

# PRIMARY IMPACT MEASUREMENT FOR ACTION CORE INDICATORS



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# TABLE OF CONTENTS

<b>INTRODUCTION .....</b>	<b>3</b>
Overview .....	3
PHC Indicators .....	4
Adaptation of Indicators .....	4
<b>INPUTS.....</b>	<b>6</b>
IN1: Facilities meet core physical infrastructure requirements .....	6
IN3: PHC Health worker vacancy rates .....	10
IN5A: Availability of essential medicines .....	13
IN5B: Availability of priority medical equipment and other medical devices .....	16
<b>PROCESSES.....</b>	<b>21</b>
P1B: Existence of a formal Community Health Worker program .....	21
P2A: Facilities provide proactive population outreach at community and household levels according to local health needs and priorities .....	24
P3: Existence of an Empanelment System which assigns patients to providers and is used for proactive population outreach .....	28
P5: Extent to which subnational units and facilities ensure social accountability of PHC to the community served .....	32
P6: Existence of facility budgets and expenditures meeting criteria.....	36
P8A: Supportive supervision routinely conducted for PHC facilities .....	39
P8B: Provider availability (health care worker absence rate).....	42
P8C: Facility and sub-national management capability and leadership .....	45
P15: Performance measurement and management for PHC quality improvement .....	50
P16: Facilities have systems to support the improvement of quality of primary health care and safety.....	53
<b>OUTPUTS .....</b>	<b>56</b>
OP1A: Geographic access to PHC services.....	56
OP4: Patient-reported experience of first-contact accessibility.....	59
OP5A: Average of the service gaps between a) ANC1 and ANC4; and b) DPT1 and DPT3 .....	63
OP5B: Patient-reported experience of service continuity .....	66
OP6: Existence of referral completion tracking system (facility).....	70
OP7: Patient-reported experience of comprehensiveness.....	73
OP8A: Completion of referral loops.....	77

OP8B: Patient-reported experience of coordination .....	80
OP9A: Patient-reported experience of health system responsiveness and trust in care.....	84
OP9B: Facility has a mechanism for client complaints and feedback.....	90
OP10: Composite indicator for integrated service delivery.....	93
<b>OUTCOMES .....</b>	<b>96</b>
OC1: Health service coverage index (based on Universal Health Coverage [UHC] SCI) .....	96
<b>IMPACTS .....</b>	<b>102</b>
IMP2E: Premature mortality index .....	102

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# INTRODUCTION

## Overview

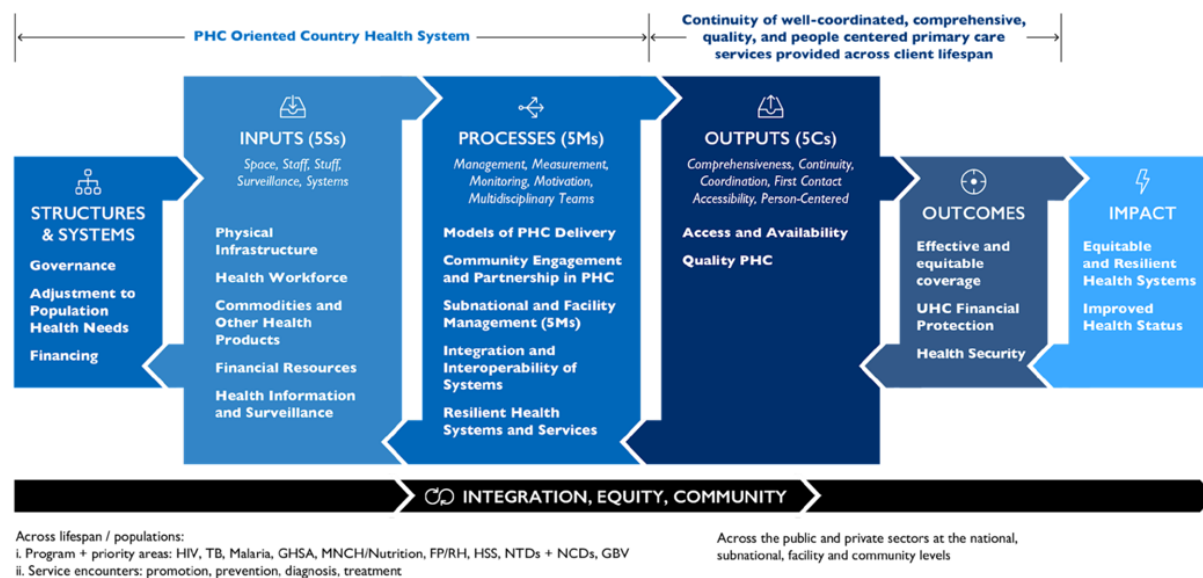
Primary health care (PHC) services are foundational to USAID's health portfolio. By increasing its focus on PHC, USAID intends to reduce programmatic silos and strengthen coordination among its global health program investments.

PHC relies on a platform of essential foundational capacities, policies, and resources, as well as critical processes that transform these foundations into the delivery of integrated, equitable, and high-quality PHC. Robust measurement will enable USAID Missions, Ministry of Health (MOH) colleagues, and implementing partners to better identify and document critical needs and monitor implementation and adapt as needed—and will provide evidence needed for wider implementation and scale, in and beyond focus countries. USAID has developed the Primary Impact Measurement Framework (see Figure 1) that maps these health system foundations through the transformational processes to achieve equitable, high-quality PHC for all.

The Primary Impact Measurement Framework focuses on inputs, processes, and outputs at the subnational and facility levels and prioritizes areas where USAID has existing resources and partnerships that can be mobilized quickly. The framework is organized according to the following conceptual categories:

- **Structures & Systems.** These include the national governing policies, frameworks, and management and financial structures in place to define, monitor, finance, and deliver PHC in a country.
- **Inputs.** These include the facilities, health care professionals, supplies, and funds needed for the delivery of high-quality PHC.
- **Processes.** This category refers to the operationalization and functionality of the PHC system in practice at the subnational level and point of service delivery (for example, the facility or community).
- **Outputs.** These include the near-term results and health system improvements (for example, service access, availability, and quality) expected as a result of USAID's investments in PHC.
- **Outcomes.** These include the changes in effective coverage across essential services, financial protection, and health security that occur over time as a result of strengthening the PHC system.
- **Impacts.** This category refers to the distal, longer-term impacts expected from PHC system strengthening, including equitable/resilient health systems and improved health and mortality.

Figure 1: PHC Measurement For Action Framework



## PHC Indicators

To operationalize the Primary Impact Measurement Framework, USAID identified three key measurement groups—Measuring PHC Foundations (measured early on and at two-year review), Monitoring for Change (measured every 6–12 months), and Measuring for Impact (measured early on and at two-year review). Within these measurement groups, 86 indicators reflecting effective PHC service delivery were identified to help prioritize areas of measurement. Each indicator has been assigned to the appropriate conceptual category referenced above (e.g., Structures & Systems) and given a corresponding domain and subdomain that further provides organization to the framework. Those indicators are defined in the following Performance Indicator Reference Sheets (PIRS).

## Adaptation of Indicators

In partnership with the country's MOH and implementing partners, the USAID Mission should plan to make necessary adaptations to indicators to tailor them to the country and appropriate subnational level contexts. In each PIRS, guidance is provided on specific adaptations that should be considered given a country's context (see Figure 2). Resources are available to support specific questions or considerations concerning indicator adaptation.

Figure 2: Example of adaptation guidance found in PIRS

<b>Possible Adaptations</b>	<p>“PHC facilities” should be adapted to align with how PHC care delivery sites are defined within your context.</p> <p>We do not recommend removing the existing components of this indicator as it is currently built to measure the existence of an empanelment system and its use for outreach. However, understanding how often an empanelment system is updated is often needed for improved utility of the system, and countries can choose to measure a relevant time component if desired. For a reference on how timeliness of an empanelment system may be measured, refer to <a href="#">PHCPI Progression Model Measure 27</a>.</p>
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Once these adaptations are made, indicators will need to be mapped to existing data sources, including supportive supervision tools, the District Health Information Software 2 platform, other health information systems, and routine reporting; population and health facility level surveys; and any other administrative or relevant data sources. Adaptations made to indicators will also have implications for the data collection tools, which have been designed to serve as global guidance. Where data gaps exist, the USAID Mission can consult with the Primary Impact points of contact for guidance on tools and resources to support data collection.

# INPUTS

## IN1

### IN1: Facilities meet core physical infrastructure requirements

**Measurement Category:** Monitoring for Change

**Domain:** Physical Infrastructure

**Subdomain:** Not Applicable

#### Indicator IN1: Facilities meet core physical infrastructure requirements

##### Precise Definition

Facility composite score for core physical infrastructure requirements in water, sanitation, and hygiene (WASH); power; communications; and emergency transport.

##### Availability of basic WASH amenities (1 point)

Facilities have the five basic WASH amenities, including (*must meet all of the criteria below to qualify as “Yes”*):

- **Water:** Available from an improved source on premises, and consistently available (no interruptions of 24+ hours in the past 7 days)
- **Sanitation:** Improved toilet facilities are functional and accessible to outpatient clients, and equipped with menstrual hygiene facilities
- **Hand hygiene:** Functional hand hygiene facility (water with soap and/or alcohol-based hand rub) at all points of care **and** within 5 meters of toilets
- **Health care waste:** Waste is safely segregated into clearly labeled bins, and sharps and infectious waste are treated and disposed of safely per any of the methods listed below
  - Safe final disposal of **sharps** includes: incineration, open burning in protected area, dump without burning in protected area, or remove offsite with protected storage. If method is incineration, incinerator functioning and fuel available.
  - Safe final disposal of **infectious wastes** includes incineration, open burning in protected area, dump without burning in protected area, or remove offsite with protected storage. If method is incineration, incinerator functioning and fuel available.
- **Cleaning:** Basic protocols for cleaning are available, cleaning materials (mops, detergent, bleach, etc.) are available, and disinfectants and equipment used for sterilization are available

##### Availability of power (1 point)

Facilities meet the following criteria for availability of power: (*must meet all of the criteria below to qualify as “Yes”*):

- Facilities have a source of electrical power

	<ul style="list-style-type: none"> <li>Electricity is consistently available (no electricity interruptions of 2+ hours in the past 7 days) during the times when the facility is open for services.</li> </ul> <p><b>Availability of communications (1 point)</b></p> <p>Facilities have key communication systems as measured by two components: <i>(must meet all of the criteria below to qualify as “Yes”)</i>:</p> <ul style="list-style-type: none"> <li>Functioning telephone (landline or cellular) or radio that is available to call outside at all times client services are offered</li> <li>Access to email/internet at the facility on day of assessment</li> </ul> <p><b>Access to emergency transport for interfacility transfer (1 point)</b></p> <p>Facilities have access to emergency transport as measured by: <i>(must meet all of the criteria below to qualify as “Yes”)</i>:</p> <ul style="list-style-type: none"> <li>Access to a functional ambulance (vehicle has fuel and no mechanical problems) or other vehicle for emergency transportation for patients that is either stationed at the facility or available by call within one hour.</li> </ul> <p>Facilities are assessed and scored using a checklist on the number of physical infrastructure requirements met (WASH, power, communications, emergency transport)—see Method of Data Collection</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility Score</p> <p><b>Adapted from:</b> <a href="#">SARA</a>, <a href="#">PHC MFI</a> Indicators #23, 24, 25, 26</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>



<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Facilities need physical infrastructure to deliver high-quality PHC.</p> <p>WASH services in health care facilities are fundamental to providing quality care, adhering to infection prevention and control standards and to the acceptability of health facilities.</p> <p>Access to reliable electricity is a prerequisite for powering medical devices and light for diagnosis, disease prevention, and treatment. It is required for the operation of critical medical devices, such as vaccine refrigeration, basic surgical and diagnostic equipment, other equipment as relevant (e.g., oxygen concentrators, fetal heart monitors, neonatal infant warmers), as well as for lighting, clean water, communication, and several other services.</p> <p>Communication services in health care facilities are fundamental to providing quality care, enabling digital health capacities, and providing connectivity to patients, families, and other health facilities, and ensuring that the referrals are made and feedback received.</p> <p>Emergency transport for access to the PHC and interfacility transfer is important to improve the timely management of time-sensitive urgent/emergent conditions that cannot be adequately or completely managed in some facilities.</p>
<p><b>Possible Adaptations</b></p>	<p>The specific needs for each category can be adapted by countries as needed.</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level: Community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Facility checklist (unless there is a recent health facility assessment, in which case this indicator can be measured from existing assessment data)</p>
<p><b>Method of data collection and construction</b></p>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>

	<p>The individual or team conducting the facility assessment will use a checklist to record the presence or absence of the physical infrastructure elements in the precise definition. This will require direct observation to verify the presence or absence of WASH facilities, power source, communications, and transport.</p> <p>Once the data are collected via checklist, the facility receives 1 point for each category where the criteria are fully met, for a possible total of 4 points. The indicator is then calculated as a facility-level composite score for physical infrastructure: whether the facility meets none (0), some (1–2), most (3) or all (4) of the criteria specified in the precise definition above.</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the percent of facilities that have few, some, most or all core elements of physical infrastructure.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6–12 months (Note: recommend to only measure every 12 months, as this indicator requires a considerable number of questions (some with validation) and may not show change as rapidly).
<b>Data Quality Considerations</b>	<p>To be considered in-country</p> <p>In the assessment questions and interviewer training, observation and verification of the WASH facilities, power source, communications and transportation at the facility should be emphasized.</p>
<b>Data Use</b>	The data assesses the presence at health facilities of reliable water, sanitation, waste disposal or recycling, telecommunication connectivity, power supply, and transport systems that can connect patients to other care providers and are critical to provide effective and quality PHC. At the health facility level, these data can be used by quality improvement (QI) teams to drive improvements in physical infrastructure and systems directly or through advocacy at the subnational level. At the subnational level, policymakers and program managers can identify gaps and plan and budget to improve physical infrastructures of health facilities and relevant systems.
<b>Other Notes, Discussion, and/or Comments</b>	Note: all five of the WASH components in this indicator on physical infrastructure are also measured in indicator OP12A (Facilities compliant with selected infection prevention and control measures).
<b>Changes to indicator with date</b>	To be completed in -country
<b>This sheet was last updated on: 4/11/2023</b>	

## IN3

## IN3: PHC Health worker vacancy rates

**Measurement Category:** Monitoring for Change

**Domain:** Health Workforce

**Subdomain:** Not Applicable

## Indicator IN3: PHC Health worker vacancy rates

**Precise Definition**

Percentage of all PHC health worker positions at the facility that have been are vacant for more than 6 months at the time of assessment, i.e., are posted and funded but not filled. The PHC workforce for this indicator includes all occupations engaged in PHC who are officially hired by the facility to provide PHC, including health promotion; disease prevention; treatment services; the public health workforce, with a specific focus on physicians providing PHC including general medical practitioner; internists and pediatricians; advanced practice providers (e.g., clinical or medical officers); nurses; midwives. This indicator includes all PHC health worker positions that are under the authority of the facility manager. Community health workers should only be included if they are under the managing authority of the facility (i.e., they are hired and managed by the facility). Community health workers managed by another authority (NGO, FBO, etc.) should not be included in this indicator, since job postings and hirings for their positions would be under the purview of the NGO/FBO/etc.

Posted means that an open position for a PHC health worker has been formally advertised through the channels of job forums and boards open to the general public.

Funded means that the financial costs necessary to pay for a PHC health worker employee have been officially approved by the relevant governing body and are available for disbursement upon completion of hiring and beginning of work.

Vacant means that the position for a PHC health worker is actively being recruited to be filled within a specific time frame (e.g., 6 months), which may vary based on local or regional circumstances (per USAID's Health Workforce Indicator Compendium). This differs from absenteeism, where the health worker in a filled position does not report for duty as scheduled.

