**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 | 1.4. The proportion of mothers and children who benefitted from a postnatal visit within 48 hours after the birth (regardless of the place of delivery).  “Postpartum Care Coverage” |
| Definition | Proportion of mothers and babies who received postpartum care within two days of childbirth (regardless of place of delivery). |
| What does the indicator measure exactly | The main purpose of an indicator for postpartum care is to provide information on women's and the newborn’s use of postpartum services in the postpartum period. The majority of maternal and newborn deaths occur within a few hours after birth, mostly within the first 48 hours. Deaths in the newborn period (first 28 days) are a growing proportion of all child deaths. Postnatal care contacts, especially within the first few days following birth, are a critical opportunity for improving maternal and newborn health and survival and for provision of information about birth spacing. |
| Unit and disaggregation | Unit: Percentage.  Disaggregation: by age, sex (for newborn), parity, place of delivery, socioeconomic status, and district, state where appropriate depending on the source of data. |
| Calculation modalities | 1. Household Survey: Number of women and babies who received postpartum care within two days of childbirth x 100/ The total number of live births in the same period.  2. Routine facility information: Number of women and babies who received postpartum care within two days of childbirth x 100/ Number of births attended by skilled health personnel in the specified time period.  The number of live births is a proxy for the numbers of all women who need postnatal care. 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 foetus after 22 weeks’ gestation or weighing 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. |
| 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 comprehensive, administrative estimates are also possible based on number of births attended by skilled health personnel 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 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. |
| Data collection & processing: M&E assistants with support of M&E officers and project.  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 | This indicator is responsive to change in the short term. Annual monitoring is only feasible when the data are derived from routine data sources. For international comparisons, periods of two to five years are probably sufficient.  This indicator does not assess the content of the quality of the postpartum care itself, only that care was provided. Furthermore, after delivery, the two individuals need very different care and attention.  Recall error is another potential source of bias in the data. In household surveys, the respondent is asked about each live birth for a certain time period before the interview. The respondent may or may not know or remember if postpartum care was provided with 48 hours of birth especially if the mother had complications during delivery.  In the absence of survey data, delegations may use health facility data. However, it should be noted that these data may overestimate the proportion of mothers and babies who received postpartum care within two days of childbirth because the denominator might capture delivery assisted by skilled health personnel.  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 | Postpartum care statistics should make explicit whether care was provided principally for the mother or baby or both mother and baby, because this information may be difficult to determine retrospectively. The current demographic and health survey (DHS) questionnaire, for example, specifies postpartum care for the mother. WHO distinguishes between care for the mother and for the baby by using the term postpartum to refer to care exclusively for the mother and the term postnatal care for the baby. Analysis should include sociocultural norms and traditional beliefs as well as gender consideration (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 |