



# Monitoring the Integration of Family Planning and HIV Services

A Manual to Support the Use of Indicators to Measure Progress toward PEPFAR's 90-90-90 Targets and Protect Women's Reproductive Rights

Mary Freyder, MPH, MEASURE Evaluation

Leslie Craig, MPH, MEASURE Evaluation

Aiko Kaji, MPH, MEASURE Evaluation

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**MEASURE** Evaluation

University of North Carolina at Chapel Hill

400 Meadowmont Village Circle, 3<sup>rd</sup> Floor

Chapel Hill, NC 27517 USA

Phone: +1 919-445-9350

[measure@unc.edu](mailto:measure@unc.edu)

[www.measureevaluation.org](http://www.measureevaluation.org)

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## ABBREVIATIONS

ART	antiretroviral treatment
COP	country operational plan
CYP	couple-years of protection
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
FP	family planning
GHAIN	Global HIV/AIDS Initiative Nigeria
HCW	healthcare worker
IUD	intrauterine device
OI	opportunistic infection
M&E	monitoring and evaluation
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHDP	positive health, dignity, and prevention
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SDP	service delivery point
SIMS	Site Improvement through Monitoring Systems
STI	sexually transmitted infection
TA-SDI	technical assistance-service delivery improvement
USAID	United States Agency for International Development
USG	United States Government
WLHIV	women living with HIV
WRA	women of reproductive age

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# INTRODUCTION

This manual was developed for the family planning (FP) and HIV programs of the United States Agency for International Development (USAID), by the USAID-funded MEASURE Evaluation. Most of the indicators described are not part of the reporting requirements of the United States President’s Emergency Plan for AIDS Relief (PEPFAR); one, though, is drawn from PEPFAR’s list of required indicators for monitoring, evaluation, and reporting. That indicator measures site-level integration but does not quantify the FP services provided, the clients receiving services, or the quality and completeness of FP/HIV services.

We recommend that all USAID missions use additional indicators to track FP/HIV service delivery and client-focused outcomes; examples of such additional indicators appear below in this manual. These indicators have been developed and adapted to help program managers and service delivery providers track information on FP outcomes in HIV service delivery settings. United States Government (USG) programs will use the PEPFAR indicator to demonstrate the scope of FP/HIV integration in their programming. The other indicators will help illustrate the outcomes of the integration.

Women of reproductive age are simultaneously at risk both for HIV and unwanted pregnancy, particularly in sub-Saharan Africa. There, women living with HIV (WLHIV) and women at risk for HIV—especially adolescent girls and young women, sex workers, and female injecting drug users—also face high unmet need for FP. The integration of FP and HIV services is a strategy that is increasingly used to meet the contraceptive needs of HIV-positive women and couples. A new collaborative vision of PEPFAR and USAID seeks to ensure that women living with HIV and women at high risk for HIV have access to a full range of contraceptive options and to safe conception and safe pregnancy counseling.

Several models exist for integrating FP services in HIV service delivery points (SDPs) or HIV services in FP platforms. The choice of model depends on such in-country factors as available human resources; facility infrastructure; organizational structures and funding streams; the commodity supply chain; and the nature of the HIV epidemic (Baumgartner et al., 2014). FP/HIV integration may occur in any HIV or FP service delivery or health system setting. However, PEPFAR suggests the following technical platforms as most effective (PEPFAR, 2013):

- Prevention of mother-to-child transmission of HIV (PMTCT)
- The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) initiative
- Test and treat
- Key populations
- Community-based care and support
- Supply chain systems

Formalizing referral systems and ensuring linkages for clients in PEPFAR-supported HIV programs to FP services is essential to the success of FP/HIV integration, which necessarily involves multiple follow-up and revisit services. Generally, though, an integrated FP/HIV SDP is indicated when the site also provides:

- FP education and screening
- Counseling for specific FP methods
- Provision of FP methods, or a referral for HIV clients to access FP methods not available the same day or on-site (MEASURE Evaluation, n.d.; Medley, Bachanas, Grillo, Hasen, & Amanyiwe, 2015)

Program monitoring and evaluation (M&E) is especially important to improve integrated service delivery, and use of standardized indicators plays an important role in monitoring the results of integration efforts and evaluation of service quality (Adamchak, Okello, & Kabore, 2016; Wilcher, Hoke, Adamchak, & Cates Jr, 2013). This manual presents indicators to measure the progress and outcomes of FP/HIV integration. These indicators were recommended based on relative ease and feasibility of collection using routine health

information systems, as well as the utility of the information provided, both individually and as a combined set. Indicator selection was guided by the literature as well as review of PEPFAR’s proposed Site Improvement through Monitoring Systems (SIMS) tool.

The indicators and their reference sheets are described on pages 7–44. Prior to this description, a comparison matrix—showing the data to be collected using PEPFAR’S SIMS 2.0 tool (Column 1) and the list of indicators recommended by the MEASURE team (Column 2)—is first presented.

## **Ensuring Family Planning Voluntarism and Informed Choice**

HIV and FP integrated program activities must respect a client’s right to make informed decisions about his or her reproductive life. The principles of voluntarism and informed choice are prerequisites to high-quality reproductive healthcare and form the basis of USG-supported FP programs. U.S. government-supported HIV and FP programs are also guided by U.S. legislative and policy requirements regarding the use of foreign assistance funds. The USG takes these requirements very seriously, and works with missions and partners to ensure compliance with the legislative and policy requirements in their programs. Ongoing, active monitoring for compliance is an essential element to ensure good quality of care for the people whom PEPFAR serves.

In order to continue ensuring that voluntarism and informed choice are upheld in integrated HIV and FP programs, the USG has developed the following comprehensive approach:

- People living with HIV (PLHIV) should be provided with comprehensive information on—and be able to exercise voluntary access to—choices about their health, including their FP choices.
- All individuals, regardless of their HIV status, have the right to choose the number, timing, and spacing of their children, as well as to choose to use an FP method
- FP should always be a choice, made freely and voluntarily, independent of the person’s HIV status
- The decision to use or not to use FP should be free of any discrimination, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of contraceptive methods
- Access to and the provision of health services, including antiretroviral treatment (ART), for PLHIV should never be conditioned on a person’s choice to accept or reject any other service, such as FP (other than what may be necessary to ensure the safe use of ART, such as consideration of drug interactions)
- WLHIV who wish to have children should have access to safe and respectful conception and pregnancy counseling and antenatal and childbirth services.

When considering indicators to track FP outcomes, it is important to keep in mind the USG legislative and policy requirements related to FP targets. The Tiahrt Amendment provides that service providers and referral agents shall not implement or be subject to quotas or targets for the total number of births, number of FP acceptors, or acceptors of a particular FP method. For this purpose, a target or quota is a predetermined number that a service provider or referral agent is assigned or required to affect or achieve. While it is permissible to use quantitative estimators or indicators for planning and budgeting purposes, it is important to ensure that they do not translate into quotas or targets for individual service providers at SDPs.

If you have questions or concerns about how to implement any of the indicators in this manual while ensuring compliance with the Tiahrt Amendment or other legislative or policy requirements, please contact your agency FP/HIV or FP compliance team or your legal advisor’s office. Links to the USG FP policy and legislative compliance requirements are provided in the reference section of this document.