**Numerator:** Number of vacant PHC positions for more than 6 months (posted and funded but not filled)

**Denominator:** Total number of PHC positions which have been posted and funded (excludes positions specified in governance documents that were not posted or funded)

**Unit of measure:** Position

**Data Type:** Percentage

**Adapted from:** [Advocates for Human Potential](#)

<b>Level of Measurement</b>	Facility Subnational (facility aggregation)
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	This measure reflects the health system's capacity to deliver PHC based on the availability of planned health care workers (HCWs) for primary care at health facility level. To progress toward universal health coverage, countries need to be able to fill the posted positions that have been identified as necessary for PHC service provision.
<b>Possible Adaptations</b>	Countries may need to adapt the types of health worker occupation, particularly community health workers depending on whether or not they are directly hired and managed by facilities.
<b>Data Disaggregation</b>	Health worker cadre For subnational aggregated facility data: <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist with potential review of human resources for health (HRH)
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a census of all facilities or select a representative sample of facilities for the early-project and two-year review measurement timepoints. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for assessment of progress among sampled facilities.</p> <p>The individual or team conducting the facility assessment will review HRH rosters at the facility and identify where there are current vacancies. This may involve talking with point people at the facility and reviewing documentation, and may require additional discussion for CHWs.</p> <p>Once the data are collected via checklist, the indicator will be calculated as a percentage of posted/funded positions that are vacant at the time of the facility visit.</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the range and average vacancy rates at facilities and by cadre.</p>

<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	This indicator can be used to understand vacancy rates for HCWs in facilities and subnational areas, which gives policymakers and program managers information to determine how to intervene. By tracking this indicator, policymakers and program managers can identify areas for improvement including in HRH and other management competencies and practice, benchmark their performance against peers, and take action to ensure a stable and qualified health care workforce.
<b>Other Notes, Discussion, and/or Comments</b>	
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## IN5A

## IN5A: Availability of essential medicines

**Measurement Category:** Monitoring for Change**Domain:** Commodities and Other Health Products**Subdomain:** Not Applicable

## Indicator IN5A: Availability of essential medicines

<b>Precise Definition</b>	<p>Facilities have all essential PHC medicines available, by facility level.</p> <p>A medicine is <u>available</u> in a facility when it is observed in this facility by the interviewer on the day of data collection and is unexpired. The exact list of tracer medicines in the core list will vary depending on the country's Essential Drug List, but may include medicines for noncommunicable diseases management, family planning, maternal and neonatal health, malaria and HIV treatment, nutrition, etc. As an example: <a href="#">SARA</a> uses a list of 25 tracer medicines to calculate a composite indicator on essential medicine availability.</p> <p>Facilities are assessed with a checklist as having none, some, most or all essential PHC medicines available on the day of the visit.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (categorical)</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #31 and <a href="#">SDG 3.8.1</a></p>
<b>Level of Measurement</b>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	<p>Per <a href="#">PHC-MFI technical specifications document</a>, access to medicines is a composite multidimensional concept that is composed of the availability of medicines and the affordability of their prices. For this indicator, we are only assessing availability of medicines as this is the dimension typically measured in health facility assessments. Information on these two dimensions has been collected and analyzed since the 54th World Health Assembly in 2001, when Member States adopted the World Health Organization (WHO) Medicines Strategy (resolution WHA54.11). This resolution led to the launch of the joint project on Medicine Prices and Availability by WHO and the international non-governmental organization Health Action International (HAI/WHO), as well as a proposed HAI/WHO methodology for collecting data and measuring components of access to medicines. To this day, this methodology has been widely implemented to produce useful analyses of availability and affordability of medicines; however the two dimensions are evaluated separately.</p>

<p><b>Possible Adaptations</b></p>	<p>Countries may have different core sets of relevant essential medicines and may adapt needs to their context.</p> <p>In addition to the categorical scoring approach described below, countries can decide to look at the percentage of tracer medicines available, which would be constructed using a non-weighted score normalized to 0–100 of all the tracer medicines. All tracer medicines available on the day of the visit can be summed and divided by the total number of medicines required to provide PHC services at that facility. For example, a facility with 25 medicines available on the day of the facility visit out of the 32 required per national norms would receive a score of 78% (25/32). These scores can be averaged across facilities for all or a sample of facilities to estimate sub-national or national results.</p>
<p><b>Data Disaggregation</b></p>	<p>Facility type (as relevant to context): Community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals</p> <p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities”</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Facility checklist (unless a recent health facility assessment has been conducted, such as <a href="#">SARA</a>, <a href="#">HHFA</a>, <a href="#">DHS SPA</a>, <a href="#">World Bank Service Delivery Indicators</a>, in which case existing data from that assessment can be used)</p>
<p><b>Method of data collection and construction</b></p>	<p>Data are collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will record the presence or absence of relevant tracer medicines on the Essential Drug List. This requires visual confirmation of whether each medicine is in stock and is unexpired.</p> <p>Once the data are collected via checklist, each tracer medicine is scored as 0 (not available) or 1 (available). Facilities are then scored as having none, some, most or all tracer medicines available on the day of the visit. The scoring ranges for each category will vary depending on the number of tracer medicines deemed essential by the country. For example, if there are 25 tracer medicines, the category scores could be: none (0), some (1–19), most (20–24) or all (25).</p>

	Facility-level data will also be aggregated to the subnational level (e.g., district) to look at the percentage of facilities that have none, some, most or all (respectively) essential medicines available
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country In the assessment questions and interviewer/supervisor training, observation and verification of the availability of <b>non-expired</b> medications at the facility should be emphasized.
<b>Data Use</b>	These data will be used to assess the availability of essential PHC medicines early in the project in order to take actions to address gaps in medicine availability, and to monitor changes in availability of medicines over time.
<b>Other Notes, Discussion, and/or Comments</b>	
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	



## IN5B

## IN5B: Availability of priority medical equipment and other medical devices

**Measurement Category:** Monitoring for Change

**Domain:** Commodities and Other Health Products

**Subdomain:** Not Applicable

## Indicator IN5B: Availability of priority medical equipment and other medical devices

**Precise Definition**

Percentage of priority equipment and products for PHC that are available and functional at the facility. The list of priority equipment and products below from PHC MFI is illustrative, and should be adapted in country based on requirements for different facility levels/types and in alignment with national essential drug and commodities lists. Countries can narrow down this list to a core set of tracer equipment based on feasibility and priority. For example, **SARA uses six core tracer indicators to measure a composite of “basic equipment” availability for facilities: adult scale, child scale, thermometer, stethoscope, blood pressure apparatus, and light source.** Another example: the World Health Organization (WHO) Safe Childbirth Checklist assesses a core set of “safe birth supplies,” which includes autoclave, stethoscope, thermometer, blood pressure instrument, partograph, fetoscope/doppler, suction machine, mucus extractor, baby scale, sterilized blade/scissor, oxygen cylinder/concentrator, neonatal bag-and-mask, baby scale, sterilized blade/scissor, and consumable supplies (soap or alcohol hand rub, disinfectant, clean gloves, needle/syringe, urine dip sticks, cord tie/clamp, clean pads for mother, clean towel, bag of IV fluids).

One point is awarded for each piece of equipment / product that is available and functional.

## Examination equipment

- Scale, adult
- Blood pressure measurement device, automated
- Thermometer, digital
- Stethoscope
- Light, examination
- Scale, child
- Scale, infant
- Height board/stadiometer
- Pulse oximeter
- Measuring tape

- Otoscope
- Ophthalmoscope

#### Oxygen

- Oxygen concentrator or oxygen tank with pressure gauge and regulator
- Oxygen delivery devices (connecting ties, mask, nasal prongs)

#### Consumable supplies

- Suture, absorbable
- Needles, suturing
- Suture, non-absorbable
- Infusion set, intravenous
- Intravenous cannula (any size)
- Intravenous needle, child
- Needles, sterile (any size)
- Syringes, single use
- Splinting set, extremities
- Casts, set and materials
- Examination gloves, latex, single use
- Masks
- Alcohol swabs
- Sterile gauze, swabs
- Adhesive tape
- Condoms, male
- Urinary catheter, straight
- Urine collection bag
- Endotracheal tube (adult)
- Endotracheal tube (pediatric)

#### Medical equipment for treatments

- Phototherapy device
- Incubator, newborn
- Defibrillator

	<ul style="list-style-type: none"> <li>● Autoclave</li> <li>● Dry-heat sterilizer</li> <li>● Refrigerators (vaccines, medicines, blood)</li> </ul> <p><b>Numerator:</b> Total number of the required equipment, oxygen, supply or commodity that are available and functional on the day of the visit</p> <p><b>Denominator:</b> Total number of the required equipment, oxygen, supply or commodity</p> <p><b>Unit of measure:</b> Item</p> <p><b>Data Type:</b> Percentage</p> <ul style="list-style-type: none"> <li>● Percentage of items available in each category: <ul style="list-style-type: none"> <li>○ Examination equipment</li> <li>○ Oxygen</li> <li>○ Consumable supplies</li> <li>○ Medical equipment for treatments</li> </ul> </li> <li>● Facility equipment readiness score: average of category percent availability</li> </ul> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #33</p> <p>PHC facilities are defined as: Community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals.</p>
<b>Level of Measurement</b>	Facility Subnational (facility aggregation)
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	Access to good quality, affordable, and appropriate health products is indispensable to advance PHC and universal health coverage, address health emergencies, and promote healthier populations.
<b>Possible Adaptations</b>	As noted in the Precise Definition, the list of equipment and supplies needs to be adapted to the national standards and guidelines for PHC facilities (national lists may vary across countries). This list will also need to be adapted to the level of facility and the services it is authorized to provide in each country. For example, health centers may provide in-patient maternity services, while health posts do not offer labor and delivery services; thus health posts would not be expected to have a newborn incubator.

<b>Data Disaggregation</b>	<p>Type of equipment, supply, commodity</p> <p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record the presence or absence of priority equipment and products at the facility. This will require direct observation to verify that equipment is present and functional, and that commodities are present.</p> <p>This indicator is constructed using a non-weighted score for the items in each category (Examination Equipment, Oxygen, Consumable Supplies, Medical Equipment for Treatments) and normalized to 0–100 (unweighted) within each category. Within each category, all functional equipment and supplies available on the day of the visit can be summed and divided by the total number of equipment and supplies required within the category to provide PHC services at that facility. For example, a facility with 30 pieces of functioning equipment and supplies of the 46 required per national norms would receive a score of 65% (30/46). All four categories are then averaged to create a facility equipment readiness score as an average of category percent availability. Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the average and range of facility equipment readiness scores across facilities).</p>
<b>Data Collection and Reporting Frequency</b>	Every 6–12 months
<b>Data Quality Considerations</b>	To be considered in-country

	In the assessment questions and interviewer/supervisor training, observation and verification of the equipment (and its functionality) and supplies at the facility should be emphasized.
<b>Data Use</b>	These data will be used to assess the availability of priority equipment/supplies and any improvements over time. Facility, subnational, and national program managers can use this data to plan, budget, and advocate for functional equipment and improvements in supply logistics to improve PHC service delivery. For example, if there is a lot of equipment needing maintenance at a facility, the facility manager can prioritize or advocate for resource allocation for maintenance.
<b>Other Notes, Discussion, and/or Comments</b>	<p>The PHC MFI recommends that for diagnostic technologies there is also a total count of medical devices available in the country (by type)</p> <p>Diagnostic imaging technology (often reported as density per million population)</p> <ul style="list-style-type: none"> <li>● X-ray, general; fixed/mobile/portable</li> <li>● Ultrasound scanner</li> <li>● Electrocardiogram</li> </ul>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## PROCESSES

### P1B

#### P1B: Existence of a formal Community Health Worker program

**Measurement Category:** PHC Foundations

**Domain:** Models of PHC Delivery

**Subdomain:** Facility- and Community-Based PHC Delivery

#### Indicator P1B: Existence of a formal Community Health Worker program

##### Precise Definition

Categorical score from the number of elements related to the existence of a formal community health worker (CHW) program answered positively (Yes).

1. Is there an occupation of health workers whose primary responsibility is to conduct proactive outreach in the community to meet local population health needs? (1 point)
2. Is the occupation trained and/or accredited to provide a suite of preventative, promotive, and curative (where appropriate) services to the population? (*Accredited means officially being recognized or qualified to perform a particular activity.*) (1 point)
3. Is the occupation formally employed and officially a part of the health system? (*Formally employed means having a working agreement or contract. Note—in this measure, we are referring to CHWs being officially a part of the health system and does not include those who are employed by NGOs, etc.*) (1 point)
4. Is the occupation remunerated? *Remuneration can take place in different forms (e.g., salary, stipend, honorarium, monetary incentives) and needs to occur in accordance with employment status and applicable laws and regulations.* (1 point)
5. Are individuals in the occupation supported at frequent, regular intervals by a designated supervisor? (*e.g., check-ins, reviews, etc.*) (1 point)

Countries are assessed on the number of criteria that are met—see Method of Data Collection.

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Country/national systems

**Data Type:** National Score (categorical)

**Adapted from:** [PHCPI Progression Model Measure 21](#)

<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>“Community health workers (CHWs) and other types of community-based health workers are effective in the delivery of a range of preventive, promotive and curative health services, and they can contribute to reducing inequalities in access.”<sup>1</sup> This measure is about an occupation (cadre) of health worker whose primary responsibility is to conduct proactive population outreach (promotive, preventive, and other care in homes and communities), regardless of what this type of worker is called. The characteristics assessed in this measure are considered best practices for community-based health workers based on the “World Health Organization (WHO) guideline on health policy and system support to optimize community health worker programmes.”<sup>1</sup></p> <p>(Adapted from the <a href="#">PHCPI Progression Model Measure 21.</a>)</p> <p><sup>1</sup> <a href="#">WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes</a></p>
<b>Possible Adaptations</b>	<p>This cadre of health workers may not be called “community health workers” in all settings. Some contexts also may have multiple cadres of CHWs or other cadres who perform this outreach work as part of the formal health system. We recommend adapting this measure to assess the existence of the cadre in whatever nomenclature may be used within the country context. Additionally, if multiple cadres exist which fulfill the community health worker role, evaluate all cadres against the criteria presented in this measure.</p> <p>It is also important to note that some contexts may have CHWs that are only NGO-supported. In this instance this would not be considered to be a part of the official, nationally supported health system and would not “count” unless the Mission determined they wished to make an adaptation (e.g., similar to the inclusion of private-not-for-profit facilities in public-sector reviews).</p>
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	National Capacity and Performance Checklist
<b>Method of data collection and construction</b>	These data will be collected via document review and/or key informant interview/survey as relevant to country context. Potential sources of information for this measure include documentation of CHW training and accreditation standards, documentation of CHW employment and payment standards, documentation of supervision standards/protocols (and implementation where possible), as well as key informants who may work with or oversee the cadre.

	An individual will be responsible for collecting and collating the data necessary to complete the measure as guided by the National Capacity and Performance Checklist. Each element will be scored as No or Yes resulting in a numeric value, with each “Yes” receiving 1 point. Once the data are collected via the tool, the indicator is calculated as a national-level score: whether the country meets none (0 points), some (1–2 points), most (3–4 points) or all (5 points) elements for a formal CHW program as specified in the precise definition above. If there are multiple cadres of CHWs in the context, all questions should be answered and each individual cadre should be scored as explained above. An average score should then be calculated (total points divided by total number of CHW cadres) to create an averaged score for reporting: none (0–<1 points), some (1–<3 points), (3–<5 points) or all (5 points).
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country Ideally, evidence to support the score should accompany information from key informant interviews or self-report used for measurement
<b>Data Use</b>	These data will be used early on in the project by national policymakers, missions, program implementers, and advocates to understand whether or not the country has a CHW cadre established to provide proactive outreach to its population and identify areas for improvement and/or action. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening and formalizing the CHW cadre.
<b>Other Notes, Discussion, and/or Comments</b>	CHW definitions and criteria derived from <a href="#">WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes</a> .
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/23/2023</b>	



## P2A

## P2A: Facilities provide proactive population outreach at community and household levels according to local health needs and priorities

**Measurement Category:** Monitoring for Change

**Domain:** Models of PHC Delivery

**Subdomain:** Active Community Outreach

### Indicator P2A: Facilities provide proactive population outreach at community and household levels according to local health needs and priorities

#### Precise Definition

Facility teams (including community health workers [CHWs]) actively conduct outreach to provide promotive, preventive, and other care in homes and communities to a defined set of populations according to local health needs and priorities. Proactive outreach activities may include the following, and should include at least one household level activity if the defined populations are reachable at the household level. This list of outreach activities can be adapted according to country context; e.g., home-based care or telemedicine and community-based under-5 care and family planning delivery may not exist or may be defined differently and provided by different cadres across the countries.

