



# MOMENTUM MODULAR HFA USER GUIDE

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

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# BACKGROUND AND ORGANIZING FOR A HEALTH FACILITY ASSESSMENT (HFA)

## Background

The purpose of the modularized Health Facility Assessment (HFA) is to provide the MOMENTUM suite of awards with an HFA tool focusing on reproductive, maternal, newborn, child and adolescent health/family planning care and services, including seven modules that collect information on the following:

- Service Availability
- Service Readiness
- Quality and Safety of Patient Care
- Experience of Care
- Availability of Register
- Community Services and Mobilization
- Health Facility Oversight, Quality Improvement, and Use of Data

The assessment tool is designed to collect relevant information at various levels of health facilities, from community health centers to tertiary or national level referral hospitals. The tool is designed in a modular manner, which allows flexibility and adaptability to different country contexts to relate to the needs of the country and the specificities of its health system. Currently, in paper form, the assessment tool assessment can be digitized with skips and logic programmed to navigate the user to the appropriate module. The assessment tool is designed for mobile data collection using a phone or tablet.

This user guide is intended primarily for the use of MOMENTUM awardees in-country to develop and implement an HFA, but the assessment tool is relevant to any project interested in measuring the availability, readiness, quality, and experience of care for maternal, newborn and child health/family planning and reproductive health (MNCH/FP/RH). This guidance is useful for survey implementors and their partners, and of particular use to the survey manager and other key HFA personnel.

The guide is organized by the objectives, which are to:

- Provide overall governance guidance on implementing an HFA.
- Outline the methodology of the HFA tool.
- Summarize the sampling recommendations for the HFA.
- Detail the customization guidelines of the tool.
- Provide operational, logistical, and planning guidance for HFA implementation.
- Offer the necessary steps for data analysis and producing a final report for the HFA.
- Suggest mechanisms for disseminating the HFA report findings.

The remainder of this chapter provides guidance on the governance structure of the HFA and considers the key personnel of the survey.

## HFA oversight

The assessment tool is a comprehensive instrument that can be deployed across a large number of health facilities with wide geographic scope. This requires considerable planning and resources to ensure that each stage of the survey is well-resourced and can address inputs from key stakeholders while balancing the technical and operational needs of the project.

It is recommended to form two committees which oversee the various facets of the assessment—a Steering Committee and a Technical Committee. The role of the Steering Committee is to provide overall leadership and guidance on the HFA. The Technical Committee’s role is to support the HFA survey manager on technical issues at all phases of the survey, ensuring that the operationalization of the survey’s objectives are translated into tools and procedures for the assessment.

## THE STEERING COMMITTEE

The Steering Committee’s roles and responsibilities include the following:

- Defining the survey’s objectives and research questions, and how they link to policy.
- Providing oversight of the survey implementation process, the survey management, and institutional processes.
- Resourcing the HFA with adequate financial, operational, and human resources and supporting the survey manager.
- Ensuring that ethical issues are documented and resolved, including Institutional Review Board approvals and any issues that may come up during the fieldwork.
- Ensuring the HFA meets its timelines.
- Reviewing and providing concurrence on key outputs from the HFA process, including survey design, data collection, and analysis.
- Ensuring the HFA data and results are used by the intended audience.

The Steering Committee is convened by the lead in-country organization for the assessment, which is typically the Ministry of Health. Other government ministries are usually members of the Steering Committee, especially those that provide technical and financial resources to the project and those that will be using the findings from the assessment. These can include the Ministry of Planning, the Ministry of Finance, and the National Statistical Office. As the HFA’s data will be used across a wide range of in-country and international stakeholders, including them in the Steering Committee is advantageous in a number of ways. These stakeholders are the most knowledgeable about the country context and can provide useful input in the assessment planning phases with guidance on existing quality of care gaps, areas for focus and in customization of the tool. Additionally, engaging local stakeholders early and often encourages use of findings for programming and policy. These stakeholders can include academics, nongovernmental organizations (NGOs), and donors.

## THE TECHNICAL COMMITTEE

The responsibilities of the Technical Committee include the following:

- Reviewing and advising on the sampling plan and sample design for the HFA.
- Reviewing and advising on the customized questionnaires and manuals developed.
- Assisting in identifying resource persons for technical matters, training, field monitoring, and testing the questionnaires.
- Reviewing results and final reports from the HFA and providing technical inputs from the organizations represented.

- Developing a set of key messages for dissemination.
- Ensuring proactive communication with the Steering Committee.

The Technical Committee is comprised of a small group of technicians from the main governmental organizations in the Steering Committee. While the Steering Committee provides overall guidance and approval of key deliverables for the assessment, the Technical Committee implements the assessment on a day-to-day basis.

## Human resources

The assessment requires different skills and experience for successful implementation. Below is a set of key personnel for the HFA:

1. **SURVEY MANAGER:** The survey manager, who is the main point of contact for all technical and implementation work, is selected and appointed to provide technical and managerial expertise. The survey manager is expected to develop the tools necessary for the assessment, using the technical resources persons appointed by the Technical Committee, and present these tools to the committee. Further, the survey manager must develop and finalize a plan for the assessment, including the timeline and budget, and present these to the Technical Committee for inputs. These are then passed to the Steering Committee for approval. Finally, the survey manager must communicate regularly with the Technical Committee on all areas of work.
2. **SAMPLING STATISTICIAN:** Working with the survey manager, the sampling statistician's role is to create a sampling plan for the assessment that reflects the survey's objectives. The sampling plan must consider more than one scenario which must be considered in conjunction with other technical and operational limitations. This includes sourcing a suitable sampling frame (working with the survey manager to do so), developing and using a probability sample selection method, calculating several sampling size scenarios, and sampling allocation strategies. Finally, the statistician also creates the sample weights for the assessment and any additional sampling metadata for archiving.
3. **DATA PROCESSING EXPERT:** The data processing expert's role is to work with the survey manager to define a set of data capture/collection procedures and programs for the assessment, supervise and troubleshoot their implementation, create an analysis dataset, and generate tables with the final results. The data processing expert must be engaged throughout the survey, providing feedback on data collection instruments and forms prior to implementation, and pre-testing the data entry tools before data collection. During training, the data processing expert should orient data collectors to the data entry system and should be available during data collection to troubleshoot any data entry problems and review data as it is collected and provide timely feedback to data collectors. After fieldwork, the data processing expert cleans and anonymizes the data, and creates a final dataset with key variables for analysis, appending the sample weights. Then the expert produces the analysis tables, which are reviewed by the survey manager and Technical Committee for feedback. The final output produced by the data processing experts include a final de-identified dataset, and a survey archive with all programs, analysis files, metadata, and all datasets (including preliminary and final).

## FIELD TEAMS

A team of interviewers is needed for data collection. The assessment fieldwork can be organized into teams composed of data collectors, team supervisors, and drivers under the supervision of the survey manager. The roles and responsibilities of each are shown below:

**DATA COLLECTORS:** The HFA uses two types of data collectors. The first is an interviewer whose role is to collect the data in the designated health facilities. The interviewer also checks that all questionnaires assigned are completed and transfers data to the field supervisor. In service provision assessments such as the HFA, it is common practice to train health workers to collect data as they are familiar with the concepts and staff at health facilities. However, other

staff, such as enumerators and interviewers from national statistical offices, can also participate as data collection staff.

Administering vignettes and simulations and conducting clinical observations, on the other hand, requires more specialized knowledge of clinical algorithms. For these, we highly recommend employing clinicians trained in the specific area of interest for data collection. The proposed data collector types for each module are indicated in Appendix 1.

**FIELD SUPERVISORS:** Field supervisors are senior members of the field team and take on the overall responsibility of coordinating the work of the team, ensuring the team’s wellbeing and safety during fieldwork. The survey manager assigns the facilities to the field supervisors, who work with their team to implement the fieldwork. Field supervisors must prepare and organize the fieldwork and provide data quality assurance. The responsibilities of field supervisors include:

- Preparing for fieldwork logistics: obtaining maps for the survey area, planning the route for data collection (under the supervision of the survey manager), and preparing the fieldwork schedule, including obtaining supplies such as water, food, and accommodation as well as monetary advances and payments for the survey team in advance.
- Preparing materials for data collection: e.g., tablets, chargers, and paper questionnaires (as backups).
- Troubleshooting minor issues with data collection devices.
- Organizing the data collection visits to facilities: making contact with health facility managers and introducing the team to them.
- Supervising data collection activities.
- Ensuring that data collection protocols are followed by spot checking the completed questionnaires and observing parts of the interview process for each team member.
- Communicating with the survey manager, sharing updates on fieldwork, and reporting any challenges in the field.
- Receiving data from each data collector on a daily basis, reviewing as needed, providing feedback to data collectors, and submitting data electronically for processing.

## Budgeting

- The survey manager develops the budget for the assessment. The budget should contain the estimated total cost, including in-kind support and can be structured around the following broad categories:
- **PERSONNEL:** Include the cost of the assessment key personnel, field staff, and other staff needed throughout each stage of the survey, including wages and benefits.
- **TRANSPORTATION:** Surveys typically use drivers to transport field teams to the health facilities. As such, the budget should include the cost of vehicle rentals, fuel costs, any contingency costs, and public transportation allowances (if needed).
- **PER DIEMS:** Personnel may require per diems during different phases of the assessment. Use approaches that are country-specific and have previously been used in the country to determine per diem needs.
- **EQUIPMENT:** Data collectors will need supplies to facilitate data collection, such as mobile phones/tablets, chargers, solar chargers (where applicable), SIM cards, water-resistant bags to carry supplies and paper copies of consent or information forms (which can be left with respondents), as well as any additional equipment required to administer the simulation component of the questionnaire, such as an infant manikin like the Neo-Natalie. While most of these supplies may be locally available, some may need to be ordered internationally. Ensure that enough time is allotted for supplies to arrive prior to the main training for the HFA.



- **OTHER COSTS:** In this category, include all other costs, such as venue rentals for training, translation of documents, printing of manuals, and other supplies, such as paper, note pads, pens, bags, report design, and dissemination events.

# METHODOLOGY AND TOOL OVERVIEW

This chapter outlines the methodology used by the HFA, beginning with the stages of the survey, followed by structure of the survey, including its modules and respondents.

## Stages of the HFA and timeline planning

Implementation times for the HFA, from inception to completion, will differ based on survey characteristics. However, the HFA can generally be segmented into the following stages:

### SURVEY DESIGN

- Establish the HFA's governance (the Steering Committee and the Technical Committee) and hire key personnel (the survey manager, the data processing expert, and the sampling expert).
- Prepare technical materials: Select a sampling frame, select a sample, and finalize the questionnaire and data collection/data entry tools.
- Obtain required approvals from the local ministry and ethics review committee(s).
- Recruit and train data collection teams.
- Prepare for field work: Identify maps and plan routes, confirm data collection details with local health authorities, plan travel and accommodations, be prepared to make payments to field teams, and finalize the survey tools in a pilot study.

### DATA COLLECTION

- Visit health facilities and collect data using the HFA questionnaire tools.
- Before leaving the facilities, check completed questionnaires for completeness and inconsistencies, and resolve these issues with the respondent, if needed.
- Data collection leads should spot check questionnaires while still in the facilities and re-interview a small proportion of respondents (about 10 percent) on key parts of the questionnaire as a quality check.
- If data collection is electronic and data is regularly uploaded to an accessible server, the data should be monitored as it is submitted by the data processing expert to identify any errors or ongoing issues with collection that can be resolved while data collection is ongoing.

### DATA PROCESSING AND ANALYSIS

- Perform checks on the data: Identify inconsistencies and errors, correcting and documenting solutions.
- Create and append the sampling weights by working with the sampling expert.
- Create variables to measure the key indicators in the HFA and the disaggregates.
- Conduct analyses, creating tables and graphs.
- Present the initial findings to the Technical Committee and address feedback, including new tables and analyses, as requested.

### REPORTING AND DISSEMINATION

- Work with the Technical Committee to interpret survey results.
- Write the HFA final report, showing all tables with key indicators and disaggregates.
- Create a dissemination plan that involves all key stakeholders.

- Create a survey archive using metadata standards, with survey documents from all stages of the HFA.
- Submit de-identified datasets and supporting documentation to the USAID Data Development Library or other repository as required.

## Structure of the HFA

The HFA is designed as a modular tool to allow the selection of technical areas most relevant to a country context. The tool consists of nine modules:

- Module 1: Visit Record, Introduction, and Consent
- Module 2: Health Facility Background
- Module 3: Service Availability
- Module 4: Service Readiness
- Module 5: Quality and Safety of Patient Care
- Module 6: Experience of Care
- Module 7: Availability of Register and Data Management
- Module 8: Community Services and Mobilization
- Module 9: Health Facility Oversight, Quality Improvement, and Use of Data

Appendix 1 outlines the modules and provides a brief description of each module, including the person who collects the data and the respondent, and identifies the main indicators collected.

## Identifying the respondent

The majority of data collected in the HFA relates to the facility and its services, which is information that is known to multiple people in the facility. This means that multiple people can act as respondents. It may be possible that a respondent may know detailed information about certain parts of the questionnaire but have no knowledge about others. It is acceptable to find a more knowledgeable respondent from the facility's staff to continue with the questions for all sections with the exception of sections that evaluate provider knowledge and competency.

Often, supervisors at health facilities can provide high-level information on the facilities and can assign other staff to assist with providing responses to more specific topics. Processes for identifying the correct respondent should be covered in depth during the training for fieldwork.

# Structure of the paper tool

The HFA has nine modules spanning different technical areas and quality domains, but the tool has been developed so that it is consistent across modules.

- The first column includes the unique question identifier, for which the first number corresponds to the module. This number can be used as a variable name if the survey is programmed.
- The second column includes the question text, notes to the interviewer (IN PURPLE), an indication if customization is needed (IN RED) and question type to be used for programming (i.e., `select_multiple`).
- The third column includes response options.
- The fourth and final column includes skip logic and maps survey questions to indicators in the [MOMENTUM Monitoring, Evaluation, and Learning \(MEL\) Framework](#) (IN ORANGE).

See example below:

NO.	QUESTION	RESPONSE OPTIONS	NOTES/SKIP LOGIC
4.1.1.9	<p>Does this facility have a system for determining clients’ opinions about the health facility or its services?</p> <p>PROBE FOR ALL METHODS USED.</p> <p>SELECT ALL THAT APPLY</p> <p>[COUNTRIES TO ADAPT]</p> <p>(<code>select_multiple</code>)</p>	<p>1. Suggestion box</p> <p>2. Client survey form</p> <p>3. Client interview form</p> <p>4. Official meeting with community leaders</p> <p>5. Informal discussions with client or community</p> <p>96. Other (specify)</p> <p>97. No system for feedback</p> <p>98. Don’t know</p>	<p>Note: informs <b>XCUT.HFA.4</b></p> <p>If “Other” selected, continue to 4.1.1.9a. If any methods selected, skip to 4.1.1.10. If “No system for feedback” selected, skip to Section 2.</p>
4.1.1.9a	<p>Specify “Other” system for determining clients’ opinions.</p> <p>(<code>text</code>)</p>	<p>_____</p>	

# SAMPLING FOR THE HFA

## Overview of HFA sampling

As opposed to a complete census of health facilities, survey implementers are advised to draw a sample of health facilities from which to collect data for the HFA. When drawing a sample, survey implementers should use a probability sample design, which ensures that statistics from the HFA sample represent the health facilities in the country.

## The sample frame for the HFA

A probability sample design relies on the use of a sampling frame from which to draw the sample. A sample frame is a complete list of health facilities in the country. This includes all the public, private, non-governmental, and other types of facilities. The sampling frame should be up-to-date, void of duplicates, complete in its enumeration of health facilities, and have supplementary information, such as geographic locations (e.g., regions), facility type, and managing authority (e.g., public vs. private vs. other), which can be used in sample selection.

Some countries have a Master Facility List, which may contain all the above information. However, in many countries, a high-quality sampling frame of health facilities may not exist. The survey manager and the sampling expert should work with the Technical Committee to source a list of health facilities from the Ministry of Health and ensure the list has all the relevant information needed. If not, the list should be updated. In cases where data on private facilities is missing, organizational bodies that keep lists of private facilities, including commercial sources, may possess such information. Various ministries in the government may keep a list of NGO facilities.

## Determine the sample size: Level of aggregation, key indicators and the sample size calculation

Once the sampling frame has been selected, the sampling statistician should develop the domains for the survey. The domains should conform to the objectives of the survey. Many survey implementers wish to report their results at the national and regional level and have estimates at the facility-type level. These objectives inform the sampling domains. To operationalize this, the sampling expert will examine the sampling frame and determine if these domains can be used as sampling strata. In many cases, due to the nature of the sampling frame and the auxiliary information it contains, the domains and sampling strata are the same.

As a rule of thumb, the larger and more numerous the reporting domains, the larger the sample size will be. That is, an HFA survey which reports only national figures will have a smaller sample size than another HFA in the same country which reports on national, urban/rural, and regional estimates.

After the sampling domains and strata are established, survey implementers should select several key indicators to use in sample size calculations. These are used to create different sampling scenarios.

Calculating sample size requires several input parameters. These include:

- The margin of error, typically set at 95 percent.
- The estimated proportion of facilities with a certain characteristic or the value of another indicator. These can usually be estimated based on country knowledge or based on a previous similar survey.
- The design effect, which is the estimated impact of the sampling method to a simple random sample. As the HFA reports on different domains, sampling is expected to depart from simple random sampling and use more complex, multi-stage sampling.

Sample sizes can be calculated for each reporting domain and the resulting sum of sample sizes for each domain will be the total sample size. Alternatively, a total sample size can be calculated and then proportioned off to each domain. Various options exist for this procedure. Let's consider a hypothetical example for a country with 80 percent public facilities and 20 percent private facilities. The sample can be equally allocated to each domain. In this case, 50 percent of the sample goes to public facilities and 50 percent to private facilities. Alternatively, the sample can be proportionally allocated. Using the same example, the HFA sample would have four times as many facilities in the public facilities stratum compared with the private facilities stratum. A third alternative is to allocate more sample to domains of particular interest. Taking the same example, if survey implementers are interested in larger sample sizes for private facilities, a proportional allocation would provide a relatively small sample, while equal allocation would increase the sample size for this domain. In this case, the sample can be boosted even further to a proportion that is useful for the implementers, such as a 60-40 sample allocation to private and public facilities. It should be noted that changing the sample size within each domain implies that the confidence intervals around estimates will vary under the different procedures.

While sample size calculations are important inputs toward developing the survey, sample sizes must be balanced against the existing resources to implement the survey. A survey with small confidence intervals and many reporting domains will have a large sample size. A larger sample size, however, will have implications for cost and the time required to complete data collection.

# CUSTOMIZATION CONSIDERATIONS

This chapter provides an overview of how countries can customize the HFA questionnaire tool to reflect country contexts.

## Adapting the HFA tools at the module and question level

The HFA questionnaire has been created as a generic tool that requires adaptation to ensure that the tool reflects the objectives of the survey and the specific health system context within a country. Once the objectives of the survey are defined, the survey manager should create a set of indicators that the survey should measure. This can be done using the list of indicators collected by an HFA as a starting point and then removing and/or adding new indicators as determined in consultation with the Technical Committee. MOMENTUM awards may choose to use the Cross-MOMENTUM MEL Framework as a starting point for indicators. Once the list is finalized, the country customizations can be made. As adaptation of the tool requires in-depth knowledge of the health system, the survey manager should work closely with the Ministry of Health and other partners on the Technical Committee to complete this activity. Changes to the HFA tool need to be piloted prior to the main fieldwork to ensure that any changes function as desired in the field.

## Customization at the module and question level

Country customizations can occur at the module or question level. Based on the list of indicators developed for the HFA, countries can add or remove modules or questions from the HFA tool to measure only the indicators in which they are interested. When adding modules or questions that are not covered in the HFA, it is advised to import these from similar HFA surveys where they have been previously tested and validated.

When adding a new module, users will need to create a new set of question numbers which do not overlap with the existing question numbers. When new questions are added, the additions may occur within an existing module or at the end of the module. If the new questions are added within an existing module, number these questions in a manner that preserves the original HFA question numbering. This is necessary as the tabulation guidance for the HFA (Appendix 2) is based on the original HFA question numbering. This approach avoids unnecessary effort to renumber the questionnaire and change analysis files. In the case of adding questions to the end of a module, users can simply continue the numbering of the module.

Certain modules and questions may not be applicable to a particular country, as these data may already be available from other sources or simply be irrelevant (e.g., questions about malaria prevention and treatment in countries where malaria is not endemic). These modules and questions can be deleted from the HFA tool. Prior to deleting modules and questions, review closely if these are used in the calculation of other key indicators for the survey. If they are not necessary, they can be removed from the instrument, deleting the question numbers and avoiding using them in any other module. In general, the HFA tool is a focused, lean instrument measuring a limited set of indicators and consequently, deletions are expected to be infrequent.

As customization occurs, the instrument's skip patterns should be maintained. This preserves the denominators for the key indicators of the survey. We advise that changes to specific wording of the questions be limited in scope.

## Adapting the HFA to the national context: health system's structure and national guidelines

The HFA tool has certain areas that must be adapted before being fielded. The following terms should be adapted to reflect the national context:

### COUNTRY STRUCTURE CUSTOMIZATIONS

**PROVINCE:** These refer to the first geographic level below the national level. While province is used in some countries, in others, the term region may also be used. Substitute the relevant term and customize with the names of the geographic areas.

**DISTRICTS:** Similar to provinces, districts can also be customized to whichever term is used within the country.

### HEALTH SYSTEM STRUCTURE CUSTOMIZATIONS

*Facility level:* The facility level classification reflects a national classification of the health system and categorizes facilities into various levels. Facility levels are indicative of the service package offered. The generic HFA categories include the following:

- National Referral Hospital
- Regional (Provincial) Referral Hospital
- District Hospital
- Other General Hospital
- Specialty Hospital
- Comprehensive Health Center/Polyclinic
- Health Center
- Clinic/Dispensary
- Health Post
- Maternal/Child Health Clinic
- Other

Categories that do not conform to the country's system or which are named differently should be addressed in this customization.

**MANAGING AUTHORITY:** The HFA tool provides the following categories for the managing authority: government/public, NGO/not-for-profit, private-for-profit, Mission/faith-based, and other. The managing authority is a categorization of the type of authority that is responsible for the facility.

While the categories provided are fairly exhaustive, in certain settings, some categories may not exist and will need to be deleted, while other categories may need to be renamed to match the specificities of the country. Ultimately, the managing authority must align with the national classification of authorities in charge of a facility.

**CADRE OF PROVIDER:** In various places in the questionnaire, the cadre of provider is shown as midwife, nurse, medical officer, doctor, specialist doctor or other. In different countries, the cadres of provider may differ. When customizing the cadre of provider, the list available on the questionnaire should map to the official classification of certified health personnel and appropriate cadres provided by the Ministry of Health.