## FP/HIV Integration Indicators & SIMS 2.0 Tool Comparison Matrix

SIMS 2.0	MEASURE Evaluation_(Suggested Indicators & Rationale)
<ul style="list-style-type: none"> <li>Are job aids or tools available to help providers deliver FP counseling and/or services at this service delivery point?</li> <li>Is FP education and/or counseling routinely offered on-site to clients who wish to delay or prevent pregnancy?</li> <li>Is safer conception/pregnancy counseling routinely offered on-site to PLHIV who wish to have children?</li> <li>For clients who are referred to FP services off-site (e.g., for long-acting or permanent FP methods), is a system in place with standard tools to track completed referrals? <i>(If no referrals are needed because all methods (including permanent) are available on-site = Y)</i></li> </ul>	<p><b>Service Delivery Integration</b></p> <ul style="list-style-type: none"> <li>Percentage of HIV service delivery points (SDPs) supported by PEPFAR that are providing integrated voluntary FP services<sup>1</sup></li> <li>Percentage of clients at PEPFAR-supported HIV SDPs who received voluntary FP counseling (including safe conception/safe pregnancy counseling)</li> <li>Percentage of clients at PEPFAR-supported HIV SDPs who received a FP method.</li> <li>Percentage of clients who received a referral from PEPFAR-supported HIV SDPs to an FP clinic.</li> </ul> <p>Integrated voluntary FP services are indicated when an HIV SDP also provides (1) FP screening, (2) counseling for FP needs, and (3) FP products or referral to its clients. However, evidence suggests that neither FP screening nor the provision of FP counseling is well-recorded at the facility level. Poor documentation of FP services, and consequent failure to meet all three criteria, will result in underreporting and diminished capacity to capture FP-HIV integration regardless of actual service delivery. While the level 1 PEPFAR indicator for FP/HIV captures those facilities that are able to meet all three criteria for an integrated SDP, the other indicators focus on specific voluntary FP service elements required for an integrated SDP, thereby informing on-site-level capacity to provide integrated services and the extent to which healthcare providers deliver specific FP services.</p>
<ul style="list-style-type: none"> <li>Do clients have access to at least three contraceptive methods either on-site or through referral (e.g., condoms, oral contraceptive pills, injectables, implants, intrauterine devices (IUDs), fertility awareness methods, vasectomy, tubal ligation, etc.)?</li> <li>Has there been a stockout within the past 3 months of any contraceptive methods usually provided on-site? <i>(If no contraceptive methods provided on-site = N)</i></li> <li>Are education materials (IEC) about contraception and safe conception on display or available to clients (e.g., pamphlets, posters, brochures, inserts, etc.) accessing this service delivery point?</li> </ul>	<p><b>Contraceptive Method Availability, Uptake, and Informed Choice</b></p> <ul style="list-style-type: none"> <li>Percentage of PEPFAR-supported HIV SDPs that offer at least three types of FP method</li> <li>Number/type of contraceptive methods available at the PEPFAR-supported HIV SDPs</li> <li>Number of clients who accept (for the first time in their lives) modern contraception at PEPFAR-supported HIV SDPs</li> <li>Couple-years of protection (CYP) in United States Government (USG) supported PEPFAR programs.</li> </ul> <p>CYP measures the volume of program activity, while the number of new acceptors measures the ability of the program to accept new clients. However, neither indicator provides information on actual use/impact. Measuring the number and type of contraceptive methods available, the number of clients who accept modern contraception, and the CYP provides a bigger picture of the availability, accessibility, and acceptability of FP services and methods that are available, accepted by clients, and distributed by providers). Taken together, these indicators logically follow each other (facilitating data collection, minimizing confusion, and reducing ambiguity); provide critical information on contraceptive security; and present a profile of the relative level of use of different contraceptive methods, which can signal provider bias in the system and/or user preferences.</p>
<ul style="list-style-type: none"> <li>Is at least one healthcare provider at this service delivery point trained to provide FP counseling and services?</li> </ul>	<p><b>Training and Human Resources</b></p> <ul style="list-style-type: none"> <li>Percentage of PEPFAR-supported healthcare workers (HCWs) who completed a FP training program</li> </ul> <p>Countries with high HIV disease burden and unmet need for FP are challenged by the lack of trained providers to deliver high-quality integrated services. Training in FP is essential to the adequate and effective integration of FP services in HIV programs. This indicator presents a crude measure of training activity and, when disaggregated by service delivery point, gives evidence of provider capacity at the site level, to provide integrated services.</p>

<sup>1</sup> This indicator is the only Level 1 PEPFAR indicator required for measurement of FP/HIV integration efforts.

**Supportive Supervision**

- Percentage of PEPFAR-supported HIV SDPs who offer at least three types of FP method and have had documented routine supportive supervision of FP and HIV services within the past 12 months.

This indicator measures the occurrence of routine supportive supervisory visits, which are an essential component of ensuring quality service provision, facilitating M&E of service integration for quality improvement, and enhancing the sustainability of PEPFAR-supported programs. Evidence suggests that information on all elements of FP/HIV service integration (e.g., FP screening and FP counseling) are not well-recorded in many countries, making measurement of provision of integrated voluntary FP services difficult. However, the indicator above provides some indication of program/provider oversight and accountability and can be reasonably collected using data from service statistics.

## Summary of FP/HIV Integration Indicators

1. Service delivery integration
  - Percentage of HIV service delivery points (SDPs) supported by PEPFAR that are providing integrated voluntary FP services<sup>2</sup>
  - Percentage of clients at PEPFAR-supported HIV SDPs who received voluntary FP counseling (including safe conception and safe pregnancy counseling)
  - Percentage of clients at PEPFAR-supported HIV SDPs who received an FP method
  - Percentage of clients who received a referral from PEPFAR-supported HIV SDPs to an FP clinic
2. Contraceptive method availability, uptake, and informed choice
  - Percentage of PEPFAR-supported HIV SDPs that offer at least three types of FP methods
  - Number and type of contraceptive methods available at PEPFAR-supported HIV SDPs
  - Number of FP clients who accept (for the first time in their lives) modern contraception at PEPFAR-supported HIV SDPs
  - Couple-years of protection (CYP) in United States Government (USG) supported PEPFAR programs
3. Training and human resources
  - Percentage of PEPFAR-supported HCWs that completed a FP training program
4. Supportive supervision and healthcare worker accountability
  - Percentage of PEPFAR-supported HIV SDPs offering at least three types of FP methods that have had documented routine supportive supervision of FP/HIV services within the past 12 months

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<sup>2</sup> This indicator is the only Level 1 PEPFAR indicator required for measurement of FP/HIV integration efforts.

## Indicator Information and Reference Sheets

### Service Delivery Integration

#### Indicator

**FPINT\_SDP** Number of HIV service delivery points (SDPs) supported by PEPFAR that are providing integrated voluntary family planning (FP) services.

#### Purpose

This output indicator aims to measure progress toward integrating voluntary FP within the PEPFAR platform at the service delivery level. It captures information about whether FP integration is occurring at various HIV SDPs within PEPFAR-supported sites. Many PEPFAR sites will have numerous SDPs within each site. For example, if one hospital receives PEPFAR support for both the HIV treatment department AND the antenatal care (ANC) department, then the FPINT\_SDP total for that one site is 2 SDPs.

This indicator will enable headquarters, PEPFAR country teams, national governments, and other implementing partners to accomplish the following:

- Gain a basic but essential understanding of whether FP services are being integrated in PEPFAR-supported SDPs.
- Identify gaps, including service contexts, countries, or regions with low levels of HIV/FP integration.

Inherent within this indicator is the principle that integrated HIV/FP program activities must respect a client's right to make informed decisions about his or her reproductive life. This means that clients should have access to an appropriate and comprehensive range of contraceptive options and/or to safer conception/pregnancy counseling, depending upon their fertility desire and intentions. Judgments and personal opinions are not appropriate in a clinic setting.

This indicator will be used to monitor coverage of HIV/FP integration at a global level. Therefore, detailed information on completion of referrals, FP service uptake, types of contraceptive methods offered on-site, and other critical components of integrated programs will not be captured.

#### A. Description

This indicator is a required indicator for all PEPFAR teams and will be reported up to headquarters once a year as part of the Annual Program Results (APR). Targets should also be set each year during the country operational plan (COP) process.

#### **Definition: Voluntary Family Planning Service Provision**

In order to be considered a PEPFAR-supported SDP that directly provides integrated voluntary FP services, all 3 criteria below must be met. If a service delivery point provides fewer than 3 of the services noted below, it should not be counted under this indicator.

**The PEPFAR-supported HIV SDP must provide** for all relevant clients, including partners in HIV discordant couples (as documented by standard operating procedures, guidelines, protocols, manuals, and/or intake documents, etc.):

1. Assessment of voluntary FP needs through routine screening
2. Provision of voluntary FP counseling (including safe pregnancy counseling for those wishing to become pregnant, or those who are pregnant)

3. Provision or referral of a broad range of modern contraceptive methods, in accordance with the national FP policy guidelines, for clients who voluntarily wish to delay or prevent pregnancy. It is very much preferred for methods to be available on-site. If referrals are given, they must include detailed information (e.g., facility location, hours of operation, etc.) about where methods can be accessed.

**Definition: Assess Voluntary Family Planning Needs (Number 1 Above)**

In assessing FP needs, all clients as part of their routine care visit should be asked about their FP needs and practices. Depending upon the individual client and his or her needs, these can include reproductive goals; prior pregnancies; living and family situation; FP knowledge; previously used FP methods and satisfaction with use; and any FP-related concerns. These needs should be assessed without expressing any personal biases about a client's preference.

**Definition: Provide Voluntary Family Planning Counseling (including Safe Pregnancy Counseling) (Number 2 Above)**

Quality voluntary FP counseling should cover a wide range of topics that are client- and context-specific, and that include both safe pregnancy counseling for individuals who wish to become pregnant as well as contraception for individuals who wish to avoid, space, or delay pregnancy. "FP counseling" is not the same as "FP education." Depending upon the type of FP services that are offered at a PEPFAR-supported site, health providers or community mobilizers may provide EDUCATION and/or COUNSELING on FP.

Education activities may include distribution of printed materials, group health education, and community outreach efforts among other interventions. Education helps to increase general knowledge on the benefits and importance of FP and increase support for FP use, as well as to link women and their partners to other FP services, including contraceptive method provision.

FP counseling is an interpersonal communication between the health provider and client where topics specific to the clients' needs are discussed to help them determine if they want to use FP and, if so, to help them choose and use the FP method of their choice. HIV service providers on all levels can be trained and supported to develop or improve their FP counseling skills. A wide array of FP counseling materials exist that can be used in PEPFAR settings, including national FP flipcharts, counseling cards, and informational handouts.

Voluntary FP counseling should follow the standards and best practices outlined in the "Additional References" section below.

**Definition: Provide Modern Contraceptive Methods (Number 3 Above)**

Per USG legislation, and in line with national FP policies, a broad range of methods should be provided to clients, allowing them to choose the method most appropriate for them, either directly or through referral. For an SDP to be counted toward this indicator, at least three modern contraceptive methods should be available either on-site or through referral. Emergency contraception is an important FP method that should be available in all HIV settings as part of FP and gender-based violence (GBV) services. Information on modern contraceptive methods can be found in the references listed at the end of this sheet. All referrals should include detailed information about where methods can be accessed (e.g., facility location, operating hours, etc.).

