

# PRIMARY IMPACT MEASUREMENT FOR ACTION INDICATORS



**USAID**  
FROM THE AMERICAN PEOPLE



# TABLE OF CONTENTS

<b>INTRODUCTION .....</b>	<b>5</b>
Overview .....	5
Indicator Selection, Grouping, and Prioritization .....	6
Adaptation of Indicators .....	7
<b>STRUCTURES &amp; SYSTEMS .....</b>	<b>8</b>
S1: Existence of evidence-based national primary health care policies .....	8
S2: Existence of a social accountability system for PHC planning and governance .....	11
S3A: National M&E framework includes PHC indicators and structure for data use for improvement .....	15
S3B: Regular analytical review of PHC progress and performance including equity.....	18
S4: International Health Regulations (IHR) SPAR Composite on Preparedness .....	21
S5A: Per capita health total expenditure (and PHC-specific).....	28
S5B: Government PHC spending as percentage of government health expenditure .....	31
S6: Existence of audit procedures for public financing and/or financial reporting .....	34
S7: PHC services included in health benefits package .....	37
<b>INPUTS.....</b>	<b>42</b>
IN1: Facilities meet core physical infrastructure requirements .....	42
IN2: Health facility density and distribution of PHC care sites .....	46
IN3: PHC health worker vacancy rates .....	49
IN4: PHC human resources for health density and distribution .....	52
IN5A: Availability of essential medicines .....	55
IN5B: Availability of priority medical equipment and other medical devices .....	58
IN6: Existence of national regulatory mechanism for medicines including PHC essential medications .....	63
IN7: Funds allocated for PHC are available and sufficient at subnational and facility levels .....	66
IN8A: Existence and strength of HMIS at facilities that capture integrated data on PHC services .....	72
IN8B: Existence of LMIS that is integrated across vertical programs at national and at subnational levels.....	75
IN9: Existence of effective surveillance system including reporting from PHC.....	79
IN10: Surveillance actively occurring at the PHC system level including community .....	82
<b>PROCESSES.....</b>	<b>87</b>
P1A: Facilities have multidisciplinary team-based service delivery for PHC .....	87
P1B: Existence of a formal Community Health Worker program .....	90

P2A: Facilities provide proactive population outreach at community and household levels according to local health needs and priorities .....	93
P2B: Existence of systems for proactive population outreach .....	97
P3: Existence of an Empanelment System which assigns patients to providers and is used for proactive population outreach .....	101
P4A: Systems in place for community engagement in PHC service planning and organization .....	105
P4B: Community engagement in PHC service planning and organization is occurring .....	108
P5: Extent to which subnational units and facilities ensure social accountability of PHC to the community served .....	112
P6: Existence of facility budgets and expenditures meeting criteria.....	116
P7: Existence and strength of FMIS for PHC facilities .....	119
P8A: Supportive supervision routinely conducted for PHC facilities .....	122
P8B: Provider availability (health care worker absence rate).....	125
P8C: Facility and sub-national management capability and leadership .....	128
P9: Completeness and timeliness of routine PHC data reporting by facilities .....	133
P10: Facility capacity for information system use .....	136
P11: Physical or service delivery integration of PHC services.....	139
P12: LMIS implements integrated commodity management for PHC .....	143
P13A: Routine PHC data from different electronic information systems are integrated and available through interoperable information architecture .....	147
P13B: Facilities and subnational units are reporting across service areas within a single system .....	150
P14: Integrated financial management system for PHC funds .....	153
P15: Performance measurement and management for PHC quality improvement .....	156
P16: Facilities have systems to support the improvement of quality of primary health care and safety.....	159
P17: Facilities meet criteria for resilient health facilities and services.....	162
P18: Facilities and subnational units meet criteria for pandemic preparedness .....	165
<b>OUTPUTS .....</b>	<b>170</b>
OP1A: Geographic access to PHC services.....	170
OP1B: Sources of expenditure on health (and PHC-specific).....	173
OP1C: Patient-reported experience of acceptability .....	177
OP2A: Facilities offer services according to national defined service package (availability) .....	180
OP2B: Facilities meet minimum national standards to deliver tracer services (readiness) .....	184
OP3: Overall service utilization rate.....	187

OP4: Patient-reported experience of first-contact accessibility.....	190
OP5A: Average of the service gaps between a) ANC1 and ANC4; and b) DPT1 and DPT3.....	194
OP5B: Patient-reported experience of service continuity.....	197
OP6: Existence of referral completion tracking system (facility).....	201
OP7: Patient-reported experience of comprehensiveness.....	204
OP8A: Completion of referral loops.....	208
OP8B: Patient-reported experience of coordination.....	211
OP9A: Patient-reported experience of health system responsiveness and trust in care.....	215
OP9B: Facility has a mechanism for client complaints and feedback.....	221
OP10: Composite indicator for integrated service delivery.....	224
OP11: Adherence to clinical standards for RMNCH tracer conditions.....	227
OP12A: Facilities compliant with selected infection prevention and control (IPC) measures.....	232
OP12B: Facilities conduct maternal, perinatal, and pediatric death audits.....	235
<b>OUTCOMES.....</b>	<b>238</b>
OC1: Health service coverage index (based on Universal Health Coverage [UHC] SCI).....	238
OC2: Effective service coverage: coverage of services delivered according to technical quality standards for tracer PHC functions.....	244
OC3: Disaggregated service utilization data for FP, MNHC, TB, HIV, Malaria.....	247
OC4: Financial protection from catastrophic expenditure.....	251
OC5: Financial risk protection, including PHC.....	254
OC6: Existence of health emergency management plans/protocols.....	257
OC7: Sum of SPAR Capacity Scores for USAID-supported technical areas.....	261
<b>IMPACTS.....</b>	<b>264</b>
IMP1A: Level of disruption in essential health services.....	264
IMP1B: Equity gaps for selected PHC coverage.....	269
IMP2A: Number of child and maternal deaths prevented.....	272
IMP2B: All-cause U5 mortality rate.....	275
IMP2C: Neonatal mortality rate.....	278
IMP2D: Maternal mortality ratio.....	280
IMP2E: Premature mortality index.....	283
IMP3A: 95%–95%–95% HIV Testing and Treatment Targets.....	285
IMP3B: Prevalence of HIV.....	287

IMP3C: HIV incidence-mortality ratio .....	289
IMP4A: Malaria prevalence in children under 5 .....	291
IMP4B: Malaria incidence .....	294
IMP4C: Malaria-specific mortality (modeled) .....	296
IMP4D: TB incidence rate .....	298
IMP4E: TB mortality rate .....	300

The Primary Impact Measurement for Action Framework and associated resources were developed in partnership with MOMENTUM Knowledge Accelerator, which is implemented by Population Reference Bureau (PRB) with partners JSI Research and Training Institute, Inc. (JSI) and Ariadne Labs under USAID cooperative agreement #7200AA20CA00003.

