (4) people with disabilities, (5) people with little or no income, (6) people from another country, community, or ethnic group, and (7) migrants and refugees (PMA2020).

Service providers are also asked if they agree with the statement, "I respect her choices, even if I may disagree with them" (PMA2020); if clients' access to each FP method is restricted based on age, parity, partner consent, or marital status (MLE); and how providers decide which method to offer a client (IRH).

Recommendation

Provider attitudes should be addressed in two areas: (1) whether there are biases related to particular populations, such as adolescents, women with no children, and unmarried women; and (2) whether there are biases against certain methods related to perceived advantages, disadvantages, efficacy, or appropriateness. Though these two areas may overlap, several indicators should be tested and validated for each. Initial work has provided some potentially strong indicators, such as "Percent of providers who feel comfortable providing contraceptive information and services to adolescents" or "Percent of providers who restrict access to each offered FP method based on age, parity, partner consent, or marital status." Service delivery programs are especially well-positioned to contribute information on provider attitudes.

Indicator 19. New indicator: Client/provider communication

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

No specific wording was suggested

Assessment of Implementing Partner Feedback

Only one IP regularly collects data on client/provider communication, using the FP2020 Method Information Index (the extent to which women receive counselling on all of the following: a method other than the one they receive, side effects of the method they receive, and what to do in case of side effects).

The SPA survey tool can be used to calculate "Percent of clients reporting provider asked whether they were having (or had) a problem with the method" and "Percent of clients who have had problems with the method who mentioned them to the provider." The IRH has also used the following measures: "Percent of clients reporting provider treated him/her with respect at last visit"; "Percent of clients who felt conversation with provider was private at last visit"; "Percent of clients confident that provider will not tell others about their conversation at last visit; "Percent of clients who felt provider appeared rushed"; "Percent of clients who felt provider was friendly"; "Percent of clients who felt provider treated them respectfully"; and "Percent of clients who felt provider responded to their questions."

Recommendation

Three elements of communication should be considered when assessing provider/client communication. These are:

- Quality of communication
- Content of communication
- Provider-led communication compared with client-led communication

No single indicator will be able to fully assess client/provider communication. For example, the FP2020 Method Information Index may be sufficient for providing information on the content of the counseling but not the quality of the counseling. Agreement should be reached on a short list of indicators that can be used to assess the three elements of client/provider communication. A short list of appropriate indicators can be derived from the SPA, Quick Investigation of Quality (MEASURE Evaluation, 2016), and research by IRH and others. The assessment of client/provider communication is an important aspect of service quality, and an area in which service delivery projects are well-positioned to provide information.

Current Indicator

Included in the FP/RH Indicators Database: The contraception continuation rate (cumulative probability that acceptors of a contraceptive method will still be using any contraceptive method offered by the program after a specified period of time)

USAID-Suggested Wording

No specific wording was suggested

Assessment of Implementing Partner Feedback

Only one IP routinely collects indicators for contraceptive continuation, using "Percent of short-term method clients due to return who actually did return" and "Percent of short-term FP clients who renew the method." Another service delivery IP explores the topic through special studies, but does not use the contraception continuation rate.

PMA2020 collects "median duration of use, by main method."

Recommendation

No indicator to assess continuing use has been widely adopted. The PMA2020 indicator is most appropriate for outcome or impact evaluation, but perhaps could also be applied to a client population for program monitoring. Measuring the contraceptive continuation rate is complicated and necessitates the calculation of the discontinuation rate, usually using a reproductive calendar as part of a survey. Developing indicators for monitoring service delivery programs will depend on whether this is considered important and the data and systems are available to track indicators such as returning clients and method renewals. Such client-level indicators may be useful for service delivery programs.

Indicator 21. Switchers of an FP method

Current Indicator

Not in the FP/RH Indicators Database

USAID-Suggested Wording

No specific wording was suggested

Assessment of Implementing Partner Feedback

Only one IP routinely collects indicators for method-switching. The two indicators are "Proportion of clients who switch from a short-term to a long-acting or permanent method of FP" and "Percent of FP users who are switchers"; both are collected through a client-based information system, client exit interview, or follow-up survey.

Survey questions on this topic are collected at the facility-level, using "What was the outcome of this visit—did you decide to continue (restart) the same method or to switch methods?" (SPA), and at the population-level, using "In the last one year, have you switched the method you were using?" (MLE).

Recommendation

No indicator to assess method switching is yet in wide use. The development of indicators for monitoring service delivery programs will depend on whether this issue is considered important. Method switching could be assessed by service delivery programs at the client-level through client records or exit interviews. Method switching can also be assessed at the population-level for evaluation or research needs. For example, an indicator could be derived from the percent of switchers reported in the DHS table on discontinuation.

CONCLUSION

Consistent measurement is essential to understand the quantity and quality of diverse services delivered through an array of USAID-supported programs. Only with these data can programs be aligned and improved to reach as many women and men as possible with services that meet their reproductive health needs. The findings and recommendations in this report are the beginning of an informed discussion on how USAID-supported programs measure service delivery. The conversation will continue as criteria, guidance, and measurements are refined, shared, and incorporated in M&E plans across IPs. A key resource in this discussion will be the FP/RH Indicator Database. It will be updated according to current discussions and decisions, and will continue to be an important M&E resource for information on core service-delivery indicators.

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This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. TR-17-194.

ISBN: 978-1-9433-6472-5

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