## NATIONAL GUIDELINES

The HFA tool requires adaptation using national guidelines. The adaptation occurs at the overall tool level when customizing for facility type as well as at the question level. The HFA tool is designed for higher-level facilities which have a range of diagnostic and treatment capabilities. If the HFA is to be used to capture lower-level facilities, customization must be done to ensure that the correct level of facility capabilities is reflected in the questionnaire modules. Lower-level facilities, for example, will not have all the diagnostic tools and equipment that higher level facilities possess, nor will they be equipped or staffed to treat certain illnesses, and will instead provide referrals to higher-level facilities.

At the question level, a number of customizations need to be aligned with national guidelines. This entails reviewing the HFA tool in tandem with national guidelines on a range of facility and system characteristics related to diagnosis, treatment, drug supplies, and equipment. For example, for the observation of sick children visits (or any observations), when determining if the “correct” care was given, the survey implementers need to refer to their national treatment guidelines and update the HFA tool accordingly. The same also applies to vignettes, wherein countries must ensure that the questionnaire follows the country’s diagnosis and treatment guidelines, which share some general principles and approaches in the HFA but will need to reflect the specifics of the national guidelines.

### Box 1: Examples of question customizations using national guidelines

**ELIGIBILITY CRITERIA FOR ANC:** Module 4, which measures service readiness, requires adaptation of the questionnaire to reflect national guidelines related to provision of antenatal care services close to birth. The HFA tool provides a generic eligibility criterion of 32 weeks or more of pregnancy but this may differ at the country level, which may vary the actual number of weeks or other criteria.

**LIST OF ANTIMALARIAL DRUGS:** Question No. 5.4.2.20 should be customized to reflect the anti-malarial drugs that are on the market. This list is usually available from the Ministry of Health. Include drugs that are available in the public and private health system.

**DOSAGE FOR FIRST-LINE TREATMENTS:** Similar to the list of antimalarial drugs, question No. 5.4.2.22 should also be customized to indicate the first-line drugs used in treating malaria (based on weight) in the country.

## PERSONAL INFORMATION FROM CLIENT INTERVIEWS

**HIGHEST LEVEL OF EDUCATION:** This refers to the highest level of education that the client attended, even if the client did not complete that level. At present, the levels are no education, primary, secondary, and higher. These categories should reflect the country’s national education system as these will be the ones mentioned by clients and be easier to code by interviewers.

The remaining adaptations in the HFA are question-specific and require customizations by the survey manager, in collaboration with the Technical Committee.

## Translation considerations

The HFA tool is currently available in English and should be translated into the languages used by respondents. In health facilities, national languages may be the primary mode of communication but other languages should be considered for translation.

A high-quality translation usually involves two groups of translators. Initially, the translators translate the HFA tool from English into the target language. Then, a second group of translators who did not work on the first translation, translates the document back to the original language. Differences between the original document and back-

translated document are discussed and any issues are resolved. After this is done, the instrument must be piloted before the main field work to detect if respondents and interviewers have any issues with the terminology.

While much of the HFA uses everyday language, many terms are specialized. Care should be taken when translating these, and if possible, specialized translation services should be used.

While in the field, interviewers are expected to use the specific language in the questionnaires as part of standardized interviewing techniques used by this survey. Interviewers should avoid changing the language or translating “on the fly.” If the instrument is not available in the language of the respondent, report this to the field supervisor. A second option is to interview another suitable respondent who understands the language of the questionnaire.

# TRAINING AND PREPARING FOR THE FIELDWORK

This chapter provides details on how to train fieldworkers for the HFA and outlines preparations that the survey team should make for the fieldwork.

## Organizing the training for fieldwork

Prior to collecting data, the field teams must be trained on the HFA methodology and how to conduct the fieldwork. The objectives of the training are:

- To learn about the background and objectives of the HFA tool.
- To introduce key personnel of the survey and outline their duties during the survey.
- To train field supervisors on how to conduct fieldwork for the HFA and outline roles and responsibilities during the survey.
- To train data collectors to use the HFA questionnaires (including paper and electronic versions) and outline their roles and responsibilities.
- To outline a detailed plan for the field implementation, including transportation and accommodations.

Before the training takes place, the survey manager must identify a location or venue for the training. When implementing the HFA, a central venue is desired as the number of data collectors is expected to be significant enough to train all staff at the same time. At the training, organizers should:

- **CREATE AN ACTIVE AND PARTICIPATORY ATMOSPHERE:** This can include asking trainees to ask questions frequently and participate by volunteering to answer questions and reading out loud different parts of the questionnaire.
- **PROVIDE GUIDELINES ON HOW TO HANDLE AN INTERVIEW:** All interviewers should be taught how to conduct themselves during the interview. This includes training on working professionally, how to obtain informed consent, remaining neutral, when and how to use probing techniques to elicit and clarify responses, and how to be respectful during the interview.
- **PRACTICE:** Trainees should practice as much as possible in the classroom setting. This can involve individual practice reading questions out loud, practice in pairs, and demonstrations using mock interviews. Practice should reflect the main issues that are expected to arise during fieldwork.
- **DEMONSTRATE HOW TO FILL IN QUESTIONNAIRES:** Trainers should demonstrate how to fill in the questionnaires using phones or tablets (the primary data collection system) and on paper, which is necessary in case a phone or tablet does not work during fieldwork. Starting the training by reviewing the paper questionnaires usually provides trainees with a useful overview and grasp of the questionnaire's structure.
- **PROVIDE AFTER-HOURS ASSIGNMENTS (AS NEEDED):** Additional assignments outside the training can also be provided to trainees. These can include additional practice on reading and understanding the questionnaires and reading additional materials on the content of the HFA.

## Questionnaire approaches in the HFA

The HFA questionnaire uses multiple approaches to collect data, and draws on a range of respondents across various modules. Each questionnaire approach requires specific training and practice for field teams to master the material. Below is an outline of the general principles of each type of questionnaire approach used in the HFA and guidelines on how to train on these approaches.

**QUESTIONS:** The vast majority of the HFA uses a question and response approach, where the interviewer reads a question aloud to a specific respondent and records the response on the questionnaire. Interviewers for the HFA will engage with clients at the facilities as well as managers and technicians in the facilities who act as respondents for different modules. Throughout the questionnaire, standardized interviewing techniques should be used where all interviewers use the same approach to gather data. It is expected that each question is read aloud exactly as written in the questionnaire. If a respondent does not understand a question, the interviewer should reread the question. If necessary, the interviewer can explain the meaning of the question or specific terms based on the materials shared in the fieldwork training. The interviewer should also use probing techniques if the response appears vague or the respondent appears uncertain.

**RECORDS REVIEW:** As the HFA collects data from records, training and practice using records should be given to trainees. During the training, it would be useful to source example materials that might be encountered in the field, and use these as training materials. Records such as registers, appointment books, appointment card boxes, databases, or other lists can be sourced and used during the training for practice. This will allow the teams to become more familiar with these materials, how they appear, how to handle and interpret them, and how to collect data from them. During the training, be sure to anonymize the records if possible or, at minimum, ensure that any information in the records is held confidentially by the trainees.

Apart from the mechanics of reviewing and understanding the records, trainees will also need to learn how to select a section of records for data collection. Each section that requires records review will detail how to perform a record selection. During the training, trainers should show trainees how to operationalize the procedure, answer any questions that arise, and allow the trainees to practice choosing a selection of records for a certain part of the questionnaire.

**OBSERVATIONS:** The HFA also requires data to be collected using observations at various places in the instrument. Observations are made by visually reviewing the item or service of interest. In most cases, observations of records or stock requires only minimal handling by the interviewer, if at all. For example, in Module 4 (Service Readiness), section 5 (Basic Client Amenities), question No. 4.1.5.4, the interviewer is asked to observe the duty schedule for 24-hour staff coverage. In this case, the interviewer should request to see the schedule, review it, and check off the appropriate response on the questionnaire.

The HFA tool also uses a second type of observation. In several places in the questionnaire, the interviewer is asked to make clinical observations of the clinician and the client. In these cases, consent is required from both the clinician and the client.

**VIGNETTES:** The HFA uses vignettes as a means to gauge the knowledge of different health care providers. A vignette is a hypothetical situation that the interviewer describes to the respondent and then asks a series of questions related to the specific situation. Before beginning, review the vignettes alongside the national guidelines for each facility level as well as provider cadre to ensure that the responses align with national standards. For example, you may need to add the types of medications and the doses so they meet national guidelines, or you may need to remove a response if it is only applicable at referral facilities in the country and you will be conducting the survey only at primary health care facilities.

For vignettes, the interviewer is indicated in Appendix 1. As many of these vignettes require specialized knowledge, a trained interviewer who is also a trained clinician should administer these modules.

In Module 4, question No. 4.4.1.1.4a, for example, the trained clinician administers this module to the respondent, who in this case, is a provider of antenatal care. To initiate the vignette, it is important that the interviewer reads out

the introduction slowly and carefully as the introduction serves to reassure the respondent that they are not being personally evaluated and that responses are confidential and will not be shared with the facility's administration.

**SIMULATION:** The HFA uses a simulation exercise to identify provider knowledge of newborn resuscitation. In the simulation, the interviewer, who is a trained clinician, obtains informed consent from the provider of newborn/delivery care, then reads out a scenario. Throughout the scenario, the provider shows his/her actions using the manikin, and the interviewer indicates the baby's response, to which the provider must react.

Overall, the length of the training depends heavily on the content of the questionnaire. Large, longer questionnaires require longer training and more practice. Team supervisors also need to be trained to perform quality assurance through spot checking questionnaires, observing interviews, and reinterviewing respondents. Training should not exceed eight hours a day, and should include lunch and tea/coffee breaks. At the end of the day, trainers should meet to discuss any feedback from the day and plan the following day.

Throughout the training, the trainers should include a number of small assessments to gauge how well participants understand the material. These assessments are not intended to be difficult but to help build a profile of which trainees have the capacity to become field supervisors and how motivated the trainees are, which is key for achieving success in the survey.

## Conducting an interview

Obtaining high-quality data for the HFA requires developing good interviewing techniques that cover the various types of data collection approaches. In general, interviewers must be trained on the following:

- Approaching the correct respondent.
- Obtaining informed consent.
- Listening carefully during interviews and when to use prompts for clarifications.
- Remaining neutral and not offering advice or opinions.
- Reading questions as stated in the questionnaire.
- Ending an interview by thanking the respondent.

## Preparing for the fieldwork

Several key activities must be done in preparation for the fieldwork for the HFA.

### CREATING FIELD TEAMS

Based on the performance of the trainees in the field teams, the trainers will be knowledgeable enough to identify which trainees can be sorted into the two different roles of interviewer or field supervisor. Among the interviewers, several will be used for the unspecialized parts of the HFA questionnaire while others will be used for the vignettes and simulations.

### DEVISING A FIELDWORK SCHEDULE

During fieldwork planning with field supervisors, the survey manager will assign each supervisor to areas of the country for their work and include a set of health facilities within each area assigned. The assignment also includes the name and location of the facility and any identifying information about the facility that is needed to fill in the HFA questionnaire. The survey manager, in many cases, will be able to supply the name of a contact person at the health facility who can help in the HFA implementation. Contact information should include the name, telephone number, other means of contact, such as email, and facility hours. The field supervisor is expected to provide the team with a

map showing the locations of all of the facilities to be interviewed and a plan detailing when each facility should be visited.

Field teams should arrive at the facility prior to official hours to plan the day of work, collect supplies and materials, and clarify the plan for the day.

### **CONTACTING HEALTH FACILITIES IN ADVANCE**

At the start of the HFA, an official notice is sent from the Ministry of Health (and any other appropriate government agencies) to the health facilities selected for the HFA. These notices indicate the nature of the HFA and its purpose, and requests their cooperation during the survey process.

Prior to fieldwork, the survey manager or the field supervisor notifies the appropriate authorities of the health facilities about the arrival of the survey teams, and makes appointments to meet with the contact person at the health facility.

### **MAKING LOGISTICAL ARRANGEMENTS AND GATHERING SUPPLIES**

At the start of each day of fieldwork, the field supervisor ensures that the interviewers and driver have all materials and supplies needed for the day to complete their assigned work. This includes questionnaires (in paper as a backup), tablets, battery chargers, SIM cards, and mobile phones. Arrangements for food and lodging should also be made in advance.

Prior to approaching facilities, field teams must have official identification with a photograph and a copy of any letters shared by the Ministry of Health about the survey. These documents will facilitate a smooth introduction and process for the survey.

## **Activities at the health facilities**

When field teams arrive at health facilities, the data collection team should:

### **VERIFY THE HEALTH FACILITY**

Once the field team has arrived at the health facility, the field supervisor is responsible for verifying that the facility matches the name provided by the survey manager. If the field supervisor is unable to find the facility indicated, contact the survey manager. If a facility is closed when the team arrives at the facility, revisit the facility at different times on different days. Revisits may also be necessary to meet different respondents for various modules in the HFA.

If the facility has closed its operations completely, note this on the questionnaire and discuss this with the survey manager. No substitutions of facilities should be made to compensate for the loss of any non-operational facilities.

### **MEETING WITH THE HEALTH FACILITY CONTACT PERSON**

Across the public, private, and other facility types in the HFA, the field supervisors should meet with the contact person for the facility, introduce themselves and the team, provide any introductory/official letters about the survey, and obtain informed consent for the survey to proceed.

If a specific contact is not provided for the facility or is not available at the time of the interview, the team can either speak with another official at the health facility or return at a different time to the facility. If the contact refuses to provide informed consent, discuss this with the survey manager, and provide the name of the facility and other identifying information. The survey manager may be able to contact appropriate parties who can facilitate the work of the survey.

## **INTERVIEWING THE RESPONDENT**

Each module of the HFA requires respondents with knowledge of the services and facilities to be on the premises. Therefore, the field team will need to interview various respondents in the facility to obtain complete information. Interviewers are responsible for developing a plan for completing all modules of the questionnaire at the facility to which they are assigned. It may be useful for the team supervisor to discuss this plan with the contact person at the health facility who can provide any feedback on who to meet and when.

At the end of the day, the team must return to the facility to complete any incomplete questionnaires. All data should be transferred from interviewers to the field supervisor on a daily basis.

## **ENSURING QUALITY ASSURANCE WHILE IN HEALTH FACILITIES**

While in the health facilities, the team supervisor is responsible for providing quality assurance measures. The field supervisor should observe several interviews a day, taking note of any issues identified with the respondent, provide adequate and timely feedback to interviewers on their performance, and devise ways to improve performance. Additionally, the supervisor is expected to review completed questionnaires while in the facilities for completeness and identify any inconsistencies in the responses. Any errors detected should be rectified while in the facilities, either on the same day or the days following the interview. On average, a supervisor should also re-interview about 10 percent of respondents to check for quality and consistency of the responses. During the re-interviews, the supervisor should indicate that this is a quality check and only cover key parts of the questionnaire. That is, the supervisor does not have to verify the entire questionnaire during the re-interview process.

# ANALYSIS, DISSEMINATION, AND FURTHER ANALYSIS OF THE HFA DATA

Following the fieldwork, a number of stages in the data processing and analysis phase should be completed before final results can be created. Data that is entered in the field must be checked and cleaned before it is exported to a final dataset for producing the final tables of the HFA, and before a report is written.

## Edit and clean the data

At the main office, the data processing expert should first aggregate all the data files from all supervisors for each health facility. During this process, the expert should work closely with the survey manager to account for all health facilities, making sure that all facilities that were visited have a final interview code, with data on each facility. With this information, the data processing expert works with the sampling expert to create response rates which are used to calculate the sample weights for the survey.

The HFA questionnaire tool and data collection system uses tablets with built-in data checks that were executed during the fieldwork to reduce data quality issues. Despite this, the survey manager and the data processing expert must perform a review of the key variables in the final dataset. They should check the number of cases and look for inconsistencies from expected values, review key variables to ensure they appear credible, and list any inconsistencies. Key disaggregates, such as facility type, managing authority, urban/rural, and region, for example, should not have any missing cases for the analysis. Other variables, such as consent and the final result code for each interview, should also be completely filled in.

A number of questions have an “other” response option. In this stage, the survey manager and the data processing expert are expected to work with subject matter experts to list these responses and re-categorize these into existing responses where possible, thereby minimizing the overall proportion that are “other.” The survey manager and the data processing expert should also examine the extent of missing data in the survey. As the HFA uses tablets with built-in safeguards in the instrument, missing data is expected to be minimal. Nevertheless, if there is missing data on key variables, these need to be investigated and resolved. Ideally, this cleaning would take place in parallel with data collection in order to identify and manage any issues at the onset of data collection. However, this cleaning should also take place once all the data has been submitted. Any changes to the data and resolution measures, such as imputations, must be clearly documented and included in the survey’s data archive, marking these variables clearly in the dataset.

## Export the data

Once these changes are made, the final dataset can be exported to a format that can be easily accessed and used for analysis. The final sample weights can be added to this dataset for analysis. The exported dataset contains data that has been checked for consistency, with result codes for all interviews and sample weights.

## Data analysis

With the final dataset, the data processing expert can create the final tables for the HFA report. To do so, the expert must create two sets of variables. The first is a set of variables that will be used as disaggregates in the tables. Suggested disaggregates for each indicator can be found in Appendix 2.

The second set of variables is the key variables or outcome variables for the HFA. Appendix 2 contains detailed descriptions of the key variables. The appendix also provides a mapping of question numbers in the questionnaire to the key/outcome variables and can be used to construct the algorithm for the key outcome indicators.



## Scoring for the vignettes/case scenarios and the simulation

Below is the general outline for scoring of the vignettes/case scenarios and the neonatal simulation.

### **HYPERTENSIVE DISORDERS OF PREGNANCY**

*Developed by MOMENTUM Knowledge Accelerator*

This vignette is composed of parts, each with various sections (totaling 21 points):

- Prevention of preeclampsia in a patient with chronic hypertension (3 sections, 7 points total)
- Diagnosis and management of severe preeclampsia (3 sections, 9 points total)
- Treatment of eclampsia in labor (1 section, 5 points total)

#### *Prevention of preeclampsia in a patient with chronic hypertension*

##### **Section 1**

Vignette (No. 4.4.2.1.4): A 28-year old patient, gravidity 3, parity 2, reports for a first antenatal visit at 12 weeks pregnant. For her first two births, she attended a different clinic that has since closed. She recalls that during her most recent pregnancy 1.5 years ago, the midwife said that she had high blood pressure close to when she delivered. She cannot remember how or if the midwife treated it. She has been experiencing headaches during her pregnancy. You measure her blood pressure and find that it is 145/95. You repeat the blood pressure measure a few hours later and find it is 143/96. What is your diagnosis?

Total of 1 point maximum based on mentioning any of the following:

- Chronic hypertension
- Hypertension
- High blood pressure

##### **Section 2**

Vignette (No. 4.4.2.1.5): What would you do at this visit? Answer assuming that equipment and medications that you would normally use to manage patients at this level are stocked and functional.

Total of 3 points maximum based on the following:

- Collect baseline labs (based on national guidelines): 1 point
- 24-hour urine collection OR urine protein dipstick: 1 point
- Refer to primary care doctor or specialist to control hypertension: 1 point

##### **Section 3**

Vignette (No. 4.4.2.1.6): What would you recommend for the remainder of the pregnancy?

Total of 3 points maximum based on the following:

- Low-dose acetylsalicylic acid starting immediately for the remainder of the pregnancy (aspirin, 75mg, or adapt to national or facility guidelines) (based on national guidelines): 1 point
- Ongoing regular antenatal screenings/testing throughout pregnancy (reference national or facility guidelines for frequency) (based on national guidelines): 1 point
- Discuss possible need for early induction or delivery in higher-level facility: 1 point

## *Diagnosis and management of severe preeclampsia*

### **Section 1**

Vignette (No. 4.4.2.1.8): A 24-year-old patient, gravidity 2, parity 1 with a previous uncomplicated birth two years ago, reports for an antenatal care visit at 30 weeks pregnant. This is her second visit to the clinic during this pregnancy. She reports that she has been having persistent headaches for the last two weeks. Her blood pressure is 175/100. When looking at her chart, you see that when she came in at 16 weeks, her blood pressure was 130/80 with a normal urine analysis. Fetal wellbeing is reassuring. What would you do at this visit? Answer assuming that equipment and medications that you would normally use to manage patients at this level are stocked and functional.

Total of 6 points maximum based on the following:

- Repeat the blood pressure measurement after at least four hours: 1 point
- 24-hour urine collection or urine protein dipstick: 1 point
- Provide medications to manage headache (reference national or facility guidelines for choice, route, and dose) (based on national guidelines): 1 point
- Prescribe magnesium sulfate (reference national or facility guidelines for route and dose) (based on national guidelines): 1 point
- Prescribe antihypertensive drugs (reference national or facility guidelines for choice, route, and dose) (based on national guidelines): 1 point
- Prescribe beta course for fetal lung maturity (reference national or facility guidelines for choice, route, and dose) (based on national guidelines): 1 point

### **Section 2**

Vignette (No. 4.4.2.1.9): The patient's blood pressure four hours later is 170/80, and urine dipstick revealed 2+ proteinuria. What is your diagnosis?

Total of 1 point maximum based on the following:

- Pre-eclampsia with severe features
- Severe pre-eclampsia

### **Section 3**

Vignette (No. 4.4.2.1.9): What would you recommend for the remainder of the pregnancy?

Total of 2 points maximum based on the following:

- Make a plan for delivery/induction: 1 point
- Ongoing fetal surveillance throughout pregnancy (reference national or facility guidelines for frequency and type of fetal surveillance) (based on national guidelines): 1 point

## *Treatment of eclampsia in labor*

### **Section 1**

Vignette (No. 4.4.2.1.12): A 41-year-old patient, gravidity 1, parity 0 at 38 weeks comes to the clinic in active labor complaining of headache. The patient's blood pressure is 140/90. The fetal status is reassuring, and she is 4 cm dilated. The patient seizes during initial evaluation. How would you manage the patient? Answer assuming that equipment and medications that you would normally use to manage patients at this level are stocked and functional.

