

Performance Monitoring for Family Planning and Reproductive Health Programs

An Approach Paper

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ABSTRACT

The International Conference on Population and Development (ICPD) in Cairo shifted family planning program attention from a focus on achieving demographic targets to meeting individual needs of women for family planning and reproductive health services. Several governments in developing countries are responding by placing increased emphasis on program quality, meeting the expressed needs of clients, and placing less emphasis on achieving quantitative indicators of program performance.

This report summarizes some of the changes in performance monitoring taking place in selected countries. There is considerable variability in how countries are making this transition.

- While Indonesia has been one of the most successful developing countries to meet its demographic objectives, it has recently made great strides in shifting the focus of its family planning program from a target-driven program to one based on the concept of understanding and fulfilling the needs and preferences of the family. Work is now underway to operationalize the policy at the field level, incorporate the approach in national and local planning, and devise strategies for collecting information that will allow assessment of its success.
- In the Philippines, focus is placed on improving maternal and child health and meeting the reproductive intentions of women. Work is proceeding to improve the national MIS, make better use of existing data from a variety of sources to produce an annual status report for the PFPP, as well as to strengthen monitoring systems at the local level. There is currently a lot of variability in capabilities by LGU. While pilot approaches are being tested in a few LGUs, it is unclear to what extent these will be endorsed by either the DOH or other LGUs.
- In Zimbabwe, greater attention is being paid to reproductive health in service provision, particularly STDs treatment and prevention. A new report form is being tested to ascertain more clearly the quality of care provided and patterns of method switching. The next five-year plan, to be developed during 1996, is expected to formalize this new reproductive health strategy.
- Increased emphasis is being placed on reproductive health in Mexico, although it's too early to know how the performance monitoring system will evolve to address these new concerns.

While experience is beginning to accumulate, shifting from advocacy for a reproductive health approach to program implementation at national, subnational and local levels will require much new work to obtain timely, accurate information for planning, implementation and monitoring of reproductive health and family planning programs.

Performance Monitoring for Family Planning and Reproductive Health Programs

Family planning programs in many developing countries focus their efforts on achieving certain demographic goals. These goals include birth-rate reductions and slower population growth through increased use and coverage of family planning services. The International Conference on Population and Development (ICPD), held in Cairo in September 1994, suggested a broader range of concern for family planning programs by incorporating reproductive health issues into program mandates. Indeed, reproductive health concerns appear in a prominent position in the recommendations that emerged from that meeting. Many governments are now considering how to adapt their program strategies to address the broader goals of family planning and reproductive health.

Background

The Government of India is among those governments that have used achievement of demographic targets as a means of monitoring program performance and for developing administrative measures when performance is inadequate. Senior officials set targets for national and state levels of government. The targets then devolve to district levels and subdistrict units, including primary health care centers and subcenters, and on to workers, by method and month. These targets are set in terms of number of acceptors, sterilizations, and IUD insertions, and quantities of contraceptive products distributed within a given time period.

In many countries, using quantitative targets to measure achievement of demographic goals has resulted in considerable program success. In India, however, excessive emphasis on quantitative targets has hampered program management over the years. There is widespread falsification of records of method acceptance so that service units can show better performance than is actually being achieved.

Concern for qualitative aspects of service delivery (e.g., reasons for discontinuation and client satisfaction) have been neglected by program managers. The weights used to measure performance give too much credit to female sterilization. Managers thus push this method over all others and neglect services oriented to low parity and younger couples who wish to space their births. There is broad agreement on the need to replace targets with new management tools for evaluating program performance.

Changing a way of thinking and behaving that has grown up over 25 to 30 years of programme experience requires careful thought and action lest we wind up doing more harm than good.

-- Sinding and Fathalla

The Cairo conference shifted world attention from demographic goals to concerns for the reproductive health of women. Increasingly, emphasis is being placed on meeting the needs of women in terms of

their stated fertility preferences. Research has shown that by satisfying unmet need for contraception (based on a woman's stated fertility preferences), programs could reach the same or higher levels of prevalence as is possible through focusing on quantitative demographic targets (Sinding et al., 1994; Ross, 1994). The Cairo conference also highlighted the importance of ensuring quality of care as part of a comprehensive reproductive health approach.

The Government of India (GOI) has removed targets from the entire country effective April 1, 1996. It has constituted a committee for identifying an alternative set of indicators that can be used for performance monitoring. The GOI would also need to establish systems for tracking the indicators at various levels.

The Challenges of Adopting a New Emphasis for Family Planning Programs

What it means to adopt a reproductive health approach is not readily understood. While many programs already address a number of reproductive health concerns, such as quality family planning services, safe motherhood, prevention of HIV/AIDS and STDs, and adolescent programs, family planning program success is usually not measured in these terms. The focus is still on the family planning component and fertility reduction. While it has been said that the success or failure of programs should be judged in terms of the extent to which they help individual women achieve their reproductive goals and not solely according to their impact on fertility (Kumar and Jain, 1989), definitive methods for doing so have not been developed.

One cannot simply change the design of services -- that is, require these programs to add reproductive health services -- without modifying their primary objective and the main criterion for evaluation of their success or failure.

-- Jain

Shifting from advocacy for a reproductive health approach to program implementation at national, subnational and local levels will require much new work to obtain timely, accurate information for planning, implementation and monitoring of reproductive health and family planning programs. In Figure 1, Jain and Bruce (1995) have suggested a number of criteria for measuring the efficacy of reproductive health and family planning programs, but they leave unspecified the monitoring mechanisms that could match these ideals. Unfortunately, available data are seldom used for reproductive health purposes, or the data available are not suitable for these uses due to poor conceptualization, low quality, inappropriate and missing outcome indicators, or limited measurement techniques. Sinding and Fathalla (1995) point to the lack of research on how a focus on individual unmet need could replace the demographic orientation of family planning programs. Clearly this will have broad policy, program and methodological implications. Numerous reproductive health indicators have been compiled (Bertrand and Tsui, 1995; Bulatao and Shrestha, 1995), but there is little experience in their systematic application.

Figure 1
Reproductive Health Approach to Assessment of Family Planning Programs

"The proposed shift in the primary objective of family planning programs implies certain criteria for measuring the efficacy of these programs.

- The evaluation framework must follow and evaluate the clients' behavior rather than the service delivery point or a given method.
- It must not penalize the services that foster or effectively support switching among methods or service points...
- It must acknowledge the desirability of voluntary, freely chosen use of fertility regulation.
- It should allow for the disaggregation of clients into significant subgroups whose needs are distinct.
- The framework must include in its universe only those women who express a need for fertility regulation..."

