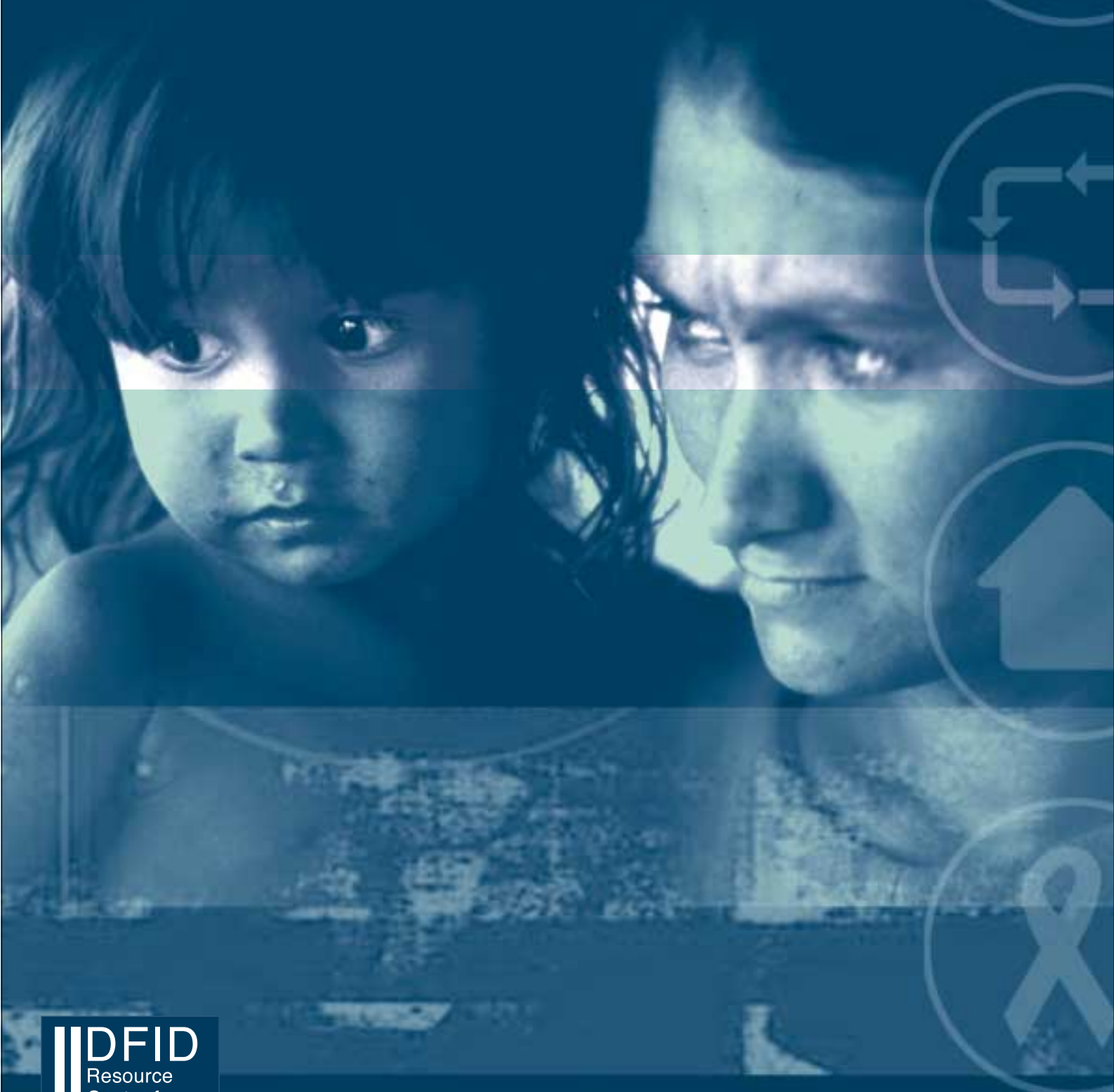
MONITORING SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES

Indicators



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Resource Centre for Sexual and Reproductive Health

The series on monitoring focuses primarily on Community Based Distribution and Social Marketing*

Indicators provide the objective basis for monitoring. They clarify programme objectives by specifying anticipated quantitative and/or qualitative changes over a specified time-scale.

This paper presents a spectrum of indicators. The validity of each indicator will depend upon the ease with which verifiable data can be collected.