Total of 5 points maximum based on the following:

- Ensure that the patient is in the left lateral position: 1 point
- Regularly monitor vital signs and reflexes: 1 point
- Administer magnesium sulfate (reference national or facility guidelines for route and dose) (based on national guidelines): 1 point
- Regularly monitor fetal heart rate: 1 point
- Make a plan for and delivery the baby (reference local guidelines for type of delivery) (based on national guidelines): 1 point

## **MANAGEMENT OF PROLONGED LABOR**

*Developed by MOMENTUM Knowledge Accelerator*

The management of prolonged labor vignette is composed of three sections, totaling 2 or 5 points, depending on level at which it is administered points. Each section contributes to individual sub-section scores and an overall summed score as follows:

### **Section 1**

Vignette (No. 4.4.2.2.4): A 30-year-old woman (gravidity 1) at 40 weeks' gestation is admitted to the facility at 10am with membranes intact. The fetal head is at -3 station; her cervix is 4 cm dilated and 80 percent effaced. There are two contractions in 10 minutes, each lasting less than 20 seconds. The fetal heart rate is 136. Her blood pressure is 120/70, and her pulse is 80. By noon, the fetal heart rate is 136, contractions remain two every 10 minutes and last 20 seconds each, her pulse is 88, and temperature is 36.2 Celsius. The fetal head remains in the same position with her cervix unchanged and membranes still intact. What are your concerns, if any?

Total of 1 point maximum based on the following:

- Prolonged latent phase

### **Section 2**

Vignette (No. 4.4.2.2.5): What would you do to manage this patient?

Total of 3 points maximum based on the following:

- Encourage her to rest and hydrate: 1 point
- Encourage emptying of bladder every 2-4 hours: 1 point, OR
- Refer to higher-level facility: 1 point

### **Section 3**

Vignette (No. 4.4.2.2.6): By 3pm, the fetal heart rate is consistently 180 beats per minute, her contractions are still two every 10 minutes and last 20 seconds. Her heart rate is 90, and her cervix remains unchanged with membranes still intact. What would you do to manage this patient? Answer assuming that equipment and medications that you would normally use to manage patients at this level are stocked and functional.

Total of 2 points maximum based on the following:

- Artificial rupture of membranes: 1 point
- Labor augmentation with oxytocin: 1 point

## **NEWBORN CARE: MANAGEMENT OF LOW BIRTH WEIGHT BABIES**

*Adapted from Vesel, Linda, Alexander Manu, Terhi J. Lohela, Sabine Gabrysch, Eunice Okyere, Augustinus H. A. ten Asbroek, Zelee Hill, Charlotte Tawiah Agyemang, Seth Owusu-Agyei, and Betty R. Kirkwood. 2013. "Quality of Newborn Care: A Health Facility Assessment in Rural Ghana Using Survey, Vignette and Surveillance Data." BMJ Open 3 (5): e002326. <https://doi.org/10.1136/bmjopen-2012-002326>.*

The management of low birth weight babies vignette is composed of two sections, totaling 20 points. Each section contributes to individual sub-section scores and an overall summed score as follows:

### **Section 1**

Vignette (No. 4.4.3.1.5): A 17-year-old woman pregnant for eight months delivered a baby at home. A trained community volunteer weighed the baby and found it to be 1.4 kg. As a result, she referred the baby to your facility. What would you do for this baby?

Total of 10 points maximum based on the following:

- Detain for thorough examination: 1.50 points
- Ensure breastfeeding is established and provide support if necessary: 2.05 points
- Put the baby in an incubator OR skin-to-skin with the mother: 2.13 points
- Teach the mother to keep baby skin-to-skin/kangaroo mother care position (if in incubator, when taken out): 1.92 points
- Check cord dressing and other potential sources of infection: 1.28 points
- Encourage and ensure hygiene in care: 1.12 points

### **Section 2**

Vignette (No. 4.4.3.1.6): The mother says the baby is not breastfeeding and was contemplating giving glucose solution. What would you do?

Total of 10 points maximum based on the following:

- Watch her breastfeed her baby and teach her good positioning and attachment: 3.03 points
- Examine the baby's mouth to ensure there are no anatomical deformities: 1.47 points
- If baby is not breastfeeding, teach her to express the milk and feed with a clean cup: 2.50 points
- Encourage infant formula only if exclusive breast milk is not possible and mother can afford: 1.00 points
- Educate her and encourage her to practice exclusive breastfeeding for the first six months of the baby's life: 2.00 points

## **MALARIA IN PREGNANCY**

*Adapted from USAID Data For Impact (D4I)*

The malaria in pregnancy vignette is composed of five sections, totaling 12 points. Each section contributes to individual sub-section scores and an overall summed score as follows:

### **Section 1**

Vignette (No. 4.4.1.1.5): Ada is 23 years old and has been married for four years. She arrives for her second visit to the antenatal clinic at 26 weeks after her last menstrual period. Ada's husband works in a distant village and visits her

occasionally. She lives with her mother, father, and sister-in-law. Her mother-in-law has accompanied her to the clinic. Ada complains of feeling tired. She has to carry buckets of water from a nearby tube well every day. What questions do you ask her? Anything else?

Total of 4 points maximum based on the following:

- Number of pregnancies, number of deliveries (live births), number of miscarriages, number of children alive, number of children born alive who have died: 1 point if one or more mentioned
- History of hypertension, history of diabetes, family health history, past illnesses: 1 point if one or more mentioned
- Complaints during this pregnancy, feeding/nutrition: 1 point if one or more mentioned
- Sexual history, marital status, occupation, education level, family/support network, religious affiliation: 1 point if one or more mentioned

## Section 2

Vignette (No. 4.4.1.1.6): She tells you that this is her second pregnancy. She has had chills and a fever for a few days and also complains of headaches. The only notable elements from her social history are that she has been married for four years and works on her family's farm. What does your physical examination of the patient include? Anything else?

Total of 3 points maximum based on the following:

- Temperature: 1 point
- Height, weight, blood pressure, pulse, respiratory rate, check for anemia, nutritional assessment, dehydration: 1 point if one or more mentioned
- Abdominal palpation, fetal heart rate, fundal height, presence of edema: 1 point if one or more mentioned

## Section 3

Vignette (No. 4.4.1.1.7): Ada is 1.5 m tall and weighs 70 kgs. Her blood pressure is normal, pulse is 65 beats per minute, and there is no edema. But her body feels warm and her temperature reading is 37.8 Celsius. You detect fetal movement. What tests, if any, do you order? Assume that the needed tests can be conducted at your facility.

Total of 2 points maximum based on the following:

- Malaria/mRDT (malaria rapid diagnostic test): 1 point
- Hemoglobin, hematocrit: 1 point if one or more mentioned

## Section 4

Vignette (No. 4.4.1.1.8): The mRDT test is positive. She is not anemic and urine protein levels fall within a normal range. Based on the history, exam, and test results, what is your assessment of the patient?

Total of 1 point maximum based on the following:

- Malaria/mRDT: 1 point

## Section 5

Vignette (No. 4.4.1.1.9): What is your next step? Assume that everything that is needed is in stock in the facility. Indicate the frequency and dose if applicable.

Total of 2 points maximum based on the following:

- Artemisinin-based combination therapy: 1 point

- Antipyretics/analgesics: 1 point if one or more mentioned

## NEWBORN RESUSCITATION SIMULATION

*Adapted from the DHS Program Service Provision Assessment*

The scoring for this simulation requires the following steps, which tallies up two sets of questions and creates a passing score as follows:

**Step 1.** Sum all answers to No. 4.4.3.2.6 to No. 4.4.3.2.12, and enter total with code "1" (Done) circled. If none are recorded, record "00."

**Step 2.** Sum answers to questions marked with an asterisk in the question.

These are No.4.4.3.2.7b + No.4.4.3.2.8d + No.4.4.3.2.8f + No.4.4.3.2.8g + No.4.4.3.2.8a + No.4.4.3.2.8b.

Score these with code "1" (Done) circled, and enter total. If none are recorded, record "0."

**Step 3.** Check Step 1 for total done, and Step 2 for total done, and indicate status:

Passed: Step 1= 17 and Step 2= 6

As such, to pass, the respondent must have 17 of 23 correct and must be observed for the six items marked with an asterisk in the module.

## Tables for the HFA report

Numerous analyses can be produced using the HFA dataset. However, the focus of the final report for the HFA should be to produce a set of easy-to-read statistical tables that contain analyses of all key indicators with their suggested disaggregates. Having produced the key outcome variables and the disaggregate variables in the dataset, the preliminary result tables can now be produced (using the sample weights) and then shared with the Technical Committee for in-depth review. Their review should indicate if new or additional analysis is needed and specify the analysis.

Each table in the HFA report must contain several elements to ensure that the data are presented in a complete and correct manner. The tables are composed of rows and columns. The rows house the survey disaggregates, such as health facility type, while the columns present the key or outcome variables. Tables should contain the following information:

- **TITLE:** The title outlines the key indicators and identifies the analysis. For example, "Table 1 Antenatal Care Readiness by key characteristics, [Country, year]"
- **SUB-HEADING:** Located below the title, the sub-heading provides an in-depth description of the key indicators in the table. For example, "Percentage of facilities with staff and guidelines, equipment, medicines and commodities (with no stock-outs in the past 3 months) to provide ANC [antenatal care] services, including Intermittent Preventive Treatment of Malaria for Pregnant Women (IPTp)"
- **COLUMN NAMES:** This shows a short name for the key indicator being analyzed, such as "ANC readiness." Note that a table may have several columns with different key indicators.
- **ROW NAMES:** The row headings are the disaggregate variables named in each row. For example, Managing Authority is one disaggregate, with the following categories: Government/public, NGO/not-for-profit, private-for-profit, Mission/faith-based, and other.
- **DENOMINATORS FOR EACH KEY INDICATOR:** Each key indicator should have a column to its right showing the name of the denominators and the value of the denominators for the indicator.

## Structure of the HFA report

After the HFA tables are finalized, a narrative containing the interpretation of the tables needs to be written. The suggested chapters for the HFA are as follows:

- Executive Summary: Key survey findings
- Chapter 1: Introduction: Outline of the survey's objectives, partners, and how the survey meets data needs
- Chapter 2: Methodology: Outline of the sampling methodology (including response and consent rates), questionnaire structure and methodology, training dates, and fieldwork dates
- Chapter 3: Health Facility Background main findings
- Chapter 4: Service Availability main findings
- Chapter 5: Service Readiness main findings
- Chapter 6: Quality and Safety of Patient Care main findings
- Chapter 7: Experience of Care main findings
- Chapter 8: Availability of Register and Data Management main findings
- Chapter 9: Community Services and Mobilization main findings
- Chapter 10: Health Facility Oversight, Quality Improvement, and Use of Data main findings
- Appendix 1: Questionnaires
- Appendix 2: Personnel involved in the survey

Throughout the report, various graphs and maps can be used to illustrate the main findings.

## Gathering feedback for the HFA report

After the initial review of the tables by the Technical Committee, a second batch of tables can be produced. With these in hand, the survey manager may opt to hold a workshop with sector experts and specialists to gather the interpretation of the tables. This will be particularly useful as much of the HFA's material requires specialized knowledge. Survey implementers may consider hiring a specialized technical writer for writing up the final report. Once produced, the final report must be approved by both the Technical and Steering Committees.

## Report release and dissemination

After the final report is approved, it can be disseminated. Many countries gather stakeholders to present the results in a national dissemination exercise. The purpose of the dissemination exercise is to ensure that the results reach the key data users in the country. The audiences for the dissemination exercise come from across the government, funders, and NGOs. Specific sub-national and facility level dissemination can also be considered, along with the possibility of having workshops on using the micro-data from the survey.

National dissemination and discussion of the results usually create momentum to further investigate the data in the report and package findings for different audiences. Policymakers, for example, can be targeted with specific policy briefs on selected topics from the HFA, while further analysis of the data can be of interest to academics who work closely with government agencies.

## Survey and data archiving

The microdata from the assessment should be appropriately archived. The purpose of archiving is to ensure that the data are easily available and contain sufficient metadata to allow data users to understand and analyze the data correctly. At its most basic, the archive contains the survey final report, the dataset, and metadata about the survey. This includes additional materials not included in the final report or dataset, such as training materials and manuals and further documentation of sampling and survey processes, including challenges encountered and their resolutions. The dataset can also be accompanied by further metadata, such as descriptions of data files, procedures on how to use them (such as aggregation and matching), and variable descriptions (including question references, universe, variable labels, and imputations used). This data, which should have all personal-identifying information removed, will also be uploaded to the USAID Development Data Library (DDL) in accordance with the USAID Open Data policy. More information about the USAID Open Data Policy and requirements for submission is available at [data.usaid.gov](https://data.usaid.gov).



## RELATED RESOURCES

The MOMENTUM modular HFA draws from a number of existing tools, including those developed by MOMENTUM awards. The primary tools used to create this assessment include, but are not limited to:

- MCSP Service Availability and Readiness Assessment Tool 2014
- [WHO Harmonized Health Facility Assessment 2022](#)
- [UNICEF Nest360 Health Facility Assessment 2021](#)
- [Service Provision Assessment Tool 2022](#)
- [WHO Infection Prevention and Control Assessment Framework at the Facility Level 2019](#)
- [MOMENTUM Country and Global Leadership Infection Prevention and Control for COVID-19 2020](#)

## APPENDIX 1. SURVEY MODULES, DATA COLLECTORS AND RESPONDENTS

HFA MODULE	DATA COLLECTOR	RESPONDENT
<b>Module 1: Visit Record, Introduction and Consent</b>	Interviewer	Health facility respondent
<b>Module 2: Health Facility Background</b>	Interviewer	Health facility respondent
<b>Module 3: Service Availability</b>		
1. Staffing and training	Interviewer	Health facility respondent most knowledgeable about each cadre
2. Inpatient and observation beds	Interviewer	Health facility respondent
<b>Module 4: Service Readiness</b>		
1. Infrastructure		
a. Communications	Interviewer	Health facility respondent
b. Emergency and referral transport	Interviewer	Health facility respondent
c. Power supply	Interviewer	Health facility respondent
d. Water source	Interviewer	Health facility respondent
e. Basic client amenities	Interviewer	Health facility respondent
f. Payment for services	Interviewer	Health facility respondent
g. Infection control	Interviewer	Health facility respondent most knowledgeable about infection control
<i>+IPC checklist</i>	Interviewer	Health facility respondent most knowledgeable about infection control
<i>+IPC stocks</i>	Interviewer	Health facility respondent most knowledgeable about infection control
<i>+healthcare waste management</i>	Interviewer	Health facility respondent most knowledgeable about infection control

h. Processing of equipment for reuse	Interviewer	Health facility respondent most knowledgeable about infection control
2. Available Services		
Reproductive, Maternal, Newborn and Child Health		
a. Family planning (FP) services	Interviewer	Health facility respondent most knowledgeable about family planning services
b. Antenatal services	Interviewer	Health facility respondent most knowledgeable about antenatal care services
c. Obstetric and newborn care	Interviewer	Health facility respondent most knowledgeable about delivery services
d. C-section	Interviewer	Health facility respondent most knowledgeable about delivery services
e. Other FP/OB/GYN surgical procedures	Interviewer	Health facility respondent most knowledgeable about reproductive health services
f. Small and sick newborn care	Interviewer	Health facility respondent most knowledgeable about newborn care services
g. Gender-based violence services	Interviewer	Health facility respondent most knowledgeable about gender-based violence services
Child and Adolescent Health		
a. Child immunization	Interviewer	Health facility respondent most knowledgeable about childhood Immunization Services
b. Child preventative and curative care	Interviewer	Health facility respondent most knowledgeable about child preventative and curative care services
c. Adolescent health services	Interviewer	Health facility respondent
d. Nutrition readiness	Interviewer	Health facility respondent most knowledgeable about inpatient care for management of severe acute malnutrition (SAM) with medical complications
3. Diagnostics	Interviewer	Health facility respondent within the main laboratory
4. Provider Knowledge and Competency	Trained Clinician	Health facility service provider

a. Antenatal Care	Trained Clinician	Health care worker in antenatal care
b. Delivery Services	Trained Clinician	Health care worker in delivery services
c. Newborn Care	Trained Clinician	Health care worker in newborn care
d. Child Health	Trained Clinician	Health care worker in child health
e. Family Planning	Trained Clinician	Health care worker in family planning
<b>Module 5: Quality and Safety of Patient Care</b>		
1. Facility adherence to standards	Interviewer	Health facility respondent most familiar with quality improvement and quality assurance of the facility (for part 1)
		Health facility respondent most familiar with pharmaceutical commodities (for part 2)
2. General/patient outcomes	Interviewer	Health facility respondent most knowledgeable about health management information system or a manager's office
3. Patient Care Process (observations)	Trained Clinician	Health care worker
a. Antenatal Care	Trained Clinician	Health care worker in antenatal care services
b. Delivery Services— Admission	Trained Clinician	Health care worker in admissions to labor and delivery
c. Delivery Services— Postpartum Monitoring	Trained Clinician	Health care worker in postpartum monitoring
d. Child Health	Trained Clinician	Health care worker in sick child evaluation
e. Nutrition	Trained Clinician	Health care worker in sick child evaluation
4. Patient Outcomes (Record Review)	Interviewer	<i>Record of records</i>
a. Antenatal Care	Interviewer	<i>Record of records</i>

b. Malaria in children under 5	Interviewer	<i>Record of records</i>
<b>Module 6: Experience of Care</b>	Interviewer	Client
a. Antenatal Care	Interviewer	Client
b. Labor and Delivery/Early Postnatal Care	Interviewer	Client
c. Child Health	Interviewer	Client
d. Family Planning	Interviewer	Client
<b>Module 7: Availability of Register and Data Management</b>		
Register Review	Interviewer	<i>Review of the registries of different departments in the health facility</i>
<b>Module 8: Community Services and Mobilization</b>		
1. Community Outreach	Interviewer	Health facility respondent most knowledgeable about community outreach
2. Demand Creation	Interviewer	Health facility respondent most knowledgeable about community outreach
<b>Module 9: Health Facility Oversight, Quality Improvement, and Use of Data</b>	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer
1. Data visualization and use	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer
2. Health Facility QI Process	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer
3. Decision making using data	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer

4. District-level support	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer
5. Supervision by DHO	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system (HIS) officer
6. Data Dissemination and Community Engagement	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer
7. Data collection and use at health facility	Interviewer	Medical officer in charge of the facility. If unavailable, (an)other doctor(s) who is a provider of reproductive, maternal, newborn and child health services or nurses/ midwives or monitoring and evaluation/ health information system officer

# APPENDIX 2. MOMENTUM INDICATORS OF QUALITY OF MNCHN/FP/RH SERVICES PERFORMANCE INDICATOR REFERENCE SHEETS

## Indicator MNH.HFA.1

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM HFA INDICATOR MNH.HFA.1

**Indicator MNH.HFA.1:** Antenatal care (ANC) readiness: The percentage of facilities with staff and guidelines, equipment, medicines and commodities (no stock-outs in the past 3 months) to provide ANC services, including Intermittent Preventive Treatment of Malaria for Pregnant Women (IPTp)

#### Precise Definition

**Numerator:** Number of facilities with staff

(a. trained on any aspect of ANC **No. 4.2.1.2.3a=1** and

b. trained on IPTp **No. 4.2.1.2.3b=1**)

and guidelines

(c. national ANC guidelines, **No. 4.2.1.2.2a= 1 or 2**

d. any ANC checklists or job aids, **No. 4.2.1.2.2b= 1 or 2**

e. national guidelines on IPTp, **No. 4.2.1.2.2c= 1 or 2**

f. any IPTp checklists or job aids), **No. 4.2.1.2.2d= 1 or 2**

equipment

(g. blood pressure apparatus **No. 4.2.1.2.4 a1= 1 or 2,**

h. foetal stethoscope **No. 4.2.1.2.4 c= 1 or 2,**

i. adult weighing scale **No. 4.2.1.2.4 f1= 1 or 2,**

j. examination bed **No. 4.2.1.2.4 g1= 1 or 2,**

k. tape measure **No. 4.2.1.2.4 h= 1 or 2,**

l. ITN or vouchers for ITN **No. 4.2.1.2.4 j= 1 or 2),**

medicines

(m. sulfadoxine-pyrimethamine (SP) for IPTp **No. 4.2.1.2.6 h1=1 and No. 4.2.1.2.6 h2=0,**

n. iron supplement (**No. 4.2.1.2.6 a1=1 and No. 4.2.1.2.6 a2=0**) or (**No. 4.2.1.2.6 c1=1 and No. 4.2.1.2.6 c2=0**),

o. folic acid (**No. 4.2.1.2.6 b1=1 and No. 4.2.1.2.6 b2=0**) or (**No. 4.2.1.2.6 c1=1 and No. 4.2.1.2.6 c2=0**),

p. low dose aspirin **No. 4.2.1.2.6 f1=1 and No. 4.2.1.2.6 f2=0,**

q. TT immunization **No. 4.2.1.2.6 d1=1 and No. 4.2.1.2.6 d2=0,**

r. penicillin **No. 4.2.1.2.6 e1=1 and No. 4.2.1.2.6 e2=0,**

s. calcium supplements **No. 4.2.1.2.6 g1=1 and No. 4.2.1.2.6 g2=0**) and

	<p>commodities</p> <p>(t. HIV tests <b>No. 4.2.1.2.5c1=1 and No. 4.2.1.2.5c2=0,</b></p> <p>u. syphilis tests <b>No. 4.2.1.2.5b1=1 and No. 4.2.1.2.5b2=0,</b></p> <p>v. proteinuria tests <b>No. 4.2.1.2.5a1=1 and No. 4.2.1.2.5a2=0</b>) (no stock-outs in the past 3 months) to provide ANC services, including IPTp (where applicable).</p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>The indicator should be calculated separately for each of the twenty-two elements included in the numerator definition. Reporting could be re-aggregated by readiness group type (i.e. commodities, equipment, training and guidelines).</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Antenatal care provides an opportunity to screen for and treat diseases (both pregnancy related and pre-existing), provide preventative and curative interventions and build a relationship and trust between provider and pregnant woman. The equipment, supplies and adequately trained staff available at the facility are a necessary, though not sufficient, component of providing quality maternal care. This is a recommended indicator by HHFA</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>The data for each element will be collected via facility inventory, wherein the data collector will record the components listed in the numerator definition as being “observed”, “reported but not observed” or “not available”. The data collector will examine equipment to determine if it is functional, and medicines and testing commodities to determine if they are valid (i.e. not expired).</p>
<p><b>Method of data collection and construction</b></p>	<p>Facility inventory</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Records of stock-outs may be incomplete or not updated and verbal report of stock outs subject to recall and social desirability bias.</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess facility readiness to provide quality antenatal care services.</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	<p>The indicator should be customized by MOMENTUM awards based on malaria burden in countries and to reflect national policies regarding IPTp.</p>



<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.2

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.2	
<b>Indicator MNH.HFA.2:</b> Physical examination and screening minimum elements: The percentage of ANC clients receiving minimal elements of physical examination and screening appropriate for ANC visit	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of ANC clients receiving minimal elements of physical examination including</p> <ul style="list-style-type: none"> <li>a) Height <b>No. 5.3.1.9=3 (1st visit only),</b></li> <li>b) Weight <b>No. 5.3.1.9=2 ,</b></li> <li>c) Examination for dates (e.g. fundal height) <b>No. 5.3.1.9=4,</b></li> <li>d) Fetal heartbeat <b>No. 5.3.1.9=5,</b></li> <li>e) Auscultation of heart and lungs (1st visit only) <b>No. 5.3.1.9=6;</b></li> <li>f) Blood pressure measured <b>No. 5.3.1.9=1 [ANC visit 1 only for height and auscultation of heart and lungs]</b> and screening for</li> <li>g) anemia/hemoglobin <b>No.5.3.1.10a=1 or 2 or 3,</b></li> <li>h) syphilis <b>No.5.3.1.10d=1 or 2 or 3;</b> and</li> <li>i) HIV status <b>No.5.3.1.11=1 or 2 or 3 or 4 or 5</b></li> </ul> <p><b>Denominator:</b> Number of observed ANC client-provider consultations and/or number of review of client ANC cards</p> <p><b>Unit of measure:</b> ANC client</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Antenatal care provides an opportunity to screen for and treat diseases (both pregnancy related and pre-existing), provide preventative and curative interventions and build a relationship and trust between provider and pregnant woman. There are a number of elements of care that must be provided during a visit to be considered adequate. This is an indicator recommended for the SPA.
<b>Data Disaggregation</b>	Type of SDP; Age (<20; 20-25; 25+), ANC visit (first visit vs. others)
<b>Data Source(s) and Data</b>	This data will be collected via direct observation of an ANC visit and review of ANC client card. A trained study staff will use a questionnaire including a checklist to

<b>Collection Instruments</b>	record the components of care provided. Following the visit, the study staff will review the ANC client card to confirm services provided during the visit.
<b>Method of data collection and construction</b>	Direct observation and ANC client card review
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Hawthorne effect, whereby providers may act differently because they are aware of the study team's presence at the facility. Potential selection bias if women with certain characteristics systematically forget to bring their ANC client card. Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias
<b>Data Use</b>	This data will be used to assess the quality of antenatal care provided at the facility. Each element should be reported separately in an annex to identify gaps in ANC service quality.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.3

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.3

**Indicator MNH.HFA.3:** Evidence based preventive interventions during ANC: Percent of ANC clients receiving all preventive treatments appropriate for the ANC visit and in accordance with national guidelines.