# INTRODUCTION

## Overview

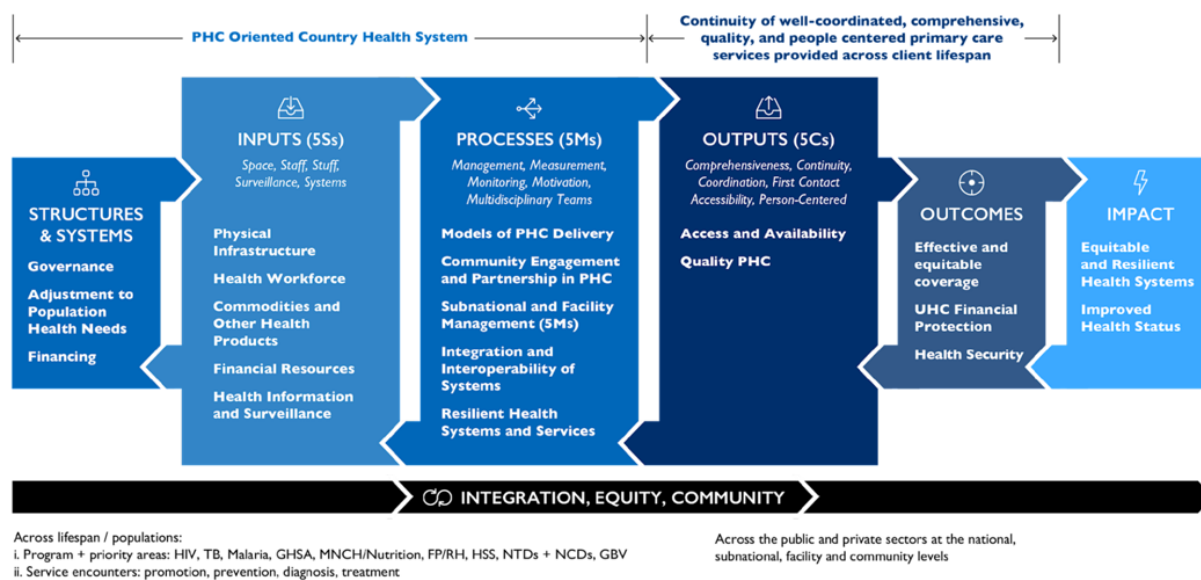
Primary health care (PHC) services are foundational to USAID’s health portfolio. By increasing its focus on PHC, USAID intends to reduce programmatic silos and strengthen coordination among its global health program investments.

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 for Action (M4A) 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 M4A 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 in alignment with the [WHO/UNICEF Primary Health Care Measurement Framework and Indicators \(PHCMFI\)](#):

- **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



## Indicator Selection, Grouping, and Prioritization

The M4A Framework is populated with 86 indicators which are drawn from PHCMFI, existing USAID programmatic indicators, and other measurement and survey tools including the Primary Health Care Initiative's Progression Model, Performance Monitoring for Action and others. Three indicators are completely new as they capture PHC concepts around integration, management, and quality not previously measured.

Indicators are organized into three measurement groups, which specify the frequency and purpose of data collection. All indicators will be assessed at the beginning and end of the two year period of the Primary Impact investment period. **PHC Foundations** indicators (measured early on and at two-year review) are areas critical for PHC governance, design, and delivery but not easily changed or directly targeted by USAID's PHC work. These indicators capture the policies and systems that govern PHC design and delivery at the National, Subnational, and Facility Levels. **Monitoring for Change** indicators (measured every 6–12 months) are areas USAID can directly or indirectly strengthen for timely change within three months to a year. These indicators capture the PHC Processes and Outcomes (including the five core functions of high-quality PHC) at the subnational and facility levels to provide data to guide pragmatic efforts, learning, and adaptation. **Measuring for Impact** indicators (measured early on and at two-year review) cover the longer-term outcomes and impacts representing the main goals of USAID's PHC work. These indicators capture whether PHC investments support improvement in effective and equitable coverage and improved health status.

USAID has prioritized a subset of 31 Core Indicators in order to make the framework implementation more actionable and feasible. A list of those prioritized indicators can be found in the document "Primary Impact Measurement for Action Core Indicators."

## 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**

<p><b>Possible Adaptations</b></p>	<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>
------------------------------------	--

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.



## STRUCTURES & SYSTEMS

# S1

### S1: Existence of evidence-based national primary health care policies

**Measurement Category:** PHC Foundations

**Domain:** Governance

**Subdomain:** Not Applicable

**Indicator S1: National PHC policies exist (integrated into overall health system policies or as standalone), which include evidence-based strategies and fundamental policy concepts known to support strong PHC organization and goals.**

#### Precise Definition

Countries have national primary health care policies in place, which include:

1. A current National Health Plan or National Strategic Plan.
2. A National Health Plan and/or National Strategic Plan designed around PHC. (This could occur either through the existence of an explicit PHC plan, strategy or policy and/or through the embedding of core PHC principles into the Plan.)

*“Policies designed around PHC mean that these policies put PHC at the core of a country’s health strategy; emphasize the five key functions of primary health care: first point of contact, continuity, comprehensiveness, coordination, and patient-centered care; integrate primary care with other service delivery structures and other policy aims and objectives; and emphasize the individual and community at the center of policy and implementation.” —PHCPI Progression Model*

3. Policies around PHC that are data-driven

*“Data Driven” means it takes necessary population data and/or analyses into consideration (e.g., PHC policies reflect analyses of population and/or health services data).*

4. Policies in place related to PHC include the key components (must include: service package defined, financing mechanism described, monitoring and evaluation (M&E) framework established).

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 policy

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

**Adapted from:** [PHCPI Progression Model Measure 1](#)

<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	PHC policies are decisions and plans undertaken by governments with input from other stakeholders to achieve specific PHC goals. PHC policies promote, support, and establish system orientation, financing, inputs, and service delivery mechanisms to ensure quality and improve and develop PHC functions and outcomes. This measure seeks to understand not only that national PHC policies exist, but also whether they are data-driven and include the necessary key strategies and policy concepts known to support strong PHC. (Adapted from the <a href="#">PHCPI Progression Model Measure 1</a> )
<b>Possible Adaptations</b>	We do not recommend removing elements from the indicator. If a country is keen on understanding more about their PHC Policies, further adaptations can be made to include additional elements, particularly the formulation of policies through a participatory process and the existence of a joint review of progress towards PHC-related goals. More on this additional information can be found in the unmodified version of the <a href="#">PHCPI Progression Model Measure 1</a> .
<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>	<p>These data will be collected via document review and/or key informant interview/survey as relevant to the country context. Potential sources of information for this measure include published policy documents from government websites, published reports, ministry-level key informants, policy and planning leads, policy advocacy organizations, and non-governmental organization (NGO) leaders. Given this measure analyzes policy, it is ideal if written evidence of the existence of such policies is identified and reviewed. Data collection will be carried out using the National Capacity and Performance Checklist, which is designed for this initiative and largely draws from existing data sources.</p> <p>An individual or team will be responsible for collecting and collating the data necessary to complete the measure as guided by the National Capacity and Performance Checklist. Once the data are collected via the tool, the indicator is calculated as a national-level score: whether the country meets none (0), some (1-2), most (3) or all (4) of the criteria specified in the precise definition above.</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review

<b>Data Quality Considerations</b>	To be considered in-country 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 in the project to understand whether or not the country has appropriate PHC policies that are evidence-based and include PHC fundamentals to provide a foundation for delivering, strengthening, and promoting PHC. It can be used by national policymakers and advocates to inform the creation of national programming and policy strengthening where needed. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening national policies related to PHC.
<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: 5/30/2023</b>	

S2

## S2: Existence of a social accountability system for PHC planning and governance

**Measurement Category:** PHC Foundations

**Domain:** Governance

**Subdomain:** Not Applicable

INPUTS

PROCESSES

OUTPUTS

OUTCOMES

IMPACTS

### Indicator S2: Existence of a social accountability system for PHC planning and governance.

#### Precise Definition

Categorical score of the sum of the responses on the presence of elements related to social accountability systems for national-level PHC planning and governance.