**Definition: PEPFAR-Supported SDP**

A PEPFAR-supported SDP uses PEPFAR funds to directly provide HIV-related services. It offers one or more HIV-related services, including but not limited to HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); antiretroviral treatment (ART); screening and prophylaxis for opportunistic infections; other health

services for PLHIV (e.g., positive health, dignity, and prevention (PHDP) and nutrition support), and prevention activities for priority populations (key populations and adolescent girls and young women). It can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include different HIV services within clinics, hospitals, health facilities, and community-based organizations (government, private, or nongovernmental). Individual community health workers are not considered to be individual SDPs. Rather, the organizations with which they are affiliated are considered to be the SDP(s).

PEPFAR SDPs for FP/HIV integration include the following:

1. Treatment services. This includes services where ART is initiated and monitored. This can also include Option B+ services, where a client is transferred from a PMTCT ward to an HIV treatment area.
2. Care and support service. This can include home-based care activities and PHDP activities. Comprehensive FP services include safe conception and pregnancy services for PLHIV who wish to become pregnant and can be offered as part of the comprehensive HIV care package.
3. Antenatal/maternity services. This includes FP education and healthy timing and spacing messages in the ANC setting (when a woman is pregnant and receiving PMTCT services and/or FP counseling and method provision postpartum).
4. Priority/key population prevention services. This includes priority/key population programming, such as drop-in centers (FP integration can also take place across the clinical cascade for priority/key populations, including care and treatment) and prevention sites focused on adolescent girls and young women and other priority/key populations (i.e., DREAMS).
5. HIV testing services. FP services can be made available with HIV testing services, especially for key populations and adolescent girls and young women as well as for HIV serodiscordant couples.

#### Method of Measurement

##### **Numerator**

Number of SDPs supported by PEPFAR that are providing integrated voluntary FP services

##### **Denominator**

Total number of SDPs supported by PEPFAR

See definition above for a PEPFAR-supported SDP. Note: a service delivery point is NOT the same as a site. There can be numerous SDPs within one site.

#### B. Data Quality Issues

##### Initial Data Quality Assessment

Data should be reviewed regularly for the purposes of program management including monitoring progress toward achieving targets and identifying and correcting any data quality issues. Follow PEPFAR guidance for data quality review as circulated in Q4 reporting guidance.

Potential data quality issues for this indicator:

**Indicator counts SDPs, not sites:** This indicator counts the number of SDPs, NOT the number of sites that integrate FP services. See above for SDP definition.

**Denominator is greater than or equal to the numerator:** The total number of PEPFAR-supported SDPs (the denominator) must be greater than or equal to the total number of PEPFAR-supported SDPs that have integrated FP (the numerator).

## C. Comments and Special Considerations

### Special Considerations

#### 1. HIV/FP Integration Principles

As articulated in the FY14 COP guidance, USG-supported FP and HIV and AIDS programs must adhere to the following principles:

- PLHIV and their partners should be provided with information on and be able to exercise voluntary choices about their health, including their reproductive health.
- The USG, including PEPFAR, supports a person's right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as use of FP methods, regardless of HIV status.
- FP use should always be a choice, made freely and voluntarily, independent of the person's HIV status.
- The decision to use or not to use FP should be free of any discrimination, judgment, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
- Access to and provision of health services, including antiretroviral treatment (ART), for PLHIV should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of ART and avoid drug interactions).
- PLHIV who wish to have children should have access to safe and nonjudgmental pregnancy counseling services.

How often to report:

- Q4 only

How to calculate across reporting periods:

- Total number at the end of year
- DREAMS subnational unit-specific guidance

FP/HIV integration is a core component of the DREAMS package of services. FP services (education, counseling and/or method provision) should be made available through HIV prevention and treatment sites for adolescent girls and young women.

### Additional Resources

Voluntary FP counseling should follow the highest standards of quality and best practices outlined in the documents below:

- **World Health Organization Family Planning Clinical Guidelines and Counseling Tools** ([http://www.who.int/reproductivehealth/publications/family\\_planning/clinical/en/index.html](http://www.who.int/reproductivehealth/publications/family_planning/clinical/en/index.html))
- **The Balanced Counseling Strategy Plus (BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings** is a tool to improve the quality of FP services and to strengthen the integration in FP of HIV prevention, detection, and care, such as the risk assessment of STIs.
- **Family Planning: A Global Handbook for Providers** (<http://www.k4health.org/resources/family-planning-global-handbook-providers>) offers clinic-based healthcare professionals in developing countries the latest guidance on providing contraceptive methods.

### Other Resources

- “PEPFAR Blueprint: Creating an AIDS-Free Generation” (<http://www.pepfar.gov/documents/organization/201386.pdf>)
- United Nations Population Fund: “Preventing HIV and Unintended Pregnancies: Strategic Framework 2011–2015” (<http://www.unfpa.org/publications/preventing-hiv-and-unintended-pregnancies-strategic-framework-2011-2015>)
- “USAID’s Family Planning Guiding Principles and U.S. Legislative and Policy Requirements” (<http://www.usaid.gov/what-we-do/global-health/family-planning/usaid-family-planning-guiding-principles-and-us-0>)

In order to ensure high-quality FP/HIV integrated services, a variety of other indicators can be tracked by USG teams at the program management level. A list of relevant indicators is available in MEASURE Evaluation’s *Handbook of Indicators for Evaluating Family Planning Programs*: <http://www.cpc.unc.edu/measure/publications/ms-94-01>. For more information on these indicators or questions about developing FP/HIV indicators appropriate to your program, please contact Jennifer Mason ([jmason@usaid.gov](mailto:jmason@usaid.gov)), Nithya Mani ([nmani@usaid.gov](mailto:nmani@usaid.gov)), or Sarah Yeiser ([syeiser@usaid.gov](mailto:syeiser@usaid.gov)).



Service Delivery Integration
<p><b>Indicator</b></p> <p>Percentage of clients at PEPFAR-supported service delivery points (SDPs) who received voluntary family planning (FP) counseling (including safe conception/safe pregnancy counseling)</p>
<p><b>Purpose</b></p> <p>The indicator will measure voluntary FP counseling—a key component to quality FP services—provided to people living with HIV (PLHIV), key populations, and adolescent girls and young women at PEPFAR-supported community and facility sites. Voluntary FP counseling in PEPFAR sites is a direct measurement of voluntary FP counseling and a proxy measurement of both FP and HIV integration and quality of care.</p>
<p><b>A. Description</b></p>
<p><b>Definition: Women of Reproductive Age (WRA)</b></p> <p>WRA are women between the ages of 15–49 years.</p> <p><b>Definition: Voluntary Family Planning Counseling (including Safe Pregnancy Counseling)</b></p> <p>High-quality voluntary FP counseling should cover a wide range of topics that are client- and context-specific, and that include both safe pregnancy counseling for individuals who wish to become pregnant as well as contraception for individuals who wish to limit, space, or delay pregnancy. Voluntary FP counseling should follow the highest standards of quality and best practices outlined in the documents below:</p> <ul style="list-style-type: none"> <li>• <i>World Health Organization: Contraception Clinical Guides and Counselling Tools</i> (<a href="http://www.who.int/reproductivehealth/publications/family_planning/clinical/en/index.html">http://www.who.int/reproductivehealth/publications/family_planning/clinical/en/index.html</a>)</li> <li>• <i>The Balanced Counseling Strategy Plus (BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings</i> (<a href="http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service">http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service</a>) is a tool to improve the quality of FP services and to strengthen the integration of HIV prevention, detection, and care in FP, such as the risk assessment of sexually transmitted infections (STIs).</li> <li>• <i>Family Planning: A Global Handbook for Providers</i> (<a href="http://www.k4health.org/resources/family-planning-global-handbook-providers">http://www.k4health.org/resources/family-planning-global-handbook-providers</a>) offers clinic-based healthcare professionals in developing countries the latest guidance on providing contraceptive methods.</li> <li>• <i>Global Health University: FP counseling e-learning course</i> (<a href="http://www.globalhealthlearning.org/course/family-planning-counseling">http://www.globalhealthlearning.org/course/family-planning-counseling</a>)</li> </ul>
<p><b>Unit of Measurement</b></p> <p>Percentage (%)</p>
<p><b>Method of Measurement</b></p> <p><b>Numerator</b></p> <p>% WRA who receive FP counseling at a PEPFAR-supported SDP</p> <p><b>Denominator</b></p> <p>Total WRA who receive services at a PEPFAR-supported SDP</p>

**Note on U.S. Government (USG) Legal Requirements**

It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. **Numerical indicators for FP service delivery and/or couple years of protection (CYP) can be used for planning and budgeting purposes.** However, service providers and referral agents cannot be subject to quotas or other numerical targets of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or CYP should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.

**Disaggregation(s)**

Data can be disaggregated by:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms (e.g. FP-integrated school, community, or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., a mobile service unit, hospital, or health center)
- Sex/age (male: <15, 15–19, 20–24, 25+; female: <15, 15–19, 20–24, 25+)
- Rural/urban location
- Type of counseling (e.g., FP counseling; safe conception counseling; safe pregnancy counseling)

**Justification/Management Utility**

Access to voluntary FP services and information is critical for individuals to exercise their reproductive health rights and is considered a standard component of care for PEPFAR programs—particularly for prevention, care, and treatment, PMTCT, and key population services. Integrating FP services in HIV platforms increases access to voluntary FP among HIV-affected populations. Increased access to and use of FP can promote PMTCT, prevent unintended pregnancies, and ensure safe conception and safe pregnancy among HIV-affected populations.