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of ANC clients receiving all preventive interventions during antenatal care visits including</p> <ul style="list-style-type: none"> <li>a) IPTp (adapted to reflect national policies) <b>No. 5.3.1.12=2</b></li> <li>b) iron/folate (IFA) <b>No. 5.3.1.12=1,</b></li> <li>c) Tetanus Toxoid <b>No. 5.3.1.12=5,</b></li> <li>d) provision of an insecticide treated net (ITN) (in malaria endemic areas) <b>No. 5.3.1.12=3</b></li> </ul>
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	<p>e) de-worming medication (where applicable) appropriate for the specific ANC visit and in accordance with national guidelines <b>No. 5.3.1.12=4</b>.</p> <p><b>Denominator:</b> Number of observed ANC client-provider consultations and/or number of reviewed client ANC cards</p> <p><b>Unit of measure:</b> ANC client</p> <p><b>Data Type:</b> Percentage</p> <p>As a composite indicator, all evidence-based practices must be observed or recorded by the data collector. However, when reporting, this indicator could be disaggregated by ANC element and reported in an annex to highlight gaps in ANC care.</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Antenatal care provides an opportunity to screen for and treat diseases (both pregnancy related and pre-existing), provide preventative and curative interventions and build a relationship and trust between provider and pregnant woman. There are a number of elements of care that must be provided during a visit to be considered adequate.</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; Age (&lt;20; 20-25; 25+); ANC visit (first visit vs. others)</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via direct observation of an ANC visit and review of ANC client card. A trained study staff will use a questionnaire including a checklist to record the components of care provided. Following the visit, the study staff will review the ANC client card to confirm services provided during the visit.</p>
<p><b>Method of data collection and construction</b></p>	<p>Direct observation and ANC client card review</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility. Potential selection bias if women with certain characteristics systematically forget to bring their ANC client card. Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of antenatal care provided at the facility</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	

This sheet was last updated on: 9/15/2021

## Indicator MNH.HFA.4

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.4

**Indicator MNH.HFA.4:** Person-centered ANC (composite 8-item): % clients who score at least 75% on person-centered ANC scale - See Gen.2 below

### PERFORMANCE INDICATOR REFERENCE SHEET INDICATOR GEN.2

**Indicator Gen.2: Percent of provider/client interactions where clients were treated respectfully (respectful treatment) in MOMENTUM-supported facilities**

#### Precise Definition

#### OVERALL DEFINITION

For maternal care, family planning, and antenatal care, this indicator is a score measuring the degree of respectful/person-centered care experienced by the client during their most recent visit with a service delivery provider in MOMENTUM-support facilities.

**Unit of measure:** Clients

**Data Type:** Mean score for respectful/person-centered maternal care, family planning, and antenatal care; Percentage for respectful/family-centered pediatric care

This indicator will be broken down by technical service area and links to MNH.8 related to respectful maternal care and FP/RH.9 related to FP quality of care

#### RESPECTFUL/CLIENT-CENTERED ANTENATAL CARE DEFINITION

The person-centered antenatal care score will be determined using the validated person-centered maternal care scale (13 items) developed by [Afulani et al.](#)

**The score can be calculated by adding up the responses from the following variables and dividing by 42.**

**No. 6.2.1.1b + No. 6.2.1.2b + No. 6.2.1.3b + No. 6.2.1.4b + No. 6.2.1.5 + No. 6.2.1.6 + No. 6.2.1.8 + No. 6.2.1.9 + No. 6.2.1.11 + No. 6.2.1.13 + No. 6.2.1.18 + No. 6.2.1.19 + No. 6.2.1.20 + No. 6.2.1.21 + No. 6.2.1.22 + No. 6.2.1.23 + No. 6.2.1.24 + No. 6.2.1.25**

**Note: Don't Know/Can't remember responses should not be included in the calculation**

#### Respectful/person-centered antenatal care

Adapted from the definition of respectful maternal care and person-centered maternal care, respectful/person-centered antenatal care (RAC/PCANC) refers to

	antenatal care that is respectful of and responsive to individual pregnant women and their families' preferences, needs, and values.
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Respectful care and person-centered/family-centered care is a component of quality of care, and influences health outcomes. This indicator monitors one dimension of quality of care experienced by women and caregivers who access health services in MOMENTUM facilities or program areas.
<b>Data Disaggregation</b>	Age (<20, 20-24; 25+); technical area (maternal care, antenatal care, family planning, pediatric care); urban/rural; type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	Data for this indicator can be collected through client exit interviews with women accessing services at MOMENTUM health facilities; or household surveys with women of reproductive age in MOMENTUM program areas. <b>RESPECTFUL/CLIENT-CENTERED ANTENATAL CARE</b> Client exit interviews using a scorecard of the validated person-centered antenatal care scores (13-item) developed by <a href="#">Afulani et. al.</a> The indicator will be calculated following Afulani et al's approach and an annual mean score will be provided.
<b>Method of data collection and construction</b>	A sample of women or caregivers will be interviewed after receiving services at MOMENTUM-supported facilities where MOMENTUM interventions have been carried out. Data may also be collected through household-based surveys.
<b>Data Collection and Reporting Frequency</b>	Data collection will occur as assessments are completed for client exit interviews; and annually if household based surveys are conducted. Reporting will be annually.
<b>Baseline timeframe</b>	
<b>Data Quality Considerations</b>	Women and clients may be biased in their reporting if interviews are completed at the facility just after services have been provided
<b>Data Use</b>	Used to monitor experience of care over time.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 07/24/2021	

## Indicator MNH.HFA.5

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.5

**Indicator MNH.HFA.5:** ANC Communication during pregnancy/ anticipatory postnatal care - 6 elements:  
The percentage of ANC clients who report discussing specific pregnancy/anticipatory postnatal care elements with their provider

<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of ANC clients who report discussing all or none of the following specific pregnancy and anticipatory postnatal care elements with their provider:</p> <ul style="list-style-type: none"> <li>- IFA supplements <b>No. 6.2.1.12=1</b>, and</li> <li>-birth preparedness <b>No. 6.2.1.10=1</b>, and</li> <li>- fetal movement <b>No. 6.2.1.7=1</b>, and</li> <li>- early and exclusive breastfeeding <b>No. 6.2.1.14=1 or No. 6.2.1.15=1</b>, and</li> <li>- postpartum family planning <b>No. 6.2.1.17=1</b> , and</li> <li>- ITN use <b>No. 6.2.1.16=1</b></li> </ul> <p><b>Denominator:</b> Number of ANC clients interviewed</p> <p><b>Unit of measure:</b> ANC client</p> <p><b>Data Type:</b> Percentage</p> <p>The indicator will be calculated in two different ways to show the percentage of ANC clients who report discussing all six of the elements with their provider and the percentage of ANC clients who report discussing none of the six elements with their provider. <b>The calculation shown above provides the algorithm for the former. To calculate the latter, modify all response categories to 0.</b></p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Counseling during antenatal care allows for dissemination of important health and nutrition information as well as preparing women for delivery and postpartum activities including breastfeeding and family planning. This is an indicator recommended for the SPA.</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; Age (&lt;20; 20-25; 25+); Counseling element</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via client exit interview, where ANC clients will be administered a questionnaire immediately following the ANC visit where they will be asked to recall whether they received counseling on the subjects outlined above.</p>
<p><b>Method of data collection and construction</b></p>	<p>Client exit interview</p>

<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility. Social desirability bias, where a pregnant woman may report receiving counseling in more subjects in order to appear more favorable to the interviewer.
<b>Data Use</b>	This data will be used to assess the communication and quality of antenatal care provided at the facility. These counseling elements should be reported separately in an annex to identify gaps in ANC communication. The suggested composite indicators described above can be broken down in different ways to meet the needs of the awards.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.6

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.6	
<b>Indicator MNH.HFA.6:</b> EmONC Availability: Availability of functional EmONC facilities (# per population and % of facilities) in MOMENTUM-supported areas	
PIRS details available in MNH.1 in MOMENTUM Result 1 PIRS Annex 1.	

PERFORMANCE INDICATOR REFERENCE SHEET INDICATOR MNH.1	
<b>Indicator MNH.1: Availability of functional EmONC facilities (Percent of facilities and number per population) in MOMENTUM-supported areas</b>	
<b>Precise Definition</b>	<p><b>Numerator:</b> N1: Number of facilities in MOMENTUM-supported areas that have the seven (BEmONC) or nine (CEmONC) EmONC signal functions</p> <p>N2: Number of facilities in MOMENTUM-supported areas that have the seven (BEmONC) or nine (CEmONC) EmONC signal functions x 500,000</p> <p><b>Denominator:</b> D1: Number of facilities in MOMENTUM-supported areas assessed</p> <p>D2: Estimated population in MOMENTUM-supported areas</p>

	<p>Estimated population-based denominators need to be treated with care. When using these denominators, the following considerations should be noted: Estimates of target denominators (or a suitable proxy indicator) are available and sufficiently accurate for their intended use; Reporting from facilities that serve the target denominator population needs to have very high reporting rates (e.g. above 90%) and reflect all facilities serving that population; The quality of the data reported must be high and consistent over time. (<a href="https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf?ua=1">https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf?ua=1</a>)</p> <p><b>Unit of measure:</b> Health Facilities</p> <p><b>Data Type:</b> D1: Percent; D2: Density Ratio</p> <p>A basic emergency obstetric and newborn care (EmONC) facility is one in which all functions 1-7 below are performed. A comprehensive emergency obstetric and newborn care (CEmONC) facility is one in which all functions 1-9 below are performed in the last three months.</p> <p><u>Basic services signal functions (1-7)</u></p> <ol style="list-style-type: none"> <li>1. Administer parenteral* antibiotics (<b>No. 4.2.1.3.17a=1</b>)</li> <li>2. Administer uterotonic drugs† (i.e. parenteral oxytocin) (<b>No. 4.2.1.3.17b=1</b>)</li> <li>3. Administer parenteral anticonvulsants for preeclampsia and eclampsia (i.e. magnesium sulfate). <b>No. 4.2.1.3.17c=1</b></li> <li>4. Manually remove the placenta <b>No. 4.2.1.3.17e=1</b></li> <li>5. Remove retained products (e.g. manual vacuum extraction, dilation, and curettage) <b>No. 4.2.1.3.17f=1</b></li> <li>6. Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery) <b>No. 4.2.1.3.17d=1</b></li> <li>7. Perform basic neonatal resuscitation (e.g. with bag and mask) <b>No. 4.2.1.3.17g=1</b></li> </ol> <p><u>Comprehensive Services - perform signal functions 1-7, plus:</u></p> <ol style="list-style-type: none"> <li>8. Perform surgery (e.g. cesarean section) <b>No. 4.2.1.3.17h=1</b></li> <li>9. Perform blood transfusion <b>No. 4.2.1.3.17i=1</b></li> </ol> <p>(<a href="https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf?sequence=1&amp;isAllowed=y">https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf?sequence=1&amp;isAllowed=y</a>)</p>
<b>Rationale</b>	<p>Recommended by GSWCAH, EPMM, ENAP, CD</p> <p>“To save women with obstetric complications, the health system must have facilities that are equipped, staffed, and actually provide EmONC. The composite nature of this</p>

\* Injection or intravenous infusion.

† Uterotonic drugs are administered both to prevent and to treat postpartum hemorrhage. A recent WHO technical consultation (Nov 2008) to develop guidelines for interventions for preventing postpartum hemorrhage, reviewed all available evidence, and identified parenteral oxytocin as the recommended choice of drug for the prevention of postpartum hemorrhage. Parenteral ergometrine (2nd line) and misoprostol (3rd line) are options that should only be used where oxytocin is not available.



<i>(and any Link to Foreign Assistance Framework)</i>	<p>indicator tells us not only whether the signal functions were performed recently; it also indirectly tells us about the availability of equipment and drugs and the availability and skill of the staff. A health center that provides basic EmONC can prevent many maternal and perinatal deaths.”</p> <p>(<a href="https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf?sequence=1&amp;isAllowed=y">https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf?sequence=1&amp;isAllowed=y</a>)</p>
<b>Data Disaggregation</b>	BEmONC/CEmONC; Type of Service Delivery Point (SDP); (country, district and urban/rural through meta-data)
<b>Data Source(s) and Data Collection Instruments</b>	<p><u>Rapid Health Facility Assessment/Audit</u> - The first step in gathering the required data is to make an exhaustive, up-to-date list of all the facilities in each selected area that may be providing delivery and EmONC services (basic or comprehensive), as defined by the signal functions performed in the last 3 months. A facility that may be providing EmONC services is: (1) on the government’s list of hospitals and lower-level facilities that should be providing delivery services; (2) on a list of private hospitals and lower level facilities that might be providing at least some delivery services; or (3) known by the area medical officer as possibly providing delivery services. The list should be as complete as possible so that no EmONC facility is overlooked; however, care should be taken to avoid double counting. The health facility assessment (HFA) should include a checklist of signal functions performed by the facility.</p> <p><a href="https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf?sequence=1&amp;isAllowed=y">https://apps.who.int/iris/bitstream/handle/10665/44121/9789241547734_eng.pdf?sequence=1&amp;isAllowed=y</a></p>
<b>Method of data collection and construction</b>	Facility assessment conducted with on-site visit and completion of EmONC checklist via direct observation or interview with facility staff to confirm the facility performs the signal functions.
<b>Data Collection and Reporting Frequency</b>	As assessment completed
<b>Baseline timeframe</b>	N/A
<b>Data Quality Considerations</b>	<p><u>From the D4I database:</u> The use of this indicator in a wide variety of countries has revealed at least three difficulties in its application. First, where geographical terrain is particularly challenging and transportation is precarious, the ratio of facilities to population may require adjustment for local use. Second, the reference period for assessing whether a signal function or procedure has been performed is generally three months, but when patient volume is low, one or more of the signal functions may not be performed, because an occasion did not present itself, not for lack of infrastructure or provider skills. Finally, a third situation concerns normative medical practice that fails to include one of the procedures, for example, assisted vaginal delivery. In some countries, vacuum extraction or forceps delivery is no longer taught to medical students or midwives and only a few older providers are experienced at performing these procedures.</p> <p>To solve these problems, one may consider preparing the indicator in several ways. However, to compare facilities across space and time effectively, it is recommended</p>

	to maintain the original operational definitions of these ratios. Evaluators should well document alternative calculations, and should report the adjusted ratio of population to facility; the length of the new reference period, (if it is extended); the way a category of “potential” basic EmONC was created (if a procedure is generally performed, but during the study period was not); or the way country-specific criteria were established (if the criteria omits a particular signal function).
<b>Data Use</b>	This indicator measures the availability of basic and comprehensive Emergency Obstetric and Newborn Care in MOMENTUM-supported areas and will support monitoring of program performance in strengthening readiness to deliver and institutionalize quality MNCHN/FP/RH services. The indicator will also support reporting for internal MOMENTUM technical and program reviews and adaptive learning.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	9/15/2022: Added the three-month recall period for the performance of the signal functions to reflect the standard definition
This sheet was last updated on: 09/15/2022	

## Indicator MNH.HFA.7

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.7	
<b>Indicator MNH.HFA.7:</b> Labor and delivery readiness: The percent of facilities with readiness components for essential labor and childbirth care and management of obstetric and newborn complications.	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with readiness components for essential labor and childbirth care and management of obstetric and newborn complications.</p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>Readiness components can be broken down into two categories: equipment and medication/commodities.</p> <p>Data collectors should indicate whether or not each piece of equipment is available (i. Observed ii. Reported, not seen. iii. Not Available) and functional, where applicable. To be considered “available”, equipment should be physically located in the service delivery area or close enough that a provider could access and use it.</p> <p>Equipment to be inventoried includes:</p> <p>a) blank partograph <b>No. 4.2.1.3.21a=1,</b></p>

- b) delivery bed with stirrups **No. 4.2.1.3.21b1=1,**
  - c) disposable non-sterile latex gloves **No. 4.2.1.3.21c1=1,**
  - d) disposable sterile latex gloves **No. 4.2.1.3.21d1=1,**
  - e) examination light **No. 4.2.1.3.21e1=1,**
  - f) delivery pack **No. 4.2.1.3.21f=1** (includes items g-k),
  - OR** [g] cord clamp **No. 4.2.1.3.21g1=1,** h) episiotomy scissors **No. 4.2.1.3.21h1=1,** i) scissors or blade to cut cord **No. 4.2.1.3.21i1=1,** j) suture thread with needle **No. 4.2.1.3.21j=1** , k) needle holder **No. 4.2.1.3.21k1=1** ]
  - l) manual vacuum extractor **No. 4.2.1.3.21l1=1,**
  - m) forceps for outlet application **No. 4.2.1.3.21m1=1,**
  - n) vacuum aspirator **No. 4.2.1.3.21n1=1,**
  - o) D&C kit **No. 4.2.1.3.21o1=1,**
  - p) speculum **No. 4.2.1.3.21p1=1,**
  - q) pulse oximeter **No. 4.2.1.3.21q1=1,**
  - r) blood pressure apparatus **No. 4.2.1.3.21r1=1,**
  - s) foetal stethoscope/pinard/foetoscope/digital Doppler **No. 4.2.1.3.21s1=1,**
  - t) towel for drying newborn **No. 4.2.1.3.21t=1,**
  - u) infant scale **No. 4.2.1.3.21u1=1** ,
  - v) ultrasound **No. 4.2.1.3.21v1=1** ,
  - w) resuscitation table **No. 4.2.1.3.21w1=1** ,
  - x) infant incubator **No. 4.2.1.3.21x1=1** ,
  - y) electric or manual suction pump **No. 4.2.1.3.21y1=1** ,
  - z) suction catheter for suctioning newborn **No. 4.2.1.3.21z1=1** ,
  - aa) suction bulb (single use **No. 4.2.1.3.21aa1=1** ),
  - bb) suction bulb (sterilizable multi-use) **No. 4.2.1.3.21ab=1** ,
  - cc) thermometer **No. 4.2.1.3.21ac=1** ,
  - dd) adult sized resuscitation bag and mask **No. 4.2.1.3.22a=1,**
  - ee) preterm infant resuscitation bag and mask **No. 4.2.1.3.23a=1,**
  - ff) term infant resuscitation bag and mask **No. 4.2.1.3.24a=1.**
- Oxygen -related equipment inventoried should include:**
- a) central oxygen supply (**No. 4.2.1.3.27d1=1 OR No. 4.2.1.3.27e1=1**),
  - b) oxygen concentrator, **No. 4.2.1.3.27b1=1**
  - c) oxygen tank with attached pressure gauge, pressure regulator, **No. 4.2.1.3.27a1=1**
  - d) flowmeter for oxygen source, with gradations in mL **No. 4.2.1.3.28a1=1,**
  - e) humidifier **No. 4.2.1.3.28b1=1,**

	<p>f) oxygen delivery apparatus (key connecting tubes and mask/nasal prongs <b>No. 4.2.1.3.28c1=1</b>),</p> <p>g) pediatric sized oxygen delivery apparatus <b>No. 4.2.1.3.28d1=1</b></p> <p>Medication and commodities should also be located within the service delivery areas and expiry status should be noted, i.e. (i. Observed and not expired, ii. observed and expired, iii. not observed but reported available/not seen, iv. not observed/not available today and v. not observed/never available). Data collectors should also ask about any stock-outs in the past 3 months.</p> <p>Medication and commodities to be inventoried include:</p> <p>a) magnesium sulfate injection <b>No. 4.2.1.3.31a1=1</b>,</p> <p>b) betamethasone injection <b>No. 4.2.1.3.31b1=1</b>,</p> <p>c) dexamethasone injection <b>No. 4.2.1.3.31c1=1</b>,</p> <p>d) intravenous infusion set <b>No. 4.2.1.3.31d1=1</b>,</p> <p>e) dextrose and water 5% (D5W) intravenous solution <b>No. 4.2.1.3.31e1=1</b>,</p> <p>f) sodium chloride (.09NS) intravenous solution <b>No. 4.2.1.3.31f1=1</b>,</p> <p>g) other plasma expander such as Ringer’s lactate <b>No. 4.2.1.3.31g1=1</b>,</p> <p>h) any skin disinfectant <b>No. 4.2.1.3.31h1=1</b>,</p> <p>i) misoprostol tablet 200 mcg <b>No. 4.2.1.3.31i1=1</b>,</p> <p>j) oxytocin injection <b>No. 4.2.1.3.31j1=1</b></p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Many of the direct causes of maternal mortality occur during labor and delivery including severe bleeding, infections after childbirth and other complications with delivery. The first step in preventing these deaths is ensuring that facilities are equipped with the essential components for labor and delivery. This is a recommended indicator for the SPA.</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; readiness component</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>The data will be collected via facility inventory as outlined in the HHFA, pages 221-224/5, where the different equipment and medicines will be determined to be available (either observed, reported by not observed, or not available) and functioning (for equipment) or out of stock in the last three months (for medicines)</p>
<p><b>Method of data collection and construction</b></p>	<p>Facility inventory</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>

<b>Data Quality Considerations</b>	Ensuring that equipment is confirmed functional and medicines confirmed valid
<b>Data Use</b>	This data will be used to assess facility readiness. Ideally, each element should be reported separately in an annex to identify gaps in labor and delivery readiness.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.8

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.8	
<b>Indicator MNH.HFA.8:</b> Maternal and perinatal death registration and review readiness: The percentage of facilities with standard operating procedures for registration and review of maternal deaths, neonatal deaths and stillbirths	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with systems in place to identify and conduct routine reviews of newborn mortality, maternal mortality and stillbirths (<b>No. 9.7.7=1 and 9.7.3=1 and 9.7.9=1 and 9.7.10=1</b>)</p> <p>.</p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>Systems, for maternal and perinatal deaths (newborn and stillbirths), are defined as death reviews that are conducted routinely for:</p> <ul style="list-style-type: none"> <li>• women who die in the facility within six weeks of giving birth</li> <li>• stillbirths and live births who die within 7 days of birth</li> </ul> <p>“Routinely” is defined as criteria in place for when the reviews will be carried out and a defined process for conducting the review.</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	The routine tracking of stillbirths and maternal and neonatal deaths allows for the identification of associated risk factors in order to inform future policy and programmatic actions. This indicator is based on existing questions in the WHO HHFA.