Source: Jain and Bruce, 1995, p. 199-200

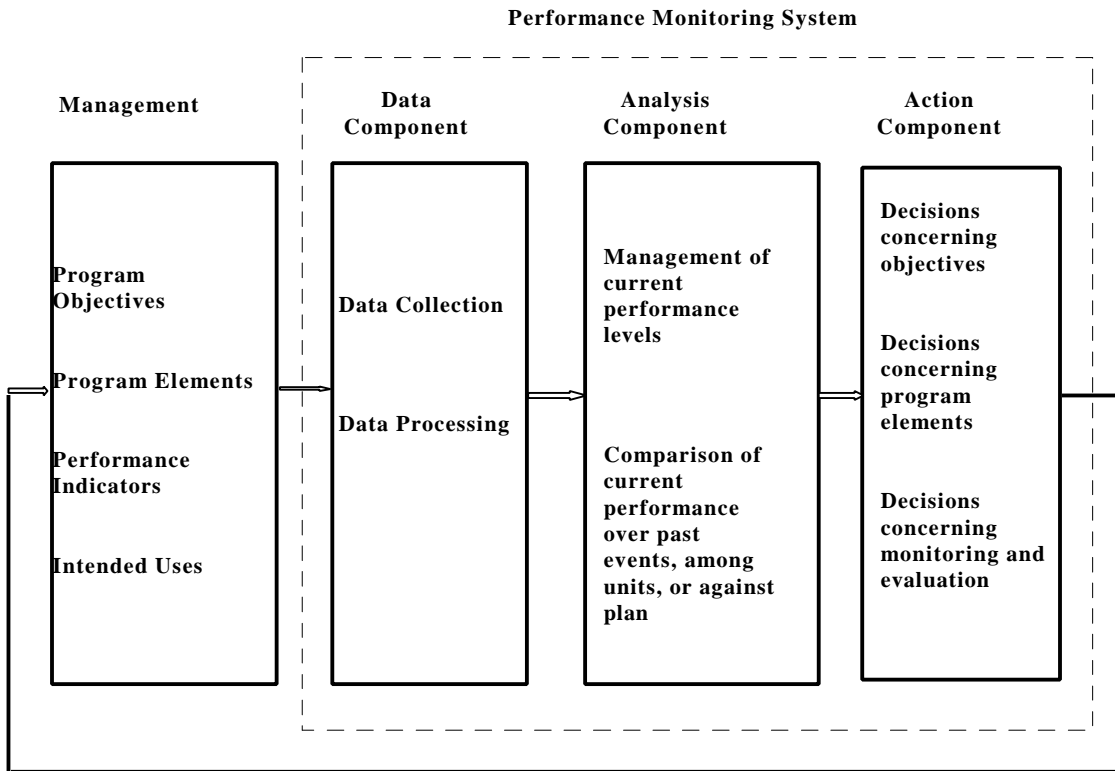
In light of these challenges, the remainder of this paper examines alternative approaches to performance monitoring. Specifically, it:

- presents a framework for developing a performance monitoring system for family planning and reproductive health programs;
- provides information on how countries, such as Indonesia, the Philippines, Zimbabwe and Mexico monitor family planning program performance; and
- makes recommendations for implementing a monitoring and evaluation system with the emphasis on the quality of services.

Performance Monitoring Framework

As the goals of Cairo are operationalized in family planning programs worldwide, program managers will need to rethink their performance monitoring systems. Changing a program's focus initiates a long process of overhauling the program and its subculture, beginning with a rethinking of program goals and objectives, specifying the appropriate constellation of services based on this focus, determining appropriate indicators by which to measure program performance, and figuring out how to use this information for program improvement.¹ Having made these management decisions, design of the performance monitoring system can begin. The logic behind the development of a performance monitoring system is presented in Figure 2. Each of the components of this framework are discussed below.

Figure 2
Performance Monitoring System Logic



* Source: Poister, 1983

¹ One anxiety in India and elsewhere is what to substitute for quantitative demographic targets. If they are removed, it is feared that workers will not produce. There will also be a need for much training and improved supervision to improve the quantity and quality of worker performance, which will subsequently impact on program performance.

Management Process: Policymakers and program managers have the responsibility for setting overall program goals and objectives and for determining appropriate strategies and program elements that will allow goals and objectives to be achieved. Then, together with evaluation and operational staff, appropriate indicators can be determined based on the types of decisions that will be made to improve performance. Involvement of stakeholders is important, and there is a need for agreement between policymakers and operational levels on appropriate indicators. They should be acceptable to national program officers as well as to staff at various levels who must record them, and as a result, should not be susceptible to manipulation by the unit being assessed.

Family planning programs traditionally use several kinds of indicators to monitor performance, which may come from a variety of sources. These indicators should show program responsiveness and change during reasonably short periods of time as well as signal movement toward or away from longer-term goals. The indicators should also reflect changing resource inputs. Several lists of such indicators have been developed in the family planning and reproductive health areas (Bertrand et al., 1994; Bertrand and Tsui, 1995; Bulatao, 1995; Bulatao and Shrestha, 1995). Finally, it is important to determine how the indicators and information will be used at each level in the decision-making hierarchy.

Data collection: The performance monitoring system includes the data component of collection and processing of information. Performance monitoring systems may draw upon information from a management information system, but typically go beyond it and include quantitative and qualitative data from a variety of sources, including existing data sources and specially commissioned studies. Information collected should be focused on how to improve program performance. Considerations for data collection include the accuracy and periodicity of data; the flow of information flow among staff at various levels (information should be easy to collect and use); ease of data processing; and feasibility of aggregation.

Analysis: Once available, data should permit rapid, easily interpreted analysis, which includes measurement of current performance levels and comparison of current performance with past levels. Analysis also permits comparisons among units (also among different geographic areas and perhaps different population subgroups) and against planned objectives (using the information for programmatic adjustment and remedying problems to further enhance the process).

Action/Feedback: Once begun, the analysis should be quickly followed with action. Action can include decisions concerning objectives: Are objectives being met? Do they need adjustment or refinement? Program elements can be changed and adjusted as well. Finally, analysis can test the efficacy of the system of monitoring and evaluation. It can assess whether the system of performance checking works as planned or needs adjustment. The performance monitoring system thus provides feedback to the management process itself. It completes a continuous circular flow of information, decision, action, implementation, analysis and further decision.

Any change in program goals and objectives would require changes in job responsibilities of the health personnel at various levels. Therefore, the indicators of performance monitoring should not only reflect the new goals and objectives but also the modified job functions of health personnel. This in turn dictates the development of new performance indicators. These modifications ripple through the

monitoring system: managers may need to modify data collection methods, introduce new measurement benchmarks, and review both program and monitoring decisions.

A performance monitoring system should not be developed in a vacuum. It should be an integral part of the service delivery system that can assist administrative and operational personnel at various levels to identify problems and to take corrective actions. The linkages between job functions, decision-roles, and information requirements should be clearly understood before designing a new system.

The development of a performance monitoring system is an evolutionary process : it takes time and constant update and refinement. The system must be flexible and incorporate mechanisms that can accommodate changing/evolving program emphasis.

Country Experience

How then have country program managers responded to changing program objectives? Have program elements changed? Are new performance indicators coming into use? Do workers and managers behave differently toward each other and toward clients now that reproductive health concerns are replacing demographic targets? The country case studies that follow offer only preliminary answers to these questions. Less than 18 months have passed since the conclusion of the ICPD in Cairo, but concerns were emerging prior to being highlighted in this major forum. While many countries have modified their program focus to respond more directly to reproductive health needs, they require considerable resources and efforts to develop new systems for information flow and feedback. The following case studies highlight the key elements of select performance monitoring approaches and provide some guidance for other countries.

Country Experience: Indonesia

Indonesia, comprised of over 13,000 islands, has an estimated population size of 190 million persons. The annual growth rate is about 1.8 percent, and the contraceptive prevalence rate in 1995 was estimated at 55 percent. The total fertility rate has declined from 4.7 in 1980 to 2.9 in 1993. The contraceptive methods of choice include oral pills, IUDs, injectables, Norplant,[®] and other modern methods. Government facilities are the source for 49 percent of contraceptive users while the rest receive their contraceptive methods from such private providers as nurse midwives, private doctors, drug stores, and community-based health posts.

Goals and Objectives of the Indonesia National Family Planning Program

The Indonesia National Family Planning Program has two main objectives: the normative objective that promotes the program goal of the small, happy and prosperous family norm (NKKBS), and the demographic objective to lower the birth rate and total fertility rate. Program implementation focuses on increasing the need for and desirability of family planning, improving the quality of contraceptives

and services, increasing participation of the private sector in the provision of services, and integrating family planning activities with other development efforts.