**B. Data Collection****Data Sources**

- Service delivery statistics, including FP registers, HIV client charts, or electronic records and community outreach log books

**Timing/Frequency of Data Collection**

- Annually

**C. Data Quality Issues****Initial Data Quality Assessment**

The indicator will better assess the quality and effectiveness of FP services that are integrated in PEPFAR HIV platforms. HIV SDPs would be expected to collect FP counseling data on a daily basis to aggregate for quarterly and semiannual and annual reviews.

**Known Data Limitations and Significance (If Any)**

- Poor documentation of FP and/or other counseling provided to clients can lead to under-reporting.

**Actions Taken or Planned to Address Data Limitations**

- Standard protocols, as well as consistency in provider trainings, with an aim to improve staff motivation and documentation of services, can help minimize bias.

To ensure that USAID-supported activities are in compliance with USG FP legislation and policy, **targets for service delivery and/or CYP should be used for planning and budgeting purposes only**. Any targets related to FP services or CYP should not be used to motivate individual, provider, or service delivery team performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.

For more information on these indicators or questions about developing FP/HIV indicators appropriate to your program, please contact: Jennifer Mason (jmason@usaid.gov), Nithya Mani (nmani@usaid.gov), or Sarah Yeiser (syeiser@usaid.gov).

#### **D. Comments and Special Considerations**

See Appendix I for definition:

- PEPFAR-supported HIV service delivery point (SDP)

Service Delivery Integration	
<b>Indicator</b>	Percentage of clients at PEPFAR-supported HIV service delivery points (SDPs) who received a family planning (FP) method
<b>Purpose</b>	The focus of this indicator is to monitor FP service delivery. This indicator measures the provision of a FP method to male and female clients, within PEPFAR-supported HIV SDPs.
<b>A. Description</b>	
<b>Definition</b>	<ul style="list-style-type: none"> <li>The percentage of individuals of reproductive age (i.e., 15–49 for women; 15–54 for men) who were clients at a PEPFAR-supported HIV service delivery point (SDP) and received an FP method (e.g., condoms, pills, injectables)</li> </ul>
<b>Unit of Measurement</b>	<ul style="list-style-type: none"> <li>Percentage (%)</li> </ul>
<b>Method of Measurement</b>	<p><b>Numerator</b></p> <p>Number of clients of reproductive age (i.e. 15–49 for women; 15–54 for men) who received a FP method at a PEPFAR-supported HIV SDP during the reporting period.</p> <p><b>Denominator</b></p> <p>Total number of clients of reproductive age (i.e. 15–49 for women; 15–54 for men) served at the PEPFAR-supported HIV SDP during the reporting period.</p> <p>Data requirements include the number of clients of reproductive age served at a PEPFAR-supported HIV SDP during a given timeframe (e.g. annually) as well as the confirmation of how many received a FP method.</p> <p><b>Note on U.S. Government (USG) Legal Requirements</b></p> <p>It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. <b>Numerical indicators for FP service delivery and/or couple years of protection (CYP) can be used for planning and budgeting purposes.</b> However, service providers and referral agents cannot be subject to quotas, or other numerical targets, of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or CYP should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.</p>
<b>Disaggregation(s)</b>	<ul style="list-style-type: none"> <li>Data can be disaggregated by:</li> <li>HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS</li> <li>Non-HIV focused service delivery platforms (e.g., FP-integrated school, community, or facility health programs) that are supported by PEPFAR</li> <li>Type of SDP (e.g., mobile service unit, hospital, or health center)</li> </ul>

- Sex/age (male: <15, 15–19, 20–24, 25+; female: <15, 15–19, 20–24, 25+)
- Rural/urban location
- Type of FP method provided
  - HIV status (e.g., HIV-positive or -negative status)
  - Relationship status (i.e., not in a relationship; with seroconcordant/serodiscordant partner)

**Justification/Management Utility**

This indicator monitors FP service delivery and provides specific information on FP service uptake at HIV SDPs (critical components of FP/HIV integrated programs).

Data from this indicator can inform changes in the demand for and use of FP services over time.

**B. Data Collection**

**Data Sources**

- Service delivery statistics

**Timing/Frequency of Data Collection**

- Annually

**C. Data Quality Issues**

**Initial Data Quality Assessment**

This indicator assumes that screening for FP needs and FP counseling have occurred prior to FP method provision. Unfortunately, although each HIV SDP should maintain a record of services provided to clients, FP information is sometimes not well-recorded for HIV SDPs, making it difficult to accurately measure service delivery.

Data collection for this indicator allows for monitoring changes in FP service delivery over time but provides no direct information on the quality of FP/HIV service delivery integration. Over-reporting may occur if individuals outside of the specific age range (15–49 for women and 15–54 for men) are included.

**Known Data Limitations and Significance (If Any)**

Poor documentation of FP services and methods provided to clients can lead to under-reporting. Also, those PEPFAR-supported HIV SDPs that only distribute condoms may be included in this indicator.

**Actions Taken or Planned to Address Data Limitations**

Standard protocols, as well as consistency in provider trainings with an aim to improve staff motivation and documentation of services, can help minimize bias. Surveys and interviews with training participants following training sessions can provide feedback on training strengths and missed opportunities.

**D. Comments and Special Considerations**

See Appendix I for definitions:

- PEPFAR-supported HIV SDP
- FP method

**Additional Resources**

MEASURE Evaluation: “Percent of HIV-related service delivery point clients who received a family planning method or referral after family planning counseling” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/family-planning-and-hiv/proportion-of-people-using-any-fp-method-who](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/family-planning-and-hiv/proportion-of-people-using-any-fp-method-who))

## Service Delivery Integration

### Indicator

Percentage of clients who received a referral from the PEPFAR-supported HIV service delivery points (SDPs) to the family planning (FP) clinic.

### Purpose

The focus of this indicator is to monitor FP service delivery. This indicator aims to measure FP service integration, by providing information on the number of referrals for FP services issued to male and female clients within PEPFAR-supported HIV SDPs.

### A. Description

#### Definition

- The percentage of individuals of reproductive age (i.e., 15–49 for women; 15–54 for men) who were clients at a PEPFAR-supported HIV SDP and received a referral for an FP method (e.g., condoms, pills, injectables)

Referral occurs if the client is advised where he or she can go to find their preferred or recommended FP method not provided at the site, and the referral is documented at the referral source as proof that a referral was made.

#### Unit of Measurement

- Number (#) and percentage (%)

#### Method of Measurement

##### **Numerator**

Number of clients of reproductive age (i.e., 15–49 for women; 15–54 for men) who received a referral from the PEPFAR-supported HIV SDP to the FP clinic, for FP methods that were not available on-site

##### **Denominator**

Total number of clients of reproductive age (i.e., 15–49 for women; 15–54 for men) served at the PEPFAR-supported HIV SDP during the reporting period

Data requirements include the number of clients of reproductive age served at a PEPFAR-supported HIV SDP during a given period (e.g., annually) as well as the confirmation of how many were referred for an FP method.

#### **Note on U.S. Government (USG) Legal Requirements**

It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. **Numerical indicators for FP service delivery and/or couple years of protection (CYP) can be used for planning and budgeting purposes.** However, service providers and referral agents cannot be subject to quotas, or other numerical targets, of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or CYP should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.

#### **Disaggregation(s)**

Data can be disaggregated by:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS

- Non-HIV focused service delivery platforms (e.g., FP-integrated school, community, or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., mobile service unit, hospital, or health center)
- Type of referral provided
- Sex/age (male: <15, 15–19, 20–24, 25+; female: <15, 15–19, 20–24, 25+)
- Rural/urban location

#### **Justification/Management Utility**

This indicator monitors FP service delivery and provides specific information on the provision of referrals at HIV SDPs—critical components of FP/HIV integrated programs.

For example, public health facilities supported by the Global HIV/AIDS Initiative Nigeria (GHAIN)<sup>3</sup> successfully used an intervention model that strengthened referral links in co-located FP and HIV clinics, and used data from routine monitoring and evaluation (M&E) systems of FP and three HIV service settings—HIV care and treatment (HCT), antiretroviral therapy (ART), and prevention of mother-to-child transmission of HIV (PMTCT)—to improve FP service utilization by clients accessing HIV services. Recent studies have also suggested that facilitated referrals can be highly effective, particularly when used in conjunction with appropriate tools, registers and guidelines. Thus, as services become better integrated and referral networks better established, this information can be used in conjunction with FP records to track completed referrals.

#### **B. Data Collection**

##### **Data Sources**

- Service delivery statistics

##### **Timing/Frequency of Data Collection**

- Annually

#### **C. Data Quality Issues**

##### **Initial Data Quality Assessment**

This indicator similarly assumes that screening for FP need and FP counseling have occurred prior to referral and faces similar challenges in accurately measuring FP service provision, owing to the poor recording of FP information for HIV SDPs.