<b>Data Disaggregation</b>	Type of SDP; death type (maternal, newborn and stillbirth)
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected by facility inventory, using the processes outlined by the HHFA on pages 228 & 230. The interviewer conducting the inventory will inquire if there are standard operating procedures for the reviews of stillbirths and maternal and neonatal deaths and if they occur “routinely”, “sometimes”, “No [never]” or “never had a stillbirth/maternal or neonatal death”, and if possible to view the procedures.
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	If the report of standard operating procedures is strictly verbal, rather than visually confirmed, there is the possibility of social desirability bias whereby the facility staff report procedures being in place even if they are not as to appear more favorable to the interviewer.
<b>Data Use</b>	This data will be used to assess the facility readiness to review maternal and neonatal deaths and stillbirths.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.9

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.9	
<b>Indicator MNH.HFA.9:</b> Vital signs documented at admission: The percentage of women with maternal vital signs (blood pressure, temperature, pulse) and fetal vital signs (fetal heart tones) documented at admission to L&D	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of women with maternal vital signs</p> <p>a) blood pressure, <b>(No. 5.3.2.7 = 3)</b></p> <p>b) temperature <b>(No. 5.3.2.7 = 1)</b></p>

	<p>c) pulse (No. 5.3.2.7 = 2)  and fetal vital signs (No. 5.3.2.7 = 4)  (d) fetal heart tones (No. 5.3.2.7 = 4)</p> <p>documented at admission to labor and delivery over a specific time period</p> <p><b>Denominator:</b> Number of women who delivered at facility during the same time period</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b>  <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>The monitoring of maternal and fetal vital signs during labor and delivery allow for the identification of complications, including pre-eclampsia and eclampsia, which are a leading cause of maternal death and preterm birth. This is an indicator recommended for the SPA and by the 2016 WHO standards for improving quality of maternal and newborn care in health facilities.</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; vital sign</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected by record review if minimal data elements are available and of sufficient quality in country's registers. If the registers are incomplete and/or not up to date, the data will be collected via direct observation of labor and delivery at the facility, where a trained observer will use a checklist to record if the different vital sign checks were performed.</p>
<p><b>Method of data collection and construction</b></p>	<p>Record review</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Concerns regarding timeliness and completeness of registers. If data is collected by direct observation, potential of Hawthorne effect, whereby providers alter care because they are aware they are being observed. Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of maternal care, specifically labor and delivery services, provided at the facility</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	

<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.10

<b>PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.10</b>	
<b>Indicator MNH.HFA.10:</b> Monitored for bleeding, pulse, temperature and blood pressure: The percentage of women monitored for bleeding, pulse, temperature and blood pressure after delivery	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of women monitored for a) bleeding, b) pulse, c) temperature and d) blood pressure after delivery over a specific time period <b>(No. 5.3.3.7 = 1 and No. 5.3.3.7 = 2 and No. 5.3.3.7 = 3 and No. 5.3.3.7 = 4)</b></p> <p><b>Denominator:</b> Number of women who delivered at facility during the same time period</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Hemorrhage, infection following childbirth and pre-eclampsia/eclampsia are three of the leading causes of maternal death globally. The close monitoring of woman following delivery allows for the identification and treatment of these conditions in order to reduce maternal mortality. This is an indicator recommended for the SPA and by the 2016 WHO standards for improving quality of maternal and newborn care in health facilities.
<b>Data Disaggregation</b>	Type of SDP
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected by record review if minimal data elements are available and of sufficient quality in a country's registers. If the registers are incomplete and/or not up to date, the data will be collected via direct observation of labor and delivery at the facility, where a trained observer will use a checklist to record if the different vital sign checks were performed.
<b>Method of data collection and construction</b>	Record review or direct observation
<b>Data Collection and Reporting Frequency</b>	Quarterly



<b>Data Quality Considerations</b>	Concerns regarding timeliness and completeness of registers. If data is collected by direct observation, potential of Hawthorne effect, whereby providers alter care because they are aware they are being observed. Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias
<b>Data Use</b>	This data will be used to assess the quality of maternal care, specifically postpartum care services, provided at the facility
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.11

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.11	
<b>Indicator MNH.HFA.11:</b> Pre-eclampsia/Eclampsia - Providers knowledge score of hypertensive disorders of pregnancy (HDP): The percentage of providers with minimum knowledge score of management of hypertensive disorders of pregnancy	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of providers with minimum 80% knowledge score of HDP management</p> <p><b>Sum of:</b></p> <p><b>No. 4.4.2.1.4=1, 2 OR 3 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.5=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.5=2 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.5=3 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.6=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.6=2 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.6=3 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.8=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.8=2 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.8=3 - Assign 1 point</b></p>

	<p><b>No. 4.4.2.1.8=4 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.8=5 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.8=6 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.9=1 OR 2 - Assign 1 point</b></p> <p><b>No. 4.4.2.1.10=1 – Assign 1 point</b></p> <p><b>No. 4.4.2.1.10=2 – Assign 1 point</b></p> <p><b>Sum all and divide by 21.</b></p> <p><b>Denominator:</b> Number of providers interviewed</p> <p><b>Unit of measure:</b> Provider</p> <p><b>Data Type:</b> Percentage</p> <p>This indicator is a composite knowledge score, but can also be reported as individual components focusing on diagnosis, including correct classification of HDP, management based on diagnosis, and gestational age, maternal and fetal status, postnatal counseling, and pre-discharge interventions including MgSO4 loading dose where applicable.</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Hypertensive disorders during pregnancy, which includes pre-eclampsia, gestational hypertension, chronic hypertension, and pre-eclampsia superimposed on chronic hypertension, are leading causes of morbidity and mortality for mothers and newborns globally. Pre-eclampsia and eclampsia specifically are one of the leading causes of maternal mortality and interventions are available to prevent death if administered in a timely and appropriate manner. Provider knowledge of and ability to identify and treat these conditions is critical to reduce associated burden of disease and mortality. This indicator is recommended for the SPA.</p> <p><a href="http://apps.who.int/iris/bitstream/handle/10665/44703/9789241548335_eng.pdf?sequence=1">http://apps.who.int/iris/bitstream/handle/10665/44703/9789241548335_eng.pdf?sequence=1</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; cadre of provider</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via a written clinical vignette, administered to providers to assess their knowledge of HDP management.</p>
<p><b>Method of data collection and construction</b></p>	<p>Written clinical vignette</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>

<b>Data Quality Considerations</b>	Written vignettes do not capture actual decision making or provision of care (know-do gap), so serves as a proxy for quality of services rather than a direct measure <a href="https://jamanetwork.com/journals/jamapediatrics/article-abstract/2118580">https://jamanetwork.com/journals/jamapediatrics/article-abstract/2118580</a>
<b>Data Use</b>	This data will be used as a proxy measure to assess quality of maternal and labor and delivery services at the facility
<b>Other Notes, Discussion, &amp;/or Comments</b>	n/a
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.12

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.12

**Indicator MNH.HFA.12:** Prolonged labor - Providers knowledge score of prolonged labor management: The percentage of providers with minimum knowledge score of prolonged labor management

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of providers with minimum 80% knowledge score of prolonged labor management</p> <p><b>[if lower-level facility that refers these cases to higher level facilities]</b></p> <p><b>No. 4.4.2.2.4=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.2.5=3 - Assign 1 point</b></p> <p><b>Sum and divide by 2.</b></p> <p><b>[if higher level facility that manages prolonged labor]</b></p> <p><b>No. 4.4.2.2.4=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.2.5=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.2.5=2 - Assign 1 point</b></p> <p><b>No. 4.4.2.2.6=1 - Assign 1 point</b></p> <p><b>No. 4.4.2.2.6=2 - Assign 1 point</b></p> <p><b>Sum and divide by 5.</b></p> <p><b>Denominator:</b> Number of providers interviewed</p> <p><b>Unit of measure:</b> Provider</p>
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	<p><b>Data Type:</b> Percentage</p> <p>This indicator is a proxy to assess provider knowledge of appropriate prevention and management of prolonged labor.</p> <p>The indicator is a composite knowledge score, but can also be reported as individual components which focus on prevention, avoidance of non-indicated uterotonics, diagnosis, management –augmentation, indwelling urinary catheter, referral and postnatal counseling.</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Prolonged labor is a common birth complication that, if not managed appropriately, can lead to poor birth outcomes, hemorrhage, infection and even death. This indicator is recommended for the SPA.</p> <p><a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-233">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-233</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; cadre of provider</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via a written clinical vignette, administered to providers to assess their knowledge of prolonged labor management.</p>
<p><b>Method of data collection and construction</b></p>	<p>Written clinical vignette</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Written vignettes do not capture actual decision making or provision of care (know-do gap), so serves as a proxy for quality of services rather than a direct measure.</p> <p><a href="https://jamanetwork.com/journals/jamapediatrics/article-abstract/2118580">https://jamanetwork.com/journals/jamapediatrics/article-abstract/2118580</a></p>
<p><b>Data Use</b></p>	<p>This data will be used as a proxy measure to assess quality of labor and delivery services at the facility.</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	

This sheet was last updated on: 9/15/2021

## Indicator MNH.HFA.13

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.13

**Indicator MNH.HFA.13:** Provider competency for neonatal resuscitation: The percentage of simulated neonatal resuscitation cases meeting a minimum standard

<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of simulated neonatal resuscitation cases meeting a minimum standard (80% correct performance)</p> <p><b>Denominator:</b> Number of simulated cases with providers</p> <p><b>Unit of measure:</b> Provider [could be aggregated to facility]</p> <p><b>Data Type:</b> Percentage</p> <p><b>For calculation guidance, see Vignette and Simulation Scoring section of the user guide.</b></p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Approximately 10% of infants born every year will require respiratory intervention and support and birth asphyxia accounts for over 20% of neonatal deaths every year. This is an indicator recommended for the SPA and an indicator of health provider competency for the management of neonatal asphyxia, corresponding to Standard 1.5 (WHO 2016)</p> <p><a href="https://www.sciencedirect.com/science/article/pii/S0300957211007027?casa_token=aNP8W8bQEnkAAAAA:pxFpz5XieOFiSyKjay6Juv_Xgr_iWJ1DlvywRESeX1_6z5BoPOAo_jlk2WBURmoCKfdFYRsr50Q">https://www.sciencedirect.com/science/article/pii/S0300957211007027?casa_token=aNP8W8bQEnkAAAAA:pxFpz5XieOFiSyKjay6Juv_Xgr_iWJ1DlvywRESeX1_6z5BoPOAo_jlk2WBURmoCKfdFYRsr50Q</a></p> <p><a href="https://www.who.int/docs/default-source/gho-documents/world-health-statistic-reports/6-june-18108-world-health-statistics-2018.pdf">https://www.who.int/docs/default-source/gho-documents/world-health-statistic-reports/6-june-18108-world-health-statistics-2018.pdf</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; cadre of provider</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via simulation with providers, by adapting an existent neonatal resuscitation simulation tool (e.g., Helping Babies Breathe, Neonatalie).</p> <p><a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6172134/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6172134/</a></p>
<p><b>Method of data collection and construction</b></p>	<p>Simulation using model</p>

<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	
<b>Data Use</b>	This will be used to assess provider competency of neonatal resuscitation
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.14 – NOT COLLECTED IN MODULAR HFA

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.14

**Indicator MNH.HFA.14:** Provider Competency for immediate care after birth: The percentage of cases of simulated immediate care after birth for mother and newborn meeting minimal standard

**Precise Definition**

**Numerator:** Number of simulated routine cases meeting a minimum standard  
 Simulated immediate care after birth for mother and newborn meeting minimal standard:

- Immediate and thorough drying and skin-to-skin
- Prophylactic uterotonic preparation and administration
- Delayed cord clamping
- Put to breast soon after birth
- Postpartum vital signs
- Preparation for neonatal resuscitation
- Postpartum palpitation of uterus
- Assessment of placenta
- Explanation of procedures during labor
- Use of partograph
- Assessment of lacerations

**Denominator:** Number of simulated cases with providers  
**Unit of measure:** Provider [could be aggregated to facility]

	<b>Data Type:</b> Percentage
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Many maternal and neonatal deaths occur within the a few days following delivery. Postpartum maternal and newborn care provides the opportunity to identify and manage complications and initiate good health behaviors, like early initiation of and exclusive breastfeeding. This indicator measures provider competency to provide integrated essential early newborn care and PPH prevention, Statements 1.1 and 1.3 in the WHO standards for improving quality of maternal and newborn care in health facilities(WHO 2016). This indicator is recommended for the SPA.
<b>Data Disaggregation</b>	Type of SDP; cadre of provider
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via a simulation with providers using an adaptation of a 13-item index validated in numerous sub-Saharan African countries. <i>Additional guidance on how to adapt the scale for use in HFAs is forthcoming.</i>  13-item index: <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2281-z">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2281-z</a>
<b>Method of data collection and construction</b>	Simulation
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	
<b>Data Use</b>	This indicator measures provider competency to provide integrated essential early newborn care and PPH prevention.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.15

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.15

**Indicator MNH.HFA.15:** Companion of choice: The percentage of women who wanted and had a companion of their choice supporting them in the health facility:

- (1) during labor
- (2) during childbirth
- (3) after birth until time of discharge

<p><b>Precise Definition</b></p>	<p><b>Numerators:</b></p> <ul style="list-style-type: none"> <li>1) Number of women who wanted and had a companion of their choice supporting them during labor <b>No. 6.2.12b=1</b></li> <li>2) Number of women who wanted and had a companion of their choice supporting them during childbirth <b>No. 6.2.13b=1</b></li> <li>3) Number of women who wanted and had a companion of their choice supporting them after birth until the time of discharge <b>No. 6.2.14b=1</b></li> <li>4) an “all or none” composite indicator where women reported having a companion of their choice present at all times they were wanted</li> </ul> <p><b>“All” indicator: No. 6.2.12b=1 and No. 6.2.13b=1 and No. 6.2.14b=1</b></p> <p><b>Denominator:</b> Number of women interviewed</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>The presence of a labor companion is considered a component of respectful care, which is a key component of quality maternal care. The presence of a labor companion has been shown to increase the woman’s satisfaction with care and impact the provider-patient interaction.</p> <p><a href="https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012449.pub2/full#CD012449-sec-0044">https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012449.pub2/full#CD012449-sec-0044</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; Age (&lt;20; 20-25; 25+); timing of support (labor, childbirth, after birth until discharge)</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via client exit interview, where women who recently delivered in the facility will be asked to report whether they were able to have of a companion of their choice at the three time periods (labor, childbirth and after birth until discharge).</p>
<p><b>Method of data collection and construction</b></p>	<p>Client exit interview</p>



<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility. Courtesy bias, whereby women report more positive care (in this case, presence of companion) than they actually received when asked at the facility.
<b>Data Use</b>	This indicator will be used to assess the experience of care, a key component of the quality of care, provided at the facility.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.16

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.16

**Indicator MNH.HFA.16:** Person-centered care: The percentage of recently delivered women who report a high person-centered maternity care score[1] in MOMENTUM-supported areas (facilities)

PIRS available in Gen.2 in MOMENTUM Result 1 PIRS Annex 1.

## Indicator Gen.2

### PERFORMANCE INDICATOR REFERENCE SHEET INDICATOR GEN.2

**Indicator Gen.2:** Percent of provider/client interactions where clients were treated respectfully (respectful treatment) in MOMENTUM-supported facilities

<b>Precise Definition</b>	<p><b>OVERALL DEFINITION</b></p> <p>For maternal care, family planning, and antenatal care, this indicator is a score measuring the degree of respectful/person-centered care experienced by the client during their most recent visit with a service delivery provider in MOMENTUM-support facilities.</p> <p><b>Unit of measure:</b> Clients</p>
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	<p><b>Data Type:</b> Mean score for respectful/person-centered maternal care, family planning, and antenatal care; Percentage for respectful/family-centered pediatric care</p> <p>Numerator for short-scale: Sum of (No. 6.2.21, No. 6.2.22, No. 6.2.23, No. 6.2.28, No. 6.2.29, No. 6.2.30, No. 6.2.31, No. 6.2.33, No. 6.2.34, No. 6.2.35, No. 6.2.36, No. 6.2.38, No. 6.2.40)</p> <p><u>Denominator: 13</u></p> <p>Numerator for long-scale: Sum of No. 6.2.20 - No.6.2.47.</p> <p><u>Denominator: 28</u></p> <p>This indicator will be broken down by technical service area and links to MNH.8 related to respectful maternal care and FP/RH.9 related to FP quality of care</p> <p><b>MNH.8: RESPECTFUL/PERSON-CENTERED MATERNAL CARE DEFINITION</b></p> <p>Respectful/Person-centered maternal score will be determined using the validated person-centered maternity care scale (28 or 13 items) developed by <a href="#">Afulani et. al.</a></p> <p>Unit of measure: Women who recently gave birth</p> <p>Data Type: Mean</p> <p><b>Descriptions of respectful/person-centered or family-centered care:</b></p> <p><b>Overall:</b> Respectful care refers to a set of rights, obligations, and principles due to every client. Person-centered care refers to care that is respectful of and responsive to individual clients and their families’ preferences, needs, and values.</p> <p><b>1. Respectful/person-centered maternal care</b></p> <p>Childbearing women and newborn children are entitled to human rights protections from disrespect, neglect, trauma, and abuse, while maternity caregivers, institutions, and national governments have an obligation to comfort, inform, and protect the health and rights of women and newborn children. Included in respectful maternal care (RMC) is the principle that a woman’s positive or negative experience in childbearing will affect her, her child, her family members, and the community and influence decision-making. These experiences have an impact on maternal morbidity and mortality ratios, and the quality of relationships between caregivers and the communities they serve. Person-centered maternity care (PCMC) refers to maternity care that is respectful of and responsive to individual women and their families’ preferences, needs, and values.</p> <p><a href="https://www.thelancet.com/action/showPdf?pii=S2214-109X%2818%2930403-0">https://www.thelancet.com/action/showPdf?pii=S2214-109X%2818%2930403-0</a>.</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Respectful care and person-centered/family-centered care is a component of quality of care, and influences health outcomes. This indicator monitors one dimension of quality of care experienced by women and caregivers who access health services in MOMENTUM facilities or program areas.</p>

<b>Data Disaggregation</b>	Age (<20, 20-24; 25+); technical area (maternal care, antenatal care, family planning, pediatric care); urban/rural; type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	Data for this indicator can be collected through client exit interviews with women accessing services at MOMENTUM health facilities; or household surveys with women of reproductive age in MOMENTUM program areas.  <b>RESPECTFUL (PERSON-CENTERED) MATERNAL CARE</b>  Client exit interviews using a scorecard of the validated person-centered maternity care scales (28-item or 13-item, depending on context) developed by <a href="#">Afulani et. al.</a> The indicator will be calculated following Afulani et al's approach and a mean score for the time period will be provided
<b>Method of data collection and construction</b>	A sample of women or caregivers will be interviewed after receiving services at MOMENTUM-supported facilities where MOMENTUM interventions have been carried out.  Data may also be collected through household-based surveys.
<b>Data Collection and Reporting Frequency</b>	Data collection will occur as assessments are completed for client exit interviews; and annually if household based surveys are conducted. Reporting will be annually.
<b>Baseline timeframe</b>	
<b>Data Quality Considerations</b>	Women and clients may be biased in their reporting if interviews are completed at the facility just after services have been provided
<b>Data Use</b>	Used to monitor experience of care over time.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 07/24/2021	

## Indicator MNH.HFA.17

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.17

**Indicator MNH.HFA.17:** Newborns weighed at birth: Percent of all newborns (live born and stillborn) born in the health facility who are weighed

<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of newborns for whom register/ chart is reviewed where weight is documented</p> <p>Alternate numerator: Number of live births weighing less than 2500 grams (low birthweight)</p> <p><b>Denominator:</b> Number of newborns for whom register/ chart is reviewed</p> <p>Alternate denominator: Number of live births for whom register/ chart is reviewed</p> <p><b>Unit of measure:</b> Infant</p> <p><b>Data Type:</b> Percentage</p> <p>Note: for this indicator, the MOMENTUM modularized HFA will collect the information via client exit interview</p> <p>As such, the definition is as follows:</p> <p><b>Numerator:</b> Number of caregivers reporting that newborn was weighed at birth (<b>No. 6.2.15=1</b>)</p> <p><b>Denominator:</b> Number of caregivers interviewed who reported a live birth</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Infants should be weighed at birth for a baseline for monitor growth as well as to identify infants who are low birthweight (weight &lt; 2500 grams), as these infants require additional, specialized care to reduce risk of morbidity and mortality. Furthermore, higher prevalence of low birthweight infants may be a indicator of maternal malnutrition in the population. This indicator is adapted from WHO Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities (WHO 2020), standard 1, quality statement 1.5</p> <p><a href="https://www.who.int/nutrition/topics/globaltargets_lowbirthweight_policybrief.pdf">https://www.who.int/nutrition/topics/globaltargets_lowbirthweight_policybrief.pdf</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; Age (&lt;20; 20-25; 25+); Birth outcome</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via record review or client exit interview, where women who recently delivered will be asked to recall whether their baby was weighed before discharge.</p>
<p><b>Method of data collection and construction</b></p>	<p>Client exit interview</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>There is potential of recall bias, as maternal recall of events around labor and delivery has been shown to have varied accuracy</p>