Overview of Service Delivery

In Indonesia, the responsibility for implementing and coordinating the family planning program has been delegated to the National Family Planning Coordinating Board (BKKBN). BKKBN is the lead organization in the State Ministry of Population. The director of BKKBN is also the Minister of Population and reports directly to the President. BKKBN coordinates government activities, such as through the Ministries of Education, Information and Communication, Health, Population, and Women's Affairs, along with activities of several nongovernmental organizations, such as the Family Welfare Movement (PKK), religious organizations, and other organizations providing family planning and maternal/child health service delivery.

INDONESIA CASE STUDY

- Emphasis on community-based service delivery and program monitoring
- Shift from demographic goals to individual demand fulfillment, reproductive health and quality of care issues influence national planning
- Data collection oriented to program planning and program evaluation needs at all levels

BKKBN has offices at three administrative levels of the government: the central, provincial and district levels. At the subdistrict and village levels, BKKBN is staffed by the Family Planning Field Worker Supervisor (PPLKB) and the Family Planning Field Worker (PLKB), respectively. Below the PLKB are the community volunteers, the *kader*. Among the *kaders*, the PPKBD (family planning subdistrict management units) are responsible for the subvillage level, and the subPPKBD are responsible for the hamlet level. Both the PPKBD and the subPPKBD are members of family planning acceptor groups. The *kaders* are responsible for promoting the small family norm, distributing temporary contraceptive methods, screening and making referrals for clinical methods, and following-up family planning clients.

While the BKKBN is the executive body that coordinates activities at every level of administration, the political head of each administrative level is responsible for the failure and success of the family planning program in his administrative area. Thus, the governor, the regency head (*Bupati*) and the subdivision health officer (*Camat*) are responsible for nine sectors, including the family planning program, at the province, district and subdistrict levels, respectively.

While the administrative heads of each level have the ultimate responsibility for the implementation of the family planning program, the BKKBN functions through coordinating meetings at every level. The purpose of these coordinating meetings is not only to create, strengthen and sustain commitment among BKKBN staff, but also to develop annual plans and review program performance. The meetings are held regularly and attended by the government and nongovernmental staff, implementing units, community leaders, and volunteers. The purpose of the meetings is to evaluate the previous

implementation of the family planning program, discuss and solve problems, and plan future program activities.

BKKBN coordinates the services delivered in both the public and private sector. About half of family planning services are provided in the public sector, primarily through government-run health centers (*Puskesmas*) and hospitals. The health center or *Puskesmas* are administered at the lowest level of the Ministry of Health, (e.g., at the subdistrict or *Kecamatan*). They provide curative, preventive, promotive and rehabilitation services including : maternal and child health, family planning, nutrition, immunization and communicable diseases control, treatment, community health education, public health nursing, dental health, mental health and simple laboratory services. Data on maternal and child health are collected by the *Puskesmas* personnel, aggregated, and sent up through the various levels of the Ministry of Health management information system (MIS).

In the private sector, family planning services are provided primarily by private midwives and local health and family planning posts (*Posyandus*). The *Posyandu*, or the Integrated Services Post, targets women and children under five years of age. It is conducted once a month at the village or subvillage level and focuses on the health of mothers and children. The integrated health posts are organized by the community for the community. The primary responsibility for organizing these posts is with the community *kader*, under the supervision of the family planning field worker (PLKB) and his/her supervisor (PPLKB). The *Posyandu* works in collaboration with the personnel from the government health centers (*Puskesmas*) at the subdistrict level.

The *Posyandu* activities follow the "Five Table" system. The flow of clients from Table 1 to Table 5 enables them to receive all *Posyandu* services. At Table 1, the client is registered. At Table 2, the child is weighed. At Table 3, the weight of the child is recorded in a register. At Table 4, the mother is provided with information on nutrition for herself (if she is pregnant) and for her child. The child (between ages 1-5 years) is given a vitamin A capsule every six months and oral rehydration solution in case of diarrhea. The pregnant and lactating woman receives iron tablets. At Table 5, the child is provided with clinical services if necessary (e.g., immunization), and the women receives contraceptives or is referred to the *Puskesmas* if necessary. Data on family planning services are recorded separately at Table 5. For each acceptor, the nurse midwife or the para-medical staff records data on contra-indications for contraceptives, the method received and the follow-up date. The family planning data are collected by the PLKB to be aggregated and sent up to the various levels of the BKKBN (MIS).

At the end of the *Posyandu* activities, the *kaders*, supervised by the PLKB, and often accompanied by the village head, conduct a post-*Posyandu* meeting. At this meeting, the activities of the *Posyandu* are summarized, problems discussed and follow-up activities planned. Most impressive is the rapid summary of key indicators that are plotted on a *Posyandu* monthly graph chart. These simple statistical calculations are done by the *kaders*, with the guidance of the PLKB. A graph of key child health indicators, drawn every month at the *Posyandu*, enables the community to see the progress of their children's health on a monthly basis.

Program Monitoring

The post-ICPD focus on reproductive health is bringing about change in the way in which the program is monitored. However, the shift began even before the Cairo conference. Overall development, rather than just contraceptive use, was introduced as an objective for the family planning program in the early 1990s.

BKKBN has a strong management-oriented data system, which was created and is maintained using a bottom-up approach. Service statistics are primarily generated by the community-based workers and staff of government health centers. The sources of service statistics include : the family planning client card, the new acceptor form, the clinic registry, the monthly recapitulation of data that is reported to BKKBN, and the yearly inventory of staff, training and equipment. The client card contains important information about the contraceptive method, time for revisits, etc. The new acceptor card is useful in screening and counseling clients regarding the most appropriate method, in accordance with age/parity, past contraceptive experience, etc. Every month all health centers send data to BKKBN for the following indicators: number of new or existing acceptors served; age and parity of clients; number of acceptors who changed methods; number of clients counseled; number of clients treated for contraceptive side effects; number of clients experiencing contraceptive failure; and contraceptive stock expended.

At the village level, family planning field workers collect data monthly from community-based workers on: family planning acceptors by source; pills and condoms distributed; stocks of pills and condoms; and establishment of new community groups. The strength of the service statistics-based component of program monitoring is due to the reliability and simplicity of information collected, its speed of collection, and its completeness.

BKKBN also conducts annual registration of all couples. For health and family planning workers, this registration and mapping of eligible couples (ELCOs) is an important source for identifying women at risk of pregnancy, children with special needs, logistics requirements, etc. Each eligible couple is listed in the register with their contraceptive and fertility status, source of contraceptive method, etc. A limitation of this method has been incomplete registration of couples in some areas. Recently this registration format has been modified to cover two elements : family welfare and family planning use. Data on family welfare include indicators on : basic needs; social and psychological needs; and development needs. Data on family planning include such indicators as: number of children ever born; marital status of women; risk of pregnancy; age of wife; births and deaths during the last year; breastfeeding status; time started contraceptive use; contraceptive source; and if not a user, reasons for nonuse of contraception. These data are used by agencies involved in health and education to develop specific programs to meet the family welfare and family planning needs of communities. They are also used to develop eligible couple (ELCO) maps, which are updated monthly and used to develop workplans for community-based workers and plans for supervision by the family planning field workers. On the ELCO maps, color-coded stickers are placed for each ELCO, each color symbolizing a contraceptive method. By superimposing one sticker over another, the CBD worker is able to convey the contraceptive history of each acceptor.

In addition to public sector service statistics and the annual registration of households, Indonesia has a long history of conducting national, population-based contraceptive prevalence and demographic and health surveys for use in program monitoring and evaluation. Survey data is essential to track the share of private sector in service provision and to identify trends in method switching, method discontinuation, client satisfaction, the crude birth rate, TFR, etc. Surveys have also been used to measure: 1) the provision of family planning services; 2) sources of contraceptive methods; 3) characteristics of clients using public and private providers; 4) fees paid to providers; and 5) other types of payment schemes that support family planning activities such as community funds.