##### **Known Data Limitations and Significance (If Any)**

The indicator assumes that FP referrals will be completely and consistently recorded, and poor documentation can lead to under-reporting of the number referrals issued.

Tracking referrals remains a challenge in many countries and following up on individuals from PEPFAR-supported HIV SDPs who complete referrals at FP clinics may be difficult until coordination between services improves and linkages are strengthened.

<sup>3</sup> GHAIN is the largest PEPFAR-funded HIV program worldwide and has piloted the integration of FP services in its HIV program since 2007. GHAIN's FP/HIV integration intervention focused on upgrading the skills of providers, supporting them on the job, formalizing referrals between FP and HIV clinics and M&E by adding HIV data elements in the family planning register, and streamlining data flow from facility to the state and federal levels. In addition, a GHAIN reproductive health officer supervised each health facility monthly, and helped the facility coordinator check whether providers used the job aids, routinely counseled clients, assessed their FP needs, and completed data entry in the registers.

**Actions Taken or Planned to Address Data Limitations**

Provider trainings, strategies (e.g., facilitated referrals and supportive supervision) and job aids (e.g., monitoring forms, checklists, and reference charts) can be employed to improve documentation, tracking, and completion of referrals.

Efforts can be made to better coordinate referrals and improve communication between PEPFAR-supported HIV- and USAID-supported FP clinics or centers to facilitate FP/HIV service delivery integration and client tracking. Surveys and interviews with staff can be conducted to identify challenges, successes, and suggestions for better tracking of FP referrals.

**D. Comments and Special Considerations**

See Appendix I for definitions:

- PEPFAR-supported HIV SDP
- Referral(s)
- FP method

**Additional Resources**

Chabikuli, N.O., et al. “The Use of Routine Monitoring and Evaluation Systems to Assess a Referral Model of Family Planning and HIV Service Integration in Nigeria” (<http://www.ncbi.nlm.nih.gov/pubmed/20081394>)

MEASURE Evaluation: “Percent of HIV-related service delivery point clients who received a family planning method or referral after family planning counseling” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/family-planning-and-hiv/proportion-of-people-using-any-fp-method-who](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/family-planning-and-hiv/proportion-of-people-using-any-fp-method-who))



## Contraceptive Method Availability, Uptake, and Informed Choice

### Indicator

Percentage of PEPFAR-supported service delivery points (SDPs) that offer at least three types of family planning (FP) methods

### Purpose

This indicator measures the extent to which PEPFAR-supported HIV SDPs are capable of providing a particular component of integrated FP/HIV services.

PEPFAR-supported HIV SDPs may generally offer male and/or female condoms to clients, but because PEPFAR funds may not be used to purchase FP commodities, SDPs may not typically offer other FP methods. Provision of more than one FP method on-site (i.e. condoms plus another FP method) may therefore be indicative of some level of FP/HIV integration.

### A. Description

#### Definition

- The number and percentage of PEPFAR-supported HIV SDPs that provide at least three types of FP methods (e.g., condoms, oral contraceptives, injectable contraceptives, intrauterine device (IUD), implants, emergency contraception, fertility awareness based methods, etc.) on-site

#### Unit of Measurement

- Percentage (%)

#### Method of Calculation

##### **Numerator**

Number of PEPFAR-supported HIV SDPs that provided at least three types of FP methods during the reporting period

##### **Denominator**

Total number of PEPFAR-supported HIV SDPs that provide FP services, including prevention of mother-to-child transmission of HIV (PMTCT), care and treatment, key populations, and DREAMS sites

Data requirements include the number of PEPFAR-supported HIV SDPs in the area of interest and confirmation from providers or facility administrators that at least three types of FP methods are available on-site.

#### **Note on U.S. Government (USG) Legal Requirements**

It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. **Numerical indicators for FP service delivery and/or couple years of protection (CYP) can be used for planning and budgeting purposes.** However, service providers and referral agents cannot be subject to quotas, or other numerical targets, of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or CYP should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.

#### **Disaggregation**

Data can be disaggregated by the following:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms (e.g., FP-integrated school, community, or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., mobile service unit, hospital, or health center)
- Number of FP methods available on-site (i.e., at least two or at least three)

**Justification/Management Utility**

This indicator provides site-level information on a critical component of FP and HIV service integration.

Increasing the number of HIV SDPs providing voluntary FP services will improve access to FP services among clients with unmet need for a method. This indicator assesses whether SDPs are providing a particular component of integrated FP/HIV services and can inform the extent of integrated FP/HIV service delivery at SDPs receiving support.

In addition, PEPFAR’s SIMS 2.0 tool asks whether a site is providing at least three methods (e.g., condoms, oral contraceptive pills, injectables, implants, intrauterine devices (IUDs), fertility awareness methods, vasectomy, tubal ligation, etc.) directly or through referral, further supporting the feasibility and relative ease of collection of data for this indicator.

**B. Data Collection**

**Data Sources**

- Service delivery statistics

**Timing/Frequency of Data Collection**

- Annually

**C. Data Quality Issues**

**Initial Data Quality Assessment**

Although each HIV SDP should maintain a record of services provided to clients, FP information (particularly the provision of FP screening, counseling, and/or referral) is sometimes not well-recorded for HIV SDPs. Poor documentation and subsequent failure to meet all three criteria for providing clients with integrated FP services (i.e., the provision of FP screening, counseling for FP needs, and FP products or referral), will lead to difficulty and under-reporting of integrated PEPFAR-supported HIV SDPs. PEPFAR-supported HIV SDPs may generally offer male and/or female condoms to clients, but because PEPFAR funds may not be used to purchase FP commodities, may not typically offer other FP methods. Provision of more than one FP method on-site may therefore be indicative of some level of FP/HIV integration and provision of at least three types of FP method suggests access to good-quality services.

**Known Data Limitations and Significance (If Any)**

This indicator is an adaptation of another FP and HIV indicator taken from the MEASURE Evaluation Population and Reproductive Health (PRH) website and has not been tested. Also, the indicator does not capture those PEPFAR-supported HIV SDPs that offer referrals for FP methods not available on-site.

**Actions Taken or Planned to Address Data Limitations**

As linkages and tracking of referrals improve, the indicator could be modified to include the number and percentage of PEPFAR-supported HIV SDPs that offer more than the full range of FP methods available, either directly (i.e., on-site) or indirectly (i.e., through referral).

#### D. Comments and Special Considerations

See Appendix I for definitions:

- PEPFAR-supported HIV SDP
- FP method

#### **Additional Resources**

MEASURE Evaluation: “Number/percent of HIV-related service delivery points with family planning/HIV integrated services” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/family-planning-and-hiv/proportion-of-family-planning-service-sites](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/family-planning-and-hiv/proportion-of-family-planning-service-sites))

## Contraceptive Method Availability, Uptake, and Informed Choice

### Indicator

Number/type of contraceptive methods available at the PEPFAR-supported HIV service delivery points (SDPs)

### Purpose

This indicator is a critical component of contraceptive security, providing information on those observable and nonexpired contraceptive methods at a given service delivery point, for which a trained provider is available to administer: for example, insertion of an intrauterine device (IUD) or performance of a tubal ligation.

### A. Description

#### Definition

- The number and type of different contraceptive methods that are available at PEPFAR-supported HIV SDPs, based on documentation specifying the contraceptive methods offered through the PEPFAR, USAID, and/or other governmental, nongovernmental, or international agencies, as applicable

Contraceptive methods might include combined oral pills, progestin-only pills, injectables, implants, IUDs, male condoms, female condoms, emergency contraceptives, voluntary male sterilization, voluntary female sterilization, and the standard days method (i.e., CycleBeads).

“Available” refers to the presence of unexpired contraceptive methods at a point in time (e.g., the day of the visit). However, because this indicator applies to FP products documented to be offered at the particular SDP, availability at a point in time may reflect only the length of time since the past shipment arrived rather than FP method level adequacy or effectiveness of inventory management procedures. Measurement over time (e.g., six months or a year) is thus ideal, but may be possible only where information systems are automated.

#### Unit of Measurement

- Number (#)

#### Method of Calculation

##### **Numerator**

Number and type of contraceptive methods available at the PEPFAR-supported HIV SDPs

##### **Denominator**

N/A

Data requirements include a list of contraceptive methods available in PEPFAR-supported HIV SDPs.

This indicator should be calculated and reported separately for each FP method of interest so that each method receives a unique measure.

#### Disaggregation

Data should be disaggregated by the following:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms, such as FP-integrated school, community, or facility health programs that are supported by PEPFAR
  - Type of SDP (e.g., mobile service unit, hospital, or health center)

- Rural/urban location

### Justification/Management Utility

As a critical component of contraceptive security, this indicator provides a count of different types of methods available at the SDP that are not expired, combined with verification that appropriate service providers are available to deliver the methods to clients.

This indicator measures the “necessary but not sufficient” condition for ensuring a full range of contraceptive methods for clients—one of the six elements in the Bruce framework (Bruce, 1990). For a method to be available, action is required at two levels: (1) at the managerial level, to ensure that unexpired contraceptive supplies and trained providers are available at a given point; and (2) at the provider level, to effectively offer all appropriate methods to a given client. (In this sense, “appropriate” is used in reference to the client’s reproductive intentions and possible medical contraindications.) The observation of existing supplies measures the manager’s ability to stock all nationally–approved methods for the type of facility in question.