<b>Data Use</b>	This data will be used to assess the clinical quality of care provided at the facility
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.18

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.18

**Indicator MNH.HFA.18:** Newborn only receives breastmilk: The percentage of mothers who delivered at facility who report infant received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of mothers who delivered at facility who report infant received only breast milk (either from their own mother or from a human milk bank) throughout their stay at the facility <b>No. 6.2.17=0</b></p> <p><b>Denominator:</b> Number of mothers who delivered at facility</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percent</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Early initiation of and exclusive breastfeeding are evidence-based interventions that reduce morbidity and mortality and improve immunological function in infants. This is a proposed indicator for the Baby Friendly Hospital Initiative, for the WHO standards for improving quality of maternal and newborn care in health facility and recommended for the SPA.</p> <p><a href="https://link.springer.com/article/10.1186/1471-2458-13-S3-S19">https://link.springer.com/article/10.1186/1471-2458-13-S3-S19</a></p>
<b>Data Disaggregation</b>	Type of SDP; Age (<20; 20-25; 25+)
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via client exit interview, where women will be asked to report if their infant received only breastmilk (either their own or from a milk bank) between delivery and discharge from the facility.
<b>Method of data collection and construction</b>	Client exit interview

<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Recall bias, as maternal report of events around labor and delivery has been shown to have variable accuracy. Social desirability bias if the woman believes reporting exclusive breastfeeding to be more favorable, even if this wasn't what actually occurred.
<b>Data Use</b>	This data will serve as an outcome measure
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.19

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.19

**Indicator MNH.HFA.19:** Pre-discharge counseling & education: The percentage of maternity patients who report having received pre-discharge counseling and education

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of maternity patients who received pre-discharge counselling on each element on the list after childbirth and before discharge on:</p> <p>Family planning <b>No. 6.2.19a=1</b>, exclusive breastmilk feeding <b>No.6.2.19b=1</b> or optimal feeding of newborns [including</p> <ol style="list-style-type: none"> <li>1) signs of adequate intake <b>No. 6.2.19d=1</b></li> <li>2) cues for child hunger and <b>No. 6.2.19e=1</b></li> <li>3) dangers of using feeding bottles, teats and pacifiers <b>No. 6.2.19f=1</b>],</li> </ol> <p>Nutrition <b>No. 6.2.19g=1</b>,</p> <p>IFA supplements <b>No. 6.2.19h=1</b>,</p> <p>emotional well-being of mother <b>No. 6.2.19i=1</b>,</p> <p>danger signs for the mother <b>No. 6.2.19j=1</b>,</p> <p>newborn danger signs <b>No. 6.2.19k=1</b>,</p> <p>birth registration <b>No. 6.2.19L=1</b>,</p> <p>newborn immunization <b>No. 6.2.19m=1</b>,</p> <p>stimulation and play with child <b>No. 6.2.19n=1</b>,</p>
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	<p>when to return to the health facility for mother and newborn <b>6.2.19o=1.</b></p> <p><b>Denominator:</b> Number of mothers who delivered at facility</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Counseling on postpartum related subjects are key for the health and well-being of both mother and child and increasing maternal self-efficacy of practices such as breastfeeding. This indicator is recommended for the SPA.</p> <p><a href="https://link.springer.com/article/10.1186/s12905-020-00947-1">https://link.springer.com/article/10.1186/s12905-020-00947-1</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; Age (&lt;20; 20-25; 25+)</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via client exit interview.</p>
<p><b>Method of data collection and construction</b></p>	<p>Client exit interview</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Recall bias, as maternal report of counseling receipt has been shown to have variable accuracy. Social desirability bias if the woman believes reporting receiving more counseling topics to be more favorable, even if this wasn't what actually occurred.</p>
<p><b>Data Use</b></p>	<p>This data will serve as a measure of clinical quality of care and counseling provided at the facility</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	
<p>This sheet was last updated on: 9/15/2021</p>	

# Indicator MNH.HFA.20

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.20	
<p><b>Indicator MNH.HFA.20:</b> Small and sick newborn readiness: The percentage of facilities with readiness components for care of small and sick newborns</p>	
<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of health facilities with readiness components in place</p> <p>Components include nutrition support and growth monitoring, screening, diagnosis and management of infection, jaundice, respiratory conditions, prematurity/low birthweight.</p> <p><b>Denominator:</b> Number of health facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percent</p> <p>As part of this indicator, data collectors will assess readiness components including policies/ guidelines, staff training, equipment/materials/ supplies, and space (where applicable) using a facility audit.</p> <p>Areas of the facility to be assessed include the outpatient department, surgery wards, maternity wards, pediatric and neonatal inpatient departments and emergency departments.</p> <p>Equipment to be assessed for availability and functionality (where applicable) includes: a) oxygen analyzers, b) pulse oximeters, c) pressure regulators, d) cylinder gauges, e) humidifiers, f) low flow meters (0-5L), g) nasal catheters, h) oxygen masks, i) nasal prongs (pediatric in OPD/peds areas and neonatal in OPD/maternity/neonatal areas), j) air-oxygen blenders (maternity/neonatal areas).</p> <p><b>Note: This indicator will be updated based on the global metrics work done on small and sick newborns.</b></p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Infants who are born low birthweight, including premature or small for gestational age, and/or with other complications such as bacterial infections or congenital conditions, are at much higher risk for death and disability than infants born with adequate birthweight and complication-free. These small and sick infants require additional care, including equipment, medicines, guidelines, and specially trained staff.</p> <p><a href="https://www.who.int/publications/i/item/9789240010765">https://www.who.int/publications/i/item/9789240010765</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via facility inventory, where the readiness components outlined above will be recorded as “observed”, “reported but not observed” or “Not available” as well as “functioning” or “Not functioning” / “valid” or “invalid” where applicable.</p>



<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	If the report of standard operating procedures is strictly verbal, rather than visually confirmed, there is the possibility of social desirability bias whereby the facility staff report procedures being in place even if they are not as to appear more favorable to the interviewer.
<b>Data Use</b>	This data will be used to assess facility readiness to provide care for small and sick newborns.
<b>Other Notes, Discussion, &amp;/or Comments</b>	This indicator overlaps with equipment assessed in MNH.HFA.7.
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator MNH.HFA.21

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.21	
<b>Indicator MNH.HFA.21:</b> Kangaroo mother care (KMC): The percentage of newborns weighing $\leq 2000$ g born or admitted to the health facility who are initiated on kangaroo mother care (or admitted to the kangaroo mother care unit, if a separate unit exists)	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of clients interviewed reporting their sick newborn weighing <math>\leq 2000</math> g born or admitted to the health facility was initiated on KMC  <b>(No. 6.2.15a<math>\leq 2000</math>) AND (No. 6.2.15C=1)</b></p> <p><b>Denominator:</b> Number of clients who delivered an infant that weighed <math>\leq 2000</math> g at the facility (or who was admitted to the facility following delivery)</p> <p><b>Unit of measure:</b> Client</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Kangaroo mother care for low birthweight and preterm infants is an evidence-based, simple, and affordable intervention that has been shown to reduce neonatal deaths within the first 72 hours and 28 days of life.</p> <p><a href="https://www.nejm.org/doi/full/10.1056/NEJMoa2026486">https://www.nejm.org/doi/full/10.1056/NEJMoa2026486</a></p>

<b>Data Disaggregation</b>	Type of SDP
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via client exit interview, where mothers of infants who weight = < 2000g who recently delivered in or were admitted to the health facility will be asked to report whether they initiated kangaroo mother care and/or were admitted to the kangaroo mother care unit, if applicable for the facility.
<b>Method of data collection and construction</b>	Client exit interview
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Maternal report of skin-to-skin contact immediately following delivery has been shown to have poor validity at exit interview (and at survey nine months after delivery) <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4871064/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4871064/</a> <a href="https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0060694#s3">https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0060694#s3</a>
<b>Data Use</b>	This data will be used to assess the quality of maternal and neonatal care provided at the facility
<b>Other Notes, Discussion, &amp;/or Comments</b>	Note: The MOMENTUM-developed HFA only reports on infants receiving KMC who were born in the facility as data is collected from exit interviews from women who delivered at the facility.
<b>Changes to indicator with date</b>	Indicator numerator updated (10/19/2021)
This sheet was last updated on: 10/19/2021	

## Indicator MNH.HFA.22

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.22

**Indicator MNH.HFA.22\***: Nutrition assessment readiness: The percentage of facilities adequately equipped for measuring height, weight, mid-upper arm circumference (MUAC)

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facility managers who confirm that the facility has...</p> <p>a) At least one functioning scale for adults (<b>No. 4.2.1.2.4f1=1 and No. 4.2.1.2.4f2=1</b>) and MUAC tape for adults in the prenatal unit <b>No. 4.2.1.2.4i=1</b></p> <p>b) At least one functioning scale for children (<b>No. 4.2.2.2.8b1=1 and No. 4.2.2.2.8b2=1</b>), length board, height measure (<b>No. 4.2.2.2.8c1=1 and No.</b></p>
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	<p><b>4.2.2.2.8c2=1, indicated as length/height measuring equipment in the Questionnaire), and MUAC tape for children in the pediatric unit (No. 4.2.2.2.8g1=1)</b></p> <p>Note: This indicator will need to be revised depending on the structure of the health facility</p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Malnutrition is associated with poor immunological response, increased risk of disease (infectious and chronic) and death. Undernutrition specifically has been attributed as an underlying cause of 45% of all of under-five deaths. Facilities must be equipped with the necessary tools to assess nutritional status in order to provide appropriate care. This indicator is recommended by SPRING tool for Rapid Evaluation of Facility-level nutrition assessment, counseling, and support</p> <p><a href="https://pubmed.ncbi.nlm.nih.gov/23746772/">https://pubmed.ncbi.nlm.nih.gov/23746772/</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; client type/unit</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>This data will be collected via facility inventory, where an interviewer will record whether the different components listed above are available and record the answers as done in the SPRING tool, “Yes, assigned [to this facility]” “Yes, shared”, “No” or “N/A” and if the component is available, the interviewer will record the number that are in working condition.</p>
<p><b>Method of data collection and construction</b></p>	<p>Facility inventory</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	
<p><b>Data Use</b></p>	<p>This will be used to assess facility readiness to perform nutritional assessments.</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	

This sheet was last updated on: 9/15/2021

\*indicates nutrition-related

## Indicator MNH.HFA.23

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR MNH.HFA.23

**Indicator MNH.HFA.23\***: Nutritional assessment & counseling; The percentage of clients in supported facilities that are nutritionally assessed and counseled

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of observed clients during which time the provider assessed nutritional status (as defined below) and also counseled the client on nutrition. For the purposes of this rapid assessment, nutrition counseling is defined as the provision/communication of any information related to nutrition. This can be provided through group nutrition education and/or individual counseling.</p> <p>Assessment:</p> <ul style="list-style-type: none"><li>• Measured (or reviewed in client chart) MUAC for pregnant women – <b>No. 5.3.1.9 =7</b></li><li>• Asked age, checked for edema, and measured (or reviewed in client chart) height and weight for children (<b>No. 5.3.4.2.11 =complete AND No 5.3.4.2.14 =12 AND No. 5.3.4.2.14=13 AND No.5.3.4.2.14=11</b>)</li><li>• Assessed for edema and measured (or reviewed in client chart) height and weight for non-pregnant adults. (Not collected by HFA)</li></ul> <p><b>Denominator:</b> Number of clients observed in the facility</p> <p><b>Unit of measure:</b> Client</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Malnutrition is associated with poor immunological response, increased risk of disease (infectious and chronic) and death. Undernutrition specifically has been attributed as an underlying cause of 45% of all of under-five deaths. There are evidence-based interventions and counseling that have been shown to improve nutrition status and reduce risk of morbidity and mortality. This indicator is recommended by SPRING tool for Rapid Evaluation of Facility-level nutrition assessment, counseling, and support</p> <p><a href="https://pubmed.ncbi.nlm.nih.gov/23746772/">https://pubmed.ncbi.nlm.nih.gov/23746772/</a></p> <p><a href="https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext">https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60996-4/fulltext</a></p>
<b>Data Disaggregation</b>	Age; type of SDP; client type (pregnant women, children, recently delivered women [where applicable], non-pregnant adults)

<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via direct observation, where a trained study observer will record using a questionnaire/checklist whether the components outlined above were delivered during a client visit.
<b>Method of data collection and construction</b>	Direct observation
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Hawthorne effect, whereby providers may act differently because they are aware of the study team's presence at the facility. Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias.
<b>Data Use</b>	This data will be used to assess the quality of nutrition-related services provided at the facility.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

\*indicates nutrition-related

# IMMUNIZATION, CHILD HEALTH + NUTRITION INDICATORS

## Indicator Imm.HFA.1

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR IMM.HFA.1	
<b>Indicator Imm.HFA.1:</b> Functional refrigerator: The percentage of health facilities with a functioning refrigerator with a temperature monitoring device and operating in the appropriate temperature range	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with a temperature monitored refrigerator operating in the appropriate temperature range</p> <p><b>No. 4.2.2.1.5=I AND No. 4.2.2.1.6=I and (No. 4.2.2.1.7a2=I OR No. 4.2.2.1.7b2=I) AND (No.4.2.2.1.11=I)</b></p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>Data collectors should request to see the cold chain equipment, if reported by facility staff to record whether or not it was observed (SPA Question #1008). The data collector should then review the temperature monitoring chart (if available) to determine if it has been completed twice daily for the past 30 days, including weekends and holidays (SPA Question #1011) and then use the thermometer to determine whether the refrigerator is kept between 2 and 8 degrees Celsius (or record if the thermometer is not available or not functional) (SPA Question #1013).</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	A functioning refrigerator is a key component of facility readiness in order to keep vaccines and other cold chain required interventions viable and available. This indicator is used in the SPA and by the WHO.
<b>Data Disaggregation</b>	Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected through a facility inventory, where the refrigerator is observed, the temperature monitoring chart is checked and the temperature of the refrigerator is checked for appropriateness (SPA cut offs are between 2 and 8 degrees Celsius).
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly

<b>Data Quality Considerations</b>	For data collection, it is important that the refrigerator temperature and temperature monitoring charts are checked in addition to refrigerator being observed.
<b>Data Use</b>	This data will be used to assess facility readiness to provide immunizations
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator Imm.HFA.2

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR IMM.HFA.2	
<b>Indicator Imm.HFA.2:</b> Childhood vaccine availability: The percentage of facilities with availability of child vaccines, required by the national immunization calendar	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with age-appropriate primary vaccines (pentavalent <b>No. 4.2.2.1.13b1=1</b>, OPV <b>No. 4.2.2.1.13c1=1</b>, BCG <b>No. 4.2.2.1.13d1=1</b>, Measles <b>No. 4.2.2.1.13a1=1</b>, PCV <b>No. 4.2.2.1.13f1=1</b>, IPV <b>No. 4.2.2.1.13g1=1</b>, rotavirus <b>No. 4.2.2.1.13e1=1</b> and human papillomavirus vaccine <b>No. 4.2.2.1.13h1=1</b> on day of visit</p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facilities</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Childhood vaccination programs are critical for reducing under five mortality and health facilities are a main provider of vaccines. This indicator is recommended for the SPA and by the WHO
<b>Data Disaggregation</b>	Type of SDP

<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected through a facility inventory, where the requisite vaccines will be observed or not observed on the day of the inventory. If observed, the vaccines will be examined to determine if there is “at least one valid” (valid = not expired, vaccine vial monitor changed < not frozen) or “available but not valid”. If not observed, the interviewer can report that the vaccines were “reported available but not seen”, “not available today or don’t know” or “never available” at the facility.
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	The interviewer must confirm validity of vaccines if observed.
<b>Data Use</b>	This data will be used to assess the facility’s readiness to provide vaccinations to children.
<b>Other Notes, Discussion, &amp;/or Comments</b>	The list of vaccines should be adapted to reflect the national vaccine schedule.
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator Imm.HFA.3

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR IMM.HFA.3	
<b>Indicator Imm.HFA.3:</b> Micro-plan: The percentage of facilities with an up to date immunization micro-plan	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with an immunization micro-plan updated within last year: <b>No. 4.2.2.1.16=1 or 2, and No. 4.2.2.1.17=1</b></p> <p>A micro-plan defines how to reach clients, how many people should be targeted for services in the area, and how frequently high-quality services are provided. A micro-plan is developed by all stakeholders at each level. An effective micro-plan will support health facilities and district teams to: 1) identify target population; 2) design data and graphic mapping; 3) prioritize plans to reach target population; 4) define realistic actions; 5) reduce inequity and improve the quality of immunization services.</p>



	<p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>A micro-plan provides an opportunity to engage stakeholders in order to provide high-quality, person-centered care.</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected during a facility inventory, where the interview will ask the staff to show them the facility’s micro-plan.</p>
<p><b>Method of data collection and construction</b></p>	<p>Facility inventory</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Annually</p>
<p><b>Data Quality Considerations</b></p>	<p>Ensure that the micro-plan has been updated within the last year, not simply that one exists. Awards may consider collecting information on whether or not the updated microplan has been used as the existence of an updated microplan does not necessarily indicate use.</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the facility’s readiness to provide vaccinations to children.</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	

This sheet was last updated on: 9/15/2021

# Indicator Imm.HFA.4

PERFORMANCE INDICATOR REFERENCE SHEETMOMENTUM MEL HFA INDICATOR IMM.HFA.4	
<p><b>Indicator Imm.HFA.4:</b> Child immunizations services: Mean frequency of child immunization services offered on a monthly basis</p>	
<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Sum of the number of fixed/outreach immunization sessions conducted in facilities on a monthly basis</p> <p>Birth doses (hepB0): <b>(No. 4.2.2.1.3.a2)</b></p> <p>Birth doses (BCG): <b>(No. 4.2.2.1.3.b2+ No. 4.2.2.1.3.b3)</b></p> <p>Birth doses (OPV0): <b>(No. 4.2.2.1.3.c2+ No. 4.2.2.1.3.c3)</b></p> <p>Infant vaccines (under 1 year): BCG: <b>(No. 4.2.2.1.3.d2+ No. 4.2.2.1.3.d3)</b></p> <p>Infant vaccines: polio: <b>(No. 4.2.2.1.3.e2+ No. 4.2.2.1.3.e3)</b></p> <p>Infant vaccines: DPT-containing vaccine (DPT, DPT-Hib-HepB/pentavalent): <b>(No. 4.2.2.1.3.f2+ No. 4.2.2.1.3.f3)</b></p> <p>Infant vaccines: rotavirus: <b>(No. 4.2.2.1.3.g2+ No. 4.2.2.1.3.g3)</b></p> <p>Infant vaccines: IPV (inactivated polio vaccine): <b>(No. 4.2.2.1.3.h2+ No. 4.2.2.1.3.h3)</b></p> <p>Vaccine-containing measles (e.g. measles-rubella/MMR): <b>(No. 4.2.2.1.3.i2+ No. 4.2.2.1.3.i3)</b></p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b></p> <p><b>Data Type:</b> Integer</p> <p>For each childhood antigen of interest (i.e. DPT+HepB+Hib (i.e., pentavalent), polio, measles, BCG), data collectors will document whether immunizations are offered by the facility, and then the number of days per month the service is provided at the facility and the number of days per month the service is provided via outreach.</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Immunizations are a key intervention for reducing under-five mortality. It is critical that facilities are offering frequent child immunization services to increase coverage and that those services are tailored to the geographic catchment area (particularly for rural versus urban locations).</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; outreach and fixed; antigen</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected during facility inventory, during which the documentation of child immunization services (both outreach and fixed) will be reviewed</p>

<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Timeliness and completeness of the documentation of these services
<b>Data Use</b>	This data will be used to assess the facility's readiness to provide vaccinations to children.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator Imm.HFA.5

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR IMM.HFA.5	
<b>Indicator Imm.HFA.5:</b> Vaccination record assessed: The percentage of children visiting the health facility for routine/acute care who had their vaccine record assessed	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of sick child observations where vaccination status was checked: <b>No. 5.3.4.2.19=1</b></p> <p><b>Denominator:</b> Number of sick child observations</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p> <p>This item is from the Observation of Sick Child Services section in the SPA in which the observer notes if the provider looked at the child's health card before beginning the sick child consultation, while collecting information from the caretaker, or while examining the child.</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	The immunization schedule is structured to optimize vaccine effectiveness. Vaccine records are used to track dates and doses of vaccines to ensure complete coverage for children according to the national schedule. Review of the vaccine records can

	identify lapses in vaccinations in order to provide catch up doses. This indicator is recommended for the SPA and by the WHO
<b>Data Disaggregation</b>	Age of child; Sex of child; Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire and/or checklist.
<b>Method of data collection and construction</b>	Direct observation
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias
<b>Data Use</b>	This data will be used to assess the quality of sick child services provided at the facilities.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator Imm.HFA.6

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR IMM.HFA.6	
<b>Indicator Imm.HFA.6:</b> Missed Opportunities: The percentage of children visiting the health facility for routine/acute care who did not receive a vaccination for which the child was eligible.	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of sick or well child observations where vaccination status was checked, child had incomplete vaccinations and was administered those doses: <b>No. 5.3.4.2.19 =1 and No. 5.3.4.2.48=1</b></p> <p><b>Denominator:</b> Number of sick child observations</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p>

<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Immunization is a critical intervention for reducing under-five mortality and catch up vaccinations are recommended if a child has an incomplete vaccine record. This indicator is recommended for the SPA and by the WHO.
<b>Data Disaggregation</b>	Age of child; Sex of child; Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire and/or checklist.
<b>Method of data collection and construction</b>	Direct observation
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias.
<b>Data Use</b>	This data will be used to assess the quality of immunization services at the facility.
<b>Other Notes, Discussion, &amp;/or Comments</b>	Dependent on the facility's readiness to provide vaccinations (IMM.HFA.1 and IMM.HFA.2)
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.1

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.1	
<b>Indicator Ch.HFA.1:</b> IMCI equipment: Percent of health facilities with equipment and supplies for the essential IMNCI assessment in the child curative area (pediatric OPD)	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with</p> <ul style="list-style-type: none"> <li>a) child weighing scale <b>No. 4.2.2.2.8.b I=1</b>,</li> <li>b) infant scale <b>No. 4.2.2.2.8.a I=1</b>,</li> <li>c) specific pediatric MUAC tape <b>No. 4.2.2.2.8.g I=1</b>,</li> <li>d) height/length board <b>No. 4.2.2.2.8.c I=1</b>,</li> </ul>

	<p>e) timer/clock <b>No. 4.2.2.2.8.fl=I</b> ,</p> <p>f) stethoscope <b>No. 4.2.2.2.8.el=I</b> ,</p> <p>g) pulse oximeter <b>No. 4.2.2.2.8.hl=I</b> ,</p> <p>h) jar/jug for ORS <b>No. 4.2.2.2.8.il=I</b> ,</p> <p>i) cup/spoon <b>No. 4.2.2.2.8.jl=I</b> ,</p> <p>j) thermometer <b>No. 4.2.2.2.8.dl=I</b> ,</p> <p>k) malaria rapid diagnostic tests (RDTs) <b>No. 4.2.2.2.10.al=I</b></p> <p><b>Denominator:</b> Number of facilities providing child curative services</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>The IMCI strategy offers a holistic approach to child health, including both preventative and curative interventions. The availability of the necessary equipment and supplies to provide curative interventions is a component in the facility’s ability to provide these services. This indicator is recommended for the SPA and by the WHO.</p> <p><a href="https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/integrated-management-of-childhood-illness/">https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/integrated-management-of-childhood-illness/</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected during a facility inventory, where the interviewer will mark the individual pieces of equipment and supplies as “observed”, “reported by not seen” or “not available”. For the rapid diagnostic tests, the data collector should also indicate whether or not observed tests are valid (not expired).</p>
<p><b>Method of data collection and construction</b></p>	<p>Facility inventory</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	
<p><b>Data Use</b></p>	
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	<p>For certain components, such as the weighing scales, they must be observed and functioning</p>

Changes to indicator with date

This sheet was last updated on: 9/15/2021

## Indicator CH.HFA.2

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.2

**Indicator CH.HFA.2:** Medicine availability: The percentage of health facilities with medicines and supplies to treat pediatric acute diarrhea, pneumonia and malaria

#### Precise Definition

**Numerator:** Number of facilities with medicines and supplies to treat **diarrhea**

- (a) ORS **No. 4.2.2.2.10.b I=I**,
- b) zinc **No. 4.2.2.2.10.c I=I**,
- c) normal saline or ringers **No. 4.2.2.2.8.m=I**,
- d) IV cannulas **No. 4.2.2.2.8.i=I**,
- e) pediatric IV set);

**pneumonia,**

- (f) injectable ampicillin **No. 4.2.2.2.10.e I=I**,
- g) injectable gentamicin **No. 4.2.2.2.10.d I=I**,
- h) injectable benzyl penicillin **No. 4.2.2.2.10.f I=I**,
- i) injectable ceftriaxone **No. 4.2.2.2.10.g I=I**,
- j) oral amoxicillin (syrup or dispersible tablet) **No. 4.2.2.2.10.i I=I**;

**malaria**

- (k) artemether-lumefantrine **No. 4.2.2.2.10.j I=I**,
- l) artesunate-amodiaquine **No. 4.2.2.2.10.k I=I**,
- m) injectable artesunate **No. 4.2.2.2.10.l I=I**,
- n) artesunate suppositories **No. 4.2.2.2.10.m I=I**,
- o) quinine **No. 4.2.2.2.10.n I=I**)

**Denominator:** Number of facilities

**Unit of measure:** Facility

**Data Type:** Percentage

Each of the medications and supplies should be reported separately to identify gaps in readiness to treat malaria, diarrhea and pneumonia.