1. Engagement of national government around PHC-related issues with the private sector, civil society, and/or non-governmental organizations (NGOs) occurs:
  - a. Rarely, if ever. There is minimal to no opportunity for engagement. (0 points)
  - b. On an ad hoc basis. Engagement occurs only for a particular purpose and engagement is not systematic. (1 point)
  - c. Systematic with some stakeholders. Methods and structure for engagement are established and consistently used at regular intervals for stakeholder consultation with only some stakeholder types. (2 points)
  - d. Systematically with all stakeholders. Methods and structure for engagement are established and consistently used at regular intervals for consultation with all stakeholder types. (3 points)
2. Involvement of the private sector, civil society, and/or NGOs in health care planning, policy formulation, and monitoring and evaluation (M&E) is:
 

*Involvement seeks to understand the degree to which stakeholders have an impact on PHC related planning, policy, and M&E.*

  - a. None. Stakeholders are not informed nor given opportunities to provide input. (0 points)
  - b. Minimal. Stakeholders are informed but given few or no opportunities to provide input. (1 point)
  - c. Moderate. Stakeholders are informed and given the opportunity to provide feedback, but are *not* given equal voice or decision making power. (2 points)
  - d. Significant. Stakeholders (some or all) are collaborators in the process and are given equal voice and have influencing power. (3 points)
3. Public disclosure on the status of PHC implementation and results occurs:

	<p><i>Public disclosure is the sharing of information, results, or progress related to PHC implementation that is readily available and accessible to the general public. This may take place in a variety of formats e.g., reports, digital websites, news articles, etc.</i></p> <ol style="list-style-type: none"> <li>Does not occur. (0 points)</li> <li>Rarely. There are few examples of public disclosure taking place but it is not normally occurring. (1 point)</li> <li>Occasionally. There is evidence of public disclosure for some PHC implementation and results, but this is not done according to a fixed plan or schedule. (2 points)</li> <li>Systematically. According to a fixed plan or schedule. (3 points)</li> </ol> <p><u>Social accountability</u> is a measure of whether a country is held responsible for responding to existing and emerging social concerns and priorities based on needs relevant to PHC stakeholders (e.g., community, employees, governmental and nongovernmental organizations, etc). Social accountability can be promoted through close involvement and collaboration among citizen groups, marginalized populations, private sector, civil society organizations, non-governmental organizations, non-health actors, and other stakeholders in health care planning, policy formation, monitoring and evaluation. (PHCPI Progression Model)</p> <p><u>Systems for social accountability</u> should provide evidence of how inputs from non-governmental sectors are translated into changes reflective of and responsive to the concerns of external stakeholders. In its best form, social accountability should be a bi-directional process in which the government seeks and prioritizes external input, while non-governmental actors also seek to amplify or improve government-led PHC efforts.</p> <p>Countries are assessed on the number of criteria that are met—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> Country/national systems</p> <p><b>Data Type:</b> National Score (categorical)</p> <p><b>Adapted from:</b> <a href="#">PHCPI Progression Model Measure 4</a></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>Social accountability is a measure of whether a country is held accountable to existing and emerging social concerns and priorities based on need relevant to PHC of internal and external stakeholders (e.g., community, employees, governmental and nongovernmental organizations, management, and owners). Social accountability can be promoted through close involvement and collaboration among citizen groups, marginalized populations, private sector, civil society organizations,</p>

	<p>NGOs, non-health actors, and other stakeholders in health care planning, policy formation, M&amp;E. Systems for social accountability should provide evidence of how inputs from non-governmental sectors are translated into changes reflective of and responsive to the concerns of external stakeholders. In its best form, social accountability should be a bi-directional process in which government seeks and prioritizes external input, while non-governmental actors also seek to amplify or improve government-led PHC efforts.</p> <p>This measure does not look at social accountability at the local and facility level, which is captured under Process measures.</p> <p>(Adapted from <a href="#">PHCPI Progression Model Measure 4</a>)</p>
<b>Possible Adaptations</b>	Given the intent of measuring PHC policies at the national level, we do not recommend removing elements from the indicator.
<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>	<p>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 published reports, published health committee charters, NGO or civil society leaders, and policy advocacy organizations. For this measure, we recommend consulting at least one non-governmental source. Given this measure analyzes whether a system for social accountability is functioning, it is ideal if written evidence such as meeting notes, published charters, etc. are provided as evidence.</p> <p>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. 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 (1-4 points), most (5-8 points) or all (9 points) elements for social accountability as specified in the precise definition above.</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>	These data will be used early in the project to understand whether or not the country has the appropriate foundational systems in place to ensure that it is held accountable to emerging social concerns and priorities related to PHC and identified by non-parliamentary stakeholders. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening social accountability structures related to PHC.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator measures the existence of a social accountability system at the national level; refer to indicator P5 to understand the extent to which subnational units and facilities ensure social accountability of PHC to the communities served.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 5/30/2023</b>	

## S3A

## S3A: National M&amp;E framework includes PHC indicators and structure for data use for improvement

**Measurement Category:** PHC Foundations

**Domain:** Adjustment to Population Health Needs

**Subdomain:** Not Applicable

**Indicator SA3: National M&E framework includes PHC indicators and structure for data use for improvement.**

<p><b>Precise Definition</b></p>	<p>Existence of core components of a current national monitoring and evaluation (M&amp;E) plan for PHC.</p> <ol style="list-style-type: none"> <li>1. Does your country have a national M&amp;E plan which includes PHC or a specific national PHC M&amp;E plan? (1 point)</li> <li>2. Does your national or PHC-specific M&amp;E plan contain the following elements? (1 point for every element)             <ol style="list-style-type: none"> <li>a. Core indicator list with baselines and targets related to PHC</li> <li>b. Specification on data collection methods</li> <li>c. Data quality assurance mechanisms</li> <li>d. Data analysis and review process specifications</li> <li>e. Specified use of data for policy and planning</li> <li>f. Specified dissemination of the data</li> <li>g. Specified resource requirements to implement the plan/strategy</li> </ol> </li> </ol> <p>Countries are assessed on a categorical score of the number of elements answered positively (yes)—see Method of Data Collection below.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Country/national systems</p> <p><b>Data Type:</b> National Score (categorical)</p> <p><b>Adapted from:</b> <a href="#">WHO SCORE Measure E3.1 National monitoring and evaluation (M&amp;E) is based on standards</a></p>
<p><b>Level of Measurement</b></p>	<p>National</p>
<p><b>Rationale</b> <i>(and any Link to Foreign)</i></p>	<p>An M&amp;E plan should be comprehensive, addressing the goals and objectives of national health sector plans and PHC policies and supporting the selection of a balanced set of core indicators, including PHC, with well-defined baselines, targets based on accepted standards, and data collection methods. In an ideal scenario,</p>