New Directions in Program Planning and Monitoring

Several new directions are underway or under active discussion:

1. Demand-fulfillment Approach : With the increasing focus on family welfare through the promotion of a small family norm, the program is also changing its planning and monitoring framework. The “Family Planning Demand Fulfillment Policy” was adopted at a national conference in 1994. Using this approach, program goals and service delivery plans are developed to meet client needs and preferences of couples. The approach has three major elements : 1) estimating the demand for family planning methods by identifying the level of demand for family planning, categorizing types of demand, and identifying an appropriate mix of contraceptive methods for each type of demand; 2) understanding why women with an unmet need for family planning services do not use contraception; and 3) identifying service delivery requirements by analyzing the types of facilities and providers that are best suited for providing a particular method of contraception and estimating overall client flow by method and source.

The challenge in implementing this approach lies in how to operationalize the concept so as not to substitute one type of target for numbers of a different kind. Having demonstrated empirically that its program goals could be reached by meeting couple’s unmet need for contraception, BKKBN is beginning the thought process of operationalizing the new program objectives, developing tools and indicators by which to measure progress, and planning training activities for subnational managers on how to diagnose and measure client needs for family planning services. Evaluation criteria of local political leaders may likewise need to be revised to motivate changes in program emphasis.

2. Surveys to assess quality and client satisfaction: In the past, data for monitoring program outputs came largely from routine service delivery reports. This data was supplemented by periodic contraceptive prevalence and other population-based surveys. In an effort to improve the quality of services, BKKBN will also explore the use of checklists to assess whether service providers are following established norms. Under the USAID-funded Private Sector Family Planning Project, a number of checklists have been developed to measure the quality of services of specific contraceptive methods. Similarly, exit interviews of clients may be used to gauge client’s satisfaction with the quality of services. Together with the measurement of service delivery processes (compared against standards), client satisfaction data will provide an excellent measure of overall service delivery quality.

Conclusion

While Indonesia has been one of the most successful developing countries to meet its demographic objectives, it has recently made great strides in shifting focus of its family planning program from a target-driven program to one based on the concept of understanding and fulfilling the needs and preferences of the client. Work is now underway to operationalize the policy at the field level, incorporate the approach in national and local planning, and devise strategies for collecting information that will allow assessment of its success.

Indonesia is a large country with considerable geographic and cultural diversity. There is a lot of variation in the skills and capabilities of local program managers and in the diffusion of information from the center to the periphery. Nonetheless, there are several mechanisms in place for participation of subnational units and local and community organizations in planning and evaluating the Indonesian national family planning program.

Country Experience: Philippines

The Philippines has an estimated population size of approximately 68.7 million people with an annual growth rate of about 2.5 percent per year between 1980 and 1990. The 1993 Demographic and Health Survey showed a contraceptive prevalence rate of 40 percent, including 25 percent for modern methods. The total fertility rate has declined from 5.9 in 1973 to 4.1 as estimated in 1993. The public sector is the main source for users of modern contraception (71%). The medical private sector provides about 26 percent of services: 16 percent from hospitals or clinics and 10 percent from pharmacies or private doctors (1993 DHS). NGOs are an important component of private sector service delivery.

Overview of Service Delivery System

In 1988, responsibility for coordination and provision of services for the National Family Planning Program shifted from the Population Commission (POPCOM) to the Department of Health (DOH). With transfer of responsibility for the family planning program, the program also shifted its emphasis from fertility reduction with a heavy emphasis on the use of quantitative targets, to an emphasis on improvement of maternal and child health (MCH), with fertility reduction only as a consequence. Since 1992, the program has focused both on the health benefits of family planning as well as on the development benefits of lower population growth.

Since 1991, DOH has also had to deal with the implementation of the Local Government Code, which devolved responsibility for the provision of social services, including health and family planning, to local government units (LGUs). LGUs consist of 75 provinces and 60 cities (which have equivalent political status) and 1,537 municipalities. Provinces and cities are responsible for planning, overall coordination of population/family planning/MCH activities, and for family planning services provided through provincial and city hospitals. Municipalities are responsible for delivery of family planning/MCH services through a network of clinics and outreach services. Nearly all provinces and cities have a Population Office and a Health Office and staff responsible for planning and monitoring of family planning-related activities. These offices are also responsible for coordinating the efforts of NGOs to ensure the broadest possible coverage for services and to facilitate information transfer to the local and national MIS. The DOH has retained responsibility for overall monitoring and evaluation of local programs, projects, facilities, setting of standards, and for technical support services such as logistics, training, IEC and information systems.

PHILIPPINES CASE STUDY

- Emphasis on health-oriented, demand-driven strategy, not on quantitative program targets
- Reproductive health and quality of care issues influence national planning, but not yet translated into local programs
- Data collection oriented to national-level needs
- Wide variation in LGU data collection and use for decision-making

Goals and Objectives of the Philippine Family Planning Program (PFPP)

The Office for Public Health Services (OPHS) in DOH is now responsible for coordination and monitoring of the PFPP. Since 1992, the DOH has broadened its mandate to emphasize a new health-oriented, demand-driven strategy based on concerns for both the health of women and children who would be exposed to adverse risk in the absence of family planning and respect for the individual rights of women who wish to regulate their fertility. The objective of the PFPP is to promote family planning as a means of improving family well-being. One of DOH's priority concerns, the safe motherhood and women's health program, "aims to ensure universal access to family planning information and services in accordance with the health needs and fertility preferences of couples, reduce maternal mortality through proper prenatal care and safe delivery services, and reduce maternal morbidity through quality maternal care, better nutrition and adequate spacing of pregnancies" (World Bank, 1995, p. 8). In 1994, the Philippine government endorsed the ICPD Programme of Action and its emphasis on improving the reproductive health of women.

Program Monitoring

Indicators of program progress have not placed much emphasis on the health rationale for providing family planning services or meeting the reproductive health needs of women. While a philosophical shift in program emphasis has occurred at the highest policy levels, it is only just beginning to filter

down into program planning and monitoring at subnational levels. Even for family planning, performance indicators traditionally have not been given appropriate attention: there has been too much emphasis placed on recording the numbers of new acceptors without considerations for additional information on the characteristics of acceptors, continuation, or method choice. There has also been a lot of emphasis placed on quantities of commodities and supplies for monitoring the distribution system as well as for offering a measure of increasing acceptance of modern contraceptive methods (USAID, 1992).

Monitoring of the PFPP has relied heavily on service statistics and acceptor information compiled through the DOH Family Health Services Information System (FHSIS) and on the commodities distribution and logistics information system (CDLMIS). For the last two years, information from the FHSIS and CDLMIS has been supplemented with information from other existing data sources and consolidated and reported in an annual FP/MCH status report produced by the DOH.

Since DOH took over responsibility for the family planning program, the FHSIS has gathered information on all health services including family planning. FHSIS is a facilities-based reporting system, which uses 12 registers to collect service statistics for different areas of program emphasis. It is a hierarchical information system in which data are aggregated upward from barangay service points, to municipalities, to cities and provinces before being sent to the national office. FHSIS compiles family planning information on numbers of new acceptors, numbers of continuing users, drop-outs, clinic visits and referrals. FHSIS has not included information on NGOs or private practitioners.

Unfortunately, FHSIS has never been very effective or produced accurate, reliable statistics. It suffers from many of the same problems that beleaguer information systems elsewhere: non-standardized reporting of acceptors and continuing users, long delays in consolidation of information and reporting, recording errors from hand tallies, and too much information collected. The quality of data input to FHSIS also varies tremendously among LGUs. A recent assessment of monitoring systems at the LGU level shows that they are in disarray and that considerable time and effort is needed to get the systems to function well (Eckroad and Helms, 1994). There is little use of data at local levels as a result of long delays in reporting and processing, data inaccuracy, and lack of expertise on how to make use of the information to improve program performance at the local level.

