

## Basic Indicators for IUD Program Monitoring and Evaluation

### Introduction

There are a large variety of indicators you can use depending on the purpose, availability of data, and your budget.

The first problem is to reduce the large number of potential indicators to a handful of programmatically meaningful ones that can be easily obtained and understood.

Monitoring the progress of the program allows the manager to determine where program performance is outstanding, adequate, or inadequate. In turn, this information can be used to target areas for improvement and to strategically allocate resources that will contribute to improved performance. Improvement of services is fundamental to achieving the program goal – increasing access to and high quality use of IUD over time.

Program progress can be measured by improvements in 1) knowledge and attitudes, 2) access, 3) service provision, 4) prevalence of use, and 5) quality. The following section discusses a few specific indicators of program progress and suggests definitions, data sources, reporting frequency, and suggested analysis for each indicator.

### Access Indicators

Two access indicators are recommended. The first is number and type of providers trained in IUD insertion. All providers who have undergone the program's prescribed training course should be considered "trained." "Type of provider" refers to the professional background of the provider, e.g., physician, nurse, auxiliary nurse. If feasible, it is also recommended that programs report the proportion of providers who complete both theoretical *and* practical/applied training (compared to those who drop out midway) as well as the proportion of providers who have completed training who then go on to insert an IUD within a specified amount of time (e.g., six months) after the training.

The second indicator is the number, type, and location of facilities where insertion is available. "Type of facility" refers to whether the facility is a hospital, urban clinic, rural health post, etc. If the program is using different service modalities for providing the IUD, the type of modality (postabortion, etc.) should also be mentioned. "Location" refers to the geographic areas into which the program is divided.

These data are most easily collected from training course reports and should be updated after each course. The manager should track trained providers over time. Analysis should focus on the percent of facilities, by type of facility in each area, which has one or more trained providers. Monitoring should focus on progress toward making the IUD available in all appropriate facilities, in all areas.

Access can also be measured by reporting the number and proportion of health facilities in a given area that made at least one IUD insertion during the last reporting period (e.g., the last three or six months).

## Output Indicators

The output indicator of an IUD program is the number of IUDs inserted. This indicator should be collected by type of provider, area, and service delivery modality. Comparisons should be made across categories and over time. It is recommended that the definition of “insertion” include all insertions, and that no distinction be made between first and reinsertions.

Data on the number of insertions should be the starting point of periodic evaluation of the factors affecting the relative performance achieved. For example, some areas or facilities may be low-performing because they serve small populations or groups with little demand for family planning, while others may be low-performing because of lack of provider motivation. Units or areas with low relative performance (for example a hospital whose performance is low compared to other hospitals of the same type, available resources, and overall family planning output) should be targeted for improvement.

Improvement should be measured by changes in the output of the same area or facility over time. The indicators need not be examined more than twice per year, but they should be compared at the same time and over the same period of time (e.g., the first quarter of the current year with the first quarter of the previous year) to determine if improvement has taken place. Changes in the annual number of insertions should also be monitored to measure progress toward the program goal of increased use of the IUD over time.

## Indicators of Prevalence of IUD Use

The prevalence of IUD use is a summary indicator of IUD use in a population. It is calculated as the number of IUD users divided by all women of fertile age in a country or area. A secondary calculation is also often made: the proportion of IUD users among all family planning users. Prevalence data cannot be obtained from routine program statistics, but only from surveys. Most countries periodically conduct their own reproductive health surveys, or use data obtained from the USAID-sponsored Demographic and Health Surveys.

Survey information on IUD use provides information on method use by area, sector (private, NGO, public), and often by other locally relevant program factors as well. The surveys show changes in IUD use over time, by sector, and in comparison to changes in

the use of other methods. The information is principally helpful in showing the manager the extent to which national IUD goals are being attained.

## Quality Indicators

“Quality” refers to whether or not the appropriate service is provided, and how well it is provided. Good quality is a basic program goal. Basic quality indicators that can be obtained without elaborate special studies include IUD perforation, expulsion, and infection rates. Occasionally, such information is routinely available through service statistics. When this is not the case, the program manager may wish to conduct a brief survey in a sample of service delivery points. The survey instrument need be no more elaborate than a brief, self-administered form that the provider fills out every time she detects one of the above complications. Providers should continue to fill out the forms for a fixed period of time so that the minimum number of observations needed for reliable analysis can be gathered.

The data can be used to make comparisons across provider types, areas, and other comparisons that the program may find relevant. The data can be used to target service delivery units for additional training or other quality improvement activities. Data on service quality should not be gathered more than once per year, because changes in this parameter cannot be meaningfully monitored on a more frequent basis. Also, if a special study is required, necessary resources will probably not be frequently available.