<b>Assistance Framework)</b>	these indicators would also include metrics for integration, gender, and/or equity. The M&E plan also details ways to address data gaps and weaknesses in the various data systems, specifies analytical outputs, defines communication and dissemination mechanisms, includes data quality assurance mechanisms, and outlines plans for institutional capacity building. The M&E plan and its relationship to the health sector and PHC strategies provide the basis for multi-year investment in strengthening information systems and the health system at large. (Adapted from <a href="#">WHO SCORE Measure E3.1 National monitoring and evaluation (M&amp;E) is based on standards</a> )
<b>Possible Adaptations</b>	We do not recommend modifying the elements of this measure.
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	National Capacity and Performance Checklist. Several elements that do not require PHC-specificity can be captured by the World Health Organization (WHO) SCORE Assessment instead of the checklist if it has been completed within your country ( <a href="#">2018 data available here</a> ).
<b>Method of data collection and construction</b>	<p>These data will be collected via document review and/or key informant interview/survey as relevant to the country's context. Potential sources of information for this measure include published M&amp;E plans, national health sector plans, published reports, ministry-level informants (specifically those involved in M&amp;E), and/or policy advocacy organizations. Several elements for this measure that do not require PHC-specificity can be pulled from the <a href="#">WHO SCORE Assessment</a> if completed for your country. If data are not derived from the WHO SCORE Assessment, it is ideal if written evidence such as existing policies, reports or M&amp;E plans are provided as evidence.</p> <p>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. Question 1 and each element of question 2 will be scored as "No" or "Yes" with a value placed on "Yes" (1) and "No" (0), resulting in a numeric value. 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 (1–4 points), most (5–7 points) or all (8 points) elements for strong PHC M&amp;E as specified in the precise definition above.</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country

	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 in the project to understand whether or not the country has an appropriate M&E plan in place to ensure that it has a foundation for monitoring the health sector, specifically PHC, targets, and processes for analyzing and using that data. These data can be utilized by national stakeholders to strengthen frameworks and structures related to the M&E of PHC. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening M&E structures related to PHC.
<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: 5/30/2023</b>	

## S3B

## S3B: Regular analytical review of PHC progress and performance including equity

**Measurement Category:** PHC Foundations

**Domain:** Adjustment to Population Health Needs

**Subdomain:** Not Applicable

## Indicator S3B: Regular analytical review of PHC progress and performance including equity

**Precise Definition**

There is a regular analytical review at the national level analyzing PHC progress and performance against its PHC plan or policy that includes the extent to which equity has been achieved and incorporates the following elements:

1. Analysis of health systems progress in PHC against targets
2. Analysis of inequalities in PHC access/services related to and/or across subnational regions
3. Analysis of inequalities in PHC access/services related to and/or between sexes (male, female)
4. Analysis of inequalities related to in PHC access/services related to socioeconomic status
5. Subnational rankings for key indicators or index
6. Analyzes linkages of PHC service performance to health inputs (like health workforce, infrastructure, commodities, etc)
7. Links findings to PHC policy

*Note - suggestions for policy changes are sufficient to consider this element as present*

8. Utilizes all data sources referenced in the country monitoring and evaluation (M&E) plan
9. Findings are published publicly (meaning available to the public and transparent)

*Regular, as defined in World Health Organization (WHO) SCORE, is within the last five years. If the data and analyses described are greater than five years old, your country would receive a score that indicates this process is "not regularly done."*

Integration of these results into PHC Policies is captured in indicator S1 (Existence of evidence-based national primary health care policies).

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** National

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

	<b>Adapted From:</b> <a href="#">WHO SCORE Indicator R1.Regular analytical reviews of progress and performance, with equity</a>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Regular analytical reviews of PHC progress and performance are conducted to measure and used to drive progress towards efficiency, performance, and benchmarking. More specifically, analytical reviews conducted with an equity lens enable countries to understand the extent to which equity in access has been achieved, and to address inequalities in PHC services. Inequity reviews should provide in-depth analysis and synthesis (in the form of a report) of all relevant data on health indicators. Relevant data should be disaggregated by dimensions of equity across population subgroups, such as sex, place of residence, income, and other country or context-specific factors. Health equity analytical reviews should include broad involvement of key stakeholders at all levels and be linked to responses to address identified gaps. Establishing and maintaining partnerships with an institute that has analytical capacity to support government reviews that ensure transparency and allow for debate between stakeholders. (Adapted from the <a href="#">WHO SCORE Report</a> and <a href="#">WHO SCORE Essential Interventions Guidance</a> )
<b>Possible Adaptations</b>	Given the intent of measuring the existence of regular analytical review of PHC progress and performance with equity at the national level, we do not recommend removing elements from the indicator.  Countries may consider doing analytical reviews more frequently and can adapt the timeframe for the indicator accordingly.
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	National Capacity and Performance Checklist  Data from the WHO SCORE Assessment can be used for several elements if this has been completed within your country ( <a href="#">2018 data available here</a> ).
<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 published analyses and documents from government websites, published reports, ministry level key informants, and M&E leads. Where possible, evidence detailed by key informants should be supported by the documentation previously suggested to support observations.  Note, this measure is adapted from the WHO SCORE Indicator R1, so information for some of these domains may already have been collected. If your country has completed the WHO SCORE Assessment, several elements for this measure can be

	<p>pulled from this assessment if your country's SCORE assessment takes into consideration PHC-relevant initiatives and documentation.</p> <p>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, which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. Once the data are collected via the tool, the indicator is reported as a national-level score: whether the country meets few (0–2), some (3–6) or most/all (7–9) elements in the criteria specified in the precise definition above. If a country has an analytical review more than five years prior to the date of data collection, the indicator will result in a score of “Not Regularly Done.” If multiple analyses take place within your context, all must have occurred at least once within the last five years for it to be considered regular.</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 the country has appropriate and ongoing analyses of PHC progress, as guided by relevant M&amp;E frameworks and conducted with a lens of understanding equity. Data can be used by national-level policymakers, M&amp;E focal points, and advocates to understand the state of the system and drive improvements for PHC-strengthening and better equity. It will be measured again at the two-year review of the project to understand if any progress has been made in performing regular analytic reviews of PHC progress with equity.</p> <p>To understand more on whether or not your country has an appropriate M&amp;E framework, refer to indicator S3A.</p>
<b>Other Notes, Discussion, and/or Comments</b>	To understand how analytical reviews of PHC are integrated into PHC Policies, refer to indicator S1 (existence of evidence-based national primary health care policies).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 05/30/2023</b>	

## S4

## S4: International Health Regulations (IHR) SPAR Composite on Preparedness

**Measurement Category:** PHC Foundations

**Domain:** Adjustment to Population Health Needs

**Subdomain:** Not Applicable

### Indicator S4: International Health Regulations (IHR) SPAR Composite on Preparedness

#### Precise Definition

Composite score of eight preparedness domains graded into five levels, corresponding to a continuum from limited to consolidated performance as indicated in the World Health Organization's (WHO's) [IHR SPAR Tool](#). Of IHR SPAR's 15 domains, this composite score covers the eight domains below:

- National IHR focal point functions
- Multisectoral coordination mechanisms
- Financing for IHR implementation
- Implementation of a laboratory biosafety and biosecurity regime
- Effective national diagnostic network
- Planning for health emergencies
- Management of health emergency response
- Emergency logistic and supply chain management

*(Note: scoring levels 1–5 for each domain are defined in detail below)*

**Unit of measure:** Average maturity level score across domains

**Data Type:** Composite score

**Adapted from:** The contents of this indicator have been directly taken from [IHR SPAR](#) without alteration.

#### National IHR focal point functions

- **Level 1:** The terms of reference describing the roles and responsibilities of the established IHR National Focal Point are not in place or under development and represented by one individual who is entirely familiar with the mandatory National Focal Point functions under the IHR but lacks the authority, capacity and resources to effectively carry out these functions, including around-the-clock accessibility.
- **Level 2:** National IHR Focal Point is a designated center and has a duty officer system to ensure accessibility at all times for urgent communications with WHO but legal, normative and institutional instruments and arrangements, including terms of reference describing the roles and responsibilities, are insufficient to communicate effectively with all levels and relevant sectors of the State Party's administration.