### B. Data Collection

#### Data Sources

- Service statistics or logistics management information system

#### Timing/Frequency of Data Collection

- Annually

### C. Data Quality Issues

#### Initial Data Quality Assessment

Although this indicator is an important index of method mix and a building block for contraceptive security, it does not reveal any information regarding other barriers women and men may face in accessing and using contraceptives, such as access to facilities, cost, etc.

#### Known Data Limitations and Significance (If Any)

- Does not describe utilization of contraceptive methods among clients

#### Actions Taken or Planned to Address Data Limitations

- Population-based surveys such as Demographic and Health Surveys could also be used to measure the utilization of contraceptive methods.

### D. Comments and Special Considerations:

See Appendix I for definitions:

- PEPFAR-supported HIV SDP
- Contraceptive methods

#### Additional Resources

MEASURE Evaluation: “Number of contraceptive methods that are supposed to be offered in NGO facilities” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/commodity-security-and-logistics-1/number-of-contraceptive-methods-that-are-supposed-to-be-offered-in-ngo-facilities](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/commodity-security-and-logistics-1/number-of-contraceptive-methods-that-are-supposed-to-be-offered-in-ngo-facilities))

## Contraceptive Method Availability and Uptake

### Indicator

Number of clients who accept (for the first time in their lives) modern contraception at PEPFAR-supported HIV service delivery points (SDPs)

### Purpose

This indicator measures the ability of the program to attract new clients from an untapped segment of the population to its services. The measure eliminates the problem of counting as “new” those clients who switch from one source to another for reasons of convenience or cost. As an indicator, it may also reflect the success of special communication programs or other interventions (e.g., social marketing projects) aimed at increasing service utilization among those previously missed by the program. However, in this latter case, one must be mindful that some of the new acceptors might have obtained the same or another method from an alternate source (e.g., the unsubsidized pharmacy sector) if the special intervention had not taken place.

### A. Description

#### Definition

- The number of clients who accept for the first time in their lives any (program) contraceptive method at PEPFAR-supported HIV service delivery points (SDPs); to be reported for a defined reference period (e.g., one year)

#### Unit of Measurement

- Number (#)

#### Method of Calculation

##### *Numerator*

The number of clients who accept (for the first time in their lives) modern contraception at PEPFAR-supported HIV SDPs

##### *Denominator*

N/A

Data requirements include counts of persons accepting any (program) contraceptive method for the first time in their lives during a one-year period

#### Note on U.S. Government (USG) Legal Requirements

It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. **Numerical indicators for FP service delivery and/or couple years of protection (CYP) can be used for planning and budgeting purposes.** However, service providers and referral agents cannot be subject to quotas, or other numerical targets, of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or CYP should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.

#### Disaggregation

Data should be disaggregated by:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms (e.g., FP-integrated school, community, or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., mobile service unit, hospital, or health center)
- Sex/age (male: <15, 15–19, 20–24, 25+; female: <15, 15–19, 20–24, 25+)
  - Parity, ethnicity, place of residence, rural/urban location, and/or other factors judged relevant in the country context, such as vulnerable populations (e.g., poor women and female sex workers)

#### Justification/Management Utility

This indicator measures the ability of the program to attract new clients. Further, by measuring the **number of clients who accept modern contraception for the first time in their lives**, this indicator reduces ambiguity, avoids a duplication of cases, and eliminates the problem of counting as “new” those clients who switch from one source to another.

Disaggregated data can provide a sociodemographic profile of the client population, which may be useful in tracking changes in the composition of the client population over time and determining whether programs intended to reach certain subgroups are effectively doing so.

### B. Data Collection

#### Data Sources

- Service delivery statistics

#### Timing/Frequency of Data Collection

- Annually

### C. Data Quality Issues

#### Initial Data Quality Assessment

Although this indicator is an important index of method availability and acceptability, it does not reveal any information regarding other barriers women and men may face to accessing and using contraceptives, such as access to facilities, cost, etc.

#### Known Data Limitations and Significance (If Any)

- Does not describe utilization of a contraceptive method and continuation among clients

#### Actions Taken or Planned to Address Data Limitations

- Population-based surveys such as Demographic and Health Surveys could measure the utilization of contraceptive methods.

### D. Comments and Special Considerations

See Appendix I for definitions:

- PEPFAR-supported HIV SDP
- Contraceptive methods

**Additional Resources**

MEASURE Evaluation: “Number of acceptors new to modern contraception”

([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/fp/number-of-acceptors-new-to-modern-contraception](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/number-of-acceptors-new-to-modern-contraception))



## Contraceptive Method Availability and Uptake

### Indicator

Couple-years of protection (CYP) in U.S. Government (USG)-supported PEPFAR programs

### Purpose

This output indicator provides an estimate of the protection provided by FP (family planning) methods during a one-year period, based upon the volume of all contraceptive methods provided to clients during that period. In this context, the indicator will be used to track CYP from contraceptive methods provided at USG-supported PEPFAR sites. At the country level, CYP from PEPFAR-supported sites may be combined with CYP from non-PEPFAR-supported FP sites to establish USG-wide CYP.

CYP measures the volume of FP and/or reproductive health (RH) program activity. Program managers and donor agencies use it to monitor progress in the delivery of contraceptive services to a given population in a given year at the program and project levels. CYP is correlated with contraceptive prevalence and reduction in unintended pregnancies and is an annually-available proxy for the modern contraceptive prevalence rate (MCPR).

### A. Description

#### Definition

- The estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period

#### Unit of Measure

- Number (#)

#### Method of Calculation

##### **Numerator**

The CYP is calculated by multiplying the quantity of each FP method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure.

##### **Denominator**

N/A

Data requirements include the quantities of pills and condoms distributed to clients; the numbers of IUDs and implants inserted; the number of injections administered; the number of sterilization operations performed; the number of trained, confirmed clients of natural FP; number of lactose amenorrhea method (LAM) clients during the reference period; as well as the CYP conversion factors.

#### Note on USG Legal Requirements

It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. **Numerical indicators for FP service delivery and/or CYP can be used for planning and budgeting purposes.** However, service providers and referral agents cannot be subject to quotas, or other numerical targets, of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or CYP should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.

CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, such as condoms and oral contraceptives, may be used incorrectly and then discarded, or that intrauterine devices (IUDs) and implants may be removed before their life span is realized. The most updated CYP conversion factors are as follows:

Method	CYP Per Unit
Copper-T 380-A IUD	4.6 CYP per IUD inserted (3.3 for 5 year IUD, such as LNG-IUS)
3-year implant (e.g. Implanon)	2.5 CYP per implant
4-year implant (e.g. Sino-Implant)	3.2 CYP per implant
5-year implant (e.g. Jadelle)	3.8 CYP per implant
Emergency contraception	20 doses per CYP
Fertility awareness methods	1.5 CYP per trained adopter
Standard Days method	1.5 CYP per trained adopter
LAM	4 active users per CYP (or .25 CYP per user)
Sterilization*	
Global	10
India, Nepal, Bangladesh	13
Oral contraceptives	15 cycles per CYP
Condoms (male and female)	120 units per CYP
Vaginal foaming tablets	120 units per CYP
Depot medroxyprogesterone (DMPA) injectable	4 doses per CYP
Norethisterone enantate (NET-En) injectable	6 doses per CYP
Cyclofem monthly injectable	13 doses per CYP
Monthly vaginal ring/patch	15 units per CYP

\*The CYP conversion factor for sterilization varies, because it depends on when the sterilization is performed in the reproductive life of the individual. For more specific data on CYPs and sterilization, consult national Demographic and Health Surveys and U.S. Centers for Disease Control and Prevention reproductive health survey records, which may provide a historical calculation based on a specific country's context.

Goals for CYP may be appropriate at the level of the service delivery site or higher (e.g., district or national program level) for the purposes of planning or budgeting. CYP targets should not be set for individual service providers.

**Disaggregation**

Data should be disaggregated by:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms (e.g., FP-integrated school, community or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., mobile service unit, hospital, or health center)
  - Rural/urban location

**Justification/Management Utility**

As one of the most widely used indicators, CYP measures the volume of program activity and can be used to monitor progress in the delivery of contraceptive services at program and project levels. Other advantages of this indicator are the ease of collection and calculation via routine program data collection (thus minimizing the data collection burden) and allowance for program comparison of the contraceptive coverage provided by different FP methods.

**B. Data Collection****Data Sources**

- Service statistics or logistics management information system

**Timing/Frequency of Data Collection**

- Annually

**C. Data Quality Issues****Initial Data Quality Assessment**

The CYP calculation provides an immediate indication of the volume of program activity and, because the term “CYP” reflects distribution, is a way to estimate coverage but not actual use or impact.

**Known Data Limitations and Significance (If Any)**

Disadvantages of this indicator are that it is not intuitively easy to understand by those outside the field; the number of individuals represented by CYP cannot be ascertained; it primarily reflects distribution and not actual use or impact; the number of years that are included in the estimates has an impact on the average duration of use; and the effectiveness of the methods is included in the continuation estimates, because discontinuations for all reasons, including due to pregnancy, are looked at together.

Further, CYP should ideally be based on the volume of contraceptives delivered to clients who will presumably use them and not on those delivered to facilities, where they may remain unused in cartons or on shelves.