DOH also relies on information from the CDLMIS, supported by USAID, to provide information on commodity receipts, disbursement of supplies to users, and stocks on hand. The CDLMIS seems to provide reasonable quality information on supply methods of contraception, and can be used for estimating couple years of protection (CYP) with fairly high reliability.

New Directions

Several new directions are underway:

1. While the need for a systematic, service-based information system remains, the DOH is making use of the substantial amount of readily available information from a variety of sources to provide information on the PFPP as a whole. These data sources include: national vital statistics, census data, the 1993 DHS, annual population-based surveys conducted by the National Statistics Office (NSO),

logistics data, NGO service delivery data, and commercial marketing data from pharmaceutical companies and the social marketing program. For the last two years, these indicators (together with MCH service utilization indicators) have been reported in an annual family planning/MCH status report produced by DOH. The family planning and demographic/health impact indicators included in this assessment are presented in Figure 3. Urban/rural and regional comparisons are possible. Additional indicators may be included once the system becomes institutionalized.

2. There has been a lot of discussion about the feasibility and desirability of continuing the FHSIS. For now, it appears the FHSIS will remain in place. The FHSIS system is being improved to incorporate all family planning service providers, to standardize reporting across LGUs and organizations, to simplify and improve record keeping at the local level, and to reduce the amount of information required for each program area. Fiscal information on budgets, costs, and use of resources will also be included eventually. This information will enable LGUs to satisfy legislative information requirements and justify program budget allocations. However, FHSIS remains oriented to national-level reporting, rather than to the needs of LGU population and health offices.

3. Through the Family Planning Services Division of the OPHS, UNFPA is also funding development of what is being called a unified family planning information system that would include information on outreach, clinics, hospitals, NGOs and commercial organizations and also report on service delivery, IEC, equipment and supplies, and training. This system has been in the design stage for a long time, and it is uncertain whether it will ever get off the ground or be able to overcome the difficulties inherent in existing data systems.

4. As LGUs now have responsibility for program planning, implementation and monitoring, DOH has initiated the LGU Performance Program (LPP), funded by USAID/Manila. The objectives of the LPP are twofold: to develop the capabilities of LGUs to plan and implement FP/MCH services and to assist the national level OPHS adapt to its role of providing technical assistance to and monitoring the performance of LGUs (FPMD, 1995). LPP uses a performance-based disbursement process based on the achievement of benchmarks reflecting substantial progress toward program objectives. Benchmarks in consecutive years of the program include: setting up appropriate program structure, strengthening capabilities of LGUs to staff and run their own programs, expanding service availability, and ultimately measuring and achieving program outputs. Monitoring of service availability and program impact is not the immediate concern, but programs in LGUs will gradually move toward this end. Technical assistance is also being provided to LGUs to improve the LGU system for collecting and reporting service information for use at the LGU level as well as for input to the national FHSIS. However, much remains to be done in terms of getting LGUs to figure out the types of data they need to improve program performance in their own jurisdictions.

Figure 3
Family Planning Service Utilization and Demographic/Health Impact Indicators

Indicators	Data Sources	Frequency
Contraceptive Prevalence Rate	DHS NSO surveys	5 years annual
Method mix	NSO surveys	annual
Supply of contraceptives	CDLMIS	annual
Frequency of stock-outs	CDLMIS	annual
Private sector sales	SOMARC Pharmaceutical firms	annual annual
Unmet need for family planning services	DHS	5 years
Proportion high-risk births	Vital Statistics DHS	annual 5 years
Infant Mortality Rate	Vital Statistics	annual
Maternal Mortality Rate and Ratio	Vital Statistics	annual
Total Fertility Rate	DHS Vital Statistics Census	5 years annual
Population growth	Vital Statistics Census	annual

Source: DOH and USAID/Manila, 1994; DOH, 1995

Forty-eight LGUs are now part of the LPP. Lessons learned show that shifting responsibilities to LGUs for program implementation and monitoring does not relieve the central level of responsibilities for technical direction and assistance; that there is tremendous variability in the skills, capabilities and commitment of LGUs to participate in this program; that a lot of training to strengthen capabilities at the local level is needed; and that implementing change of this magnitude requires a lot of time and effort on everyone's part. (See FPMD, 1995 for other lessons learned pertaining to the implementation and monitoring required for a performance-based disbursement program.)

5. As an additional program management tool at the lowest administrative levels, work is proceeding under the LPP on the development of a community-based monitoring system that can be used to improve service delivery at the local level, not as an input to the national MIS. The community-based monitoring tool would be used by family planning and health workers to collect information on eligible women 15-49 and their health risk characteristics, to track contraceptive use and nonuse, identify high-risk women, and prioritize cases for follow-up (Timmons, 1995). The data produced can be used for managing service delivery activities, improving performance and forwarding to LGU population offices. This approach is being pilot-tested in a few LGUs, but it is unclear to what extent it will be

adopted more broadly by DOH or other LGUs. However, it does represent an attempt to develop a simple monitoring system that yields information that is closely linked to program goals, focuses on the needs of clients, and can be easily used by volunteers and program managers alike to improve program performance.

Conclusion

The re-orientation of the PFPP has not changed the way in which program performance is monitored, except that explicit quantitative targets are not used by the DOH. A lot of effort has been expended in trying to improve management information systems in the Philippines, but according to a recent proposal for consolidating MIS activities, DOH does not have a clear strategy. Scant attention has been paid to the information needed at different levels of a devolved health care system; to the sources of data that should be exploited; or to the ways in which programs should monitor facility functions, administrative operations, trained personnel, and supplies and equipment that support service delivery (Timmons, 1996).

The MIS is designed with national-level reporting requirements in mind. There is also a large gap in how data are used at the national level and how they should be used at the local level. LGUs still look for guidance from the national office to specify information requirements. Although a number of LGUs have made tremendous strides in improving their data collection systems and using data for local-level decision-making, this varies tremendously by LGU.

Changes in program direction and adjustments to devolution are both recent events. It will take time to get a coherent and well-functioning monitoring system in place and for lessons learned in its implementation to be generalized across LGUs.

Country Experience: Zimbabwe

Located in southeast Africa, Zimbabwe has a population of about 11.3 million people. Total fertility rates have declined in recent years from 5.5 in 1988 to 4.3 in 1994, but the rate of natural increase remains high at 2.7 percent a year implying a population doubling time of 26 years. Contraceptive use is high, with 42 percent of married women using modern methods, and 6 percent using traditional methods.

Overview of Service Delivery System

Sources of Family Planning Services and Supplies : Family planning services in Zimbabwe are delivered through a variety of sources. The public and quasi-public sectors are responsible for the majority of services provided (85%, according to the 1994 Zimbabwe Demographic and Health Survey (ZDHS). Best known, and responsible for coordination, standard setting, and policy development, is the Zimbabwe National Family Planning Council (ZNFPC), a parastatal organization under the authority of the Ministry of Health and Child Welfare (MOH). As family planning services have expanded during the past decade, ZNFPC's relative importance as a source of supply has declined, from 56 percent in 1984 to 23 percent in 1994. Nevertheless, its cadre of 800 community-based distributors (CBDs) is essential to meet the needs of rural contraceptive users, and its nearly 40 clinics provide an important urban resource.

The largest share of services are provided by rural and municipal clinics, operated by local authorities. In 1994 these sites served almost one-third of current modern contraceptive users.

Slightly fewer than 30 percent used other public sources, including government hospitals and clinics, MOH mobile clinics, and mission facilities.

Private sector sources supplied about 14 percent of users. Private hospitals and doctors are important in delivery of long-term and permanent methods, particularly IUDs and female sterilization. A single nongovernmental organization operates three clinics in urban areas.