- **Level 3:** National IHR Focal Point is a designated center and has a clear legal and governmental mandate, with terms of reference describing the roles and responsibilities, is sufficiently organized, resourced, and accessible at all times to communicate with WHO, but intersectoral collaboration and communication is inadequate to consolidate surveillance information or to obtain clearance from decision-makers in other domestic sectors.
- **Level 4:** National IHR Focal Point is a center sufficiently organized, resourced, and positioned within the government with levels of authority and institutional arrangements and instruments to access the relevant information sources and decision-making level within the national surveillance and response system.
- **Level 5:** National IHR Focal Point is a center appropriately organized, positioned, trained, and equipped with adequate levels of authority, efficient communication channels, as well as administrative, human, technological, and financial resources to meaningfully engage with all relevant sectors and carry out the function as by IHR provisions and its functioning is exercised, reviewed, evaluated, and updated on a regular basis and actions have been taken to strengthen and maintain its capacities.

#### Multisectoral coordination mechanisms

- **Level 1:** Multisectoral coordination mechanisms for IHR implementation are not in place or under development. Multisectoral coordination activities occur on an ad hoc basis.
- **Level 2:** Multisectoral coordination mechanisms for IHR implementation are developed but not disseminated. Multisectoral coordination activities occur on an ad hoc basis.
- **Level 3:** Multisectoral coordination mechanisms for IHR implementation are in place, disseminated, and are being implemented at national level.
- **Level 4:** Multisectoral coordination mechanisms for IHR implementation are in place, disseminated, and are being implemented at national and intermediate levels.
- **Level 5:** Multisectoral coordination mechanisms for IHR implementation are being implemented at all levels, and are exercised, reviewed, evaluated and updated on a regular basis.

#### Financing for IHR implementation

- **Level 1:** There is no financial planning, budget line or budgetary allocation available to finance IHR implementation, and is handled through extrabudgetary means.
- **Level 2:** Financial planning is limited with a budgetary allocation or substantial external financing made for some of the relevant sectors and their respective ministries to support the IHR implementation at the national level.

- **Level 3:** Financial planning based on identified gaps and estimated resource needs with a budgetary allocation and/or substantial external financing made for relevant sectors is available to support IHR implementation at national level and some monitoring and accountability mechanisms are in place.
- **Level 4:** Financial planning based on identified gaps and estimated resource needs with sufficient budgetary allocation for IHR implementation that may include external financing. The budget is predictable, flexible, and distributed in a timely manner at the national and intermediate levels in all relevant ministries or sectors, with monitoring and accountability mechanisms in place to measure implementation and effectiveness
- **Level 5:** Financial planning with sufficient budgetary allocation for IHR implementation that may include external financing is available at national, intermediate and local levels and all sectors; with predictable and flexible budget, distributed in a timely manner. The country is able to collaborate and provide financial support to other countries considering regional priorities, needs, and global threats. The budget is monitored against objectives, and accountability mechanisms are in place at each level for transparent and effective use of funds.

#### Implementation of a laboratory biosafety and biosecurity regime

- **Level 1:** National laboratory biosafety and biosecurity guidelines and/or regulations are under development.
- **Level 2:** National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by some laboratories at the national level.
- **Level 3:** National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by all laboratories at the national level.
- **Level 4:** National laboratory biosafety and biosecurity guidelines and/or regulations are implemented by all laboratories at national, intermediate and local levels.
- **Level 5:** National laboratory biosafety and biosecurity guidelines and/or regulations are exercised, reviewed, evaluated, and updated on a regular basis, as applicable and a system for oversight of the regulation is in place.

#### Effective national diagnostic network

- **Level 1:** Tier-specific diagnostic testing strategies are not available or under development.
- **Level 2:** Tier-specific diagnostic testing strategies are developed.
- **Level 3:** Tier-specific diagnostic testing strategies exist, but not fully implemented.



- **Level 4:** Tier-specific diagnostic testing strategies are being implemented at national level.
- **Level 5:** Tier-specific diagnostic testing strategies are being implemented at national, intermediate and local levels, and exercised, reviewed, evaluated, and updated on a regular basis, as applicable.

### Planning for Health Emergencies

- **Level 1:** An all-hazard risk informed health emergency plan is not available or under development.
- **Level 2:** All-hazard risk informed health emergency plan is developed but not being implemented.
- **Level 3:** All-hazard risk informed health emergency plan is developed and being implemented at the national level.
- **Level 4:** All-hazard risk informed health emergency plan is developed and being implemented at the national and intermediate levels.
- **Level 5:** All-hazard risk informed health emergency plan is developed and being implemented at national, intermediate, and local levels and exercised, reviewed, evaluated, and updated, with improvements based on SimEx and lessons learned from real-world events, e.g., IARs or AARs.

### Management of Health Emergency Response

- **Level 1:** An incident management system integrated with a national public health emergency operations center or equivalent structure is not available or under development
- **Level 2:** An incident management system integrated with a national public health emergency operations center or equivalent structure is developed but not operational.
- **Level 3:** An incident management system integrated with a national public health emergency operations center or equivalent structure is in place and operational at the national level.
- **Level 4:** An incident management system integrated with a national public health emergency operations center or equivalent structure is in place and operational at the national level and able to support intermediate levels.
- **Level 5:** An incident management system integrated with a national-level public health emergency operations center or equivalent structure is in place and operational at national level and is able to support national level work. Intermediate and local level health emergency response systems are exercised, reviewed, evaluated, and updated, with improvements based on SimEx and lessons learned from real-world events, e.g., IARs or AARs.