An illustrative computation for calculating CYP, based upon conversion factors, is below:

Method	Quantity	CYP
Oral contraceptives	5,022	334.8
IUDs	87	400.2
Condoms	62,810	523.4
Vaginal tablets	3,900	32.5
Tubal ligations (globally)	13	130.0
DMPA	1,277	319.3
<b>Total</b>		1,740.2

Regarding the calculation of CYP for long-term methods, most programs “credit” the entire amount to the calendar year in which the client accepted the method. For example, if an FP program performed 100 voluntary surgical contraception procedures in a given year, it would credit all 1,000 CYP (100 procedures x 9 years/each) to that calendar year, even though the protection from those procedures would, in fact, be realized over that and the next nine years. An alternative approach is to “annualize” this projection, allocating it over a nine-year period. The same principle applies to IUDs and implants. Although the first approach (of crediting the full amount of CYP in the calendar year of acceptance) has been harshly criticized, it represents current practice in most programs that report CYP, probably because it is easier to apply.

#### Actions Taken or Planned to Address Data Limitations

To ensure relevance to the specific country, programs should use country-specific statistics and are referred to the Stover, Bertrand, and Shelton (2000) report for the appropriate CYP: “Empirically Based Conversion Factors for Calculating Couple-Years of Protection” (<http://www.ncbi.nlm.nih.gov/pubmed/10747769>)

#### D. Comments and Special Considerations

See Appendix I for definitions:

- PEPFAR-supported HIV SDP
- Contraceptive methods

#### Additional Resources

MEASURE Evaluation: “Couple-years of protection (CYP)” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/fp/cyp](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp))

USAID: “Couple years of protection (CYP)” (<http://www.usaid.gov/what-we-do/global-health/family-planning/couple-years-protection-cyp>)

## Training and Human Resources

### Indicator

Percentage of PEPFAR-supported healthcare workers (HCWs) who completed an FP training program

### Purpose

This indicator serves as a measure of FP/HIV service integration inputs. Gathering data on the number and percentage of PEPFAR-supported HCWs who completed FP training gives a measure of how many healthcare providers are active at PEPFAR-supported HIV SDPs, which is also an indication of the robustness of FP/HIV service integration.

### A. Description

#### Definition

- The percentage of PEPFAR-supported HCWs who completed an FP training program

The FP training program can be any type of FP training event that is fully or partially supported by PEPFAR, regardless of its duration or location, which involves a trainee getting a thorough understanding of the essential knowledge required to provide FP services (e.g., counseling, distribution of methods, and referrals) and progressing from either lacking skills or having minimal skills to being proficient.

Trainings will differ depending on in-country standards and support. However, the indicator can be used to assess any trainings received via disaggregation by the level, length, and/or type of training.

#### Unit of Measurement

- Percentage (%)

#### Method of Calculation

##### **Numerator**

The numerator can be generated by summing all HCWs from the host country who successfully completed an FP training program within the reporting period with full or partial PEPFAR support. The people counted under this indicator should be based on an actual training roster that includes trainee names, professional positions, and topic of training. Successful completion of the FP training program is based on standards established by the Ministry of Health for the training program, or if the training is not approved by the Ministry of Health, by standards established by the organization conducting the training.

##### **Denominator**

The total number of PEPFAR-supported HCWs

Data requirements include the number of people trained (based on a verifiable list of actual names), their professional positions (e.g., nurses and community health workers), sex, and training topic.

#### Disaggregation

Data should be disaggregated by:

- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms (e.g. FP-integrated school, community or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., mobile service unit, hospital, or health center)

- Sex/age (male: <15, 15–19, 20–24, 25+; female: <15, 15–19, 20–24, 25+)
  - Type (and length) of training (e.g., pre-service training, refresher training, and training for specific modules such as long-acting and permanent contraceptive methods)
  - Type of project/program (e.g., PEPFAR-supported training organized by a health ministry and/or a nongovernmental organization)

**Justification/Management Utility**

As an input measure, this indicator gives evidence of provider capacity to provide integrated services and can be used to determine whether a program meets its target to monitor trainees and/or to track progress from one year to the next.

**B. Data Collection**

**Data Sources**

- Records that are usually kept by the training division

**Timing/Frequency of Data Collection**

- Annually

**C. Data Quality Issues**

**Initial Data Quality Assessment**

While this indicator provides a count of healthcare worker capacity, it does not capture knowledge or skills. As a crude measure, it neither measures the quality of training nor the outcomes of the training (e.g. competency of individuals trained and their performance in delivering quality FP services).

**Known Data Limitations and Significance (If Any)**

The “unit of measurement” is not uniform, strictly speaking, in that one healthcare worker at a particular SDP may have attended a course for one day, whereas another may have participated in a course for three months.

Further, this indicator does not indicate provider competence or confidence in delivering quality FP service and does not capture the replacement or retention in the health workforce of trained individuals in their host country.

**Actions Taken or Planned to Address Data Limitations**

This indicator can be used in conjunction with other indicators that assess competency or mastery of knowledge and/or skills. One suggested example to complement this indicator is **number and percentage of PEPFAR-supported healthcare providers who have mastered relevant knowledge following a PEPFAR- and/or USAID-supported FP training program.**

Training healthcare providers both in FP and HIV programs is essential to improve the quality of care. Further, lack of refresher trainings in both FP and HIV services may perpetuate outdated practices.

**D. Comments and Special Considerations**

See Appendix I for definitions:

- PEPFAR-supported HCWs
- PEPFAR- and/or USAID-supported FP training program
- Contraceptive methods

### **Additional Resources**

MEASURE Evaluation: “Training” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/training](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/training))

MEASURE Evaluation: “Number/percent of trainees competent to provide specific services upon completion of training” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/training/number-percent-of-trainees-competent-to-provide-specific-services-upon-completion-of-training](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/training/number-percent-of-trainees-competent-to-provide-specific-services-upon-completion-of-training))

MEASURE Evaluation: “Number/percent of trained providers who perform to established guidelines/standards” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/training/number-percent-of-trained-providers-who-perform-to-established-guidelines-standards](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/training/number-percent-of-trained-providers-who-perform-to-established-guidelines-standards))

World Health Organization: “Counting health workers: Definitions, data, methods and global results” ([http://www.who.int/hrh/documents/counting\\_health\\_workers.pdf](http://www.who.int/hrh/documents/counting_health_workers.pdf))

World Health Organization: “HIV/AIDS: Definition of key terms” (<http://www.who.int/hiv/pub/guidelines/arv2013/intro/keyterms/en/>)

World Health Organization: “Community health workers: what do we know about them?” ([http://www.who.int/hrh/documents/community\\_health\\_workers\\_brief.pdf](http://www.who.int/hrh/documents/community_health_workers_brief.pdf))

## Supportive Supervision and Healthcare Worker Accountability

### Indicator

Percentage of PEPFAR-supported service delivery points (SDPs) that offer at least three types of FP methods and have had documented routine supportive supervision of FP/HIV services within the past 12 months.

### Purpose

This indicator assesses whether or not routine supportive supervision visits are being conducted at PEPFAR-supported sites that provide a critical component of integrated FP services.

Routine supportive supervision of clinical HIV programs is an essential component of ensuring that the quality of HIV and FP services is maintained and sustained over time, and of facilitating problem-solving and improvement plans where gaps in service quality are identified. In the absence of effective supervision systems, poor service quality may result in low utilization of services. Monitoring supportive supervision is a critical quality of service indicator at the district, national, and PEPFAR program levels.

### A. Description

#### Definition

- The percentage of PEPFAR-supported HIV SDPs providing at least two or at least three types of FP methods that have had documented routine supportive supervision of FP/HIV services within the past 12 months

#### Unit of Measure

- Percentage (%)

#### Method of Calculation

##### **Numerator**

The numerator is the number of PEPFAR-supported SDPs that provide at least three types of FP methods and can document routine supportive supervision of FP/HIV services.

##### **Denominator**

The denominator is the total number of PEPFAR-supported HIV SDPs that provide at least three types of FP methods.

Data requirements include the number of PEPFAR-supported HIV SDPs that provide at least three types of FP methods as well as documentation of any routine supportive supervision visits.