#### Community promotion (1 point)

- Health promotion and education activities

#### Case findings and Follow-up (1 point—at least one activity)

- Identification of acute cases needing treatment or referral
- Proactive follow-up with chronic disease patients
- Postpartum and newborn follow-up
- Identification of pregnant women needing referrals to health facilities
- Development of registries or lists to identify higher priority patients for proactive outreach (e.g., HIV/TB patients; vulnerable populations and geographies, postpartum and neonatal, etc.)

#### Care delivery (1 point—at least one activity)

- Mobile health units
- Provision of under-five mortality care
- Home-based care
- Family planning provision

	<p>Facilities are assessed with a checklist as doing outreach activities in none, some, most or all of these categories, and whether any of the activities explicitly target underserved or marginalized populations (see Method of Data Collection).</p> <p><b>Routine household visits (1 point)</b></p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (categorical)</p> <p><b>Adapted from:</b> <a href="#">Progression Model</a> Measure 28 (Proactive Population Outreach) and <a href="#">PHC MFI</a> M58 (Proactive Population Outreach)</p>
<b>Level of Measurement</b>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Proactive population outreach initiated by facilities and leveraging community-based health care workers (HCWs) is an important mechanism for providing PHC for everyone, and particularly for marginalized and underserved populations and those with chronic conditions. These services are often preventive or promotive or diagnostic (though may also be curative directly or as part of the multidisciplinary team, palliative), and are often provided by CHWs or similar occupations.</p>
<b>Possible Adaptations</b>	<p>The design of proactive population outreach programs may vary across countries and subnational settings (e.g., urban versus rural), including the cadre responsible for outreach (CHWs may have different titles across country settings) and the scope and frequency of outreach. The indicator definition (categories and lists of outreach activities) and scoring can be adjusted accordingly.</p>
<b>Data Disaggregation</b>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural as relevant</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Facility checklist</p>

<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record whether the facility is doing proactive population outreach at community and household levels (i.e., any of the activities specified in the precise definition) and whether the outreach activities include underserved or marginalized populations. This will require talking with a key point person/people at the facility in order to understand the outreach activities being conducted, and asking to see documentation of outreach activities (i.e., data in an outreach register) if available.</p> <p>Once the data are collected via checklist, 1 point is awarded for each category (community promotion, case finding and follow-up, care delivery, routine household visits) in which the facility is doing at least one outreach activity, for a total possible score of 4 points. A facility-level score is then calculated: whether the facility is doing outreach activities in none (0), some (1-2), most (3) or all (4) of these categories. As noted above, scoring may need to be adapted depending on the categories of outreach activities that are assessed (the scope of activities may vary depending on country context). The facility also receives a binary score of whether any of the outreach activities explicitly target underserved or marginalized populations (No=0, Yes=1).</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the percent of facilities that are doing none, some, most or all (respectively) of the proactive population outreach activities in the precise definition, and the percent of facilities that have any outreach activity explicitly targeting underserved or marginalized populations.</p>
<b>Data Collection and Reporting Frequency</b>	<p>Every 6–12 months</p>
<b>Data Quality Considerations</b>	<p>To be considered in-country</p>
<b>Data Use</b>	<p>The data will be used by facility managers and subnational program managers to determine the extent to which facilities are conducting proactive population outreach at community and household levels, which is an important component of PHC, and to identify gaps where outreach activities need to be added or expanded to include marginalized and underserved populations.</p>
<b>Other Notes, Discussion,</b>	<p>This indicator falls under the cross-concept of Community, which is also covered in multiple other indicators, including P1B, P4A, P4B, and P5.</p>

<b>and/or Comments</b>	
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## P3

## P3: Existence of an Empanelment System which assigns patients to providers and is used for proactive population outreach

**Measurement Category:** PHC Foundations

**Domain:** Models of PHC Delivery

**Subdomain:** Active Community Outreach

### Indicator P3: Existence of an Empanelment System which assigns patients to providers and is used for proactive population outreach

#### Precise Definition

Categorical score of the sum of responses on the existence and use of an empanelment system. An empanelment system is the intentional, coordinated assignment of individuals to a PHC provider, PHC care team or PHC facility that is used to proactively reach the empaneled population.

1. An empanelment system in the facility unit:
  - a. Does not exist (0 points)
  - b. Exists for selected populations. (1 point)
  - c. Exists for the entire population (all individuals seen by the facility). (2 points)
2. Of the empaneled population described in the above question, what percentage is proactively reached? “Proactively reached” means reached in the patient’s home or community even if they do not have a new problem, without them needing to seek out care.
  - a. <25% of the empanelment population are proactively reached. (0 points)
  - b. 25–49% of the empanelment population are proactively reached. (1 point)
  - c. 50–74% of the empanelment population are proactively reached. (2 points)
  - d. >75% of the empanelment population are proactively reached. (3 points)

Facilities are assessed on the number of criteria that are met—see Method of Data Collection.

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Facility

**Data Type:** Categorical (Facility score)

**Adapted From:** [PHCPI Progression Model Measure 27](#)

<b>Level of Measurement</b>	Facility Subnational (aggregated up from facility)
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Empanelment serves as the foundation for effective population health management and is a critical component of strong PHC. Through empanelment, the health system can move from the delivery of reactive, targeted care towards more proactive, comprehensive care delivery. While an ideal empanelment system covers an entire population, it often starts through the empanelment of specific patient populations or is led by condition-specific programs within an area. Empanelment systems can exist in a variety of forms, including geographic, insurance-based, employment, and disease-specific empanelment, among others.</p> <p>The intentional assignment of patients to providers or care teams promoted by empanelment can extend the reach of PHC by capturing patients who may have otherwise only interacted with the health care system when emergency services were needed (e.g., at the secondary level). An empanelment system intends to promote proactive outreach to patients within a panel to better meet patient needs. An empanelment system ideally results in both a care team knowing who their patients are and patients knowing who they are empaneled to, however this is challenging to measure in lieu of an intensive household survey.</p> <p>While successful empanelment goes beyond the existence of the system itself, this indicator is solely measuring whether the system is present and to what extent the empaneled population is being proactively reached. It does not provide insight into how it impacts the delivery of high-quality primary care. However, the existence of a system is the critical first step in proactively managing and providing higher quality care for patient populations.</p> <p>(<a href="#">PHCPI Progression Model Measure 27</a>, <a href="#">PHCPI</a> Panels for Population Health: A Simplified Guide to Empanelment (forthcoming))</p>
<b>Possible Adaptations</b>	<p>“PHC facilities” should be adapted to align with how PHC care delivery sites are defined within your context.</p> <p>We do not recommend removing the existing components of this indicator as it is currently built to measure the existence of an empanelment system and its use for outreach. However, understanding how often an empanelment system is updated is often needed for improved utility of the system, and countries can choose to measure a relevant time component if desired. For a reference on how timeliness of an empanelment system may be measured, refer to <a href="#">PHCPI Progression Model Measure 27</a>.</p>
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data</b>	Facility Checklist

<b>Collection Instruments</b>	
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a census of all facilities or select a representative sample of facilities for the early-project and two-year review measurement timepoints. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for assessment of progress among sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record the presence or absence of an empanelment system at the facility that meets the criteria in the precise definition. This may require talking with key point people, looking at documentation or making observations. Potential sources of information for this measure include review of data systems, guidance documents or technical documents. If one cohesive empanelment system does not exist, it may be useful to identify guidance for or documentation of disease-specific empanelment systems (immunization, TB, HIV, postpartum, etc.).</p> <p>Once the data are collected via the tools, the indicator is calculated as:</p> <ul style="list-style-type: none"> <li>• Facility-level score: whether the facility has none (0), some (1–3), most (4 points) or all (5 points) components of an existing and utilized empanelment system as described in the precise definition above.</li> </ul> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the percentage of facilities that meet none/few, some, most or all (respectively) of the criteria for empanelment.</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	<p>To be considered in-country</p> <p>Evidence to support the score should accompany information from key informant interviews or self-report used for measurement.</p>
<b>Data Use</b>	<p>These data will be used early in the project to understand whether or not a facility unit has an empanelment system, either for a subset of the population or the entirety of the population. These data can be used by subnational policymakers and facility managers to understand the existence and utilization of empanelment within their setting and identify areas for improvement (through expansion or better utilization). It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the existence of empanelment systems at the subnational level.</p>

<b>Other Notes, Discussion, and/or Comments</b>	Empanelment is used often to conduct proactive population outreach and population health management. To better understand the concept of proactive population outreach, refer to Indicator P2A.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/24/2023</b>	



P5

## P5: Extent to which subnational units and facilities ensure social accountability of PHC to the community served

**Measurement Category:** Monitoring for Change

**Domain:** Community Engagement and Partnership in PHC

**Subdomain:** Social Accountability

### Indicator P5: Extent to which subnational units and facilities ensure social accountability of PHC to the community served

#### Precise Definition

#### Subnational-level social accountability of PHC to the community served

Subnational units demonstrate social accountability and responsibility to the communities they serve by using input from diverse members of the community to inform and implement changes to PHC service design and delivery. This is measured using the following maturity model rubric, assessed in the past 6 to 12 months (specific examples are required in order to verify the score):

- Almost no impact: Community input on how PHC is structured and delivered has generally not been taken into consideration by subnational units.
- Minimal impact: Community input on how PHC is structured and delivered has been taken into consideration by subnational units, but only occasionally incorporated into decisions about PHC.
- Moderate impact: Community input on how PHC is structured and delivered was often directly incorporated into decisions and solutions by subnational units, but final decision-making power resided with non-community representatives.
- Significant impact: Communities have been collaborators, have voice and some degree of decision-making power, with your subnational unit in determining how PHC is structured and delivered.

Definitions for the above categories will need to be further refined at country level (e.g., clarify the country definition for "generally not taken into consideration," "occasionally incorporated into decisions about PHC") in order to allow for reliable and comparable measurement across subnational units.

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Subnational unit

**Data Type:** Subnational rating

**Adapted From:** [PHCPI Progression Model](#) Measure 26—Community Engagement

	<p><b><u>Facility-level social accountability of PHC to the community served</u></b></p> <p>Facilities demonstrate social accountability and responsibility to the communities they serve by using input and feedback from clients and communities (catchment populations) to inform and implement changes to PHC service delivery. This is measured using the following components, assessed in the past 6 months:</p> <ul style="list-style-type: none"> <li>• In the past 6 months, changes have been made to PHC services at the facility as a result of client opinion or other feedback.</li> <li>• In the past 6 months, clients’ feedback about their experiences at the facility nearly always or often drove change or improvement efforts in PHC service.</li> </ul> <p>Facility-level data can also be aggregated to the subnational level to look at the distribution of facilities’ social accountability scores in the subnational area.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility binary score</p> <p><b>Adapted From:</b> <a href="#">PHCPI Progression Model</a> Measure 26—Community Engagement, PMA2020 and Bhutan Service Delivery Indicators</p>
<b>Level of Measurement</b>	Subnational Facility (aggregate to subnational)
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	It is important to understand not only whether subnational units and facilities are gathering community input on PHC services, but whether they are using this input to inform changes to PHC service design and delivery as a measure of accountability to the communities they serve.
<b>Possible Adaptations</b>	Definitions for the categories in the Precise Definition may vary across countries, as concepts like "generally not taken into consideration," "occasionally incorporated into decisions about PHC" will need to be further defined at country level in order to allow for reliable and comparable measurement across units within the country.
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	Subnational Capacity and Performance Checklist and Facility Checklist

<p><b>Method of data collection and construction</b></p>	<p><b>Subnational Data Collection</b></p> <p>Data collection will be carried out using the Subnational Capacity and Performance Checklist, which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. Data will be collected via document review and/or key informant interview/survey as relevant to country context as part of the Subnational Capacity and Performance Checklist. Potential sources of information for this measure include key informants who are knowledgeable about use of community input for PHC service design and delivery, such as local civil society organizations and community leaders, as well as documentation of input being used.</p> <p>An individual or team will be responsible for collecting and collating the data necessary to complete the measure as guided by the Subnational Capacity and Performance Checklist. The subnational unit is scored as achieving none, minimal, moderate or significant social accountability of PHC services, per the precise definition.</p> <p><b>Facility Data Collection</b></p> <p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the assessment will score the facility on the components of social accountability of PHC services specified in the Precise Definition. This will require talking with a key point person/people at the facility and asking for specific examples of how client and community input has been incorporated into PHC service delivery. Once the data are collected via checklist, the indicator is calculated as a facility-level binary score (yes / no) for social accountability of PHC services. A facility must meet both criteria in the precise definition to be scored as “yes”.</p> <p>Facility-level data can also be aggregated at the subnational level to assess the percentage of facilities in the subnational area that are demonstrating social accountability of PHC services.</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Every 6 to 12 months</p>
<p><b>Data Quality Considerations</b></p>	<p>To be considered in-country</p>
<p><b>Data Use</b></p>	<p>These data will be used early on in the project to understand the extent to which PHC services are accountable to input from the community, and to take actions to</p>

	address gaps in social accountability of PHC services at facility and subnational levels. The indicator will be regularly monitored every 6 to 12 months to assess progress.
<b>Other Notes, Discussion, and/or Comments</b>	
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## P6

## P6: Existence of facility budgets and expenditures meeting criteria

**Measurement Category:** Monitoring for Change

**Domain:** Subnational and Facility Management

**Subdomain:** Budget Allocation and Execution

### Indicator P6: Existence of facility budgets and expenditures meeting criteria

<p><b>Precise Definition</b></p>	<p>PHC facilities:</p> <ul style="list-style-type: none"> <li>• Have an annual budget for PHC services.</li> <li>• Have flexibility to use and/or re-allocate funds across budgetary lines to fit evolving financial needs.</li> </ul> <p><b>Definition of terms:</b></p> <p><u>Budgetary lines:</u> specific types of regular expenses, such as supplies, equipment, staff or income, such as from service-specific fees.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (binary)</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #55</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Facility budget systems set out how much money comes into the facility, where it comes from, and what it will be spent on. Budgets should be flexible to allow re-allocations. Budgets can simply track the flow of funds as they move in real time/retroactively, but at higher levels of performance facilities can also use budgets to proactively plan for future activities and expenditures. These forecasting exercises provide the information facilities need to make strategic decisions, such as what and how many medicines and supplies to buy, which staff to hire, etc. Source: <a href="#">PHCMFI M55</a></p>
<p><b>Possible Adaptations</b></p>	<p>If facilities don't manage their own budgets, then this indicator may be measured only at the subnational level. Additionally, the tracking of patient billing/insurance/other financial coverage within budgets and expenditures may need to be adapted for the country's system or dropped if not present.</p>

<b>Data Disaggregation</b>	<p>Subnational</p> <p>Facility type (as relevant to context) including primary care facilities (e.g., community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals)</p> <p>Urban/rural</p> <p>Sector (public/private if available)</p>
<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record the presence or absence of a facility budget for PHC services. This will require talking with key point people and examining documentation. The score for each facility is calculated as 1 if both criteria in the precise definition are met, or 0 otherwise.</p> <p>Facility-level data will also be aggregated at the subnational level (i.e., district) to look at the percentage of facilities that have annual budgets and flexibility to move funds across budget lines. meet the budget and expenditures criteria.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months (Note: recommend to only measure this indicator every 12 months as facility budgets are done annually)
<b>Data Quality Considerations</b>	<p>To be considered in-country</p> <p>Evidence to support the score should accompany information from key informant interviews or self-report used for measurement.</p>
<b>Data Use</b>	This indicator can be used for assessing the financial management practices of a facility and identifying gaps and areas for improvement. It can also be used to track progress over time and to compare the performance facilities across sub-national areas, managing authorities, urban/rural, and types of facilities.
<b>Other Notes, Discussion,</b>	

<b>and/or Comments</b>	
<b>Changes to indicator with date</b>	Evidence to support the score should accompany information from key informant interviews or self-report used for measurement.
<b>This sheet was last updated on: 03/09/2023</b>	