Administrative Structure : The MOH administers its programs in a vertical system functioning at three levels: central, provincial and district. Operations are under the authority of the Secretary for Health and three deputies, each heading one division. Maternal and Child Health and Family Planning (MCH/FP) is within the Health Care Services Division, responsible for all preventive and curative programs.

A Provincial Medical Director oversees health services in each of the 8 provinces. Eight departments provide technical support, policy guidance and supervision to the districts, and carry out some province-wide programs. The District Medical Officer in each of the 57 districts is responsible for coordination and integration of health services at this level. District staff also provide clinical, logistical and administrative support for the district hospital and rural health centers.

ZIMBABWE CASE STUDY

- Program focus is shifting to reproductive health, but changes to performance indicators lag; continued stress on family planning components
- Relatively simple MIS facilitates collection of reliable, complete data
- Program complements MIS data with survey data and special studies
- MIS data collected is not routinely analyzed at lower levels of delivery system

ZNFPC is undertaking a major decentralization effort. Much authority for day-to-day programs has been delegated to the provincial staff, with headquarters retaining it planning and program development functions. The ZNFPC Evaluation and Research Unit (ERU) is the primary source of technical support for family planning research, monitoring and evaluation. It collaborates with the MOH Epidemiology Department, the Central Statistical Office, and other government departments to undertake surveys, gather family planning statistics, and conduct and analyze data.

Strategy and Planning System

The "Strategy for the Zimbabwe National Family Planning Programme for the Five Years from 1991 to 1996" is the current planning document for ZNFPC. Program strategies are identified for the areas of: service delivery; information, education and communication; youth advisory services; training; evaluation and research; and management.

The goal of service delivery is to "expand capability to provide access to appropriate services in order to meet the potential demand" (ZNFPC, n.d.(b)). To achieve the goal, the following activities were to be carried out:

- Identify target groups
- Conduct research on women's desires, needs, concerns
- Carry out an inventory of resources
- Expand service capability
- Introduce new methods.

Key target groups are identified by province, district, and major urban areas, and classified by method and service provider type for each year. Target groups include:

- Women vulnerable to high-risk pregnancies (ages 18 or less, or 35 and older, about 40 percent of women of reproductive age (WRA); those with 5 or more children, also 40 percent of WRA; and those less than 15 months postpartum, about 30 percent WRA);
- Women not currently using contraception who say they want to delay or avoid another pregnancy;
- Adolescents; and
- Males, both as potential users and as influential decision-makers in the household.

These special groups are in addition to current users, mainly ages 20-35, who currently receive services from the program. The Strategy specifies provisional national and provincial targets for 1996, and method and provider targets by method. The targets are open to revision following provincial five-year planning exercises. While the strategy states that the targets should be revised annually "in accordance with changes in demand and ability to provide" (p.14), this does not happen regularly.

Demographic estimates are used to set an order of magnitude for program change. For example, a total fertility rate of 4.5 was set as a target for 1996, down from 5.5 in 1988. It was estimated that users of modern methods would have to increase by 60 percent, from 486,000 to 781,000, to achieve the decline. To maintain current contraceptive prevalence (from the beginning of the strategy cycle) implied recruiting 98,000 new users, assuming constant method mix and continuation.

The Monitoring System

Regular monitoring of the service delivery system is basically limited to ZNFPC facilities and CBDs. Data are collected from MOH facilities, but are not routinely analyzed. Industrial facilities that provide on-site medical care and family planning services, private doctors and pharmacies are not required to submit reports, so no information is collected from these sites.

Two forms are used to collect data for the monitoring system. MOH and municipal facilities use the T5 form, while ZNFPC clinics and CBDs use a separate reporting form. The T5 was seven years in development, undergoing repeated change and modification. When it was finalized, it was issued with no guidelines for completion, and many people encountered difficulty in filling it out.

Rural health centers send their monthly data to the District Nursing Officer (DNO) or the District Information Officer (DIO) for consolidation on the T5 form. The information is then sent to the provincial Medical Officer of Health for Epidemiology and Disease Control (EDC), for review. The data should also be shared with other relevant provincial officers for access and analysis. Once data from all districts are received at the provincial office, they are forwarded to the MOH Epidemiology Department for data entry.

ZNFPC is currently pilot testing a revised reporting form, but the method for submission of data remains the same. All service delivery units, including individual CBDs, submit monthly tallies. CBDs submit their forms to their Group Leader, who in turn forwards them to the DNO for transmission up the system. Urban clinics forward their reports to the ZNFPC provincial office. Once a month, ZNFPC sends a computer clerk to the Epidemiology Department to perform the data entry of all district and provincial data. At the same time, the clerk takes a copy of the data for inclusion of the relevant information in the data bank housed at ZNFPC headquarters. Data are stored and manipulated using commercially available computer software.

Development of Performance Indicators

Program performance indicators for ZNFPC service sites are calculated quarterly. Indicators used include:

- New acceptors
- Revisits
- Method switchers
- Couple years of protection (CYP) by method.

These indicators reflect the historical concern with family planning as the principal program orientation, although a shift to a greater emphasis on reproductive health is emerging in both the MOH and ZNFPC. Of these, CYP is cited most frequently in describing program performance. It is used to compare both the relative performance of the different provinces, and the relative contribution of the different methods toward meeting program targets.

There are plans to include non-ZNFPC sources in calculating performance indicators soon; they have not been included due to problems of incompleteness and data quality. National comparisons for the various public sector sources would then be possible.

Data are meant to be compiled and analyzed in quarterly reports to provide feedback throughout the system. As of January 1996, data had been prepared for quarterly reports through the third quarter of 1995. Report production has lagged, however, and the most recent quarterly report available is that of October-December, 1994 (ZNFPC, n.d.(b)).

Program Monitoring

In addition to the monthly reporting system, the Zimbabwe program also relies heavily on the series of data generated by three Reproductive Health and Demographic and Health Surveys conducted in 1984, 1988 and 1994. These have proven to be valuable sources of information about user characteristics, method choices, and supply sources -- data not otherwise collected. The surveys have become progressively more detailed over time, and have been modified to collect data pertinent to program priorities at the time. The most recent survey greatly increased its reproductive health content, collecting data on risk behaviors associated with AIDS and STDs, antenatal care, adolescent fertility, high-risk fertility behavior, and contact of non-contraceptors with family planning providers, among other subjects. The findings on several topics, notably risk behaviors and adolescent fertility, have already been incorporated into program planning.

Three other studies have focused on service availability and quality of care issues: the Zimbabwe Community-Based Distribution Validation Study (Phiri, 1990); the Zimbabwe Service Availability Survey 1989/1990 (CSO and IRD/Macro International, Inc., 1991) ; and the Situation Analysis of the Family Planning Program (ZNFPC, Population Council and SEATS, 1992). The findings of each were reviewed by ZNFPC administrators, and guided changes in program strategy. In particular, attention has shifted to place a greater emphasis on client counseling, and to diversify the method mix available through both more training and improved supply logistics systems.

The routine monitoring system is vertical in nature, with information aggregated at each higher level. The Situation Analysis found that service providers reported limited use of the service statistics they produced. Information is passed up the system and is ultimately available for administrative staff to use for central planning or completing donor report forms, but delays in production of standard reports limit its availability and utility at the provincial or district levels.

Finally, a USAID-funded project is using a Family Planning Monitoring and Evaluation System (FPPMES) to track program performance in two of Zimbabwe's 10 provinces. Data are collected every six months from all public service delivery points, making the system useful tracking user trends

and detecting the impact of program interventions. The key indicator calculated is the contraceptive prevalence rate, permitting more frequent estimates than is possible from more commonly used survey data. The system is readily adapted to use at different administrative levels and is easy to use by nonexperts. Its main limitation is that it requires fairly accurate logistics data.