<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Diarrhea, pneumonia and malaria are leading causes of under-five mortality, despite all having evidence-based interventions that are simple and affordable. This indicator reflects the facility's readiness to provide these curative interventions. This indicator is recommended for the SPA and by the WHO.
<b>Data Disaggregation</b>	Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected during a facility inventory, where the interviewer will mark the individual medications and supplies as "observed", "reported by not seen" or "not available" and interviewers should check that all medications are valid (i.e. not expired).
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	
<b>Data Use</b>	This data will be used to assess facility's readiness to provide curative services
<b>Other Notes, Discussion, &amp;/or Comments</b>	Medications included in the inventory should be adapted according to national IMCI policies.
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.3

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.3	
<b>Indicator CH.HFA.3:</b> General danger signs: The percentage of sick children under 5 years of age who visited the health facility for medical care and were checked for general danger signs (ability to drink or breastfeed; vomits everything; convulsions, lethargy/unconscious)	
<b>Precise Definition</b>	<b>Numerator:</b> Number of children under 5 checked for four general danger signs: a) unable to drink/breastfeed <b>No. 5.3.4.2.I3=1</b> , b) vomits everything <b>No. 5.3.4.2.I3=2</b> ,



	<p>c) convulsions <b>No. 5.3.4.2.13=3</b>,</p> <p>d) lethargy/unconscious <b>No. 5.3.4.2.13=4</b></p> <p><b>Denominator:</b> Number of sick child observations</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p> <p>Each of the four danger signs should be reported separately to identify gaps in quality of child health services.</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>The initial assessment when a sick child presents for care at a facility is critical to ensure timely and appropriate treatment and/or referral. This indicator is recommended for the SPA and by the WHO.</p>
<p><b>Data Disaggregation</b></p>	<p>Child age; Child sex; Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire and/or checklist.</p>
<p><b>Method of data collection and construction</b></p>	<p>Direct observation</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias. Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of sick child services provided at the health facilities</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	
<p>This sheet was last updated on: 9/15/2021</p>	

## Indicator CH.HFA.4

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.4

**Indicator CH.HFA.4:** IMCI: The percentage of sick children under 5 years of age who visited the health facility for medical care and received essential physical and clinical assessment in accordance with IMCI algorithm (weight, MUAC (>6 months), weight for height calculation, respiratory rate, temperature, pulse, cough, difficult breathing/chest indrawing, diarrhoea/dehydration status and palmar/conjunctival pallor/nails checked for anemia)

<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of sick children under 5 assessed for</p> <ul style="list-style-type: none"> <li>a) weight <b>No. 5.3.4.2.14=12</b>,</li> <li>b) MUAC <b>No. 5.3.4.2.14=17</b>,</li> <li>c) weight for height, <b>No. 5.3.4.2.14=14 and No. 5.3.4.2.14=15</b></li> <li>d) respiratory rate <b>No. 5.3.4.2.14=3</b>,</li> <li>c) temperature <b>No. 5.3.4.2.14=1</b>,</li> <li>d) pulse oximetry <b>No. 5.3.4.2.14=5</b>,</li> <li>e) cough <b>No. 5.3.4.2.12=2</b>,</li> <li>f) difficult breathing/chest indrawing <b>No. 5.3.4.2.12=2</b>,</li> <li>g) diarrhoea <b>No. 5.3.4.2.12=3</b>/dehydration status <b>No. 5.3.4.2.12=3 =6</b> and</li> <li>h) pallor <b>No. 5.3.4.2.14=7 or No. 5.3.4.2.14=8 or No. 5.3.4.2.14=9</b>, in accordance with the IMCI algorithm</li> </ul> <p><b>Denominator:</b> Number of sick child observations</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p> <p>Each of the sick child assessment elements should be collected and reported separately to identify gaps in quality of child health services.</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>The IMCI strategy offers a holistic approach to child health, including both preventative and curative interventions, in order to reduce mortality and morbidity in children under the age of five years. This indicator is recommended for the SPA and by the WHO.</p> <p><a href="https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/integrated-management-of-childhood-illness/">https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/integrated-management-of-childhood-illness/</a></p>
<p><b>Data Disaggregation</b></p>	<p>Child age; Child sex; Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire and/or checklist.</p>

<b>Method of data collection and construction</b>	Direct observation
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Thorough and standardized training of observers for direct observation is needed to minimize measurement error and/or measurement bias. Hawthorne effect, whereby providers may act differently because they are aware of the study team's presence at the facility
<b>Data Use</b>	This data will be used to assess the quality of sick child services provided at the health facilities.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.5

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.5	
<b>Indicator CH.HFA.5:</b> Prescription for pneumonia: The percentage of children aged between 2 months and 5 years who were classified with pneumonia in the health facility and received or were prescribed oral amoxicillin	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of children aged between 2 months and 5 years classified with pneumonia (No. 5.3.4.2.22=1) who received amoxicillin syrup or dispersible tablet (No. 5.3.4.2.50=8 or 9)</p> <p><b>Denominator:</b> Number of children aged between 2 months and 5 years classified with pneumonia</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	In 2017, 15% of all deaths in children under five years of age was attributed to pneumonia. There are antibiotics available to treat bacteria-caused pneumonia that often is delivered at health facilities. This indicator is recommended for the SPA and by the WHO.

	<a href="https://www.who.int/news-room/fact-sheets/detail/pneumonia">https://www.who.int/news-room/fact-sheets/detail/pneumonia</a>
<b>Data Disaggregation</b>	Child age; Child sex; Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire involving a checklist where the pneumonia diagnosis is recorded, as is any medication(s) received.
<b>Method of data collection and construction</b>	Direct observation
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias. Hawthorne effect, whereby providers may act differently because they are aware of the study team's presence at the facility.
<b>Data Use</b>	This data will be used to assess the quality of sick child services provided at the health facilities.
<b>Other Notes, Discussion, &amp;/or Comments</b>	Numerous required observations for numerator and denominator
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.6

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.6	
<b>Indicator CH.HFA.6:</b> ORS: The percentage of children aged between 2 months and 5 years classified with diarrhea and no or some dehydration who are given ORS + zinc	
<b>Precise Definition</b>	<b>Numerator:</b> Number of children aged between 2 months and 5 years classified with diarrhea ( <b>No. 5.3.4.2.23=1</b> ) with no or some dehydration ( <b>No. 5.3.4.2.21=0 or 2</b> ) given ORS ( <b>No. 5.3.4.2.52=1, 2, 3, or 4</b> ) (SPA questions: home ORT Q213-01 OR initial oral rehydration therapy in the facility Q213-02) AND zinc (Q210-11)

	<p><b>Denominator:</b> Number of children aged between 2 months and 5 years classified with diarrhea with no or some dehydration</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Diarrhea is the second-leading cause of death and leading cause of malnutrition in children under five years old, despite a simple and effective treatment. This indicator is recommended for the SPA and by the WHO.</p> <p><a href="https://www.who.int/news-room/fact-sheets/detail/diarrhoeal-disease">https://www.who.int/news-room/fact-sheets/detail/diarrhoeal-disease</a></p>
<p><b>Data Disaggregation</b></p>	<p>Child age; Child sex; Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire including a checklist where the diarrheal and dehydration diagnoses are recorded as well as what medication(s) were provided.</p>
<p><b>Method of data collection and construction</b></p>	<p>Direct observation</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias. Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility.</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of sick child services provided at the health facilities.</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	
<p>This sheet was last updated on: 9/15/2021</p>	

## Indicator CH.HFA.7

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.7

**Indicator CH.HFA.7:** Malaria treatment: The percent of children under 5 with diagnosis of malaria and no severe classification to whom antimalarial medication was received or prescribed (Artemether-Lumefantrine 2X daily for 3 days or Artesunate Amodiaquine 1X a day for 3 days)

<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of children under 5 with diagnosis of non-severe malaria (<b>No. 5.3.4.2.24=1</b>) with treatment received or prescribed at an appropriate dose (Artemether-Lumefantrine 2X daily for 3 days or Artesunate Amodiaquine 1X a day for 3 days) (<b>No. 5.3.4.2.51=2 or 3</b>)</p> <p><b>Denominator:</b> Number of children under 5 with diagnosis of non-severe malaria</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Malaria is a leading cause of child mortality globally. In fact, children under five years of are accounted for 67% of all malaria-related deaths worldwide in 2019. There are antimalarial medications available to reduce severity of disease and prevent mortality. This indicator is recommended for the SPA and by the WHO.</p> <p><a href="https://www.who.int/news-room/fact-sheets/detail/malaria">https://www.who.int/news-room/fact-sheets/detail/malaria</a></p>
<p><b>Data Disaggregation</b></p>	<p>Child age; Child sex; Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected through direct observation of a sick child visit by trained study staff using a questionnaire including a checklist that collects information on malaria diagnosis and medication(s) received.</p>
<p><b>Method of data collection and construction</b></p>	<p>Direct observation</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias.</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of sick child services provided at the health facilities.</p>

<b>Other Notes, Discussion, &amp;/or Comments</b>	Numerous required observations for numerator and denominator
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.8

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.8	
<b>Indicator CH.HFA.8:</b> Abuse-free care: The percentage of caregivers who report they or their child did not experience physical or verbal abuse in the health facility (felt that they were being yelled at, or screamed at [verbal], or being hit, or pinched [physical abuse])	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of caregivers who report they or their child did not experience physical (<b>No. 6.3.2.13.a=0 and No. 6.3.2.13.b=0</b>) or verbal abuse (<b>No. 6.3.2.14=0</b>) in the health facility (felt that they were being yelled at, or screamed at (verbal), or being hit, or pinched (physical abuse))</p> <p><b>Denominator:</b> Number of caregivers interviewed</p> <p><b>Unit of measure:</b> Caregivers and/or child</p> <p><b>Data Type:</b> Percentage</p> <p>During each exit interview, the data collector will ask the following questions of each caregiver about their treatment and the treatment of their child.</p> <p>1a) Were you yelled or screamed at by health facility staff during your visit in the health facility?</p> <p>1b) Was your child yelled or screamed at by health facility staff during your visit in the health facility?</p> <p>2a) Were you hit, pinched, or punched by health facility staff during your visit/stay in the health facility?</p> <p>2b) Was your child hit, pinched, or punched by health facility staff during your visit/stay in the health facility?</p> <p>This is a composite indicator, so the caregiver must respond “no” to all questions in order to be counted in the indicator. However, when reporting, this indicator would ideally be disaggregated by abuse type as well as subject (caregiver or child) and reported in an annex.</p>
<b>Rationale</b>	A core aspect of the experience of care component of quality of care is respectful care, whereby health providers treat their patients with respect and dignity. This indicator is recommended for the SPA and by the WHO.

<i>(and any Link to Foreign Assistance Framework)</i>	
<b>Data Disaggregation</b>	Age of child; Sex of caretaker; Type of SDP; subject (caregiver or child)
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data is collected during an exit interview with the caregiver, where a questionnaire will be used to inquire about verbal and physical abuse experienced by the caregiver themselves or their child during the visit with the health provider.
<b>Method of data collection and construction</b>	Exit interview
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Hawthorne effect, whereby providers may act differently because they are aware of the study team's presence at the facility. Courtesy bias, whereby caregivers report more positive care than they actually received when asked at the facility.
<b>Data Use</b>	This data will be used to assess the experience of care aspect of quality of care provided at the health facilities.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.9

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR IMM.HFA.9	
<b>Indicator CH.HFA.9:</b> Provider communication: The percent of sick children and/or their caregivers seen in the health facility who report they were told what the diagnosis was, given instructions about treatment and/or care, can say the reason that a particular treatment was given (or child's condition) and how to take the treatment	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of caregivers who report they were</p> <p>a) told the diagnosis (<b>No. 6.3.1.2.1=1</b>), were</p> <p>b) explained why certain medications were given (<b>No. 6.3.1.3.4a=1</b>), were</p>



	<p>c) explained how to give the medications <b>(No. 6.3.1.3.4b=1)</b> and</p> <p>d) feel confident in giving the medications <b>(No. 6.3.1.3.5=1)</b></p> <p><b>Denominator:</b> Number of exit interviews</p> <p><b>Unit of measure:</b> Exit interview/clients</p> <p><b>Data Type:</b> Percentage</p> <p>Interviewers will ask questions included in the Sick Child Exit Interview module of the SPA to determine if caregivers:</p> <ul style="list-style-type: none"> <li>• Were told what illness the child had (Q115)</li> <li>• Were told why certain medication/s were given (newly proposed question)</li> <li>• Were told how to give the medication/s to the child at home (Q121)</li> <li>• Feel confident in their ability to appropriately administer medication/s to the child at home (Q122)</li> </ul> <p>This indicator should be disaggregated by communication topic to better understand gaps in provider/caregiver communication at sick child visits.</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Effective communication by the health care provider is one of the factors of the experience of care aspect of good quality of care. Effective communication best ensures provider-patient information transfer and helps to establish a relationship between the two parties. This indicator is recommended for the SPA and by the WHO.</p>
<p><b>Data Disaggregation</b></p>	<p>Age of child; Sex of caretaker; Type of SDP; communication topic</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data is collected during an exit interview with the caregivers, where a questionnaire will be used to inquire about effective communication by the provider during the visit prior to the interview. Specifically, the interviewer will ask if the caretaker if they were told what the diagnosis, given instructions about care and/or treatment, the reason the treatment was given and how to take and/or administer the treatment.</p>
<p><b>Method of data collection and construction</b></p>	<p>Exit interview</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility. Courtesy bias, whereby caregivers report more positive care than they actually received when asked at the facility.</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the experience of care aspect of quality of care provided at the health facilities.</p>

<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator CH.HFA.10

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.10	
<p><b>Indicator CH.HFA.10*:</b> Feeding and danger signs: The percentage of caregivers of children who visited the health facility and reported being aware of the danger signs of their children, knew where to seek care and how to feed their children during the illness (giving extra fluids and continue feeding)</p>	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of caregivers who could</p> <p>a) recount danger signs <b>(No. 6.3.1.2.3=1 to 8),</b></p> <p>b) knew where to seek care in the event that the child’s condition worsened and <b>(No. 6.3.1.2.2=1 or 2 or 3)</b></p> <p>c) knew how to feed the child during illness (giving extra fluids and breastfeeding) <b>(No.6.3.1.3.6=3and No. 6.3.1.3.7=3)</b></p> <p><b>Denominator:</b> Number of exit interviews</p> <p><b>Unit of measure:</b> Exit interviews/clients</p> <p><b>Data Type:</b> Percent</p> <p>Interviewers will ask questions included in the Sick Child Exit Interview module of the SPA to determine if the caregivers:</p> <ul style="list-style-type: none"> <li>• Were told which signs and symptoms would require them to bring their child back for further evaluation (Q117)</li> <li>• Knew were to take the child if the child’s condition did not completely improve or worsened (Q116)</li> <li>• Knew how to feed the child during the illness (Q128-129)</li> </ul>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Caregiver knowledge of danger signs, appropriate care-seeking and continued treatment of their child(ren) beyond care at the health facility are all important for reducing severity and duration of disease and preventing related morbidity and mortality. This indicator is recommended for the SPA and by the WHO.</p>

<b>Data Disaggregation</b>	Age of child; Sex of caretaker; Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data is collected during an exit interview with the caregivers, where a questionnaire will be used to assess caregiver knowledge of danger signs, care-seeking behaviors and infant and young child feeding practices during illness through a series of multiple-choice questions.
<b>Method of data collection and construction</b>	Exit interview
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	Measurement error if caregivers respond to questions without understanding what they are being asked. Measurement bias if interviewers consistently ask questions differently (extra probing, no probing, etc.).
<b>Data Use</b>	This data will be used to assess the experience of care aspect of quality of care provided at the health facilities by assessing caregiver knowledge of information that should be provided during a sick child visit.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

\*Indicates nutrition related

## Indicator CH.HFA.11

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.11	
<b>Indicator CH.HFA.11*:</b> Nutrition assessment: The percentage of children ages 6-59 months who were nutritionally assessed via anthropometric measurement	
<b>Precise Definition</b>	<b>Numerator:</b> Number of observed children ages 6-59 months whose nutritional status is accurately assessed (a) asked age, b) checked for edema, and c) measured (or reviewed in client chart) height and weight)

	<p>No.5.3.4.2.11 =complete and No. 5.3.4.2.14 =11 and 5.3.4.2.14 =12 and 5.3.4.2.14 =13</p> <p><b>Denominator:</b> Number of observed children ages 6-59</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Nearly half of all under-five deaths are related to undernutrition. Malnutrition is associated with poor health outcomes, poorer cognitive development, and decreased productivity as an adult. Proper assessment of children can identify those in need of intervention to reduce the risk of poor outcomes proximally and later in life. This indicator is part of the SPRING rapid facility evaluation tool.</p> <p><a href="https://www.who.int/news-room/fact-sheets/detail/malnutrition">https://www.who.int/news-room/fact-sheets/detail/malnutrition</a></p>
<p><b>Data Disaggregation</b></p>	<p>Age of child; Sex of child; type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected through direct observation of a child visit by trained study staff using a questionnaire and/or checklist to record whether the different components of the nutrition assessment were completed.</p>
<p><b>Method of data collection and construction</b></p>	<p>Direct observation</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias. Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of child health services provided at the health facilities</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	

This sheet was last updated on: 9/15/2021

\*Indicates nutrition related

## Indicator CH.HFA.12

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR CH.HFA.12

**Indicator CH.HFA.12\***: Correct classification of nutrition assessment: The percent of children 6-59 months who were nutritionally assessed via anthropometric measurement and correctly classified

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of (observed) children ages 6-59 months during which time the provider correctly classified the nutritional status of the client, based on the data collection team reviewing anthropometrics taken by the provider to determine if the provider's classification was correct.</p> <p><b>Observer to review weight (No. 5.3.4.2.14=12 and No.5.3.4.2.14=13) and determine if diagnosis of MAM or SAM was accurately made (5.3.4.2.26=5 or 5.3.4.2.26=6)</b></p> <p><b>Note: if the indicator will be calculated and correct classification will be determined after the observation takes place, the survey team should add questions collecting the weight and height.</b></p> <p><b>Denominator:</b> Number of children ages 6-59 months observed in the facility whose anthropometric measurements and nutritional status was recorded by the provider (CH.HFA.11).</p> <p><b>Unit of measure:</b> Child</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Nearly half of all under-five deaths are related to undernutrition. Malnutrition is associated with poor health outcomes, poorer cognitive development, and decreased productivity as an adult. It is essential that providers correctly assess children's nutritional status in order to identify those in need of intervention to reduce the risk of poor outcomes proximally and later in life. This indicator is part of the SPRING rapid facility evaluation tool.</p> <p><a href="https://www.who.int/news-room/fact-sheets/detail/malnutrition">https://www.who.int/news-room/fact-sheets/detail/malnutrition</a></p>
<b>Data Disaggregation</b>	Age of child; Sex of child; type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected through review of the anthropometrics on the health record written by the provider during the direct observation to determine whether the classification was correct.