	<p><b>Emergency logistic and supply chain management</b></p> <ul style="list-style-type: none"> <li>● <b>Level 1:</b> Emergency logistics and supply chain management system/mechanism is under development and/or not able to provide adequate support for health emergencies.</li> <li>● <b>Level 2:</b> Emergency logistics and supply chain management system/mechanism is developed but not able to provide adequate support for health emergencies.</li> <li>● <b>Level 3:</b> Emergency logistics and supply chain management system/mechanism is developed and is able to provide adequate support for health emergencies at national level.</li> <li>● <b>Level 4:</b> Emergency logistics and supply chain management system/mechanism is developed and is able to provide adequate support for health emergencies at national and intermediate levels.</li> <li>● <b>Level 5:</b> Emergency logistics and supply chain management system/mechanism is implemented at national, intermediate and local levels, and is exercised (as appropriate), reviewed, evaluated, and updated on a regular basis.</li> </ul>
<b>Level of Measurement</b>	National
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	<p>Having the strategies, systems, and resources in place for a health system to identify and adjust to shocks and emerging population health needs is essential to maintain essential PHC health services and adapt service delivery to meet new population priorities.</p> <p>Per WHO Global Health Observatory (GHO), the revised IHR were adopted in 2005 and entered into force in 2007. Under the IHR, States Parties are obliged to develop and maintain minimum core capacities for surveillance and response, including at points of entry, in order to early detect, assess, notify, and respond to any potential public health events of international concern. Article 54 of the IHR requests that States Parties and the Director-General shall report to the World Health Assembly on the implementation of these Regulations as decided by the World Health Assembly. In 2008, the World Health Assembly, through the adoption of Resolution WHA61(2), and later on 2018 with the Resolution WHA71, decided that “that States Parties and the Director-General shall continue to report annually to the Health Assembly on the implementation of the IHR (2005), using the self-assessment annual reporting tool.” This indicator reflects the capacities State Parties of the IHR (2005) had agreed and committed to develop.</p>
<b>Possible Adaptations</b>	None

<b>Data Disaggregation</b>	IHR SPAR domain
<b>Data Source(s) and Data Collection Instruments</b>	This data point should be directly pulled from the SPAR (or other IHR assessment) and not done independently. Recommended sources include the following: <a href="#">IHR SPAR Tool</a> ; <a href="#">WHO GHO</a>
<b>Method of data collection and construction</b>	An average of all eight domain scores should be taken and normalized on a scale from 0 to 100 with each component having equal weight.  Per <a href="#">WHO GHO</a> : Computation Method:  <b>Domain Level</b> —The score of each domain level is classified as a percentage of performance along the “1 to 5” scale. For example, for a country selecting level 3 for the “ <a href="#">National IHR focal point functions</a> ” domain, the domain level will be expressed as: $3/5 * 100 = 60\%$  <b>Capacity Level</b> —The level of the capacity is expressed as the average of all domains. For example, for a country selecting level 3 for the “ <a href="#">National IHR focal point functions</a> ” domain and level 4 for the “ <a href="#">Planning for Health Emergencies</a> ” domain, the domain level for “ <a href="#">National IHR focal point functions</a> ” will be expressed as: $3/5 * 100 = 60\%$ , and domain level for “ <a href="#">Planning for Health Emergencies</a> ” will be expressed as: $4/5 * 100 = 80\%$ . The capacity level for both domains combined will be expressed as: $(60+80)/2 = 70\%$ .
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	
<b>Data Use</b>	Indicates national health systems readiness to respond to emergency health needs and shocks. In addition to understanding overall capacity through the average score, examination of each domain’s level of maturity will be useful for making specific adjustments to policy, programming, and financing decisions. This will help policymakers plan and budget to address gaps in readiness to respond and maintain essential services.
<b>Other Notes, Discussion, and/or Comments</b>	

<p><b>Changes to indicator with date</b></p>	<p>To be completed in-country</p>
<p><b>This sheet was last updated on: 3/27/2023</b></p>	

## S5A

## S5A: Per capita health total expenditure (and PHC-specific)

**Measurement Category:** PHC Foundations

**Domain:** Financing

**Subdomain:** Not Applicable

## Indicator S5A: Per capita health total expenditure (and PHC-specific)

**Precise Definition**

Per capita health expenditure (total and PHC-specific, including both government and non-government expenditure)

**Numerator:** Total current health expenditure and Total current PHC expenditure

**Denominator:** Estimated population count

**Unit of measure:** US dollars

**Data Type:** Ratio

**Adapted from:** This indicator has not been adapted and is taken directly from [A System of Health Accounts 2011](#).

Overall current health expenditure is defined in [A System of Health Accounts 2011](#).

PHC expenditure may require calculation within your context and can be calculated as follows based upon data from the [A System of Health Accounts 2011](#). Refer to System of Health Accounts for precise directions on calculation:

- General outpatient curative care (HC.1.3.1), such as visits to a general practitioner or nurse
- Dental outpatient curative care (HC.1.3.2), such as visits for regular control and other oral treatment
- Curative outpatient care not elsewhere classified. (HC.1.3.nec), excluding specialized outpatient care
- Home-based curative care (HC.1.4), such as home visits by a general practitioner or nurse
- Outpatient (HC.3.3) and home-based (HC.3.4) long-term health care
- Preventive care (HC.6), such as immunization, health check-ups, health education, disease detection, monitoring and emergency response programs
- Part of medical goods provided outside health care services (80% of HC.5)
- Part of health system administration and governance costs (80% of HC.7)

<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	This indicator calculates both the average expenditure on PHC per person as well as average expenditure on total health care per person. It contributes to understanding the health expenditure relative to population size, facilitating international comparison. The per capita expenditure for PHC demonstrates levels of health expenditure that are used for PHC and can be compared to overall health per capita expenditure.
<b>Possible Adaptations</b>	Countries may adapt units of measure to their own national currency for intra-country comparisons and inclusion criteria for PHC based on the financial system capacity
<b>Data Disaggregation</b>	Total; PHC-specific expenditure Source of funding (e.g., Domestic general government health expenditure (GGHE-D), private, external)
<b>Data Source(s) and Data Collection Instruments</b>	<b>This indicator should be measured from existing data and analysis. Recommended sources include the following:</b> <ul style="list-style-type: none"> <li>• National Health Accounts (NHA)</li> <li>• World Health Organization (WHO) Global Health Observatory</li> <li>• World Bank Open Data</li> <li>• <a href="#">Guidelines for the implementation of the SHA 2011 framework for accounting health care financing.</a></li> </ul>
<b>Method of data collection and construction</b>	Per WHO GHO, NHA indicators are based on expenditure information collected within an internationally recognized framework. NHA synthesize the financing flows of a health system, recorded from the origin of the resources (sources), and the purchasing agents (financing schemes), which distribute their funds between providers, to pay for selected health goods and services to benefit individuals. Beneficiaries are analyzed across geographical, demographic, socioeconomic and epidemiological dimensions. Total expenditure on health (THE) is measured as the sum of spending of all financing agents managing funds to purchase health goods and services. The NHA strategy is to track records of transactions, without double counting and in order to reach a comprehensive coverage. Monetary and non-monetary transactions are accounted for at purchasers' values. Guides to producing national health accounts exist. (OECD, 2000; WHO-World Bank-USAID, 2003).
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review

<b>Data Quality Considerations</b>	<a href="#">Per the World Bank metadata definition</a> : Country data may differ in terms of definitions, data collection methods, population coverage, and estimation methods used. In countries where the fiscal year spans two calendar years, expenditure data have been allocated to the later year.
<b>Data Use</b>	These data are used in-country to understand spending on health generally and PHC specifically. It can also be used by policymakers and advocates to compare investments in health across countries in the region or globally. Lower rates than comparator countries can be used to advocate for increased PHC expenditure as a critical input to achieve the function and outcomes of a strong PHC system.
<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: 4/13/2023</b>	