See also Paper 3: Data collection tools.

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*This paper authored by Neil Price, with Rupert Walder as principal editor, is part of a set of four developed from a larger document by Neil Price. This original document was an output from a programme at the Centre for Development Studies, Swansea, funded by DFID, to refine and develop tools and guidelines on programme appraisal and monitoring to assist civil society organisations working in poorer countries.

Demographic and health status (goal) indicators

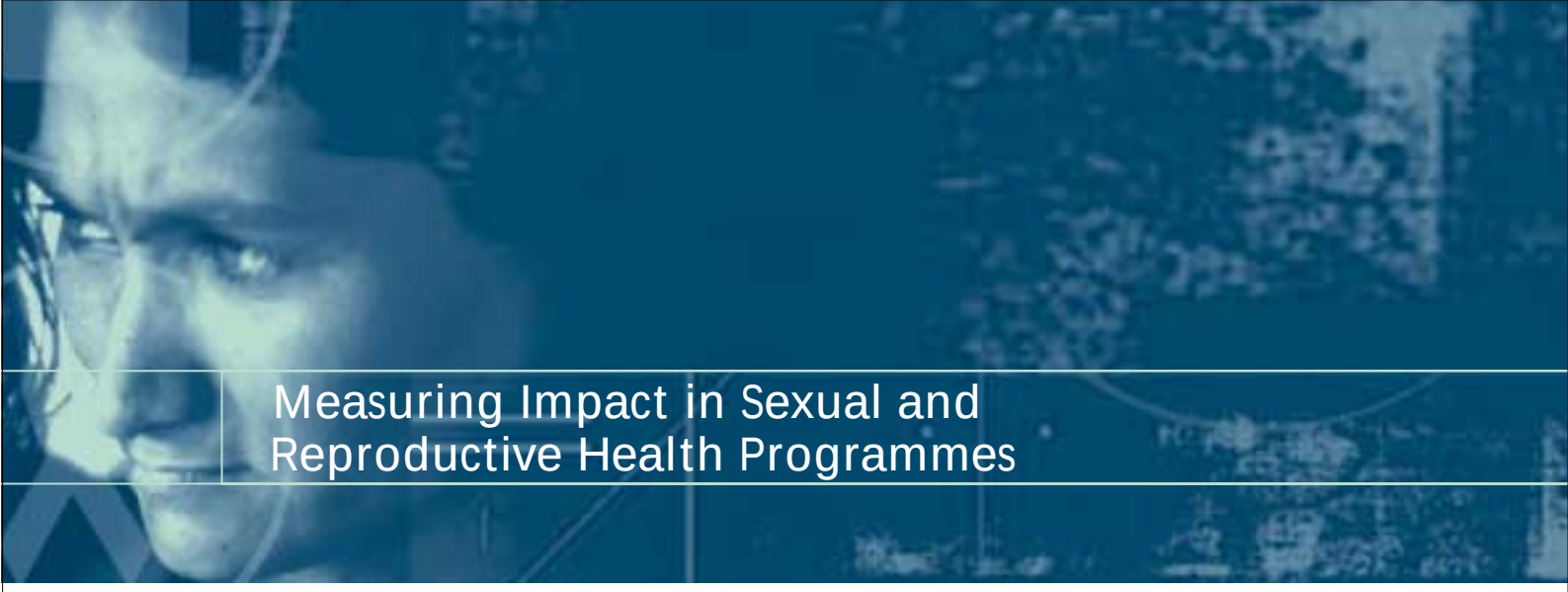
These measure wider programme impact in terms of changes in fertility and/or reproductive and sexual health status, usually some time after programme implementation has ended. There are enormous difficulties in attributing programme achievements to demographic or health outcomes. Most demographic and health indicators require large – and therefore expensive – longitudinal data sets, such as those generated by population censuses and large-scale national or sub-national surveys. An increasingly important role being played by international development agencies has been to negotiate the inclusion of key reproductive and sexual health outcome (and behaviour) questions in large national surveys. The validity of large-scale surveys for measuring fertility and health status is accepted (notwithstanding some methodological shortcomings), but their suitability for collecting data on cognitive and behavioural change is questionable.

Impact (purpose) indicators

These are used to measure the extent to which a programme meets the social and health needs of its intended beneficiaries. Impact indicators measure levels of service or product utilisation and other behavioural changes likely to benefit individual or wider community health status. Impact indicators also measure the extent to which a programme improves the social and economic conditions of the target population and wider community.