System Strengths and Weaknesses

ZNFPC staff cite the completeness of their data as a strength, as the provincial and central offices routinely follow-up late submissions to ensure they are included. The system has been in place long enough, and sufficient personnel have been trained to complete the forms, that the data are considered to be of good quality, reliable and valid. As data entry is performed at headquarters, clerks can be easily supervised and their work verified periodically. However, this only presents a part of the picture.

While data quality is generally good, human error continues to cause some inconsistencies. The T5 is a complex and comprehensive data collection form, and some non-ZNFPC personnel have difficulty completing the family planning section correctly. While this poses some problems, it points to a larger issue of data not being reviewed and used on a routine basis at the lower levels in the system as it is compiled. If the data were being studied and analyzed routinely, inconsistencies would be identified sooner. It is evident there is a need to encourage more widespread use of simple, systematic analyses for local program monitoring.

Because the data collection system is national in scope, and driven by data needs at the central level, it is difficult to be innovative in data collection at the local level. Making changes to indicators or to the data collected is a long and cumbersome process, and requires a massive effort in order to re-train staff responsible for completing forms.

The family planning program relies heavily on CYP as a measure of performance. However, this is not suitable for assessing progress in serving the key target groups identified in the family planning strategy. Data for adolescents, nonusers, men, or women vulnerable to high-risk pregnancies are not collected routinely, so it is impossible to determine whether these targeted groups are in fact being reached. Clearly, additional program indicators are needed.

Also, it appears that staff at the district and provincial levels do not feel comfortable with calculating the CYP indicator or its interpretation. More efforts are needed to inform staff about what CYPs mean, how the value can be used, and what it indicates in terms of program development and change.

Perhaps the greatest drawback to the current system is that it is difficult to obtain a comprehensive picture of the entire family planning program. Data are reported separately for ZNFPC, MOH and municipal facilities and are not summarized in a single system. The private sector is excluded altogether. Until a more unified system is developed, program managers will continue to see only their partial piece of the overall national effort.

Country Experience: Mexico

Mexico and most of its neighbors in the Latin America and Caribbean region have put human values first in their formal population policies. The National Population Council of Mexico, CONAPO, uses these words to introduce its five-year plan document (CONAPO, 1995):

Population policy requires an integral approach that fits priorities for social development, promising a change of mental attitude that can intensify the spirit of foresight and planning among families, as well as enthusiasm for fairness and equality among its members, especially between the sexes. Population policy should encourage parents to place a high value on their children and extend an awareness of the repercussions of population and demographic change on the environment and sustainability of development.

Demographic goals accompany this broad view of population policy. In the period 1995-2000, the plan anticipates a decline in the rate of population growth from 1.75 percent per annum to 1.45 percent per annum. The total fertility rate would decline from 2.4 children per woman to 2.1. For these changes to occur, the contraceptive prevalence rate would have to increase to 70.2 percent in the year 2000 and to 73.3 percent in 2005. The number of users of family planning would reach 12.6 million in 2000 and 14.8 million in 2005. New acceptors would have to increase at a sustained annual rate of 4 percent per annum to the end of this century (CONAPO, 1995: 60-61).

This formulation of the likely interaction between family planning services and demographic change does not dictate a program of action. The Government makes clear its adherence to Article 4 in the Constitution of Mexico. That article reads in part, "All persons have the right to decide, in a free, responsible, and informed manner, the number and spacing of their children." No coercion is implied by demographic goals. The policy aims instead to provide full information so that individuals and couples can reach enlightened decisions. Implicitly, the policy assumes that informed decision-making will lead to satisfactory demographic outcomes. The policy devotes ample attention to the parallel concerns of family planning and reproductive health, strengthening the family unit, improving women's position in society, and the special problems of indigenous groups^{3/4}a large and important minority in the Mexican population (CONAPO, 1995: 75-86).

Several independent agencies offer population, family planning and reproductive health services in Mexico. These include the Secretariat of Health and its state-level affiliates, the national social security systems, and a host of smaller government and NGO programs. CONAPO manages none of these

MEXICO CASE STUDY

- CONAPO coordinates the national program, specifies overall goals and targets
- Individual service delivery agencies set service delivery objectives
- Interinstitutional National Reproductive Health Program recently constituted
- The autonomy of service delivery agencies highlights the difficulty of applying a common set of indicators across different programs

programs. Its function is to set general goals and keep the nation informed on population issues and programs. It reports to a board of directors with members from 11 government agencies.

Recently, the Mexican government has announced a National Reproductive Health Program, which will be implemented by the Secretariat of Health in collaboration with other government and nongovernmental agencies, in response to the ICPD recommendations for improving the reproductive health status of women. An interinstitutional group, including CONAPO, will assess the needs for reproductive health services and training (IPAS, 1996).

Nonetheless, the new focus on reproductive health since Cairo has had little or no impact on the Mexican population program to date. Demographic goals never drove program managers, even though CONAPO has made projections and linked them to program outputs for nearly a quarter century. Each program pursues its own service-delivery objectives. There is no master plan that ascribes to each program and subprogram goals for increasing acceptors or improving reproductive health status.

While CONAPO's five-year plan blends family planning and reproductive health concerns, it does not present specific reproductive health indicators, much less goals. It remains to be seen whether CONAPO will encourage program managers to begin to gather pertinent information on reproductive health indicators. Mexico, in cooperation with international assistance agencies, does conduct periodic social surveys that can gather information on key indicators, which also pertain to program performance. The challenges for the Mexican family planning program will be to develop a unified system for monitoring program performance that encompasses the diverse organizations providing family planning and health services in Mexico.

Summary/Recommendations

The countries represented in these case studies reflect the range of experiences among regionally successful programs. There is considerable variation in the status of their information systems and the data reported therein. Although most of these programs continue to focus on outcome indicators, emphasis is also being placed on monitoring of input and process indicators.

- While Indonesia has been one of the most successful developing countries to meet its demographic objectives, it has recently made great strides in shifting the focus of its family planning program from a target-driven program to one based on the concept of understanding and fulfilling the needs and preferences of the family. Work is now underway to operationalize the policy at the field level, incorporate the approach in national and local planning, and devise strategies for collecting information that will allow assessment of its success.
- In the Philippines, focus is placed on improving maternal and child health and meeting the reproductive intentions of women. Work is proceeding to improve the national MIS, make better use of existing data from a variety of sources to produce an annual status report for the PFPP, as well as to strengthen monitoring systems at the local level. There is currently

a lot of variability in capabilities by LGU. While pilot approaches are being tested in a few LGUs, it is unclear to what extent these will be endorsed by either the DOH or other LGUs.

- In Zimbabwe, greater attention is being paid to reproductive health in service provision, particularly STDs treatment and prevention. A new report form is being tested to ascertain more clearly the quality of care provided and patterns of method switching. The next five-year plan, to be developed during 1996, is expected to formalize this new reproductive health strategy.
- Increased emphasis is being placed on reproductive health in Mexico, although it's too early to know how the performance monitoring system will evolve to address these new concerns.

The new focus for family planning program mandates has far-reaching implications: If reproductive health policies are to reflect the needs of individuals, it will be important to know what these needs are and to devise monitoring systems for measuring progress toward their fulfillment. There will also be implications in terms of training providers and field workers, developing guidelines and standards for service delivery, and devising program strategies. Moving from advocacy to implementation will take time.

In response to revised program objectives, countries are also making efforts to improve data collection and monitoring systems. Pilot approaches are being explored and major bilateral projects are underway that emphasize performance monitoring. These projects are developing performance indicators for reproductive health and quality of care but not as an inherent part of the national program. However, there will much to learn from these experiences.