## P8A

## P8A: Supportive supervision routinely conducted for PHC facilities

**Measurement Category:** Monitoring for Change

**Domain:** Subnational and Facility Management (5Ms)

**Subdomain:** HRH Management Capacity and Performance

### Indicator P8A: Supportive supervision routinely conducted for PHC facilities

<p><b>Precise Definition</b></p>	<p>PHC facility implements or receives supportive supervision (internal and/or external) for PHC on an annual basis (or more frequently if stipulated by national guidelines). Supportive supervision is characterized by the following attributes:</p> <ul style="list-style-type: none"> <li>● Routine mentoring to address gaps in performance, knowledge or skills. (1 point)</li> <li>● Collaborative problem-solving. (1 point)</li> <li>● Support in setting individual goals and reviewing progress towards their achievement. (1 point)</li> <li>● Delivery of specific technical expertise when required. (1 point)</li> </ul> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (categorical)</p> <p><b>Adapted from:</b> <a href="#">Progression Model</a> Measure 33: Performance Measurement and Management (Supportive Supervision) and <a href="#">PHCMFI</a> M54 (Existence of a Supportive Supervision System)</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Adapted from <a href="#">Progression Model</a> Measure 33: Supportive supervision of individual providers is a key component of performance and quality management and improvement. Rather than using punitive or corrective action, supportive supervision is focused on collective problem-solving and identifying gaps and opportunities to fill them in performance and provision of technical knowledge as needed. This approach strengthens relationships and builds pathways to improvement through active collaboration between providers and supervisors.</p>
<p><b>Possible Adaptations</b></p>	<p>Recommendations on the frequency of supportive supervision and who provides the supportive supervision may be dictated by national guidelines. Therefore, the frequency of supportive supervision should be modified to align with national</p>



	<p>guidelines when appropriate (for example, if national guidelines indicate that supportive supervision should be completed every six months then the desired time period should be adjusted to six months).</p>
<b>Data Disaggregation</b>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Geographic</li> <li>● Urban/Rural</li> <li>● Sector (public/private)</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Facility Checklist: Management module</p>
<b>Method of data collection and construction</b>	<p>Data will be collected during a PHC facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record whether supportive supervision is occurring that meets the criteria in the precise definition. This may require talking with key point people and reviewing documentation such as supervision reports if available.</p> <p>Each element will be scored as no (0 pt) or yes (1 pt) and summed up, resulting in a single numeric value. Once the data are collected via checklist, the indicator is calculated as a facility-level score: whether the facility meets none (0), some (1–2), most (3) or all (4) of the criteria for supportive supervision specified in the precise definition above.</p> <p>Facility-level data will also be aggregated at the subnational level (i.e., district) as the percentage of facilities that are receiving supportive supervision.</p>
<b>Data Collection and Reporting Frequency</b>	<p>Every 6 to 12 months</p>
<b>Data Quality Considerations</b>	<p>To be considered in-country</p>
<b>Data Use</b>	<p>The data will be used to assess the design and implementation of supportive supervision related to performance and quality management and improvement. It</p>

	will be measured again in 6 to 12 months to understand if any progress has been made in strengthening supportive supervision coverage.
<b>Other Notes, Discussion, and/or Comments</b>	
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/24/2023</b>	

## P8B

## P8B: Provider availability (health care worker absence rate)

**Measurement Category:** Monitoring for Change

**Domain:** Subnational and Facility Management

**Subdomain:** HRH Management Capacity and Performance

## Indicator P8B: Provider availability (health care worker absence rate)

<b>Precise Definition</b>	<p>Percentage of clinical health care workers who are expected to be at a PHC facility but are not present at that PHC facility during an unannounced visit, compared to the expected number of health care workers at that time.</p> <p><b>Numerator:</b> Number of clinical health care workers that are not off duty who are absent from the facility during an unannounced visit.</p> <p><b>Denominator:</b> Number of clinical health care workers who are supposed to be on duty at the facility at the time of the assessment. The only health care workers that are removed from the denominator are those on shift work (i.e., not present because it is not their shift) and those whose attendance is not recorded by the facility because they are fully based in the field (e.g., community health workers) or are out doing field-based work on the day of the visit.</p> <p><b>Unit of measure:</b> Health care workers</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #67</p>
<b>Level of Measurement</b>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Low levels of health care worker availability may preclude people from accessing the care that they require. Per the <a href="#">PHC MFI</a>, health care worker density and distribution measures two dimensions of staff availability. Provider (health care worker) absence measures another dimension. Presence of health care workers is a critical component for health service delivery and quality.</p>
<b>Possible Adaptations</b>	<p>If the facility records attendance for community health workers and other cadres doing field-based work, these cadres could be added to the list.</p>
<b>Data Disaggregation</b>	<p>Facility type (as relevant to context): Community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals</p> <p>Managing authority (public, private)</p> <p>Urban/rural</p>

<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record the number of clinical health care workers that are supposed to be on duty that day, and the number who are actually present at the facility.</p> <p>Per <a href="#">World Bank Service Delivery Indicators</a>: The average rate of absence at a facility is measured by assessing the presence of health care workers at a facility during an unannounced visit. Only health care workers who are supposed to be on duty are considered in the denominator. Thus, health care workers on call and off duty were excluded from the analysis. The approach of using unannounced visits is regarded best practice in the service delivery literature. If the facility records attendance for health care workers doing fieldwork, they are counted as present.</p> <p>Once the data are collected, the provider absence rate will be calculated as the percentage of clinical health workers that are not off duty who are absent from the facility during an unannounced visit.</p> <p>Facility-level data will also be aggregated at the subnational level (i.e., district) to look at the average and range of provider absence rates across facilities in the subnational area.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	<p>To be considered in-country</p> <p>There is a need to take into consideration other reasons for unpreventable absence (e.g., illness or personal emergencies).</p>
<b>Data Use</b>	The indicator can monitor changes in health care worker availability at PHC facilities over time, identify patterns in absences, and evaluate the impact of interventions aimed at reducing absences. It can also be used to inform resource allocation decisions for policymakers, such as hiring additional health care workers.
<b>Other Notes, Discussion,</b>	

<b>and/or Comments</b>	
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/7/2023</b>	

## P8C

## P8C: Facility and sub-national management capability and leadership

**Measurement Category:** Monitoring for Change

**Domain:** Subnational and Facility Management (5Ms)

**Subdomain:** HRH Management Capacity and Performance

### Indicator P8C: Facility and sub-national management capability and leadership

#### Precise Definition

#### Facility Management Capability and Leadership

PHC facilities are led by effective, trained managers. A manager of a health facility is defined as the primary individual who is responsible for overseeing the operational duties of the facility. This may include maintaining records; overseeing staff, activities, supplies or budgets; creating schedules; providing training or supervision; or communicating with partners, leadership or community members; among other responsibilities. Facility management and leadership is measured by:

- The training of the manager: Managers have received any formal training in management of a health facility. (1 point)
- Management practices: In the last 12 months, the manager has completed specific management practices at least once, including:
  - a. Setting and sharing performance targets to achieve service delivery goals. (1 point)
  - b. Holding meetings to discuss data (e.g., routine service statistics, common conditions) with staff. (1 point)
  - c. Conducting or supporting facility quality improvement activities. (1 point)
  - d. Ensuring that a formal supportive and continuous supervision system is in place and that supervision is occurring. (1 point)
  - e. Using a system (manual or FMIS) to track revenue and expenditure. (1 point)
  - f. Collecting and using community input (1 point)

Facilities are assessed with a checklist as meeting none, some, most or all of these criteria (see Method of Data Collection).

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Facility

**Data Type:** Facility score (categorical)

	<p><b>Adapted from:</b> This section of the indicator was adapted from the <a href="#">PRIME tool</a> and the PMA2020 facility survey, Section 4: Facility Management.</p> <p><b>Subnational Management Capability and Leadership</b></p> <p>Subnational entities (e.g., District Health Management Teams or other administrative units) provide management support to facilities within their subnational unit as well as management of subnational level activities, including:</p> <ul style="list-style-type: none"> <li>● Supporting the goal of staffing facilities with qualified personnel. (1 point)</li> <li>● Providing financial oversight to facilities. (1 point)</li> <li>● Ensuring that facilities have the basic infrastructure requirements. (1 point)</li> <li>● Providing training to facility staff in relevant content areas as appropriate. (1 point)</li> <li>● Providing formal, supportive, and continuous supervision to facility units including in clinical performance and/or facility management as appropriate. (1 point)</li> <li>● Collecting and analyzing data to inform implementation of PHC across the subnational unit. (1 point)</li> <li>● Serving as an intermediary to support communication between facilities and the national level. (1 point)</li> <li>● Support managing the referral system between health facilities. (1 point)</li> <li>● Support managing the supply change of drugs and supplies to PHC facilities, as appropriate. (1 point)</li> <li>● Supports the training of the facility managers—e.g. managers receive formal training in management of a health facility. (1 point)</li> </ul> <p>Subnational units are assessed with a checklist as meeting none, some, most or all of these criteria (see Method of Data Collection).</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Subnational unit</p> <p><b>Data Type:</b> Subnational unit score (categorical)</p> <p><b>Adapted from:</b> This section of the indicator was adapted from the <a href="#">Woreda Management Standards</a>, PMA 2020 Management Module, and <a href="#">PRIME tool</a>.</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational</p>

<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>This indicator needs to be measured at both the facility and subnational level to assess for different capacities at different levels.</p> <p>Adapted From <a href="#">PHCPI Progression Model</a> Measure 30: Facility and sub-national management capability and leadership are essential for facilitating the continuous delivery of high-quality health services. This measure focuses on the degree to which facility and subnational management is professionalized and whether or not facility managers are regularly evaluated based on their management capabilities and performance. It is important to understand the capacity of managers to implement performance management strategies and manage budgets and resources, and respond to challenges to ensure the delivery of high-quality health services.</p>
<p><b>Possible Adaptations</b></p>	<p>Definitions of the manager and the <i>de jure</i> decision spaces (what the local laws and regulations allow for related to authority) may influence criteria and scoring. Some elements of management (e.g., supportive supervision) may occur at the facility or sub-national level. Modifications may be needed to definitions to align management practices with local guidelines.</p> <p>The subnational unit will have to determine what constitutes “relevant content areas” for support to be provided by subnational management to facility units within their context (e.g. clinical content, reporting, management, patient safety, quality improvement, etc. as appropriate).</p> <p>The appropriate level of decision-making authority for facility managers will be dependent on facility or national guidelines as well as local norms. The decision-making authority categories should be modified to align with the local context.</p>
<p><b>Data Disaggregation</b></p>	<p>PHC facility level</p> <p>Geographic</p> <p>Urban/Rural</p> <p>Sector (public/private)</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Facility Checklist</p> <p>and</p> <p>Subnational Capacity and Performance Tool</p>
<p><b>Method of data collection and construction</b></p>	<p><b>Facility Management Capability and Leadership</b></p> <p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>



	<p>The individual or team conducting the facility assessment will use a checklist to record the presence or absence of facility management capability at the facility according to the criteria in the precise definition. This may involve talking with managers at the facility and reviewing documentation, such as manager training reports. Each element will be scored as No (0 pt) or Yes (1 pt), resulting in a numeric value. Once the data are collected via checklist, a facility-level management score will be calculated for training, management practices, and decision-making authority. Scoring will be calculated based on whether the facility meets none (0), some (1–4), most (5-6) or all (7) of the criteria specified in the precise definition above. The indicator is then reported as a percentage of facilities within a subnational unit that meet few, some or most/all of the criteria.</p> <p><b>Subnational Management Capability and Leadership</b></p> <p>Data collection will be carried out using the Subnational Capacity and Performance Checklist, which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. The data will be collected via document review and/or key informant interview/survey as relevant to country context as part of the Subnational Capacity and Performance Checklist. Potential sources of information for this measure include key informants who are knowledgeable about the management systems in place, as well as documentation of those systems. An individual or team will be responsible for collecting and collating the data necessary to complete the measure as guided by the Subnational Capacity and Performance Checklist. Each element will be scored as No (0 points) or Yes (1 point), resulting in a numeric value. Once the data are collected via the tool, the indicator is calculated as a subnational-level score: whether the subnational unit has none (0), some (1–6 points), most (7–9 points) or all (10 points) of the elements in the precise definition above.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used to assess the capacity of managers to implement performance management strategies and manage budgets, resources, and respond to challenges. The results should inform where work is needed to build further capacity and also help understand variability in process, outputs, and outcomes at the facility and subnational levels. In addition, looking at the decision space can help understand the relationship between management and these processes, outcomes and where change may be needed.
<b>Other Notes, Discussion,</b>	Other potential sources of these data include: (1) district health and/or facility management teams, (2) training records, (3) curriculum and coursework documents, (4) supervision records, (5) professional associations, (6) civil society organization

<b>and/or Comments</b>	management and leadership training programs, (7) human resources unit/division or (8) ministry of education.  This indicator includes questions related to other indicators, such as supportive supervision, quality improvement, performance targets, and community engagement. For more information about how these elements are defined, see the related indicator on supportive supervision (P8A), quality improvement (P16), performance targets (P15), and community engagement (P4A).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/1/2023</b>	

## P15

## P15: Performance measurement and management for PHC quality improvement

**Measurement Category:** Monitoring for Change

**Domain:** Subnational and Facility Management (5Ms)

**Subdomain:** Systems for Improving PHC Quality

### Indicator P15: Performance measurement and management for PHC quality improvement

<p><b>Precise Definition</b></p>	<p>Facilities conduct performance management for PHC quality improvement, as measured by the following criteria. Indicate whether the facility:</p> <ul style="list-style-type: none"> <li>• Uses established performance targets (established by facility or by a higher authority) for PHC. (1 point)</li> <li>• In the last six months, conducted routine review of data to monitor progress relative to targets. (1 point)</li> <li>• In the last six months, held meetings where routinely collected service statistics or clinical audit data are discussed. (1 point)</li> <li>• Has documented facility-level quality improvement work linked to underperforming areas. (1 point)</li> </ul> <p>Facilities are assessed with a checklist as meeting none, some, most or all of these criteria (see Method of Data Collection).</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (categorical)</p> <p><b>Adapted from:</b> <a href="#">Progression Model</a> Measure 32 (Performance Measurement and Management)</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>From <a href="#">Progression Model</a> Measure 32: Performance measurement and management involves a continuous process of establishing targets, monitoring performance against those targets, and implementing and adapting improvement efforts and is critical for ongoing learning and improvement. Targets within a health facility may relate to myriad functions or outcomes, including equipment and supplies, the process or outcomes of specific clinical or quality interventions, efficiency, quality, provider competence or patient and provider satisfaction, to name just a few. Performance indicators should give useful information on the state of achievement of these targets. Facilities should measure these indicators using systems that easily</p>

	integrate into their already existing environment and practices to facilitate their routine collection. Once facility performance data is received, the facility must have processes in place to interpret data and use results to drive adaptation and improvement processes.
<b>Possible Adaptations</b>	The specific criteria for PHC-related performance measurement and management may differ based on country standards. Guidelines for the frequency of performance target review may vary by facility or country context. The definition should be modified to align with these guidelines.
<b>Data Disaggregation</b>	For Subnational measurement: <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Geographic</li> <li>● Urban/Rural</li> <li>● Sector (public/private)</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	Facility Checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record whether performance measurement and management is occurring that meets the criteria in the precise definition. This may involve talking with key point people at the facility and reviewing documentation such as facility reports on performance targets. Each element will be scored as No (0 pt) or Yes (1 pt), resulting in a numeric value.</p> <p>Once the data are collected via checklist, the indicator is calculated as a facility-level score: whether the facility meets none (0), some (1–2), most (3) or all (4) of the criteria specified in the precise definition above.</p> <p>Facility-level data will also be aggregated at the subnational level (i.e., district) to look at the percentage of facilities that meet none, some or most/all (respectively) of the criteria for performance management for quality improvement.</p>

<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used to assess the routine establishment of performance targets, monitoring of progress towards these targets, and use of these data to inform work to address gaps through performance management, including quality improvement. The results overall and individual items at the facility and subnational level can be used to identify facilities areas where strengthening of performance management and improvement is needed and where positive outliers can serve as sources for learning
<b>Other Notes, Discussion, and/or Comments</b>	This indicator should be interpreted in conjunction with other related indicators, such as facility management (P8C) and information systems use (P10).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/1/2023</b>	