#### Disaggregation

- Data should be disaggregated by:
- HIV service platforms, such as counseling and testing, care and treatment, prevention of mother-to-child transmission of HIV (PMTCT), key populations, and DREAMS
- Non-HIV focused service delivery platforms (e.g., FP-integrated school, community or facility health programs) that are supported by PEPFAR
- Type of SDP (e.g., mobile service unit, hospital, or health center)
- Number of FP methods available on-site (i.e., at least two or at least three)



<p><b>Justification/Management Utility</b></p> <p>This indicator demonstrates the functioning of routine supportive supervision of clinical FP/HIV programs. It is reasonable to collect and provide some indication of program/healthcare worker oversight and accountability. Site supervision can be implemented at health centers, clinics, and large hospitals.</p> <p>For instance, the Government of Swaziland established a regional task force that included teams of doctors, nurses, sexual and reproductive health (SRH) officers, and M&amp;E focal points. This task force worked in collaboration with Ministry of Health regional clinical mentors to support the provision of good-quality integrated SRH and HIV services. They developed supportive supervision strategies, including use of facility-based data to track progress, review of records to check data quality, and feedback sessions with healthcare providers. This supportive mentorship increased knowledge, skills, and competency among HCWs at integrated SRH and HIV care facilities.</p>
<p><b>B. Data Collection</b></p>
<p><b>Data Sources</b></p> <ul style="list-style-type: none"> <li>• Service statistics</li> </ul> <p>Evidence of a documented routine supportive supervision visit may be determined by document review of supervision reports both at site level and/or at district level. Documentation requirements for supervisory visits will vary by country.</p>
<p><b>Timing/Frequency of Data Collection</b></p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>
<p><b>C. Data Quality Issues</b></p>
<p><b>Initial Data Quality Assessment</b></p> <p>The documentation of a routine supportive supervision visit does not provide sufficient information to determine the supervision system’s quality of effectiveness in improving programs. However, the absence of routine supervision of FP/HIV clinical services by the national health authority indicates a serious weakness in the sustainability of FP/HIV service quality over time. There are many potential reasons for ineffective supervision systems, and poor performance on this indicator would indicate a need for further evaluation.</p>
<p><b>Known Data Limitations and Significance (If Any)</b></p> <ul style="list-style-type: none"> <li>• Does not provide information on the observations or outcomes of the supervisory visits</li> </ul>
<p><b>Actions Taken or Planned to Address Data Limitations</b></p> <p>Include in the future a service provision assessment (SPA) or other more elaborate/qualitative assessment (e.g., mystery client or exit interviews and in-depth interviews with clients and/or providers).</p> <p>MEASURE Evaluation: “Service Delivery—Quality of Care/Service Provision Assessment”  <a href="http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.2">http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.2</a></p>
<p><b>D. Comments and Special Considerations</b></p>
<p>See Appendix I for definitions:</p> <ul style="list-style-type: none"> <li>• PEPFAR-supported HIV SDP</li> <li>• Referral</li> <li>• Routine supportive supervision</li> </ul>

### **Additional Resources**

World Health Organization: “WHO’s Short List of Reproductive Health Indicators for Global Monitoring” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/global/whos-short-list-of-reproductive-health-indicators-for-global-monitoring](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/global/whos-short-list-of-reproductive-health-indicators-for-global-monitoring))

MEASURE Evaluation: “Number/percent of organization/program units systematically using information to plan and monitor performance” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/mgt/number-proportion-of-organization-program-units](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/mgt/number-proportion-of-organization-program-units))

MEASURE Evaluation: “Procurement plans and coordination among suppliers/donors are monitored/managed by the program” ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators/crosscutting/commodity-security-and-logistics-1/procurement-plans-and-coordination-among-suppliers-donors-are-monitored-managed-by-the-program](http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/commodity-security-and-logistics-1/procurement-plans-and-coordination-among-suppliers-donors-are-monitored-managed-by-the-program))

United Nations Population Fund: “HIV and Sexual and Reproductive Health Programming: Innovative Approaches to Integrated Service Delivery” (<http://www.unfpa.org/publications/hiv-and-sexual-and-reproductive-health-programming-innovative-approaches-integrated>)

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## APPENDIX. GLOSSARY

### Contraceptive method(s)

The contraceptive methods available might include combined oral pills, progestin-only pills, injectables, implants, intrauterine devices (IUDs), male condoms, female condoms, emergency contraceptives, voluntary male sterilization, voluntary female sterilization, the standard days method (i.e., CycleBeads), and others.

### Contraceptive prevalence rate (CPR)

The contraceptive prevalence rate (CPR) is defined as the percentage of women of reproductive age who are using (or whose partners are using) a contraceptive method at a particular point in time, almost always reported for women married or in sexual union. Generally, the measure includes all contraceptive methods (modern and traditional), but sometimes refers to modern methods only (i.e. modern contraceptive prevalence rate (MCPR).

### Dual method use

Dual method use describes combined use of two contraceptive methods: a barrier method for protection against sexually transmitted infections (STIs) and another method for protection against unintended pregnancy. The contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, simultaneous condom use for disease prevention is recommended.

### Family planning (FP) method(s)

See “Contraceptive method(s).”

### FP clients

FP clients are defined as persons who have come to choose a method for the first time or who need to choose a new method after switching based on their needs and situation. Clients also include persons who not only need support in selecting a contraceptive method, but also need continuing support and reassurance to use that chosen method.

### Healthcare workers (HCWs)

HCWs are defined as all people engaged in the promotion, protection, or improvement of the health of the population (both professional and auxiliary professionals). Different types of health workers can be categorized under this indicator:

- Clinical health workers play clinical roles in direct service delivery and patient care.
- Community health workers are health workers who have received standardized and nationally endorsed training outside the nursing, midwifery, or medical curricula.
- Nonphysician clinicians are professional health workers capable of many of the diagnostic and clinical functions of a physician but who are not trained as physicians. These types of health workers are often known as health officers, clinical officers, physician assistants, nurse practitioners, or nurse clinicians.

- Nurses are professional nurses, enrolled nurses, auxiliary nurses, and other nurses such as dental or primary care nurses.

### **PEPFAR support**

PEPFAR support may be described as either **direct service delivery (DSD)** or **technical assistance-service delivery improvement (TA-SDI)**. A service delivery point will be counted as either **directly supported by PEPFAR** or **supported through technical assistance only**, depending on whether one or both of the below criteria are met.

1. PEPFAR support for the service delivery point (SDP) includes:
  - Partial or full support for the procurement of antiretroviral drugs; or
  - Partial or full support for HIV services, including HIV counseling and testing; prevention of maternal-to-child transmission of HIV; screening and prophylaxis for opportunistic infections and other health services for people living with HIV; or
  - Partial or full salary support for those healthcare workers actively delivering HIV services in accordance with international or national protocols or guidelines (i.e., physicians, nurses, and other healthcare workers).

AND

2. The PEPFAR-supported implementing partner has an established presence and/or frequent presence (at least one supervisory visit per quarter) at the SDP.

### **Direct service delivery (DSD)**

SDPs will be counted as receiving direct service delivery support from PEPFAR when both of the above conditions are met.

### **Technical assistance-service delivery improvement (TA-SDI)**

Sites will be counted as supported through TA-SDI when the point of service delivery receives support from PEPFAR that meets the second criterion only.

### **PEPFAR-/USAID-supported FP training program**

The FP training program can be any type of PEPFAR-supported FP training event, regardless of its duration or location, that involves a trainee getting a thorough understanding of the essential knowledge required to provide FP services (e.g., counseling, distribution of methods, and referrals) and progressing from either lacking skills or having minimal skills to being proficient. It is preferable that the training program be approved by the health ministry and implemented by ministry-approved trainers. However, this may not be feasible for training courses that are designed for HIV providers.

### **PEPFAR-supported service delivery points (SDPs)**

USAID needs to research this definition to see if it covers all services that are provided within PEPFAR's DREAMS initiative.

A PEPFAR-supported service delivery point uses PEPFAR funds to directly provide HIV services. The service delivery point (SDPs) may offer one or more HIV service, including but not limited to HIV testing and counseling; prevention of mother-to-child transmission of HIV; antiretroviral treatment (ART); screening and prophylaxis for opportunistic infections; and other health services for people living with HIV (e.g., positive health, dignity and prevention (PHDP) and nutrition support).

SDPs can be fixed locations or mobile operations offering routine or regularly scheduled services. Examples are clinics, hospitals, health facilities, and community-based organizations (government, private, or nongovernmental). Individual community health workers are not themselves considered to be SDPs. Rather, the organizations with which they are affiliated are considered to be the SDP.

### **Referral**

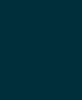
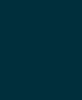
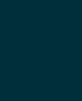
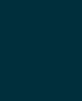
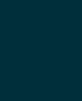
Referral occurs if a client is advised where he/she can go to find their preferred or recommended FP method not provided at the site, and the referral is documented at the referral source as proof that a referral was made. A completed referral occurs once an individual is confirmed to have visited/attended the FP clinic to which he or she was referred.

Per U.S. Government legislation, and in line with national FP policies, a broad range of methods should be provided to clients, allowing them to choose the method most appropriate for them, either directly or through referral. All referrals should include detailed information about where methods not available at the site can be accessed (e.g., facility location and operating hours).

### **Routine supportive supervision (visits)**

A PEPFAR-supported site that provides integrated voluntary FP services and has documented evidence of routine supportive supervision visits according to national guidelines—including written feedback, evidence of joint problem-solving, and follow-up in the past 12 months—should be captured in the numerator. Evidence of a documented routine supportive supervision visit may be determined by document review of supervision reports both at site level and/or at district level.

National health ministry guidelines should define the regulatory framework, standards, and implementation policy guidelines for the supervision system. This should include which organizational units of the health system have jurisdictional responsibility for the supervision of clinical HIV services; how often supervision should occur; standards for implementation and tools for assessing HIV clinical quality according to national guidelines; clinical general operational performance; health information system recording and reporting; a system of documentation of supervision visits, including written feedback; and a system of continuous follow-up and improvements.



**MEASURE** Evaluation

University of North Carolina at Chapel Hill

400 Meadowmont Village Circle, 3<sup>rd</sup> Floor

Chapel Hill, North Carolina 27517

Phone: +1-919-445-9359 • [measure@unc.edu](mailto:measure@unc.edu)

[www.measureevaluation.org](http://www.measureevaluation.org)

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