A fundamental problem is the extent to which any shift in program focus is communicated to operational levels and the extent to which field workers appreciate what that approach entails in terms of service delivery practices. Because the data collection system is national in scope, and often driven by data needs at the central level, it is difficult to be innovative in data collection at the local level. Making changes to indicators or to the types of data collected is a long and cumbersome process and requires a massive effort in order to re-train staff responsible for completing forms. The case studies show that little effort has been made to change reporting requirements of field workers to make the information they collect correspond to their needs for information.

Many programs operate without access to basic input, output, and quality indicators and that even where access exists, in too many cases data are not taken into account for management purposes.

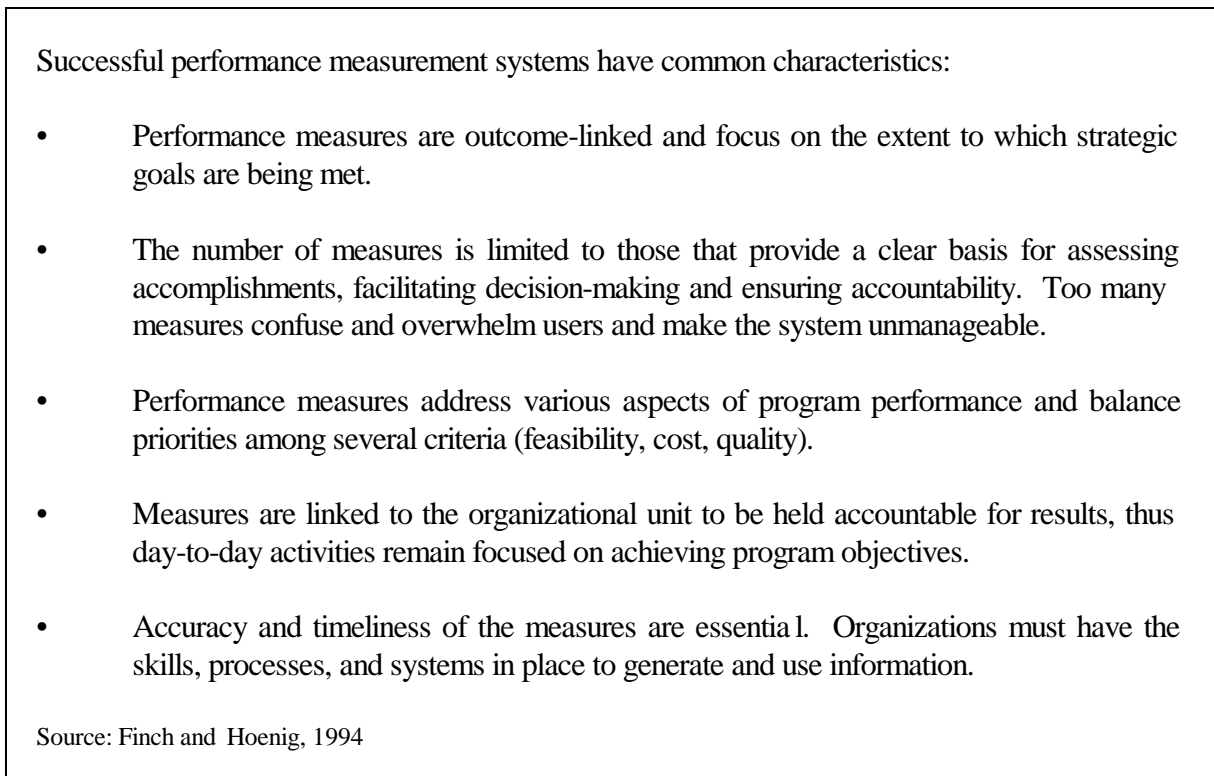
-- Keller

It is important to provide regular feedback to front-line workers who gather the raw data for indicators. It is frustrating to prepare information on program activities and never know how performance is changing. An effective information system sends data up the chain of command in raw form. At or near the top, data from hundreds or thousands of information points combine into an aggregate picture. Commonly, there is no flow of information back down the channels. Local workers remain in the dark about whether they are doing well compared to others. Such feedback can be a source of satisfaction and a spur to achievement. Poor performers in one time period can at least gain satisfaction if they show improvement in the next. The willingness to monitor performance accurately depends significantly on getting feedback.

Therefore, performance monitoring systems should emphasize the routine examination of data at the level at which they are collected. Even lowly skilled workers can be trained to perform simple monthly or quarterly comparisons. It is evident there is a need to encourage more widespread use of simple, systematic analyses for local program monitoring.

The case studies underscore and reflect the findings of other research that highlights a set of characteristics common to successful performance monitoring systems. These characteristics are presented in Figure 4.

Figure 4
Characteristics of Successful Performance Measurement Systems



Considerable resources exist, particularly regarding the definition of indicators to be included as part of a successful performance monitoring system, but there remains a need to field test these new indicators in order to determine which ones best meet local needs vis-a-vis accuracy, ease of collection, and usefulness for decision-making purposes. Other cautions to keep in mind for the selection of particular indicators to be included as part of a successful performance monitoring systems are presented below.

Involve stakeholders in the indicator design and selection process . Involving local-level staff and program managers is important because they are closest to the programs and clients and should have the best idea of what should be measured to achieve strategic goals. They will also be more likely to collect information and use it if it responds to their needs.

Limit the number of indicators included in the performance monitoring system . Not everything needs to be monitored. Having too much information places a burden on management, and as a result, little information is used for practical decision making purposes.

Anticipate how indicators will affect program workers' behavior . The most useful indicators will offer incentives to workers to improve program quality and efficiency.

Use indicators that draw on client views about quality and satisfaction . Many private organizations survey clients after they receive services to assess customer satisfaction. They ask for advice on how to improve service. Public programs can do the same. Focus group research on clients and other qualitative data collection methodologies offer a useful, low-cost means to gather information on client satisfaction. Figure 5 presents information on two other innovative approaches for assessing and improving on quality of care in family planning programs.

Avoid indicators that can easily be manipulated or falsified . The creation of an indicator of success simultaneously creates incentives to manipulate information to make the indicator look good. From the level of the clinic all the way up through the administrative organization to the chief minister, managers will be tempted to accentuate the indicator. They will do so even if their actions work against longer-term program goals. When recognized, this simple, perhaps obvious, reality can help program managers avoid some of the pitfalls associated with indicator development, monitoring and evaluation.

The incorporation of reproductive health concerns into the mandate of family planning programs sets into motion a complex process of management decisions pertaining to the operationalization of new objectives, the development of new indicators, and the use of indicators to improve program performance. While much new work is needed, experience is beginning to accumulate. Many new indicators have been developed and are beginning to be systematically field-tested. Experimentation is needed to see what works in different settings. Clearly, there will be a lot to learn from the experiences of other countries as they begin to undergo this process.

Figure 5
New Approaches for Improving Program Performance and Quality

Recently, new approaches have been developed to improve program performance: Service Quality Improvement (SQI) and COPE.

SQI integrates Bruce's quality of care framework with elements of Total Quality Management or TQM. SQI establishes an environment that enables the best quality care to be given. It works best when top management is committed to the process; involves a client orientation; focuses on the process rather than on individual employees; encourages employee involvement to identify and solve problems; and uses data to guide decision-making. SQI does not replace program elements such as training, clinical practice or supervision, but provides an environment in which components can be improved. "The hallmarks of SQI are its flexibility in a wide variety of settings; its ease of use among program managers and staff; its emphasis on the client; its reliance on input from the program staff; and its use of data for decision-making." (Hardee and Gould, 1993, p. 152)

COPE is used to evaluate and improve service delivery quality. It is a self-assessment tool that enables staff to evaluate their clinic services, identify problems and develop workable solutions. It gives qualitative and quantitative data on the process of service delivery rather than on outcome measures such as CYP. COPE works best where staff are enthusiastic and can honestly self-evaluate performance, in supportive administrative environments, and where staff have more control over resources. (See Lynam, Rabinovitz and Shobowale (1993) for more information.)

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