Measuring Impact

Many non-governmental organisations (NGOs) successfully monitor quantitative changes in service and product utilisation, using couple year protection (CYP), new acceptor and continuation rates, sales of products etc. However, there is insufficient monitoring of product or service use in terms of efficient and correct use, and proportional use by different population and target groups. Such information is essential if NGOs want to show that they are reaching their targeted population/client group, and is also central to monitoring the equity and poverty objectives of development programmes. Measures of quantity and quality are not mutually exclusive, but provide distinct programme indicators.



Measuring Impact in Sexual and Reproductive Health Programmes

Family Planning /Reproductive Health

Contraceptive use

- Rates of contraceptive prevalence
- Sales/distribution figures
- Couple year protection (as proxy for prevalence)
- Number of new service/product acceptors
- Number or percentage of people who report having tried new brand/service
- Continuation rates for contraceptives (reported regular use/intention to use again)
- Use-effectiveness of contraception
- Increase in number of referrals to health facilities by community based distribution agents for clinical methods of family planning, pregnancy complications, incomplete abortions (if appropriate)

Behaviour change

- Increased age at first intercourse/pregnancy
- Births appropriately spaced/timed for health of mother/baby
- Reduction in reported incidence of coerced sex
- Partners/spouses mutually agree to use contraception and which method to use

Sexual Health (Condom) Programmes

Condom use

- Condom prevalence rate
- Condom distribution/sales figures
- Number of new condom acceptors
- Increased correct and consistent condom use, eg:
  - Reported use with last commercial or casual sex partner
  - Reported regular use with commercial or casual partner
- Decrease in number of referrals by community based distribution agents for treatment of STIs (after initial expected increase), using trend data

Behaviour change

- Decrease in reported number of partners
- Increased age at first intercourse
- Decrease in number of unprotected casual sex acts per sexually-active male
- Reduction in reported incidence (especially by young people) of coerced sex
- Improvements in women's ability to negotiate safe and satisfying sexual relationships (eg women able to enjoy sexual relationships free of fear of pregnancy/STIs, commercial sex workers able to negotiate condom use).

Indicators of ***intermediate behaviour change*** are needed to monitor the relationship between awareness and behaviour change; eg the extent to which individuals:

- discuss health promotion messages with friends
- discuss HIV risk with partners
- discuss contraception with partners

Specific – but not exclusive – to social marketing programmes is the issue of method, brand and source switching which can provide important information on the relative affects and effects of a given social marketing programme.

Method, Brand and Source Switching Indicators

Percentage of clients who are:

- First time users
- Already practising contraception/using condoms who have switched to social marketing brands
- Already using contraception who switch from present method to one offered by a social marketing programme, or are already using condoms who switch from present method to one offered by a social marketing programme or CBD service

If clients are switching, from which source (government, private, NGO)?, and why are they switching?

Measuring Equitable Impact

Programmes need data on the vulnerability and poverty status of their clients if they are to demonstrate their equity focus. However, in many poor countries income data are difficult to obtain, and even when available are unlikely to provide an accurate measure of households' command over resources (i.e. poverty levels). Households draw incomes from multiple and fluid sources and transfer resources across time periods, saving and borrowing to shield against income variability. Thus, proxy indicators of poverty/income status are needed (based on possessions and access to amenities). Likewise, direct measures of vulnerability are problematic and are context-specific, although the most relevant proxy measures of vulnerability are likely to be gender, age, occupation and ethnicity.

The percentage of clients who are low income is a measure of the efficiency of equity targeting. The percentage of low-income users who use CBD or social marketing services - or the odds of low-income users choosing these services as opposed to another service - measures the ability of the programme to serve low-income users.

Equity Indicators

Reduced differentials:

- In social marketing programmes and those CBD programmes with user fees, no difference in proportion of medium and low income groups who report price as a barrier to product or service use
- Reduction in socio-economic status differences in percentage who know that a healthy looking person can be infected with HIV
- Reduced relative odds of modern method contraceptive use by socio-economic status, controlling for age, marital status, parity etc.

Other equity impact indicators include:

- Positive changes in women's and men's joint reproductive health decision making
- The poor, young people, and unmarried sexually active people are better able to access services

Measuring Social Impact

Social impact refers not only to the extent to which programmes serve the poor and vulnerable, but also to the 'beyond-health' impact on the social and economic lives of clients, field staff and the wider community.