## P16

## P16: Facilities have systems to support the improvement of quality of primary health care and safety

**Measurement Category:** Monitoring for Change

**Domain:** Subnational and Facility Management (5Ms)

**Subdomain:** Systems for Improving PHC Quality

### Indicator P16: Facilities have systems to support the improvement of quality of primary health care and safety

<p><b>Precise Definition</b></p>	<p>Facilities have systems to support and implement quality improvement (QI), measured against the following criteria:</p> <ul style="list-style-type: none"> <li>● Existence of a focal person for QI and patient safety (1 point)</li> <li>● Dedicated resources for action on quality and safety (1 point)</li> <li>● Regular application of QI methods (e.g., performance measurement and management, quality improvement cycles, audit and feedback, learning systems) (1 point)</li> <li>● Processes for clinical audits and mortality reviews (e.g., neonatal and maternal death review and response systems) (1 point)</li> <li>● Availability of relevant clinical guidelines/protocols and checklists (1 point)</li> <li>● Systems for adverse event reporting including medication harm (1 point)</li> <li>● Existence of an up-to-date risk management protocol (1 point)</li> <li>● System or mechanism to measure patient experience/patient voices (1 point)</li> </ul> <p>Facilities are assessed with a checklist as meeting none, some, most or all of these criteria (see Method of Data Collection).</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (categorical)</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> M60: Percent of facilities with systems to support quality improvement</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<p><b>Rationale</b></p>	<p>From <a href="#">PHC MFI</a> M60: Facility-level action on quality and safety requires a multifaceted approach with strong linkages to district management and national</p>

<b><i>(and any Link to Foreign Assistance Framework)</i></b>	strategic direction. Facility leadership and facility improvement teams drive activity and ensure relevant stakeholders are engaged. Key areas of activity span organizational aspects with focused attention to clinical improvement, reducing harm and engagement with patients, families, and communities. The listed criteria in the definition represent a translation of quality interventions to the facility level in four areas—systems environment, reducing harm, improving clinical care, and patient, family and community engagement, as outlined by the World Health Organization (WHO), the World Bank and the Organization for Economic Co-operation and Development (OECD).
<b>Possible Adaptations</b>	To be considered at the country level to reflect national systems, guidance, and processes.
<b>Data Disaggregation</b>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a checklist to record the presence or absence of facility-level QI systems that meet the criteria in the precise definition. This may require talking with various people at the facility in order to assess the extent to which the criteria are met.</p> <p>Once the data are collected via checklist, the indicator is calculated as a facility-level score: whether the facility has QI systems that meet none (0), some (1–5), most (6–7) or all (8) of the criteria specified in the precise definition above.</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the percent of facilities with QI systems that meet none, some or most/all (respectively) of the criteria in the precise definition.</p>

<b>Data Collection and Reporting Frequency</b>	Every 6–12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used by facility managers and subnational program managers to determine whether health facilities have sufficient systems in place to support and implement quality improvement for PHC, and if not, to identify and act upon gaps for specific components of QI systems (e.g., if a facility does not have a focal person for QI and safety, the facility manager can identify and appoint one).
<b>Other Notes, Discussion, and/or Comments</b>	This indicator falls under the cross-concept of Quality which is also covered in multiple other indicators, including indicators for the 5Cs under Outputs.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	



## OUTPUTS

### OP1A

#### OP1A: Geographic access to PHC services

**Measurement Category:** PHC Foundations

**Domain:** Access and Availability

**Subdomain:** Accessibility, Affordability, Acceptability

Indicator OP1A: Geographic access to PHC services	
<p><b>Precise Definition</b></p>	<p>Percentage of population in a subnational unit who live within 5 km of a comprehensive primary care facility or provider</p> <p><b>Numerator:</b> Number of people who live within 5 km of a primary care facility/provider</p> <p><b>Denominator:</b> Total estimated population in the subnational area</p> <p><b>Unit of measure:</b> Number of people</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #62</p>
<p><b>Level of Measurement</b></p>	<p>Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Access to health services is critical for the health status of a population and analysis of its variance is important in the effective allocation of national health resources. The indicator contributes to the measurement of facility infrastructure management, such as physical availability and accessibility of health services. Geographical accessibility is the preferred indicator and is often measured by distance or travel time to a static health facility.</p>
<p><b>Possible Adaptations</b></p>	<p>In some contexts, the population living within 5 km is specified as the population living <b>within 1 hour travel</b> of a comprehensive PHC facility or provider, for example, in urban settings or where transportation is variable.</p> <p>In contexts where people are assigned to a PHC facility (empaneled), data may need to be collected at the facility level.</p> <p>In contexts where the private sector plays an important role in the provision of comprehensive PHC services, private facilities should also be included in the numerator.</p> <p>The PHC MFI indicator (#62) also specifies “<i>Percentage of population who live within 2 hours of an emergency care unit,</i>” which could be included depending on the scope of PHC services in the country.</p>

<b>Data Disaggregation</b>	<p>Facility type (as relevant to context), including primary care facilities (e.g., community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals)</p> <p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	<p>These data are very often available from the Ministry of Health (MOH) in their facility database or master facility list at the facility level and aggregated and the percent averaged for estimates at the sub-national and national levels; often these data are also included in the country's Health Management Information System (HMIS) and reported in the annual statistics report for sub-national areas.</p> <p>If the data are not available in centralized databases for national or subnational areas, these data can be collected at the facility level and recorded on the facility checklist. Most facilities maintain data (or estimates) related to the distances of the population in their catchment areas from the facility for program planning and monitoring, such as outreach services for immunization.</p>
<b>Method of data collection and construction</b>	<p>These data should be extracted from existing sources in most cases, from national or subnational sources. In cases where these data are not available from routine MOH records, geospatial (GIS) analysis may be used.</p> <p>Calculation of subnational and national level estimates is by assessing the percentage of population covered by all PHC facilities within those geographical areas.</p>
<b>Data Collection and Reporting Frequency</b>	<p>Early on and two-year review</p>
<b>Data Quality Considerations</b>	<p>Government master facility lists, health facility databases or HMIS may not include all private sector health facilities (underestimating coverage if included) and/or may be out-of-date as well as estimates of distance and travel time.</p> <p>For the denominator, the official national population estimates are usually projections based on the last census and the official annual population growth rate. These projections may also be problematic in assigning to a PHC. Issues can arise with the population estimates between geographic areas—and thus geographic comparisons—if the previous census did not provide sufficient subnational population estimates or growth rates, if differential growth rates by geography are not taken into consideration in estimates/projections, and/or there were substantial</p>

	changes in population distribution within the country, e.g., urbanization or displacement and roads and transport options.
<b>Data Use</b>	These data will be used early in the project to better understand physical access to PHC services. Comparisons across subnational areas can indicate where PHC services are more or less accessible to the population and where efforts to improve infrastructure are required. It will be measured again at the two-year review of the project to help policy-makers and program managers assess efforts to expand PHC facility availability and population access to PHC services.
<b>Other Notes, Discussion, and/or Comments</b>	Not Applicable
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/11/2023</b>	

## OP4

## OP4: Patient-reported experience of first-contact accessibility

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: First-Contact Accessibility

## Indicator OP4: Patient-reported experience of first-contact accessibility

**Precise Definition**

First-contact accessibility represents the extent to which PHC facilities serve as the entry point for the majority of a person's health needs by assessing whether the PHC facility is the person's usual source of care. The following questions were written for an exit interview given at the end of a facility visit but can be adapted to a phone survey either for the patient's last visit or for care received in the last 6 or 12 months:

- Is this the facility where you go for most of you or your family's health needs?
  - Yes (1 point)
  - No (0 points)

Separately, the PHC facility should be accessible to the patient and care should be obtained within a time frame appropriate to the urgency of the problem and the patient's needs:

- Did you travel far to get to this facility?
  - Yes (0 points)
  - No (1 point)
- Were you able to access care as soon as you needed it?
  - Yes (1 points)
  - No (0 points)
- Was it easy to get to this PHC facility?
  - Yes (1 point)
  - No (0 points)

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Individual rating

**Data Type:** Binary (yes/no)

**Adapted from:** [PMA Uganda PHC module](#), forthcoming [WHO Patient experiences in primary care: patient questionnaire](#)

<b>Level of Measurement</b>	Facility (average of individual ratings within a facility) Subnational (facility aggregation)
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>The capacity of PHC to serve as a patient’s entry point into the health system will positively influence the way in which the patient population interacts with their health system. When PHC can effectively serve as patients’ first-contact in the health system, service delivery is both more effective and more properly managed and coordinated. The majority of patients’ needs can be met at the primary care level, meaning first-contact accessibility can support reduced utilization of emergency services, reduce fragmentation within the health system, and improve patient outcomes as they’re entering the health system at a level that is better suited to address their care needs. Assessing patient-reported experience of first-contact access is critical in understanding where the PHC system stands in serving as an entry point and how it can improve accessibility to the patient population.</p> <p>The ability of a country’s PHC system to serve as the first-point of contact will often depend on the proximity of PHC service delivery to that patient and whether or not there are competent health workers available to deliver care. This can vary from one context to the next depending on geographic access as well as the level of training required to deliver PHC services in a given country.</p> <p>(Adapted from <a href="#">PHC MFI</a> and <a href="#">PHCPI</a>)</p>
<b>Possible Adaptations</b>	<p>The Precise Definition above was adapted to reflect patient experience of care after a single facility visit through a client exit survey. If looking to evaluate care received over a longer period of time (e.g., over a 12-month period) or a different data collection modality (e.g., rapid telephone survey, household survey), language of both the questions and response options can be adapted to reflect that goal and data collection mode (for example, rather than last visit, use visits in the last 6 or 12 months). Similarly, in countries where community health workers (CHWs) deliver care, the survey could be adapted to ask about care delivered by CHWs.</p> <p>“PHC facilities” should be adapted to align with how PHC care delivery sites are defined within your context.</p>
<b>Data Disaggregation</b>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	Patient-reported experience questionnaire or other methods

<p><b>Method of data collection and construction</b></p>	<p>Data can be collected through a client exit survey to better understand the quality of a patient’s care experience from their perspective. The client exit survey will be conducted at the end of a patient’s visit to the facility. During the visit for the facility checklist, the person or team at the facility will ask the respondent questions which assess quality of the care experience with a subset of questions focused on patient-reported experience of first-contact accessibility. If not done during the visit to complete the facility checklist, the survey can be conducted at an earlier or later date, but not by someone providing care or management at the facility. If relevant, there is growing experience collecting these through phone surveys dependent on context. Completion of this measure will result in either a score of 0 or 1 to assess whether patients use the facility as a usual source of care and a separate score on how accessible the facility was.</p> <ul style="list-style-type: none"> <li>● Score of 1 = First-contact accessible</li> <li>● Score of 0 = Not at all first-contact accessible</li> </ul> <p>Next, the points from the three accessibility components will be summed up for each respondent and result in a categorical value where:</p> <ul style="list-style-type: none"> <li>● Score of 3 = Accessible</li> <li>● Score of 1–2 = Somewhat accessible</li> <li>● Score of 0 = Not at all accessible</li> </ul> <p>These individual respondent scores will be summed and averaged by the number of total respondents from the given facility in order to calculate an average facility score for patient-reported accessibility of care.</p> <p>Facility-level data will be aggregated at the subnational level (e.g., district) to look at the average performance of facilities across the subnational context based on a mean score (e.g., this aggregation would primarily represent the average performance of facilities across a subnational region when it comes to patients’ perception of accessible care). Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Every 6 to 12 months</p>
<p><b>Data Quality Considerations</b></p>	<p>To be considered in-country</p>
<p><b>Data Use</b></p>	<p>These data will be used to assess patients’ ability to enter the health system at the primary care level and the accessibility of the care they received. It can identify</p>

	where work is needed to understand low ratings and where change is needed in the PHC delivery and environment. It will be assessed every 6 to 12 months to continually document progress that has been made in improving patient-reported experience of accessibility and the PHC system serving as their first point of contact
<b>Other Notes, Discussion, and/or Comments</b>	<p>This indicator will be measured through a client exit survey along with the remaining patient-reported experience measures of acceptability (OP1C), continuity (OP5B), comprehensiveness (OP7), coordination (OP8B), and responsiveness and trust in care (OP9A).</p> <p>Patient’s experience of care may be influenced by their <a href="#">expectations of health care</a> (i.e., people with low expectations are more likely to be satisfied with poor quality care). As suggested by Roder-DeWan et al (2019), anchoring vignettes may help rescale ratings of patient experience.</p>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/11/2023</b>	

## OP5A

## OP5A: Average of the service gaps between a) ANC1 and ANC4; and b) DPT1 and DPT3

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Continuity

## Indicator OP5A: Average of the service gaps between a) ANC1 and ANC4; and b) DPT1 and DPT3\*

<p><b>Precise Definition</b></p>	<p>Average of the service coverage gaps between a) ANC1 and ANC4; b) DPT1 and DPT3.</p> <p><b>Calculation</b></p> <p>Average service coverage gaps = (ANC Coverage Gap + DPT Coverage Gap) / 2</p> <p>ANC and DPT Coverage gap should be calculated using the formula below:</p> <p><u>ANC coverage gap</u> = (ANC1 visits/total # of pregnant women) *100 - (ANC4 visits/Total # of pregnant women) *100 in Health System Strengthening project catchment area supported by USAID</p> <p><u>DPT coverage gap</u> = (DPT1 received/total # of children under 24 months) *100 - (DPT3 received/Total # of children under 24 months) *100 in HSS project catchment area supported by USAID</p> <p>ANC1 = Total # of pregnant women who received antenatal care at the 1st visit</p> <p>ANC4 = Total # of pregnant women who received antenatal care 4 times or more</p> <p>DPT1 = Total # of children under 24 months of age who received the first dose of the DPT1 vaccination</p> <p>DPT3 = Total # of children under 24 months of age who received the third dose of the DPT3 vaccination</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Individual</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> Taken directly from USAID PPR Health Indicator (HL-4)</p>
<p><b>Level of Measurement</b></p>	<p>Subnational (average of facility percentages)</p>
<p><b>Rationale</b></p>	<p>This is a USAID PPR Health Indicator (HL-4). From the latest PIRS for HL-4: Continuity of care not only is essential for effectiveness of care for better health outcomes but also reflects facility efforts of engaging clients for improving compliance with</p>



<b><i>(and any Link to Foreign Assistance Framework)</i></b>	suggested behavior and treatment and increasing people's trust in continuously utilizing the services. ANC and DPT service coverage indicators are the most used indicators in the USAID health system strengthening project. The indicator is an indirect reflection of health system responsiveness through improved governance of resources, meeting health needs, and being accountable to its target population for quality services. Improved responsiveness contributes to improving health status by reducing continuity of services gaps through better management of health system resources, better compliance with counseled behaviors and treatment, and increased trust and utilization of services.
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	Service area (look at ANC1–4 separately from DPT1–3) Sex (if possible)
<b>Data Source(s) and Data Collection Instruments</b>	Routine HMIS or facility registers
<b>Method of data collection and construction</b>	Data will be collected through the country's DHIS2 / HMIS, assuming the country's HMIS is configured to track continuity of care for individuals in ANC (ANC1–ANC4) and child immunization (DPT1–DPT3). Data will be compiled at the subnational level in order to account for population movement within the area (e.g., a pregnant woman might go to different facilities in the area for 1st vs 4th ANC visit, so pulling HMIS data at the subnational level will allow for tracking of service continuity between ANC 1–4).
<b>Data Collection and Reporting Frequency</b>	Every 6–12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used to monitor reductions in gaps in continuity of care.
<b>Other Notes, Discussion, and/or Comments</b>	

<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/29/2023</b>	

## OP5B

## OP5B: Patient-reported experience of service continuity

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Continuity

## Indicator OP5B: Patient-reported experience of service continuity

<p><b>Precise Definition</b></p>	<p>Patient-reported perception that PHC facilities deliver care that provides a continuous, longitudinal experience. The following questions were written for an exit interview given at the end of a facility visit but can be adapted to a phone survey either for the patient's last visit or for care received in the last 6 or 12 months:</p> <ul style="list-style-type: none"> <li>● Did you receive care from the same provider during this visit as you did during a previous visit? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> <li>● Did the provider know about your previous health concerns in addition to the concern you came in for today? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> <li>● Did the provider use information from previous visits to accurately diagnose and manage your health concerns during this visit? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> </ul> <p><b>Numerator:</b> Not Applicable  <b>Denominator:</b> Not Applicable  <b>Unit of measure:</b> Individual rating  <b>Data Type:</b> Binary (yes/no)  <b>Adapted from:</b> Forthcoming <a href="#">WHO Patient experiences in primary care: patient questionnaire</a> to reflect the visit just completed at the facility</p>
<p><b>Level of Measurement</b></p>	<p>Facility (average of individual ratings within a facility)  Subnational (facility aggregation)</p>

