**Programmatic steering**

**Indicator Reference Sheet**

**[Health]** program

**[Outcome]** O1 : To improve the availability and use (effective coverage) of good-quality essential MNCH and nutrition services with a focus on perinatal care.

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| Indicator Title | 1.1. The proportion of women who attended at least four times for antenatal care during pregnancy.  “Coverage of complete antenatal visit” |
| Definition | Proportion of women with a live birth within a given time period who attended antenatal care (ANC) four or more times during their most recent pregnancy.  Based on a review of the effectiveness of different ANC models, the World Health Organisation (WHO) has recommended a standard model of four antenatal visits. WHO guidelines on the content of ANC visits include the following components: clinical examination, blood testing to detect syphilis and severe anaemia (and HIV, malaria, etc. according to the epidemiological context), gestational age estimation, uterine height, blood pressure, maternal weight and height, test for sexually transmitted infections (STI)s, urine test, request blood type and Rh, tetanus toxoid, iron/Folic acid supplementation, and recommendations for emergencies. |
| What does the indicator measure exactly | This indicator provides information on women’s use of ANC services at the recommended level and can be used to track trends in utilization. Many health problems experienced by pregnant women can be prevented, detected and treated during ANC visits with trained health workers. Studies have found that women who attend ANC are more likely to use skilled health personnel during delivery, ANC may facilitate better use of emergency obstetric services, and ANC is also associated with improved perinatal survival (WHO, 2006; McDonagh, 1996). ANC coverage plays an important role, therefore, in the monitoring and evaluation of programs addressing newborn survival (Graham and Filippi, 1994). |
| Unit and disaggregation | Unit: Percentage.  Disaggregation: by age, place of residence, socioeconomic status, type of provider, district, state where appropriate depending on the data source. |
| Calculation modalities | 1. Household Survey: Number of women with a live birth in a given time period who received antenatal care four or more times x 100/Number of women with live births within the reference period.  2. Routine facility information: Number of women with a live birth in a given time period who received antenatal care four or more times x 100/Number of expected live births (expected deliveries) in the same reference period  The number of live births is used as proxy for the numbers of women who need ANC care. In addition, evaluators generally count all births, but usually use only live births to calculate this indicator because of the difficulty in obtaining information about non-live births.  Where data on the number of live births are unavailable, rough approximations can be made using census data for the total population and crude birth rates in a specified area as follows: Total expected births = population x crude birth rate.  In settings where the crude birth rate is unknown Total expected births = female of reproductive age x General fertility rate  Live birth is the birth of a fetus after 22 weeks’ gestation or weighting 500 g or more that shows signs of life -breathing, cord pulsation or with audible heartbeat. This cut-off point refers to when the perinatal period commences and aims at confining the definition for pragmatic purposes.  It is important to note that the two indicators (population-level and facility-level) are not comparable. Analysis plan will be different according to the source and method |
| Baseline | Baseline and endline studies through cross sectional household surveys. |
| Data collection, sources and methods | Preferred Source: Population based (household) Survey: This indicator is best calculated from a survey, since vital registration systems are lacking in Tdh priorities countries.  Other possible data source: Routine facility information systems where health information systems are more or less comprehensive, administrative estimates are also possible based on expected births for the denominator. |
| Population based survey: a cross-sectional household survey of mothers 15 to 49 years old who had a live birth in a given time period preceding the survey. A multi-stage, stratified sampling design will be used to select mothers from eligible women. Sampling of households will be based on probability proportional to size (PPS) thus ensuring villages with bigger populations had more sampled households. A structured questionnaire (adaptation of demographic health survey questionnaire) will be used to collect data from respondent.  A standardized questionnaire will be proposed. Contact HQ – Health programme |
| Data collection & processing : M&E assistants with support of M&E officers and project managers  Data analysis & interpretation : project manager, M&E officers with support of health coordinators, regional or M&E advisors |
| Frequency and timing | Population based surveys: biennial (every 2 years). More frequent surveys are probably not desirable because the survey periods may overlap and sampling error makes it difficult to assess whether small changes are real or are due to chance variation.  Routine data sources: monthly, quarterly and annual monitoring at delegation level. Reporting to HQ on quarterly basis. |
| Data quality issues | Receiving ANC care during pregnancy does not capture the timing of the visits, the reasons for seeking care, the skill of the provider, or the quality of care received and therefore, does not guarantee that women received all of the recommended and necessary interventions. However, at least four ANC visits increases the likelihood of receiving the full range of interventions (WHO, 2010).  Overestimation of coverage occurs from the use of live births only in the denominator. Furthermore, observed differences in coverage when comparing data may be due not to true changes in coverage of all pregnancies, but to differences in stillbirth and abortion rates.  With population-based surveys, recall error is a potential source of bias given that the surveys ask the respondent about each live birth for a certain time period before the interview. The respondent may or may not know or remember the number of visits, particularly as this number increases. For data compiled at the health facility level, discrepancies are possible in recording and reporting numbers of visits and these data would differ from global figures based on survey data collected at the household level. In addition, data on women’s use of ANC from routine health records may lack information on pregnancies occurring outside the public health sector, including home and private facility deliveries.  For record to be a reliable data source, staff must fill the record out consistently and accurately. Ideally, the recording form will specify the standards, will facilitate accurate charting, and will stimulate appropriate actions. |
| Analysis & Interpretation | To aid the interpretation of maternal health care indicators, it is useful to separate health service coverage into three elements:   * availability of services—potential coverage * accessibility and acceptability of services * utilization of services—actual coverage.   Both births attended by skilled personnel and antenatal care coverage are measures of health care utilization; they provide information on actual coverage (the effective population that receives the care). If analysed in conjunction with the two indicators measuring availability of obstetric care, they can provide a more complete picture of the utilization–provision synergy. Analysis should include sociocultural norms and traditional beliefs as well as gender considerations (i.e. gender sensitive services). |
| Resources | Under the technical assistance of HQ, Tdh M&E and operational teams in each delegation should work closely with health authorities to collect and interpret the data. Countries understaffed and/or with limited capacity to conduct household surveys, should consider using a consultant.  Funding needed: routine monitoring, baseline and endline studies, delegation M&E staff and HQ technical support |
| Other | Any other  question / comments |