## S5B

## S5B: Government PHC spending as percentage of government health expenditure

**Measurement Category:** PHC Foundations

**Domain:** Financing

**Subdomain:** Not Applicable

## Indicator S5B: Government PHC spending as percentage of government health expenditure\*

<p><b>Precise Definition</b></p>	<p>Domestic general government expenditure on PHC as a share of domestic general government health expenditure</p> <p><b>Numerator:</b> Government expenditure on PHC</p> <p><b>Denominator:</b> Total government expenditure on health</p> <p><b>Unit of measure:</b> US dollar</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> This indicator has not been adapted and is taken directly from <a href="#">A System of Health Accounts 2011</a>.</p> <p>PHC expenditure is calculated as follows based upon data from <a href="#">A System of Health Accounts 2011</a>:</p> <ul style="list-style-type: none"> <li>● General outpatient curative care (HC.1.3.1), such as visits to a general practitioner or nurse</li> <li>● Dental outpatient curative care (HC.1.3.2), such as visits for regular control and other oral treatment</li> <li>● Curative outpatient care not elsewhere classified. (HC.1.3.nec), excluding specialized outpatient care</li> <li>● Home-based curative care (HC.1.4), such as home visits by a general practitioner or nurse</li> <li>● Outpatient (HC.3.3) and home-based (HC.3.4) long-term health care</li> <li>● Preventive care (HC.6), such as immunization, health check-ups, health education, disease detection, monitoring and emergency response programs</li> <li>● Part of medical goods provided outside health care services (80% of HC.5)</li> <li>● Part of health system administration and governance costs (80% of HC.7)</li> </ul>
<p><b>Level of Measurement</b></p>	<p>National</p>



<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>The proportion of government spending on health devoted to PHC reflects the prioritization of PHC as a core component of health care by the government. When measured over time, it provides an indicator of the sustainability or stability of financing for PHC. Public funding should be prioritized for PHC to ensure equity of access and financial protection, and countries often supplement their PHC funding to ensure equity for hard-to-reach populations (<a href="#">Hanson et al</a>).</p> <p>This indicator is measuring PHC-specific government health expenditure as a piece of overall government health expenditure, differentiating it from Indicator S5A, which looks at current health expenditure which includes both government and non-government sources of spending.</p>
<b>Possible Adaptations</b>	Not Applicable
<b>Data Disaggregation</b>	Not Applicable
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources include the following:</b></p> <p>National Health Accounts (NHA)</p> <p><a href="#">Guidelines for the implementation of the SHA 2011 framework for accounting health care financing</a></p>
<b>Method of data collection and construction</b>	<p>Per <a href="#">WHO GHO</a>, NHA indicators are based on expenditure information collected within an internationally recognized framework. NHA synthesizes the financing flows of a health system, recorded from the origin of the resources (sources), and the purchasing agents (financing schemes), which distribute their funds between providers, to pay for selected health goods and services to benefit individuals. Beneficiaries are analyzed across geographical, demographic, socioeconomic, and epidemiological dimensions. THE is measured as the sum of spending of all financing agents managing funds to purchase health goods and services. The NHA strategy is to track records of transactions, without double counting and in order to reach a comprehensive coverage. Monetary and non-monetary transactions are accounted for at purchasers' values. Guides to produce national health accounts exist. (<a href="#">OECD, 2000</a>; <a href="#">WHO-World Bank-USAID, 2003</a>).</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>	Policymakers may use this data to ensure that expenditures for PHC reflect commitment (and changes to commitment) to PHC, while other stakeholders can use the data to advocate for better health resource allocations. Data can also be used by donors for decisions related to resource allocation and advocacy. Measurement over time reflects if and how the financial commitment to PHC as a core component of health has changed.
<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: 4/13/2023</b>	

## S6

## S6: Existence of audit procedures for public financing and/or financial reporting

**Measurement Category:** PHC Foundations

**Domain:** Financing

**Subdomain:** Not Applicable

## Indicator S6: Existence of audit procedures for public financing and/or financial reporting

<p><b>Precise Definition</b></p>	<p>Countries have audit procedures for public financing and/or financial reporting related to health, including PHC, that include:</p> <ol style="list-style-type: none"> <li>1. Audit quality and checklist procedures in place for Health Financing, including PHC-specific financing.</li> <li>2. Timely preparation, completion, and submission of annual health-related financial statements based on public financial management (PFM) system data and reporting tools after end of financial year.</li> <li>3. Performance audit reports presented to financing authority (annually).</li> <li>4. Evidence that financing authority takes time to analyze the audited financial statements (at least annually).</li> <li>5. Evidence that audit recommendations for the previous financial year are implemented.</li> </ol> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Country/national audit procedures</p> <p><b>Data Type:</b> National Score (Categorical)</p> <p><b>Adapted from:</b> World Bank <a href="#">Public Financial Management Enhancement Project (Zimbabwe)</a> Metrics</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>Timely preparation, reporting, and submission of annual financial statements to respective bodies improves public finance data management and accountability. Achievement of PHC goals requires significant budgetary allocation, and financial reporting is essential for transparency and accountability to help the government achieve its desired goals. Audit procedures are an imperative function of PFM systems in health care and conducting audits as a task is not sufficient for a robust PFM. The existence of audit procedures is important to defining PFM systems; previous iterations can provide guidance to officials to deliver their PFM-related responsibilities efficiently and effectively. Existing audit processes should contain elements of PHC program management, such as: work plan creation and scope</p>

	determination, detailed observations that would be useful for conclusive decision-making, holding annual internal audits at the ministerial level, and follow-up on specific audit recommendations. Noncompliance with audit observations has consequences for health, such as delays in fund release, item procurement, slow progress, and sometimes even abandonment of planned activities. (Adapted from the <a href="#">World Bank Discussion Paper: Diagnostic Study of Public Financial Management, SCORE for Health Data Technical Package, World Bank Financial Management Information System webpage</a> ).
<b>Possible Adaptations</b>	The text of this indicator can be adjusted to match the nomenclature for the PFM authority/financing authorities relevant to your country's context. Given the intent of measuring the existence of audit procedures for public financing at the national level, we do not recommend removing elements from the indicator. Adaptations can be made to the timeframes indicated in the precise definition, but generally we recommend that these procedures take place on at least an annual basis; if intended to be more frequent in your context, please adapt.
<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>	<p>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 published policy documents from government websites, published reports, ministry level key informants, policy/planning/financial leads, donor partners.</p> <p>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, which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as necessary. Once the data are collected via the tool, the indicator is calculated as a national-level score: whether the country meets none (0), some (1–2), most (3–4) or all (5) of the criteria specified in the precise definition above.</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be completed in-country

	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 in the project to understand whether or not the country has appropriate audit procedures in place for public financing of health, including PHC. These data are helpful to those who are involved in policymaking and health financing at the national levels and can help to improve transparency and accountability for health financing. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the management of public financing related to PHC.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator was adapted from indicators that the World Bank has used in their investment cases.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 5/30/2023</b>	

## S7

## S7: PHC services included in health benefits package

**Measurement Category:** PHC Foundations

**Domain:** Financing

**Subdomain:** Not Applicable

## Indicator S7: PHC services included in health benefits package

**Precise Definition**

Universal health coverage (UHC) package (health benefits package) defines a set of services to be financed from public sources that have been assessed for inclusion in the benefit package to promote equity in access to services as part of a systematic, transparent process, including criteria on economic evidence and budget impact/cost-effectiveness. This package should include core components of PHC as defined by the country.