<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Continuous care is a core component of strong primary care service delivery. Effective, high-quality primary care means patients are building continuous, long-lasting relationships with health care workers who are aware of previous medical history and can effectively treat their patients accordingly. Continuity of care is critical in building trust (covered in indicator OP9A) between patients, their health care worker, and the primary care system. It also has a strong influence on patient satisfaction, which can foster increased uptake of health services and continued engagement with the health system. Assessment of patient-reported continuity (both in provider and information) is an important measure to understand patient satisfaction and trust within the health system and will be even more critical to PHC delivery with the continued rise of chronic conditions and increased life expectancy.</p> <p>(Adapted from <a href="#">PHC MFI</a> and <a href="#">PHCPI</a>)</p>
<p><b>Possible Adaptations</b></p>	<p>The structure of care teams may differ from one context to the next and may affect a patient’s ability to see the same provider consistently when seeking care. For example, a patient may go to the same facility each time and been seen by a physician the first time and a nurse the second. Despite this, their care may be continuous in the sense that both health care workers are aware of their medical history and have the information they need to treat the patient effectively. Countries may adapt the scoring above to reflect this aspect.</p> <p>The precise definition above was adapted to reflect patient experience of care after a single facility visit through a client exit survey. If looking to evaluate care received over a longer period of time (e.g., over a 12-month period) or through a different data collection modality (e.g., telephone survey, household survey), language of both the questions and response options can be adapted to reflect that goal and data collection mode (for example rather than last visit, use visits in the last 6 or 12 months). Similarly, in countries where community health workers (CHWs) deliver care, the survey could be adapted to ask about care delivered by CHWs.</p> <p>“PHC facilities” should be adapted to align with how PHC care delivery sites are defined within your context.</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Patient-reported experience questionnaire or other methods</p>

<p><b>Method of data collection and construction</b></p>	<p>Data can be collected through a facility checklist client exit survey to better understand the quality of a patient’s care experience from their perspective. The client exit survey will be conducted at the end of a patient’s visit to the facility. During the visit for the facility checklist, the person or team at the facility will ask the respondent questions which assess quality of the care experience with a subset of questions focused on patient-reported experience of continuity. If not done during the visit to complete the facility checklist, the survey can be conducted at an earlier or later date, but by someone not providing care or management at the facility. If relevant, there is growing experience collecting these through phone surveys dependent on context. Completion of this measure will result in an overall score for continuity at the facility level. In order to calculate the score, the points from each component will be summed up and result in a categorical value where:</p> <ul style="list-style-type: none"> <li>● Score of 3 = Continuous</li> <li>● Score of 1–2 = Somewhat continuous</li> <li>● Score of 0 = Not at all continuous</li> </ul> <p>These individual respondent scores will be summed and averaged by the number of total respondents from the given facility in order to calculate an average facility score for patient-reported continuity of care.</p> <p>Facility-level data will be aggregated at the subnational level (e.g., district) to look at the average performance of facilities across the subnational context based on a mean score (e.g., this aggregation would primarily represent the average performance of facilities across a subnational region on the delivery of continuous care based on patient-reported experience). Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Every 6 to 12 months</p>
<p><b>Data Quality Considerations</b></p>	<p>To be considered in-country</p>
<p><b>Data Use</b></p>	<p>These data will be used to assess patients’ ability to engage in a continuous relationship with a health care worker, care team or facility each time they seek care. This health care worker, care team or facility knows the patients’ history, including care they’ve received in the past for a variety of health concerns. It can identify where work is needed to understand low ratings and where change is needed in the PHC delivery and environment. It will be assessed every 6 to 12 months to continually document progress that has been made in improving patient-reported experience of continuity when seeking care at a PHC facility.</p>

<p><b>Other Notes, Discussion, and/or Comments</b></p>	<p>This indicator will be measured through a client exit survey along with the remaining patient-reported experience measures of acceptability (OP1C) first-contact accessibility (OP4), comprehensiveness (OP7), coordination (OP8B), and responsiveness and trust in care (OP9A).</p> <p>Patient’s experience of care may be influenced by their <a href="#">expectations of health care</a> (e.g., people with low expectations are more likely to be satisfied with poor quality care). As suggested by Roder-DeWan et al (2019), anchoring vignettes may help rescale ratings of patient experience.</p>
<p><b>Changes to indicator with date</b></p>	<p>To be completed in-country</p>
<p><b>This sheet was last updated on: 04/11/2023</b></p>	

## OP6

## OP6: Existence of referral completion tracking system (facility)

**Measurement Category:** PHC Foundations

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Continuity

## Indicator OP6: Existence of referral completion tracking system (facility)

<p><b>Precise Definition</b></p>	<p><b>A referral completion tracking system at the facility, electronic or paper-based, that captures the following key elements:</b> (1 point each)</p> <ul style="list-style-type: none"> <li>● Formal procedures for documenting outgoing referrals from the facility.</li> <li>● Formal guidelines for transfer of information from other levels of care (e.g., hospitals) back to the facility.</li> <li>● Referral data capture (paper or electronic) which includes <i>all</i> of the following components: <ul style="list-style-type: none"> <li>○ Patient name.</li> <li>○ Date of initial referral.</li> </ul> </li> </ul> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Categorical</p> <p><b>Adapted From:</b> <a href="#">Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System</a>, <a href="#">WHO Policy Brief: Strategies to strengthen referral from primary care to secondary care in low- and middle-income countries</a></p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (aggregated up from facility)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>“The World Health Organization (WHO) defines referral as a process in which a health worker at one level of the health system connects with the same or a higher level that is better, or differently, resourced, either to provide assistance or to transfer the management of the patient to the higher level. Generally, the referral occurs either as a result of the nature of the treatment required or from difficulties arising due to insufficient drugs, equipment or skills to manage the patient at the lower level. In principle, referral may occur from lower to higher levels of care, or it may occur from higher to lower levels of care where that provides the most appropriate use of resources... WHO emphasizes that referral is properly seen as a two-way process: referral from primary (including community health workers) to secondary services where a higher level of care is needed, and return referral from</p>

	<p>secondary to primary care or PHC to community where that is appropriate to meet patient needs....”</p> <p>The presence of an effective referral system is an organizational and/or structural process that contributes to quality of care through improving the continuity, comprehensiveness, coordination as well as safety, effectiveness, timeliness, efficiency, and client-centeredness of services by providing the right care at the right level and the right time and keeping a client’s care team connected and coordinated. In order to understand whether or not referrals are successfully being followed through and followed-up upon at the PHC level, there is a need for effective referral tracking systems that capture transfer of relevant information up the system and back to the PHC level and serve as data to monitor the functioning of the system.</p> <p>(Directly quoted and/or adapted from the <a href="#">WHO Policy Brief: Strategies to strengthen referral from primary care to secondary care in low- and middle-income countries</a>)</p>
<b>Possible Adaptations</b>	We do not recommend removing the set of elements currently listed. Depending on the strength of referral networks within the country’s context, there may be opportunities to include additional elements and/or requirements for the country’s referral completion tracking system (e.g., electronic vs paper based, unique patient ID).
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a census of all facilities or select a representative sample of facilities for the early-project and two-year review measurement timepoints. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for assessment of progress among sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a standardized checklist to record whether the facility has key elements as described in the precise definition. This may involve talking with point people at the facility and reviewing documentation, such as referral slips, health management information systems, bookkeeping or referral management systems for verification.</p> <p>Each element will be scored as No (0 points) or Yes (1 point) and then summed, resulting in a numeric value. Once the data are collected via checklist, the indicator is calculated as a facility-level score: whether the facility meets none (0), some (1), most (2) or all (3) of the criteria specified in the precise definition above.</p>



	Facility-level data will be aggregated at the subnational level (i.e., district) to look at the percentage of facilities that meet none, some, most, or all (respectively) of the criteria for a referral completion tracking system.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used early in the project to assess the existence of a referral completion tracking system. Data can be used by subnational managers, facility managers, information system experts, and PHC staff to inform where strengthening is needed within the referral tracking system to optimize coordination and collaboration across PHC and other levels of care. The indicator will be measured again at the two-year review to understand if progress has been made in strengthening the referral completion tracking system. Effective and efficient systems can also provide promising practices for spread and scale.
<b>Other Notes, Discussion, and/or Comments</b>	To understand the rate of referral loop completion in your context, reference Indicator OP8A: Completion of Referral Loops.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## OP7

## OP7: Patient-reported experience of comprehensiveness

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Comprehensiveness

## Indicator OP7: Patient-reported experience of comprehensiveness

<p><b>Precise Definition</b></p>	<p>Patient felt the care received from this PHC facility on the day of their visit met their current health needs (e.g., helped solve their health problem or helped them feel better). The following questions were written for an exit interview given at the end of a facility visit but can be adapted to a phone survey either for the patient’s last visit or for care received in the last 6 or 12 months:</p> <ul style="list-style-type: none"> <li>● Did your provider address your overall health needs as opposed to focusing on just one health concern? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> <li>● Did the provider discuss different ways to keep you healthy in addition to addressing the health concern you came in for? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> <li>● Did the provider fully address your emotional health and well-being during this visit? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> </ul> <p><b>Numerator:</b> Not Applicable  <b>Denominator:</b> Not Applicable  <b>Unit of measure:</b> Individual rating  <b>Data Type:</b> Binary (yes/no)  <b>Adapted from:</b> <a href="#">PMA Uganda PHC module</a>, forthcoming <a href="#">WHO Patient experiences in primary care: patient questionnaire</a> to reflect the visit just completed at the facility</p>
<p><b>Level of Measurement</b></p>	<p>Facility (average of individual ratings within a facility)  Subnational (facility aggregation)</p>
<p><b>Rationale</b></p>	<p>Comprehensiveness is a core component of high-quality primary care and key in moving from a reactive care system to a proactive one. Promoting comprehensive</p>

<p><b><i>(and any Link to Foreign Assistance Framework)</i></b></p>	<p>care pushes the delivery of holistic, promotive, and preventative care in addition to addressing a patient’s most pressing health needs. Comprehensive care also enables PHC systems to capitalize on the ability to deliver a wider range of services when a patient first accesses care and its closely ties to the promotion of continuity. Patient-reported experience on comprehensiveness is an effective way to assess whether or not the primary care system is delivering on this core component of high-quality PHC from a patient perspective and can indicate where to target improvements in care delivery.</p> <p>(Adapted from <a href="#">PHCPI</a>)</p>
<p><b>Possible Adaptations</b></p>	<p>Assessment of comprehensiveness will need to be calibrated to a country’s defined package of PHC services.</p> <p>The precise definition above was adapted to reflect patient experience of care after a single facility visit through a client exit survey. If looking to evaluate care received over a longer period of time (i.e., over a 12-month period) or a different data collection modality (e.g., rapid telephone survey, household survey), language of both the questions and response options can be adapted to reflect that goal and data collection mode (for example, rather than last visit, use visits in the last 6 or 12 months). Similarly, in countries where community health workers (CHWs) deliver care, the survey could be adapted to ask about care delivered by CHWs.</p> <p>“PHC facilities” should be adapted to align with how PHC care delivery sites are defined within your context.</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Patient-reported experience questionnaire or other methods</p>
<p><b>Method of data collection and construction</b></p>	<p>Data will be collected through a client exit survey to better understand the quality of a patient’s care experience from their perspective. The client exit survey will be conducted at the end of a patient’s visit to the facility. During the visit for the facility checklist, the person or team at the facility will ask the respondent questions which assess quality of the care experience with a subset of questions focused on patient-reported experience of comprehensiveness. If not done during the visit to complete the facility checklist, the survey can be conducted at an earlier or later date, but not by someone providing care or management at the facility. If relevant, there is growing experience collecting these through phone surveys dependent on context.</p>

	<p>Completion of this measure will result in an overall score for comprehensiveness at the facility level. In order to calculate the facility score, the points from each component will be summed up and result in a categorical value where:</p> <ul style="list-style-type: none"> <li>• Score of 3 = Comprehensive</li> <li>• Score of 1–2 = Somewhat comprehensive</li> <li>• Score of 0 = Not at all comprehensive</li> </ul> <p>These individual respondent scores will be summed and averaged by the number of total respondents from the given facility in order to calculate an average facility score for patient-reported comprehensiveness of care.</p> <p>Facility-level data will be aggregated at the subnational level (e.g., district) to look at the average performance of facilities across the subnational context based on a mean score (e.g., this aggregation would primarily represent the average performance of facilities across a subnational region on the delivery of comprehensive care based on patient-reported experience). Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	These data will be used to assess patients' ability to receive holistic, comprehensive care when accessing PHC services. It can identify where work is needed to understand low ratings and where change is needed in the PHC delivery and environment. It will be assessed every 6 to 12 months to continually document progress that has been made in improving patient perception of comprehensive care at the facility level.
<b>Other Notes, Discussion, and/or Comments</b>	<p>This indicator will be measured through a client exit survey along with the remaining patient-reported experience measures of acceptability (OP1C), first-contact accessibility (OP4), continuity (OP5B), coordination (OP8B), and responsiveness and trust in care (OP9A).</p> <p>Patient's experience of care may be influenced by their <a href="#">expectations of health care</a> (i.e., people with low expectations are more likely to be satisfied with poor quality care). As suggested by Roder-DeWan et al (2019), anchoring vignettes may help rescale ratings of patient experience.</p>

<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/11/2023</b>	

## OP8A

## OP8A: Completion of referral loops

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Coordination

## Indicator OP8A: Completion of referral loops

<p><b>Precise Definition</b></p>	<p>The extent to which outgoing referrals in the last six months from the PHC facility have documentation of referral completion. This presumes that the facility has a system (electronic or paper-based) to document completed referrals.</p> <p><i>A referral loop is considered complete when the outcome of an outgoing referral is provided back to the referring PHC facility. Evidence of referral completion includes existence of documentation, completed forms, or completed follow-up visits indicating that a patient who received an outgoing referral has or has not received the care that they were referred for.</i></p> <ul style="list-style-type: none"> <li>• None—in the last six months, there has not been any completion of referral loops as supported by documentation.</li> <li>• Some—in the last six months, (less than half) of referrals have evidence supporting the completion of a referral loop as supported by documentation.</li> <li>• Most/All—in the last six months, that most (more than half) of referrals have evidence supporting the completion of a referral loop as supported by documentation.</li> </ul> <p>Note: calculation of this indicator requires the facility to provide data on completed referrals (e.g., documented in a register) for the assessment team to review. If the facility cannot provide these data, this indicator cannot be calculated.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Facility score (categorical)</p> <p><b>Adapted From:</b> <a href="#">Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System</a>, <a href="#">WHO Policy Brief: Strategies to strengthen referral from primary care to secondary care in low- and middle-income countries</a>, <a href="#">Centers for Medicare and Medicaid Services</a></p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (aggregated up from facility)</p>
<p><b>Rationale</b></p>	<p>The presence of an effective referral network and referral system contributes to quality of care through improving the safety, effectiveness, timeliness, efficiency,</p>

<p><b>(and any Link to Foreign Assistance Framework)</b></p>	<p>and client-centeredness of services by providing the right care at the right time and keeping a client’s care team connected and coordinated. (<a href="#">WHO Policy Brief: Strategies to strengthen referral from primary care to secondary care in low- and middle-income countries</a>)</p> <p>Closing the referral loop is important for the quality of services, including continuity, coordination, and safety. In order to ensure that a client’s medical history is being effectively shared across the system to provide appropriate care according to their needs, there should be a mechanism for documenting the outcome of referral care back to the referring PHC facility. Failure to document referral outcomes and to close the referral loop result in decreased quality of care and/or ineffective care. (<a href="#">Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System</a>)</p>
<p><b>Possible Adaptations</b></p>	<p>“PHC-facilities” should be interpreted in line with how the PHC system has been defined within your context—it can include multiple facility types so long as they are considered to be a part of your country’s PHC system/context; facilities within a PHC system typically include the lowest level of the system up to the first referral hospital. PHC facility referrals may also include referrals from the facility’s community catchment area if relevant to your context.</p>
<p><b>Data Disaggregation</b></p>	<p>None</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Facility checklist</p>
<p><b>Method of data collection and construction</b></p>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will use a standardized checklist to record whether the facility has documentation that indicates the completion of referral loops, and if so, whether it meets the criteria in the Precise Definition. The assessment team must review data on completed referrals (e.g., documented in a register) in order to gather evidence on referral completion. If the facility cannot provide data on referral completion (e.g. because the facility does not have a system to track completed referrals; the system exists but is only in patient records; or the system exists in a register but the facility does not give permission for the assessment team to review the data), this indicator cannot be calculated.</p> <p>The indicator will be categorically scored as the approximate proportion of outgoing referrals from the PHC facility which have documentation providing evidence of back</p>