Social Impact Indicators

- Does the programme impact positively on the lives of women CBD or sales agents, in terms of reported self-enhancement and increased autonomy?
- Do salaries/remuneration for CBD or social marketing agents have a significant effect on family and community-level empowerment?
- Does the programme impact positively on community demand for other health care? (an indicator of community mobilisation/participation)

Effectiveness (output) indicators

The effectiveness of CBD and social marketing programmes can be judged against a number of broad criteria relating to access, informed demand (knowledge and awareness), quality, and cost-effectiveness. The first three of these are the defining characteristics of the supply environment and key determinants of whether or not people decide to seek out, adopt, and sustain use of a given service or product.

Access

Access is the extent to which services and products may be obtained at a level of effort and cost (monetary, convenience and social) that is acceptable to and within the means of poor and vulnerable groups. In this sense, access, accessibility and availability are synonymous. Social marketing and CBD have the potential to make commodities more accessible in areas not reached by health facilities, because of the proximity of outlets and fieldworkers to the homes or workplaces of potential clients (i.e. their convenience).

Convenience Indicators

- Number and percentage of outlets (differentiated by type/location/opening hours) stocking social marketing products
- Location and opening times of community based distribution depots
- Number of community depots or work-based sites/depots
- Number of trained CBD agents or social marketing sales agents
- Number of client contacts per CBD agent
- Percentage of people who know where to obtain CBD or social marketing products/services
- Percentage of people who report they can readily buy social marketing products or access community based services whenever they want to

Affordability is the extent to which commodity or service prices constrain access. In measuring affordability, CBD programmes (with user fees) and social marketing programmes should, as with the equity indicators set out above, seek to demonstrate reductions in differentials: e.g. no difference in proportion of medium-high, medium and low income groups who report price as a barrier to contraceptive/condom use.

Affordability Indicators

- Percentage of retailers respecting recommended social marketing retail prices
- Prices of social marketing or CBD products based on the cost of selected household goods ('basket of goods' indicator)
- Number or percentage of clients who report that commodity/service price is not a constraint to use
- Number or percentage of clients who report that commodity/service price was a factor in their decision to discontinue use
- Number or percentage of non/never users who report that commodity/service price is a constraint to use

There is widespread agreement on the need for greater variety in service delivery approaches, in order to serve the differential social (including gender, ethnic, age etc) needs of client types. In particular, the need for privacy is largely unmet through clinic-based delivery. An important part of social access is meeting gender needs, such as women's needs for confidentiality, and improving the supply of information and services to men. Social factors act as access constraints particularly to the young and the unmarried (including widows and divorcees) in many countries. For young people and for unmarried women, community based distribution or social marketing has the potential to provide much needed anonymity. By their very nature, social marketing and community based distribution represent service delivery approaches that overcome many of the administrative/regulatory constraints inherent in clinic-based service delivery.

Social Access Indicators

- Percentage of respondents (by gender/age/ethnic group etc) who report:
  - feeling comfortable buying product/attending outlet/receiving CBD service
  - satisfaction with confidentiality/privacy
  - satisfaction with supply of information and services and other dimensions of quality

Reduced regulatory, legal and political constraints

- Regulatory authorities lobbied through meetings, briefing papers, mass media etc. to address constraints to CBD and social marketing services
- Policy and/or legislative reform (eg on age and parity restrictions, requirement of spousal consent, advertising etc.)
- Membership of civil society organisations on national advisory or policy making boards
- CBD and social marketing articulated as key strategies in delivery of national development goals
- Increase in knowledge among – and change in attitude of – key community groups, activists, opinion formers
- Increased numbers and types of local community structures established, with representation of women, youth, ethnic groups etc.
- Contraceptive/condom use etc. positively and accurately reported in the mass media (editorials, letters to editors, as well as regular reporting in newspapers, magazines, radio programmes)