<b>Method of data collection and construction</b>	Direct observation and record review
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	This relies on the health record kept by the provider being complete and accurate, as it's not being compared to a third-party gold standard direct observation. Thorough and standardized training of observers for direct observation to minimize measurement error and/or measurement bias
<b>Data Use</b>	This data will be used to assess the quality of child health services provided at the health facilities
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

\*Indicates nutrition related

# FAMILY PLANNING INDICATORS

## Indicator FP.HFA.1

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.1	
<p><b>Indicator FP.HFA.1:</b> Contraceptive availability: Percentage of facilities stocked out, by contraceptive method offered, on the day of the assessment</p>	
<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of facilities stocked out, by of each type of contraceptive offered, on the day of the assessment</p> <p>Combined estrogen progesterone oral contraceptive pills: <b>No. 4.2.1.17.a2=4</b></p> <p>Progestin-only contraceptive pills: <b>No. 4.2.1.17.b2=4</b></p> <p>Combined estrogen progesterone injectable contraceptives: <b>No. 4.2.1.17.c2=4</b></p> <p>Progestin-only injectable contraceptives (i.e., Noristerat): <b>No. 4.2.1.17.d2=4</b></p> <p>Progestin-only injectables (DMPA): <b>No. 4.2.1.17.e2=4</b></p> <p>Male condoms: <b>No. 4.2.1.17.f2=4</b></p> <p>Female condoms: <b>No. 4.2.1.17.g2=4</b></p> <p>Diaphragms with spermicide (nonoxynol): <b>No. 4.2.1.17.h1=4</b></p> <p>Cervical caps: <b>No. 4.2.1.17.h2c=4</b></p> <p>Spermicidal foam: <b>No. 4.2.1.17.h3c=4</b></p> <p>Spermicidal jelly: <b>No. 4.2.1.17.h4c=4</b></p> <p>IUCDs: <b>No. 4.2.1.17.i2=4</b></p> <p>Jadelle® implants: <b>No. 4.2.1.17.j1b=4</b></p> <p>Implanon® implants: <b>No. 4.2.1.17.j2c=4</b></p> <p>Cycle beads: <b>No. 4.2.1.17.k2c=3</b></p> <p>Emergency contraceptives: <b>No. 4.2.1.17.l2c=4</b></p> <p>Contraceptive patches: <b>No. 4.2.1.17.m2c=4</b></p> <p>Vaginal rings: <b>No. 4.2.1.17.n2c=4</b></p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>Modern contraceptive methods include: female/male sterilization, IUD, implant, injectables, oral contraceptive pills (OCP), male/female condoms, vaginal barrier methods (diaphragm, cervical cap, spermicidal foam, jelly, cream and sponge), emergency contraception and other modern methods (contraceptive patch or vaginal ring)</p>
<p><b>Rationale</b></p>	<p>Contraceptive method availability allows women (and partners) to choose the methods best suited for their needs and fertility preferences. Limited method</p>

<i>(and any Link to Foreign Assistance Framework)</i>	availability can result in lapses in contraceptive use, which can lead to unwanted pregnancies, abortion and other health risks. This is one of FP2020 and FP2030's core indicators.  <a href="https://academic.oup.com/heapol/article/36/3/273/6102833?login=true">https://academic.oup.com/heapol/article/36/3/273/6102833?login=true</a>
<b>Data Disaggregation</b>	Type of SDP; Method (Condom, OCP, EC, Copper IUD, LNG IUD, vasectomy, tubal ligation, Sayana Press, Depo-IM, implants)
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected during a facility inventory, where the interviewer will mark the individual contraceptive methods as "observed", "reported but not seen" or "not available"
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	For certain contraceptive methods, it is important that the observer determines whether the method is still valid (for example, DMPA stored at appropriate temperature and not expired).
<b>Data Use</b>	This data will be used to assess facility's readiness to provide contraceptive methods
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	Disaggregation updated (10/19/2021)
This sheet was last updated on: 10/19/2021	

## Indicator FP.HFA.2

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.2	
<b>Indicator FP.HFA.2:</b> Modern method availability: The percent of primary SDPs that have at least 3 modern methods of contraception available on the day of assessment	
<b>Precise Definition</b>	<b>Numerator:</b> Number of primary facilities that have at least 3 modern methods of contraception available on the day of the assessment



	<p>For each of the below, set to 1 if condition is satisfied, then sum and calculate the proportion that is 3+ :</p> <p>Combined estrogen progesterone oral contraceptive pills: <b>No. 4.2.1.17.a2=4</b></p> <p>Progestin-only contraceptive pills: <b>No. 4.2.1.17.b2=4</b></p> <p>Combined estrogen progesterone injectable contraceptives: <b>No. 4.2.1.17.c2=4</b></p> <p>Progestin-only injectable contraceptives (i.e., Noristerat): <b>No. 4.2.1.17.d2=4</b></p> <p>Progestin-only injectables (DMPA): <b>No. 4.2.1.17.e2=4</b></p> <p>Male condoms: <b>No. 4.2.1.17.f2=4</b></p> <p>Female condoms: <b>No. 4.2.1.17.g2=4</b></p> <p>Diaphragms with spermicide (nonoxynol): <b>No. 4.2.1.17.h1=4</b></p> <p>Cervical caps: <b>No. 4.2.1.17.h2c=4</b></p> <p>Spermicidal foam: <b>No. 4.2.1.17.h3c=4</b></p> <p>Spermicidal jelly: <b>No. 4.2.1.17.h4c=4</b></p> <p>IUCDs: <b>No. 4.2.1.17.i2=4</b></p> <p>Jadelle® implants: <b>No. 4.2.1.17.j1b=4</b></p> <p>Implanon® implants: <b>No. 4.2.1.17.j2c=4</b></p> <p>Cycle beads: <b>No. 4.2.1.17.k2c=3</b></p> <p>Emergency contraceptives: <b>No. 4.2.1.17.l2c=4</b></p> <p>Contraceptive patches: <b>No. 4.2.1.17.m2c=4</b></p> <p>Vaginal rings: <b>No. 4.2.1.17.n2c=4</b></p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>Modern contraceptive methods include: : female/male sterilization, IUD, implant, injectables, OCPs, male/female condoms, vaginal barrier methods (diaphragm, cervical cap, spermicidal foam, jelly, cream and sponge), emergency contraception and other modern methods (contraceptive patch or vaginal ring)</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Contraceptive method availability allows women (and partners) to choose the methods best suited for their needs and fertility preferences. Limited method availability can result in lapses in contraceptive use, which can lead to unwanted pregnancies, abortion and other health risks. This is one of FP2020 and FP2030's core indicators.</p> <p><a href="https://academic.oup.com/heapol/article/36/3/273/6102833?login=true">https://academic.oup.com/heapol/article/36/3/273/6102833?login=true</a></p>

<b>Data Disaggregation</b>	Type of SDP
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data will be collected during a facility inventory, where the interviewer will mark the modern contraceptive methods as “observed”, “reported but not seen” or “not available”
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	For certain contraceptive methods, it is important that the observer determines whether the method is still valid (for example, DMPA stored at appropriate temperature and not expired).
<b>Data Use</b>	This data will be used to assess facility’s readiness to provide modern contraceptive methods
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator FP.HFA.3

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.3	
<b>Indicator FP.HFA.3:</b> Modern method availability at secondary/tertiary SDPs: The percentage of secondary/tertiary SDPs with at least 5 modern methods of contraception available on day of assessment	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of secondary/tertiary facilities that have at least 5 modern methods of contraception available on the day of the assessment</p> <p>For each of the below, set to 1 if condition is satisfied, then sum and calculate the proportion that is 5+ :</p> <p>Combined estrogen progesterone oral contraceptive pills: <b>No. 4.2.1.17.a2=4</b></p> <p>Progestin-only contraceptive pills: <b>No. 4.2.1.17.b2=4</b></p>

	<p>Combined estrogen progesterone injectable contraceptives: <b>No. 4.2.1.17.c2=4</b></p> <p>Progestin-only injectable contraceptives (i.e., Noristerat): <b>No. 4.2.1.17.d2=4</b></p> <p>Progestin-only injectables (DMPA): <b>No. 4.2.1.17.e2=4</b></p> <p>Male condoms: <b>No. 4.2.1.17.f2=4</b></p> <p>Female condoms: <b>No. 4.2.1.17.g2=4</b></p> <p>Diaphragms with spermicide (nonoxynol): <b>No. 4.2.1.17.h1=4</b></p> <p>Cervical caps: <b>No. 4.2.1.17.h2c=4</b></p> <p>Spermicidal foam: <b>No. 4.2.1.17.h3c=4</b></p> <p>Spermicidal jelly: <b>No. 4.2.1.17.h4c=4</b></p> <p>IUCDs: <b>No. 4.2.1.17.i2=4</b></p> <p>Jadelle® implants: <b>No. 4.2.1.17.j1b=4</b></p> <p>Implanon® implants: <b>No. 4.2.1.17.j2c=4</b></p> <p>Cycle beads: <b>No. 4.2.1.17.k2c=3</b></p> <p>Emergency contraceptives: <b>No. 4.2.1.17.l2c=4</b></p> <p>Contraceptive patches: <b>No. 4.2.1.17.m2c=4</b></p> <p>Vaginal rings: <b>No. 4.2.1.17.n2c=4</b></p> <p><b>Denominator:</b> Number of secondary/tertiary facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p>Modern contraceptive method include: female/male sterilization, IUD, implant, injectables, OCPs, male/female condoms, vaginal barrier methods (diaphragm, cervical cap, spermicidal foam, jelly, cream and sponge), emergency contraception and other modern methods (contraceptive patch or vaginal ring)</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Contraceptive method availability allows women (and partners) to choose the methods best suited for their needs and fertility preferences. Limited method availability can result in lapses in contraceptive use, which can lead to unwanted pregnancies, abortion and other health risks. This is one of FP2030’s core indicators.</p> <p><a href="https://academic.oup.com/heapol/article/36/3/273/6102833?login=true">https://academic.oup.com/heapol/article/36/3/273/6102833?login=true</a></p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data will be collected during a facility inventory, where the interviewer will mark the modern contraceptive methods as “observed”, “reported by not seen” or “not available”</p>

<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	For certain contraceptive methods, it is important that the observer determines whether the method is still valid (for example, DMPA stored at appropriate temperature and not expired).
<b>Data Use</b>	This data will be used to assess facility's readiness to provide modern contraceptive methods
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator FP.HFA.4

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.4	
<b>Indicator FP.HFA.4:</b> Postpartum family planning counseling: The percentage of women who delivered in a facility and received counseling on FP prior to discharge	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of postpartum women who delivered in a facility who report receiving counseling about family planning prior to discharge <b>No. 6.2.48=I</b></p> <p><b>Denominator:</b> Number of postpartum women interviewed at the facility who delivered in the facility</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Postpartum family planning (PPFP) and counseling on PPFP allows women and their partners to make informed contraceptive choices to ensure proper birth spacing, which prevents associated maternal and neonatal morbidity and mortality.</p> <p>An increasing number of women and their partners can be reached through facility-based childbirth services.</p>

	<a href="https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/">https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/</a>
<b>Data Disaggregation</b>	Age (<20, 20-24, 25+); Type of SDP; Method (Condoms, lactational amenorrhea (LAM), Progestogen-only pill, Copper IUD, LNG IUD, vasectomy, tubal ligation, implants)
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data is collected during an exit interview with the women who recently delivered at the health facility, during which she will be asked whether she received counseling on family planning prior to discharge and if she chose a method, which method she chose.
<b>Method of data collection and construction</b>	Exit interview
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	
<b>Data Use</b>	This will be used to assess the quality of maternal and family planning services provided at the health facilities
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	Precise definition (numerator and denominator) and data disaggregation updated (10/19/2021)
This sheet was last updated on: 10/19/2021	

## Indicator FP.HFA.5

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.5	
<b>Indicator FP.HFA.5:</b> Postpartum family planning counseling: The percentage of women who delivered in a facility and initiated or left with a modern contraceptive method prior to discharge	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of postpartum women who delivered in a facility and initiated or left with a modern contraceptive method prior to discharge</p> <p><b>No. 6.4.1.12=1-11, 34, 14, 16, 17 or 18 (if No.6.4.1.4=1-11, 13, 14, 16 or 17)</b></p>

	<p><b>Denominator:</b> Number of postpartum women interviewed at the facility who delivered in the facility</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Postpartum family planning (PPFP) and counseling on PPFP allows women and their partners to make informed contraceptive choices to ensure proper birth spacing, which prevents associated maternal and neonatal morbidity and mortality.</p> <p>An increasing number of women and their partners can be reached through facility-based childbirth services.</p> <p><a href="https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/">https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/</a></p>
<p><b>Data Disaggregation</b></p>	<p>Age (&lt;20, 20-24, 25+); Type of SDP; Method (Condoms, LAM, Progestogen-only pill, Copper IUD, LNG IUD, vasectomy, tubal ligation, implants)</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data is collected during an exit interview with the women who recently delivered at the health facility, during which she will be asked whether she received counseling on family planning prior to discharge and if she chose a method, which method she chose.</p>
<p><b>Method of data collection and construction</b></p>	<p>Exit interview</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	
<p><b>Data Use</b></p>	<p>This will be used to assess the quality of maternal and family planning services provided at the health facilities</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	<p>Precise definition (numerator and denominator) and data disaggregation updated (10/19/2021)</p>
<p>This sheet was last updated on: 10/19/2021</p>	

# Indicator FP.HFA.6

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.6	
<p><b>Indicator FP.HFA.6:</b> Method Information Index Plus: The percentage of women currently using a method who report they received specific information from a family planning service provider when they began that FP method.</p>	
<p><b>Precise Definition</b></p>	<p><b>Numerator:</b> Number of women currently using a method who respond “yes” to all four questions in the index</p> <p><b>Denominator:</b> Number of women of reproductive age current using a method responding with a valid answer to all four questions</p> <p><b>Unit of measure:</b> Woman</p> <p><b>Data Type:</b> Percentage</p> <p><b>Among women leaving the facility with a modern method (FP.HFA.5=1)</b></p> <p>The index is composed of four questions:</p> <ol style="list-style-type: none"> <li>1) At that time (when you first started using CURRENT METHOD), were you told about side effects or problems you might have with the method? <b>No. 6.4.2.5=1</b></li> <li>2) Were you told what to do if you experienced side effects or problems? <b>No. 6.4.2.6=1</b></li> <li>3) At that time, were you told about other methods of family planning that you could use? <b>No. 6.4.2.4b=1</b></li> <li>4) At that time, were you told that you could switch to another method if you wanted to or needed to? <b>No. 6.4.2.6=1</b></li> </ol> <p>The reported value is the percent of women who responded “yes” to all four questions.</p>
	<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>

<b>Data Disaggregation</b>	Age (<20, 20-24, 25+); Type of SDP; Method (Condoms, OCP, EC, Copper IUD, LNG IUD, tubal ligation, Sayana Press, Depo-IM, implants)
<b>Data Source(s) &amp; Data Collection Instruments</b>	This data is collected during an exit interview with the women who are using select modern methods at the time of the interview (questions are asked slightly differently for women who report female sterilization and are not asked for women who report male sterilization, LAM, or traditional method use).
<b>Method of data collection and construction</b>	Exit interview
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	
<b>Data Use</b>	This will be used to assessed the quality of maternal and family planning services provided at the health facilities
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	Data disaggregation updated (10/19/2021)
This sheet was last updated on: 10/19/2021	

## Indicator FP.HFA.7

Note: Not collected by the Modular HFA.

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.7	
<b>Indicator FP.HFA.7:</b> Counseling skills: The percentage of providers that demonstrate good counseling skills	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of providers observed interacting with clients and demonstrated the following counseling skills:</p> <ul style="list-style-type: none"> <li>• Asking open-ended questions</li> <li>• Encouraging clients to ask questions</li> <li>• Treating clients with respect</li> <li>• Seeing clients in private</li> <li>• Discussing a return visit</li> </ul>



	<ul style="list-style-type: none"> <li>• Asking clients about concerns with the method chosen</li> <li>• Using a client record, and</li> <li>• Assuring the client’s confidentiality</li> </ul> <p><b>Denominator:</b> Number of providers observed</p> <p><b>Unit of measure:</b> Provider</p> <p><b>Data Type:</b> Percentage</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>Providers with good counseling skills have clients that are more likely to continue attending care because they trust the provider and feel informed on their healthcare. Effective counseling establishes trust and provider-patient information transfer.</p>
<p><b>Data Disaggregation</b></p>	<p>Type of SDP; Method (Condoms, OCP, EC, LAM, Copper IUD, LNG IUD, vasectomy, tubal ligation, Sayana Press, Depo-IM, implants)</p>
<p><b>Data Source(s) &amp; Data Collection Instruments</b></p>	<p>This data is collected through direct observation. The direct observation of a family planning visit by trained study staff using a questionnaire and/or checklist to record whether the different components of the “good counseling” quick investigation of quality checklist were completed.</p>
<p><b>Method of data collection and construction</b></p>	<p>Direct observation</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Quarterly</p>
<p><b>Data Quality Considerations</b></p>	<p>For direct observation, the Hawthorne effect, whereby providers may act differently because they are aware of the study team’s presence at the facility is a potential threat to data quality.</p>
<p><b>Data Use</b></p>	<p>This data will be used to assess the quality of family planning and general health services by assessing the quality of counseling provided at the facility.</p>
<p><b>Other Notes, Discussion, &amp;/or Comments</b></p>	
<p><b>Changes to indicator with date</b></p>	<p>Data disaggregation updated (10/19/2021)</p>
<p>This sheet was last updated on: 10/19/2021</p>	

## Indicator FP.HFA.8

Note: Some but not all of the indicators to calculate the PCFP score are included in the Modular HFA.

### PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR FP.HFA.6

**Indicator FP.HFA.8:** Mean respectful/person-centered family planning score (received respectful care) in MOMENTUM-supported facilities

PIRS available in Gen.2 in MOMENTUM Result 1 PIRS Annex 1.

# CROSS-CUTTING INDICATORS

## Indicator X-CUT.HFA.1

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR X-CUT.HFA.1	
<b>Indicator X-CUT.HFA.1:</b> External supervision: The percentage of health facilities with external supervision to improve clinical competence and/or performance in the past 6 months	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with external supervision in last 6 months AND a key quality activity was undertaken</p> <p>Note: The Modular HFA covers external supervision, but the definition of “key quality activities” is currently under discussion.</p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>External supervision is a quality improvement technique whereby external supervisors engage with facility staff to problem solve, build capacity and improve resource utilization and allocation. This indicator is recommended for the SPA.</p> <p><a href="https://pubmed.ncbi.nlm.nih.gov/26653397/">https://pubmed.ncbi.nlm.nih.gov/26653397/</a></p>
<b>Data Disaggregation</b>	Type of SDP; technical area
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via facility inventory, where an interviewer will inquire whether the facility receives any external supervision, and if so, if the supervisor came within the past six months or more than six months ago.
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	This measures whether external supervision has occurred, but does not capture the contents or quality of the supervision.
<b>Data Use</b>	This data will serve as a process indicator for health facility assessment
<b>Other Notes, Discussion, &amp;/or Comments</b>	

<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator X-CUT.HFA.2

<b>PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR X-CUT.HFA.2</b>	
<b>Indicator X-CUT.HFA.2:</b> Quality improvement: The percentage of health facilities holding at least one meeting/activity specifically for quality improvement in the last 3 months	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with routine quality improvement meeting or activities in last 3 months that</p> <p><b>No. 9.2.1=I AND No.9.2.2&gt;=I AND No.9.2.3a=I AND</b></p> <ol style="list-style-type: none"> <li>1) review data - <b>No.9.2.3a=I</b></li> <li>2) monitor performance - <b>No.9.2.3b=I</b></li> <li>3) make recommendations to address any problems <b>No.9.2.3f=I</b></li> <li>4) honor good performance <b>No.9.2.3d=I</b></li> <li>5) encourage staff or teams who are struggling to improve quality <b>No.9.2.3e=I</b></li> </ol> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Continuous quality improvement efforts at facilities are critical for closing the “quality-coverage” gap to improve effective coverage of health interventions and services. Facilities that have the capacity to collect and review their own data for monitoring purpose to identify and solve problems are best positioned to accomplish this goal. This indicator is recommended for the SPA.
<b>Data Disaggregation</b>	Type of SDP; technical area
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via facility inventory, where the interviewer will ask facility staff if the facility has routine quality improvement meetings or activities. If so, the interviewer will ask if at least one meeting or activity has occurred in the last three months or the most recent occurrence was more than three months ago. For confirmation, the interviewer can ask to see minutes from the last meeting or activity.

<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	This indicator measures whether the meetings took place, but does not measure the content of or the staff involved in the meetings. If the only report is verbal (i.e., no minutes or records can be observed), there is a risk of social desirability bias if the staff member being interviewed reports meetings or activities that did not actually occur in order to appear more favorable to the interviewer.
<b>Data Use</b>	This data will serve as a process indicator for a health facility assessment.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator X-CUT.HFA.3

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR X-CUT.HFA.3	
<b>Indicator X-CUT.HFA.3:</b> Monitoring visuals: Percentage of health facilities that analyze and produce monthly visual charts and reports for monitoring performance.	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities that use monthly trend charts and performance monitoring reports  <b>(No.9.1.1a-j=1 OR 2) AND 9.1.3=1 AND 9.1.3a=1</b></p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Facilities that have the capacity to analyze and produce routine data visualizations are best equipped to identify problems and gaps in provision.

<b>Data Disaggregation</b>	Type of SDP; technical area
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via facility inventory, where an interview will ask facility staff if they produce monthly charts and reports for monitoring performance. To confirm, the interviewer will ask to see an example from the last month.
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	
<b>Data Use</b>	This data will serve as a process indicator for a health facility assessment.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	

## Indicator X-CUT.HFA.4

PERFORMANCE INDICATOR REFERENCE SHEET MOMENTUM MEL HFA INDICATOR X-CUT.HFA.4	
<b>Indicator X-CUT.HFA.4:</b> Percentage of facilities with a mechanism for patient complaints and feedback (e.g. suggestion box) in the health facility.	
<b>Precise Definition</b>	<p><b>Numerator:</b> Number of facilities with mechanism for complaint/feedback : <b>No. 4.1.1.9=1, 2, 3, 4, 5, 96</b></p> <p><b>Denominator:</b> Number of facilities</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p>
<b>Rationale</b>	Person-centered care has widely be recognized as a central tenant to quality of care, which can be defined as care that is respectful of and responsive to the patient’s needs, values and preferences. A mechanism for complaints and feedbacks like a suggestion box offers an opportunity for the patient to directly, yet anonymously,

<i>(and any Link to Foreign Assistance Framework)</i>	report how the care could have better met their preferences and needs, which allows the facility to improve care in response.
<b>Data Disaggregation</b>	Type of SDP
<b>Data Source(s) and Data Collection Instruments</b>	This data will be collected via facility inventory, where an interviewer will ask if there is a mechanism present. If so, the interview will ask to see what the mechanism is and where it is located in the facility.
<b>Method of data collection and construction</b>	Facility inventory
<b>Data Collection and Reporting Frequency</b>	Quarterly
<b>Data Quality Considerations</b>	This measures the presence of a mechanism, but does not reflect whether the feedback and/or complaints are reviewed and incorporated on a regular basis
<b>Data Use</b>	This data will serve as a process indicator for health facility assessments.
<b>Other Notes, Discussion, &amp;/or Comments</b>	
<b>Changes to indicator with date</b>	
This sheet was last updated on: 9/15/2021	