	<p>referral or referral completion in the last six months (none, some, most/all) according to the criteria specified in the precise definition above.</p> <p>Facility-level data will be aggregated at the subnational level (i.e., district) to look at the percentage of facilities that have documentation of referral completion for none, some or most/all (respectively) referrals.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used early in the project to assess the functional or physical integration of services delivery across vertical areas into PHC design to ensure continuity, comprehensiveness and coordination, and people centeredness. These data can be used by facility managers as well as subnational stakeholders to understand whether or not referral tracking systems exist and are used. These data can also help to inform if referrals are being followed through, which can help to better implement actions to increase care coordination and comprehensive delivery of services. The indicator will be measured every six months to monitor ongoing change in strengthening referral completion systems.
<b>Other Notes, Discussion, and/or Comments</b>	This measure seeks to understand whether or not there are closed referral loops which are functioning. This may in part be influenced by your system's ability to track referral (see indicator OP6: Existence of a referral completion tracking system). Results should be used to identify where strengthening is needed to ensure comprehensiveness and continuity of care.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	



## OP8B

## OP8B: Patient-reported experience of coordination

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Coordination

## Indicator OP8B: Patient-reported experience of coordination

<p><b>Precise Definition</b></p>	<p>The extent to which a patient (or caregiver if patient is a child or an adult dependent) perceives that the care received at the PHC facility is well-coordinated and integrated across various levels of care. The following questions were written for an exit interview given at the end of a facility visit but can be adapted to a phone survey either for the patient’s last visit or care received in the last 6 or 12 months:</p> <ul style="list-style-type: none"> <li>● Have you received care at another facility for this condition in the last 12 months? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (Not Applicable)</li> </ul> </li> </ul> <p>*Note: Only proceed to the next question if the patient responded “Yes” to the question above.</p> <ul style="list-style-type: none"> <li>● Did this facility help coordinate the care you received at the other facility such as making a referral or following-up after you received care? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> </ul> <p><b>Numerator:</b> Not Applicable  <b>Denominator:</b> Not Applicable  <b>Unit of measure:</b> Individual rating  <b>Data Type:</b> Binary (yes/no)  <b>Adapted from:</b> Forthcoming <a href="#">WHO Patient experiences in primary care: patient questionnaire</a> to reflect the visit just completed at the facility</p>
<p><b>Level of Measurement</b></p>	<p>Facility (scaled average of individual ratings within a facility)  Subnational (facility aggregation)</p>
<p><b>Rationale</b>  <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Effective coordination of care is a key component in a patients’ ability to move both within the same level of care between different delivery areas, but also across different levels when more specialized care is needed. A lack of care coordination leads to an increasingly fragmented health system lending itself to lower-quality care delivery. Building strong care coordination helps to facilitate proper treatment and follow-up and can create strong linkages between different levels of the health care</p>

	<p>system in order to meet the complex needs of patients. Strong care coordination also supports cost-effectiveness and can reduce unnecessary use of emergency or in-patient services. Assessing patient experience with care coordination can help countries understand whether they're meeting patient needs both within primary care, but also across the health system.</p> <p>(Adapted from <a href="#">PHCPI</a>)</p>
<b>Possible Adaptations</b>	<p>Referral systems, or lack thereof, in the country may affect how care is integrated across the different levels and can impact patient-reported experience in receiving coordinated care. This is something to consider when evaluating scores for this indicator.</p> <p>The precise definition above was adapted to reflect patient experience of care after a single facility visit through a client exit survey. If looking to evaluate care received over a longer period of time (e.g., over a 12-month period) or a different data collection modality (e.g., rapid telephone survey, household survey), language of both the questions and response options can be adapted to reflect that goal and data collection mode (for example rather than last visit, use visits in the last 6 or 12 months). Similarly, in countries where community health workers (CHWs) deliver care, the survey could be adapted to ask about care delivered by CHWs.</p> <p>"PHC facilities" should be adapted to align with how PHC care delivery sites are defined within your context.</p>
<b>Data Disaggregation</b>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Patient-reported experience questionnaire or other methods</p>
<b>Method of data collection and construction</b>	<p>Data will be collected through a client exit survey to better understand the quality of a patient's care experience from their perspective. The client exit survey will be conducted at the end of a patient's visit to the facility. During the visit for the facility checklist, the person or team at the facility will ask the respondent questions which assess quality of the care experience with a subset of questions focused on patient-reported experience of coordination. If not done during the visit to complete the facility checklist, the survey can be conducted at an earlier or later date, but not by someone providing care or management at the facility. If relevant, there is growing experience collecting these through phone surveys dependent on context. Completion of this measure will result in an overall score for coordination at the</p>

	<p>facility level. In order to calculate the score, both components must be answered. The second component can only be answered, if the patient responds “yes” to the first component. Therefore, a score of Not Applicable will automatically be given for this measure if a patient responds “no” to the first component as the indicator is no longer relevant. It’s important that a score of Not Applicable be given and not a score of 0, as answering “no” to the first component does not speak to quality of coordination. If both components are answered, the points will be summed up in a categorical value where:</p> <ul style="list-style-type: none"> <li>● Score of 2 = Coordinated</li> <li>● Score of 1 = Not coordinated</li> <li>● Response of “No” to component 1 = Not Applicable</li> </ul> <p>These individual respondent scores will be summed and averaged by the number of total respondents from the given facility in order to calculate an average facility score for patient-reported coordination of care.</p> <p>Facility-level data will be aggregated at the subnational level (e.g., district) to look at the average performance of facilities across the subnational context based on a mean score (e.g., this aggregation would primarily represent the average performance of facilities across a subnational region on the delivery of coordinated care based on patient-reported experience). Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	<p>These data will be used to assess patients’ ability to access integrated care across or within different levels of the health system. This can include the completion of referral loops and communication pathways between different levels of care as well as follow-up. It can identify where work is needed to understand low ratings and where change is needed in the PHC delivery and environment. It will be assessed every 6 to 12 months to continually document progress that has been made in improving patient perception on the extent to which their care is well-coordinated and integrated at the facility level.</p>
<b>Other Notes, Discussion,</b>	This indicator will be measured through a client exit survey along with the remaining patient-reported experience measures of acceptability (OP1C) first-contact

<b>and/or Comments</b>	accessibility (OP4), continuity (OP5B), comprehensiveness (OP7), and responsiveness and trust in care (OP9A).  Patient’s experience of care may be influenced by their <a href="#">expectations of health care</a> (e.g., people with low expectations are more likely to be satisfied with poor quality care). As suggested by Roder-DeWan et al (2019), anchoring vignettes may help rescale ratings of patient experience.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/12/2023</b>	

## OP9A

## OP9A: Patient-reported experience of health system responsiveness and trust in care

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Responsive and People-Centered Care

### Indicator OP9A: Patient-reported experience of health system responsiveness and trust in care

#### Precise Definition

The patients' perceived responsiveness of the health system and their trust in the care received. This is assessed using a responsiveness index that calculates a scaled mean of ratings for the seven domains of the World Health Organization (WHO) World Health Survey Responsiveness Module (dignity, autonomy, choice of health care worker, confidentiality, quality of basic amenities/surroundings/environment, communication, prompt attention) related to outpatient care. The following questions were written for an exit interview given at the end of a facility visit but can be adapted to a phone survey either for the patient's last visit or care received in the last 6 or 12 months:

1. [Dignity] How would you rate the level of respect the provider showed the patient:
  - Excellent (5 points)
  - Very good (4 points)
  - Good (3 points)
  - Fair (2 points)
  - Poor (1 point)
2. [Autonomy] How would you rate your experience of being involved in making decisions for your treatment:
  - Excellent (5 points)
  - Very good (4 points)
  - Good (3 points)
  - Fair (2 points)
  - Poor (1 point)
3. [Confidentiality] How would you rate the way that health services ensured that you could talk privately to providers (e.g., without others overhearing, without concern that my information will be shared):
  - Excellent (5 points)
  - Very good (4 points)

	<ul style="list-style-type: none"><li>○ Good (3 points)</li><li>○ Fair (2 points)</li><li>○ Poor (1 point)</li></ul> <p>4. [Communication]: How would you rate the provider's availability to explain things in a way that you could understand:</p> <ul style="list-style-type: none"><li>○ Excellent (5 points)</li><li>○ Very good (4 points)</li><li>○ Good (3 points)</li><li>○ Fair (2 points)</li><li>○ Poor (1 point)</li></ul> <p>5. [Choice of Health Care Worker] How would you rate the ease with which you could see your provider of choice:</p> <ul style="list-style-type: none"><li>○ Excellent (5 points)</li><li>○ Very good (4 points)</li><li>○ Good (3 points)</li><li>○ Fair (2 points)</li><li>○ Poor (1 point)</li></ul> <p>6. [Prompt Attention] How would you rate the length of wait time at the facility before you were seen:</p> <ul style="list-style-type: none"><li>○ Excellent (5 points)</li><li>○ Very good (4 points)</li><li>○ Good (3 points)</li><li>○ Fair (2 points)</li><li>○ Poor (1 point)</li></ul> <p>7. [Quality of Basic Amenities/Surroundings/Environment] How would you rate the cleanliness of the facility:</p> <ul style="list-style-type: none"><li>○ Excellent (5 points)</li><li>○ Very good (4 points)</li><li>○ Good (3 points)</li><li>○ Fair (2 points)</li><li>○ Poor (1 point)</li></ul>
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	<p>Separate from the responsiveness index, trust in care is an outcome measured by the patient's feeling of confidence and trust in their primary care clinician at this facility as captured by the question:</p> <p>[Trust] How would you rate the level of confidence and trust in the care you received during this visit:</p> <ul style="list-style-type: none"> <li>○ Excellent (5 points)</li> <li>○ Very good (4 points)</li> <li>○ Good (3 points)</li> <li>○ Fair (2 points)</li> <li>○ Poor (1 point)</li> </ul> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Individual rating</p> <p><b>Data Type:</b> Likert scale (categorical)</p> <p><b>Adapted from:</b> <a href="#">PMA Uganda PHC module</a> and Forthcoming <a href="#">WHO Patient experiences in primary care: patient questionnaire</a> to reflect the visit just completed at the facility</p>
<b>Level of Measurement</b>	<p>Facility (average of individual ratings within a facility)</p> <p>Subnational (facility aggregation)</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Understanding whether care is responsive to patient needs and expectations strongly influences utilization of health care services and health care seeking behavior. Positive patient experiences can work to support engagement with the health system, build confidence and trust in the health system, and improve adherence to care plans. A focus on responsiveness of the health system prioritizes the perspective of the user and puts the patient at the center of their own care. It promotes the inclusion of the patient in decision-making around their care and fosters trust both between a patient and the provider as well as the broader health system. Assessing patient-reported experience of responsiveness and trust in care through facility surveys allows for the effective flow of information from the user perspective back to the health system, further allowing the health system to respond and adapt to patient needs and expectations as well as continue to build and sustain confidence in the health system from the patient perspective.</p> <p>(Adapted from <a href="#">PHCMFI, Towards patient-centred care in Ghana: health system responsiveness, self-rated health and experiential quality in a nationally representative survey</a>)</p>
<b>Possible Adaptations</b>	<p>People's ratings of health system responsiveness and trust may be influenced by their <a href="#">expectations of health care</a> (e.g., people with low expectations are more likely</p>

	<p>to be satisfied with poor quality care). As suggested by Roder-DeWan et al (2019), anchoring vignettes may help rescale ratings of patient experience and take into account the contextual factors that shape the legitimate expectations of the population and how well they are met by the health system.</p> <p>The precise definition above was adapted to reflect patient experience of care after a single facility visit through a client exit survey. If looking to evaluate care received over a longer period of time (e.g., over a 12-month period) or a different data collection modality (e.g., rapid telephone survey, household survey), language of both the questions and Likert scale responses can be adapted to reflect that goal and data collection mode (for example rather than last visit, use visits in the last 6 or 12 months). Similarly, in countries where community health workers (CHWs) deliver care, the survey could be adapted to ask about care delivered by CHWs.</p> <p>Categorical data could be transformed into a dichotomous top two box option (good and excellent vs all others).</p> <p>“PHC facilities” should be adapted to align with how PHC care delivery sites are defined within your context.</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Patient-reported experience questionnaire or other methods</p>
<p><b>Method of data collection and construction</b></p>	<p>Data can be collected through a client exit survey to better understand the quality of a patient’s care experience from their perspective. The client exit survey will be conducted at the end of a patient’s visit to the facility. During the visit for the facility checklist, the person or team at the facility will ask the participant questions which assess quality of the care experience with a subset of questions focused specifically on patient-reported experience of health system responsiveness and trust in care. If not done during the visit to complete the facility checklist, the survey can be conducted at an earlier or later date, but by someone not providing care or management at the facility. If relevant, there is growing experience collecting these through phone surveys dependent on context.</p> <p>The responsiveness index can be calculated by adding up the individual scores (0–35) and then converting into a percentage by dividing the total by 35.</p> <p>The responsiveness index can also be calculated as a scaled mean across the domains of responsiveness (see above), which include: dignity, autonomy, health care worker choice, confidentiality, quality of basic amenities, communication, and</p>



	<p>prompt attention. A scaled mean is calculated by adding all the individual scores from each domain together and dividing by the maximum possible score (35).</p> <ul style="list-style-type: none"> <li>● Average score of 0.8–1 = Completely responsive</li> <li>● Average score of 0.6–0.79 = Mostly responsive</li> <li>● Average score of 0.4–0.59 = Somewhat responsive</li> <li>● Average score of 0.2–0.39 = Barely responsive</li> <li>● Average score of 0–0.19 = Not at all responsive</li> </ul> <p>Trust in care is treated as a separate individual factor.</p> <ul style="list-style-type: none"> <li>● Score of 5 = Completely trustworthy</li> <li>● Score of 4 = Mostly trustworthy</li> <li>● Score of 3 = Somewhat trustworthy</li> <li>● Score of 2 = Barely trustworthy</li> <li>● Score of 1 = Not at all trustworthy</li> </ul> <p>These individual respondent scores will be summed and averaged by the number of total respondents from the given facility in order to calculate an average facility score for patient-reported responsiveness and trust in care. Facility-level data will be aggregated at the subnational level (e.g., district) to look at the average performance of facilities across the subnational context in overall responsiveness and trust in the health system. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	<p>These data will be used to assess patients' experience of receiving quality care centered around their needs and expectations and goes beyond a sole focus on the patients' diagnosis. It assesses a patients' perception of their entire care experience—the level at which they were included in decisions surrounding their care, the quality of communication between them and their provider, the respect afforded to them while visiting a facility, etc. It can identify where work is needed to understand low ratings and where change is needed in the PHC delivery and environment. It will be assessed every 6 to 12 months to continually document</p>

	progress that has been made in improving patient perception of responsive, person-centered, and holistic care at the facility level.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator will be measured through a client exit survey along with the remaining patient-reported experience measures of acceptability (OP1C) first-contact accessibility (OP4), continuity (OP5B), comprehensiveness (OP7), and coordination (OP8B).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## OP9B

## OP9B: Facility has a mechanism for client complaints and feedback

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Core Primary Care Functions: Responsive and People-Centered Care

### Indicator OP9B: Facilities have a mechanism for patient complaints and feedback in the health facility

<p><b>Precise Definition</b></p>	<p>Facility has a mechanism for client complaint/feedback (e.g., suggestion box, community advisory board, client exit survey or other mechanism) in the health facility.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Dichotomous (Yes/No)</p> <p><b>Adapted from:</b> This indicator is taken directly from MOMENTUM Indicator X-CUT.HFA.4, with no adaptations.</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>From MOMENTUM Indicator X-CUT.HFA.4: Person-centered care has widely been recognized as a central tenet to quality of care, which can be defined as care that is respectful of and responsive to the client’s needs, values, and preferences. A mechanism for complaints and feedback like a suggestion box offers an opportunity for the client to directly, yet anonymously, report how the care could have better met their preferences and needs, which allows the facility to improve care in response.</p>
<p><b>Possible Adaptations</b></p>	<p>Could use alternate data source of client exit survey</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</li> <li>● Variability across facilities</li> </ul>