Knowledge And Awareness

This dimension of effectiveness – also sometimes known as cognitive access – measures the success of a programme in increasing knowledge about, and creating and sustaining awareness of, the availability of products, sites of services, and of the benefits of modified behaviour. CBD programmes have tended to rely on fairly traditional media for their communications (posters, leaflets and interpersonal communication between agents and clients). Social marketing programmes use two types of communication strategies to increase awareness: brand promotion and behaviour change communication. Brand promotion seeks to create and sustain awareness and knowledge of the availability and location of the socially marketed brand, whereas behaviour change communication strategies seek to increase awareness of the benefits of modified behaviour. A typical social marketing communication programme will thus be composed of mass media campaigns which promote product use by raising awareness of the brand and its availability, and behavioural change interventions which create awareness of the benefits of modified behaviour, through increasing risk perception and self-efficacy. Behaviour change communications, using mass media, traditional media, interpersonal techniques, and public health promotion methods, are generic (not brand-specific), as they deal with subjects that are considered counter-productive to branded product promotion. Social marketing is often better placed to overcome cognitive constraints to access than other service delivery approaches.

Knowledge and Awareness Indicators

Communications Strategies and Interventions

- Appropriate messages/materials for youth and other vulnerable groups developed
- Posters and leaflets available at depots/retail outlets and distributed to and by CBD and sales agents
- Social marketing programmes combine standard forms of commercial-sector advertising such as brand recognition with other behaviour change strategies, including interpersonal communication
- Communications beyond primary target audiences to secondary audiences – religious/community/political leaders, other community/family members etc.

Sexual Health

- Percentage of high-risk respondents who can accurately assess their risk of HIV and other sexually transmitted disease infection
- Percentage of respondents who know that a healthy looking person can be infected with HIV
- Percentage of high-risk respondents who can identify risk factors for HIV/STI infection
- Percentage of respondents who know how to protect themselves against HIV/STIs
- Percentage of target population who know where to purchase/access condoms
- Percentage of target population who report receiving behaviour change communication messages about safer sex, or who can recall social marketing adverts

Family Planning

- Knowledge of contraceptive methods increased
- Percentage of target population who report receiving behaviour change communications messages and/or who can recall social marketing adverts about family planning
- Percentage of target population who know where to access CBD programme contraceptives or to purchase socially marketed contraceptives
- Percentage of target population who know CBD agents can facilitate referral for clinical methods of family planning
- Increased awareness of benefits of birth spacing, delayed first pregnancies etc

Quality of Care

Few CBD or social marketing programmes monitor quality of care, in part because of their status as service delivery approaches operating outside the controlled environment of the clinic. In quality of care monitoring, a key question is who actually defines the quality? There is ample evidence that clients' (and potential clients') assumptions about quality differ markedly from experts'. The implications of these differences for service provision are extremely important, yet there has been little recognition of the need to relate objectively measurable standards of service to clients' perceptions of the quality of care.

The dominant framework used for monitoring quality of care involves collecting data on the extent to which a programme provides the following six elements[1]

- Choice and regular availability of condoms/contraceptives
- Accurate information, including follow-up messages
- Technical competence of the provider
- Adequate arrangements for follow-up and referral
- Provider interpersonal skills
- Appropriate constellation of services

In order to integrate client views of quality of care/service with a programme perspective, the following indicators are suggested.

Indicators of Quality of Care in CBD Programmes

Client perceptions of quality

- Agents discuss reproductive and sexual behaviour intentions with their clients
- Agents discuss range of family planning methods (i.e. other than the one the client chooses), and tell client they can change method if they wish; clients receive preferred method
- Agents pay sufficient attention to establishing client's needs and discuss side effects
- No shortage/stock-outs of contraceptives/condoms
- Confidentiality and privacy respected

Technical competence of agents

- Measured by responses to questions (from agent supervisors/monitors) on side effects, contra-indications, method use and sexually transmitted infections
- Judged by observations (by supervisors) on counselling skills, referral procedures, information given

1 See Bruce (1990)

Indicators of Quality of Care in Social Marketing Programmes

Social marketing of contraceptives

- Percentage of providers/retailers who are perceived by clients to:
  - provide choice of contraceptive method
  - provide accurate information (about use, referral etc)
  - ensure regular availability of contraceptives
  - respond to contra-indications
  - have time and expertise to explain correct use of and most appropriate family planning methods
- Availability of behaviour change communications materials at sales outlets
- Number of private providers/retailers trained in service provision, quality, technical issues etc.

Social marketing of condoms

- Percentage of retailers/providers perceived by clients to be providing:
  - choice of male/female condom (and where applicable, microbicides)
  - accurate information about condom use
  - regular availability of condoms
- Availability of behaviour change communications materials at outlets
- Providers trained in STI syndromic diagnosis and referral, counselling etc.