<b>Data Source(s) and Data Collection Instruments</b>	Facility checklist
<b>Method of data collection and construction</b>	<p>Data will be collected during a facility visit. Depending on the number of facilities in project areas and available resources, countries can choose to do a repeated census of all facilities or select a representative sample of facilities to follow over time. Note: a representative sample of facilities will allow for some conclusions to be drawn from aggregated data at the subnational level, but only allows for identification and addressing of gaps among the sampled facilities.</p> <p>The individual or team conducting the facility assessment will ask if there is a mechanism present for obtaining client complaints/feedback. If so, they will ask what the mechanism is and note the specific mechanism(s) on the checklist.</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the percent of facilities with mechanisms for patient complaints and feedback.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6–12 months
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used by facility managers and subnational program managers to understand mechanisms in place at facilities to promote person-centered care, and to take action to address gaps in these mechanisms (e.g., work with facilities to add a suggestion box).
<b>Other Notes, Discussion, and/or Comments</b>	<p>This is MOMENTUM Indicator X-CUT.HFA.4. This measures the presence of a mechanism for patient complaints/feedback, but does not reflect whether the feedback and/or complaints are reviewed and incorporated on a regular basis.</p> <p>This indicator falls under the cross-concepts of Community and Quality. Specifically, the concept measured in this indicator (feedback mechanism) is also captured in indicator P4A, which measures mechanisms for community engagement in service planning and organization.</p>
<b>Changes to indicator with date</b>	To be completed in-country

This sheet was last updated on: 4/11/2023

## OP10

## OP10: Composite indicator for integrated service delivery

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Integrated Care Delivery

## Indicator OP10: Composite indicator for integrated service delivery

<p><b>Precise Definition</b></p>	<p>The degree to which PHC service delivery is integrated at facility level. Integrated service delivery is defined by the World Health Organization (WHO) as “the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.” To measure this, a composite indicator (from existing data) will be used with indicators defined by the country.</p> <p>Indicators for consideration should include the percentage of patients receiving one health service or treatment who also receive an additional PHC service that relates to a different service area or health service need. Examples of indicators measuring integrated service delivery could include (as appropriate to the local context):</p> <ul style="list-style-type: none"> <li>● % women with antenatal care (ANC) visit who got HIV testing.</li> <li>● % women with ANC visit who received syphilis testing.</li> <li>● % of women who deliver in a facility and initiate or restart a modern contraceptive method prior to discharge.</li> <li>● % of HIV-positive women on antiretroviral therapy (ART) screened for cervical cancer.</li> <li>● % of HIV-positive individuals with new or relapsed tuberculosis (TB) cases who are started or maintained on ART during TB treatment.</li> <li>● % of newly enrolled HIV patients also screened for TB OR % TB cases tested for HIV.</li> <li>● % of children receiving routine vaccination who receive vitamin A supplementation (if recommended).</li> <li>● %HIV patients screened for hypertension.</li> </ul> <p><b>Unit of measure:</b> Average integrated service delivery score</p> <p><b>Data Type:</b> Composite facility score</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>

<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Integration of health care services is a critical component of PHC. According to the WHO’s Framework on Integrated people-centered health services (2016), “care is too often fragmented or of poor quality, and consequently the responsiveness of the health system and satisfaction with health services remain low in many countries.” Additionally, “The focus on hospital-based, disease-based and self-contained ‘silo’ curative care models further undermines the ability of health systems to provide universal, equitable, high-quality and financially sustainable care.” Integrated service delivery can increase overall efficiency of the health system and patient convenience. This composite indicator measures the degree to which integration of service delivery across service areas is occurring.</p>
<p><b>Possible Adaptations</b></p>	<p>The indicators included in this composite score should be determined on the country level based on available data, relevant health indicators, clinical guidelines, and local contextual factors. Of important note, consideration should be given to the type of service delivery included in this composite—ensuring that a broad range of health priorities are represented. For example, if all components of the composite are related to HIV testing or treatment, the composite will give a limited picture on integration of service delivery beyond that service delivery category.</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Geographic</li> <li>● Urban/Rural</li> <li>● Sector (public/private)</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Facility checklist or Health Management Information System</p>
<p><b>Method of data collection and construction</b></p>	<p>Data collection will be variable and will depend on what indicators are chosen for inclusion in the composite score. For all included indicators, an average percentage should be taken and normalized on a scale from 0 to 100 with each component having equal weight using the equation: <math>z_i = (x_i - \min(x)) / (\max(x) - \min(x)) \cdot 100</math> where <math>z_i</math>=the <math>i</math>th normalized value in the dataset; <math>x_i</math>=the <math>i</math>th value in the dataset for that indicator; <math>\min(x)</math>=the minimum value in the dataset for that indicator; and <math>\max(x)</math>=The maximum value in the dataset for that indicator.</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Every 6 to 12 months</p>

<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	The data will be used early in the project to assess the functional or physical integration of services delivery across vertical areas into PHC design to ensure continuity, comprehensiveness and coordination and people centeredness.
<b>Other Notes, Discussion, and/or Comments</b>	See indicators P11, P12, P13A, P13B P14, OP6, OP7, and OP8A for measures of integration of systems and services.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/7/2023</b>	



## OUTCOMES

### OC1

#### OC1: Health service coverage index (based on Universal Health Coverage [UHC] SCI)

**Measurement Category:** Measuring for Impact

**Domain:** Effective and Equitable Coverage

**Subdomain:** Not Applicable

#### Indicator OC1: Health service coverage index (based on Universal Health Coverage [UHC] SCI)

##### Precise Definition

Coverage of essential PHC health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and service capacity and access, among the general population).

##### National level

The indicator is already reported to the [Global Health Repository](#) as an index on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. The tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population are as follows, organized by four components of service coverage:

1. Reproductive, maternal, newborn and child health
  - a. Family planning (FP): Percentage of women of reproductive age (15–49 years) who are married or in union with their need for family planning satisfied with modern methods.
  - b. Pregnancy care: Percentage of women aged 15–49 years with a live birth in a given time period who received antenatal care four or more times.
  - c. Child immunization: Percentage of infants receiving three doses of diphtheria-tetanus-pertussis-containing vaccine.
  - d. Child treatment: Percentage of children younger than 5 years with symptoms of acute respiratory infection (cough and fast or difficult breathing due to a problem in the chest and not due to a blocked nose only) in the two weeks preceding the survey for whom advice or treatment was sought from a health facility or provider.
2. Infectious diseases

- a. Tuberculosis (TB): Percentage of incident TB cases that are detected and initiated on treatment.
  - b. HIV/AIDS: Percentage of adults and children living with HIV currently receiving antiretroviral therapy.
  - c. Malaria: Percentage of population in malaria-endemic areas who slept under an insecticide-treated net the previous night [only for countries with high malaria burden].
  - d. Water, sanitation and hygiene: Percentage of population using at least basic sanitation services.
3. Noncommunicable diseases
- a. Hypertension: Prevalence of treatment (taking medicine) for hypertension among adults aged 30–79 years with hypertension (age-standardized estimate) (%).
  - b. Diabetes: Age-standardized mean fasting plasma glucose (mmol/L) for adults aged 18 years and older.
  - c. Tobacco: Age-standardized prevalence of adults  $\geq 15$  years currently using any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis (SDG indicator 3.a.1, [metadata available here](#)).
4. Service capacity and access
- a. Hospital access: Hospital beds density, relative to a maximum threshold of 18 per 10,000 population.
  - b. Health workforce: Health professionals (physicians, nurses, others) per capita, relative to maximum thresholds for each cadre (partial overlap with SDG indicator 3.c.1, [see metadata here](#)).
  - c. Health security: International Health Regulations (IHR) core capacity index, which is the average percentage of attributes of 13 core capacities that have been attained (SDG indicator 3.d.1, [see metadata here](#)).

### Subnational Level

This indicator can also be constructed at the subnational level to provide more granular and recent information. At the subnational level, the tracer services listed above will require modification so they are reflective of data that come out of the Health Management Information System (HMIS) and estimated eligible population rather than a population based survey which is the national level data source. Data construction may likewise require modification.

The tracer conditions should align with national policies, but specific indicators will need to be adapted to reflect timely data availability at the subnational level or are already regularly reported through USAID, national systems or other reporting requirements.

1. Reproductive, maternal, newborn and child health
  - a. FP: Percentage of women of reproductive age (15–49 years) who are married or in union with their need for FP satisfied with modern methods
    - i. Consider: met needs for FP
  - b. Pregnancy care: Percentage of women aged 15–49 years with a live birth in a given time period who received antenatal care four or more times
    - i. Consider: women delivering in a facility
  - c. Child immunization: Percentage of infants receiving three doses of diphtheria-tetanus-pertussis-containing vaccine
    - i. Consider: vaccination rate
  - d. Child treatment: Percentage of children younger than 5 years with symptoms of acute respiratory infection (cough and fast or difficult breathing due to a problem in the chest and not due to a blocked nose only) in the two weeks preceding the survey for whom advice or treatment was sought from a health facility or provider
    - i. Consider: diarrhea incidence
2. Infectious diseases
  - a. TB: Percentage of incident TB cases that are detected and initiated on treatment.
  - b. HIV/AIDS: Percentage of adults and children living with HIV currently receiving antiretroviral therapy.
  - c. Malaria: Percentage of population in malaria-endemic areas who slept under an insecticide-treated net the previous night [only for countries with high malaria burden].
    - i. Consider: % children with fever tested for malaria
  - d. Water, sanitation and hygiene: Percentage of population using at least basic sanitation services.
3. Noncommunicable diseases

	<ul style="list-style-type: none"> <li>a. Hypertension: Prevalence of treatment (taking medicine) for hypertension among adults aged 30–79 years with hypertension (age-standardized estimate) (%); blood pressure screening.</li> <li>b. Diabetes: Age-standardized mean fasting plasma glucose (mmol/L) for adults aged 18 years and older.</li> </ul> <p>4. Service capacity and access</p> <ul style="list-style-type: none"> <li>a. Hospital access: Hospital beds density, relative to a maximum threshold of 18 per 10,000 population.</li> <li>b. Health workforce: Health professionals (physicians, nurses, others) per capita, relative to maximum thresholds for each cadre (partial overlap with SDG indicator 3.c.1, <a href="#">see metadata here</a>).</li> <li>c. Health security: IHR core capacity index, which is the average percentage of attributes of 13 core capacities that have been attained (SDG indicator 3.d.1, <a href="#">see metadata here</a>).</li> </ul> <p>*Note service availability and readiness is captured under <b>OP2A</b>. If desired, this could be included in a composite indicator.</p> <p><b>Numerator:</b> Number of people who have received the service</p> <p><b>Denominator:</b> Total population in need of service</p> <p><b>Unit of measure:</b> Number of people</p> <p><b>Data type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">UHC Service Coverage Index</a> (SDG 3.8.1)</p>
<p><b>Level of Measurement</b></p>	<p>National</p> <p>Subnational</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>The index is used to monitor progress in achieving universal health coverage (UHC) and to identify gaps in health service coverage. <a href="#">Per WHO</a>, this indicator is used to monitor progress to SDG target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” The concern is with all people and communities receiving the quality health services they need (including medicines and other health products), without financial hardship. This indicator measures health service coverage and can be interpreted together with indicator 3.8.2 related to health expenditures in relation to a household’s budget to identify financial hardship caused by direct health care payments.</p> <p>However the index was designed to measure at the national level and draw from household surveys. To measure this indicator at the subnational level, use tracer indicators from the priority areas which can be routinely measured from HMIS and other program data.</p>

<b>Possible Adaptations</b>	Countries may need to adapt essential tracer services at the subnational level, and should expect to make modifications to construct this indicator at the subnational level.
<b>Data Disaggregation</b>	<p>Subnational (where possible)</p> <p>Sub-indices: UHC Service Coverage sub-index on infectious diseases; UHC Service Coverage sub-index on noncommunicable diseases; UHC Service Coverage sub-index on reproductive, maternal, newborn and child health; UHC Service Coverage sub-index on service capacity an access</p> <p>Full disaggregation of the index is not currently possible as not all tracer indicators have data that allow for disaggregation.</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>At the National Level, this indicator should be measured from existing data and analysis. Recommended sources include the following: <a href="#">WHO/SDG GHO</a></p> <p>The data used to derive the UHC coverage index comes from household surveys, administrative data, and special facility surveys.</p> <p>At the Subnational Level, data for this indicator can be pulled from the HMIS.</p>
<b>Method of data collection and construction</b>	<p>The UHC index is computed using geometric means of the tracer indicators and is calculated by summing the individual coverage rates for each of the 14 essential health services, and then dividing by the total number of services.</p> <p>At the subnational level, HMIS data collection and construction should occur annually.</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	<p>To be considered in-country</p> <p>This indicator is limited by the availability, timeliness, and quality of data on health service coverage. Data may be missing or unreliable, and the index does not take into account the quality of the services.</p>
<b>Data Use</b>	<p>This indicator can be used by policymakers and funders to inform policy decisions related to health service delivery, health promotion activities, resource allocation, and priority-setting. The Health Service Coverage Index is a global and comparable indicator, and can be helpful for understanding whether program efforts are effectively driving improvements in the expansion of PHC coverage. However, it is important to recognize that there are many confounding variables and effective implementation will not correspond to a one-to-one improvement in the data. At the subnational level, the data can be used by managers at that level to identify gaps in</p>

	coverage of these tracer services as a reflection of the strength of PHC service coverage.
<b>Other Notes, Discussion, and/or Comments</b>	Due to data limitations, not all tracer indicators used to compute the index are direct measures of service coverage. These proxy indicators will be replaced in future years when more data become available. The selected tracer indicators are meant to represent the broad range of essential health services necessary for progress towards UHC; they should not be interpreted as a recommended basket of services.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/7/2023</b>	

## IMPACTS

### IMP2E

#### IMP2E: Premature mortality index

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not applicable

Indicator IMP2E: Premature mortality index (proportion of deaths that occur under the age of 50)	
<p><b>Precise Definition</b></p>	<p>The premature mortality index is defined as deaths in a population most sensitive to mortality prevention efforts of USAID health programs: the proportion of all deaths in a country that occur under the age of 50.</p> <p><b>Numerator:</b> Number of deaths in a country occurring under the age of 50 from any cause during the specified time period</p> <p><b>Denominator:</b> Total number of deaths in a country from any cause during the specified time period</p> <p><b>Unit of measure:</b> Individual</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> USAID Bureau for Global Health documentation on the premature mortality index (internal document)</p>
<p><b>Level of Measurement</b></p>	<p>National</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>The Premature Mortality Index has been identified as a Global Health Common Outcome Indicator that will monitor deaths in populations most sensitive to mortality prevention efforts of USAID health programs. This indicator is useful for tracking progress in PHC (services and system functions) and broader health systems strengthening investments. It aligns with Sustainable Development Goals (SDGs) 3.1, 3.2, 3.3, and 3.4. The indicator is relatively simple to calculate using publicly available data, and most/all deaths in the numerator are considered preventable through the range of USAID Global Health programs (from family planning through Global Health Security Agenda). Given that life expectancy is 65 or less in many priority countries, changes in this indicator (a fall in the percentage of deaths that are premature and sensitive to USAID health programs) would reflect progress on multiple health-related SDG targets that USAID supports.</p>
<p><b>Possible Adaptations</b></p>	<p>The geographic area for measurement depends on scope of work in focus countries</p>

<b>Data Disaggregation</b>	When possible and relevant, by sex, by urban/rural, and by cause of death
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be calculated using existing data on deaths by specific age and sex. Recommended sources for these data include the following:</b></p> <ul style="list-style-type: none"> <li>UN Population Division, reported in the <a href="#">World Population Prospects</a>, and updated approximately every two years</li> </ul>
<b>Method of data collection and construction</b>	<p>Compile data on number of deaths among the index populations (under the age of 50, both sexes) and total number of deaths during the specified time period, and calculate the indicator as:</p> <p>Number of deaths occurring under the age of 50 in the most recent calendar year / Total number of deaths in the most recent calendar year and multiply by 100</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	Any use of alternative data sources for death rates should be undertaken with extreme caution due to concerns over the comparability of data source and estimation methods and data quality issues.
<b>Data Use</b>	To assess evidence of change in preventable deaths in populations most sensitive to USAID health programs, associated with focus on improving PHC. Over time, proportions should approach the global proportion.
<b>Other Notes, Discussion, and/or Comments</b>	Indicator focuses on mortality rate in those under the age of 50 – a simple-to-calculate beneficiary group with mortality that is sensitive to USAID health programs. The results may be hard to interpret if there are increases in mortality in other groups such as older people related to noncommunicable diseases.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 1/17/2024</b>	