A critical, but often neglected, dimension of quality of care is client-provider interactions. An understanding of the dynamics of the client-provider interaction is essential for monitoring and improving quality of care. Such monitoring requires listening to those who matter most: the people for whom the services are provided (clients and potential or former clients), and those who work on the front-line (community-based fieldworkers and providers at retail outlets in social marketing). The test of quality of care lies in the extent to which clients feel they have established a reliable relationship with a trusted provider, and have achieved some substantial measure of safe, effective, and

comfortable control over their reproductive capacity and sexual behaviour. Thus any monitoring of client-provider interactions must focus on user perspectives of choice and quality. Research has shown that adoption and continuation rates for contraceptive and condom use are directly related to the nature and quality of the relationship between provider and client.

Some of the key issues for monitoring interactions between CBD agents and their clients are:

- Is effective communication established through relationships of trust and equality?
- Are agents adequately addressing the issue of contraceptive side effects? Is the agent focusing on clients' needs?
- What are the structural constraints to agents providing quality of care?
- Does the CBD programme reflect attention to and respect for the perspective of the client or potential client as a whole person, and not merely his or her reproductive potential?

Client-Provider Indicators

In addition to the indicators set out for monitoring quality of care in CBD and social marketing (above), the following specific dimensions of interaction should be monitored

- Frequency and duration of exchange
- Client satisfaction with level of privacy and confidentiality
- Providers discuss possible side effects and respond to contra-indications
- Providers have the time, expertise and interest to explain the correct use of and most appropriate type of contraceptive methods to customers
- Relative status, power and culture of the participants (including providers' and clients' understanding of aetiology of sexually transmitted infections and how contraceptives /drugs function).

Economists argue that programme approaches with low costs and high output levels are the most desirable. The inherent difficulty in undertaking cost-effectiveness analysis in any health programme is defining an appropriate unit of output.

Cost-Effectiveness

Cost-effectiveness analysis measures the cost per unit of output. Economists argue that programme approaches with low costs and high output levels are the most desirable. The inherent difficulty in undertaking cost-effectiveness analysis in any health programme is defining an appropriate unit of output. The most widely used indicator of cost-effectiveness is cost per acceptor in CBD and cost per Couple Year of Protection (CYP) in social marketing.

Indicators for Cost-Effectiveness

- Cost per CYP (or other output unit) in family planning programmes
- Cost per condom distributed or sold in AIDS/STI prevention programmes (as percentage of overall programme costs)
- Cost per client contact (in community-based distribution)
- Cost efficiency of component expenditures (per CYP or per condom)
- Cost recovery (sales income per CYP or per condom sold)
- Cost per DALY averted (in sexual health programmes)
- Cost per case of HIV averted

Costing Social Marketing

In social marketing programmes, CYP is usually calculated from sales to distributors. However, there is no standard mechanism that identifies how costs are defined. Some social marketing programmes only include donor expenditures, which may or may not include donated commodities; some exclude sales income. All social marketing programmes exclude the price paid by consumers as a cost. Cost effectiveness in social marketing which continue to use CYP as the output unit should be reported in two ways:

- Total Project Cost (including commodities at cost to the supplier) per CYP, i.e. total expenditures less revenue, divided by CYP.
- Total Project and Consumer Cost Per CYP, i.e. total cost less revenues plus the price paid by consumers divided by CYP.

To gain a better understanding of the cost efficiency of expenditures (budget line-items) social marketers could record costs per output unit (CYP or condom sold) for primary expenditure items:

- cost of goods (including commodities, testing, packaging)
- communications (including advertising, promotion, education)
- administrative support
- operations
- monitoring and evaluation
- overheads

All social marketing programmes should report cost recovery (sales income) per CYP or per condom sold as a percentage of overall programme costs.

Cost per DALY[2] averted, as an alternative measure of cost effectiveness, should be considered to enable a better understanding of social marketing programme impact in the light of an increased focus on STD/HIV/AIDS prevention activities. No examples exist to illustrate how useful this indicator might be.

Costing Community Based Distribution

There are numerous problems with cost-effectiveness analysis in CBD programmes. First, as with social marketing, cost data are notoriously difficult to standardise and interpret. Secondly, the emphasis on outcome indicators such as CYP and new acceptors misses some of the most important dimensions of the CBD agents' role – support and information, referral, community empowerment etc.

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