1. There is a set of explicitly defined benefits for PHC (defined by the country) for the entire population (adapted from the World Health Organization (WHO) Health Financing Progress Matrix Q5.1)

*Entitlements refer to a defined set of services that a person/population within a country has a legal right to access.*

- a. Emerging—Entitlements are implicit (not explicitly or formally defined) for most of the population. There is no prioritization for at-risk groups. Entitlements described miss major areas of PHC (promotion, prevention, diagnostic, curative, rehabilitation, palliation). (1 point)
  - b. Progressing—Explicit (formally defined) entitlements are linked to contributions (payments) for relatively well-off groups but are implicit and not clearly defined for most of the population in PHC. Many but not all areas of PHC are covered (e.g., antenatal care is covered, but not immunization or nutrition services). (2 points)
  - c. Established—PHC entitlements are explicit for most of the population, and measures are taken to explicitly universalize certain benefits on a non-contributory basis and go across most or all areas of PHC; differences in entitlements across schemes or program/service areas remain. (3 points)
  - d. Advanced—Benefit entitlements are defined explicitly for the entire population with provisions for at-risk populations and/or for other health policy goals. Covers all areas of PHC. (4 points)
2. Decisions on those services to be publicly funded made transparently, using explicit criteria and participatory processes (adapted from WHO Health Financing Progress Matrix Q5.2):
    - a. Emerging—Decisions on publicly funded benefits are not made transparently, with no criteria or process defined as the basis for decisions, and no inclusion of stakeholder perspectives. (1 point)

	<ul style="list-style-type: none"> <li>b. Progressing—Some decisions on publicly funded benefits are assessed against selected criteria and plans to establish a formal process are being considered, but decision-making is largely opaque (not transparent). (2 points)</li> <li>c. Established—Larger number of assessments conducted to inform benefit decisions, and decisions taken to institutionalize an explicit process including criteria such as cost-effectiveness and budgetary impact. (3 points)</li> <li>d. Advanced—Laws or regulations in place requiring proposed changes to publicly funded benefits to be subjected to systematic assessment and deliberation; expert and non-expert stakeholders are incorporated. (4 points)</li> </ul> <p>3. Entitlements and conditions of access are clearly defined and communicated to the population (adapted from WHO Health Financing Progress Matrix Q5.3):</p> <ul style="list-style-type: none"> <li>a. Emerging—Entitlements and conditions of access are not clearly defined, and people do not understand them. (1 point)</li> <li>b. Progressing—Entitlements and conditions of access are clear for part of the population but remain uncertain for most; some efforts made to communicate but limited. (2 points)</li> <li>c. Established —Significant action taken to make entitlements and conditions of access explicit for most of the population but remains unclear for many. (3 points)</li> <li>d. Advanced—Entitlements and obligations are clearly defined on the key dimensions and are clearly communicated and understood by the population. (4 points)</li> </ul> <p>4. User charges are clear and include mechanisms to exempt at-risk populations (adapted from WHO Health Financing Progress Matrix Q5.4) of 4.</p> <ul style="list-style-type: none"> <li>a. Emerging—Regardless of policy design, patients typically must make informal payments in order to obtain care. (e.g., patients typically make informal payments to obtain care. Large number of fees exist, and user charges (co-payments) are poorly designed and implemented, leading to access barriers and financial hardship.) (1 point)</li> <li>b. Progressing—Patient co-payments are highly detailed and/or defined in percentage terms and linked to treatment provided rather than ability to pay; some protection mechanisms in place. (e.g., people have limited understanding of what they will have to pay out of and mechanisms to protect vulnerable populations are poorly implemented. Financial obligations for patients are difficult to understand.) (2 points)</li> </ul>
--	---

	<p>c. Established—Co-payment schedule is limited and clear, organized by level of care, structured as fixed fees, and includes mechanisms to exempt the poor; implementation challenges remain. (3 points)</p> <p>d. Advanced—Co-payment schedule is easy to understand, and has a structure and design that protects vulnerable persons. (4 points)</p> <p>Countries are given a categorical score based on the summation of scores for each individual element)—see Method of Data Collection below.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Country/national systems</p> <p><b>Data Type:</b> National Score (categorical)</p> <p><b>Adapted from:</b> <a href="#">WHO Health Financing Progress Matrix</a></p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Per PHC-MFI (microfinance institution) technical specification document, benefit policy comprises decisions on population entitlements (e.g., publicly funded services) and medicines and other medical products. Also, part of benefit policy decisions are based on the conditions of access, such as the need for a co-payment or adherence to a referral system. Together, these two aspects can shape the way in which publicly funded services are delivered, and how they are accessed. This covers entitlements and conditions of access, but is not a measure of access to health services itself.</p> <p>International experience shows that general declarations of UHC or benefit entitlements for the population are not enough to make real progress; in contrast, being explicit and clear about entitlements and any related conditions of access, reduces uncertainty for the population (which generally constitutes a barrier to accessing services) and is a move in a positive direction. Increasing transparency does not mean defining benefits in detail, as this can be confusing, especially where covered services are defined in long complicated lists. Many countries are becoming more explicit about what the population is, and is not, entitled to—for example, through packages of essential services.</p> <p>This measure considers whether or not PHC benefits have been defined for the entire population, the related decisions are explicit and transparent, entitlements are clearly communicated to the population, that user charges are clear, and that there is stakeholder participation across the development process. To understand geographical access to services, refer to indicator OP1A.</p>
<b>Possible Adaptations</b>	In some contexts, health insurance bodies may span both the public and private sector. For measurement, countries will adapt to what is relevant in their context. If multiple insurance schemes are relevant, they should be reflected in the measure.



<b>Data Disaggregation</b>	Not applicable
<b>Data Source(s) and Data Collection Instruments</b>	<a href="#">WHO Health Financing Progress Matrix</a> and/or National Capacity and Performance Checklist
<b>Method of data collection and construction</b>	<p>Assessment Area 5. Benefits and Conditions of Access from the <a href="#">WHO Health Financing Progress Matrix</a> has been extracted and adapted into the National Capacity and Performance Checklist. If your country has completed Q5.1–Q5.4 in the WHO’s Health Financing Progress Matrix, these data can be utilized during completion of the National Capacity and Performance Checklist for elements described in the precise definition.</p> <p>Data collection will be carried out using the National Capacity and Performance Checklist, which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. For this indicator, adaptations have been made to the scoring of the measure, but information can be pulled directly from the WHO Financing Progression Matrix if already completed by your country.</p> <p>If the WHO Financing Progression Matrix has not been completed in your context, collecting this information may require interviews with key informants or a desk review of country documents. All questions within this measure can achieve a score from 1 to 4 points. Once the data are collected via the tool, the indicator is calculated as a national-level score by adding up the total points: whether the country meets few (0–4 points), some (5–8 points), many (9–12 points) or most/all (13–16 points) elements for a PHC health benefits package as specified in the precise definition above.</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>	These data will be used early in the project by national policymakers, advocates, and donors to understand whether or not the country has a health benefits package that is appropriately financed from public resources. These data will help to understand if payment systems that promote PHC-oriented models of care are in place and can be used to make improvements in the existing health benefits package as well as improving stakeholder engagement and/or transparency around surrounding processes. It will be measured again at the two-year review of the project to

	understand if any progress has been made in strengthening the health benefits package, public understanding of the package, as well as financing of the package.
<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: 5/30/23</b>	

# 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

<p><b>Precise Definition</b></p>	<p>Facility composite score for core physical infrastructure requirements in water, sanitation, and hygiene (WASH); power; communications; and emergency transport.</p> <p><b>Availability of basic WASH amenities (1 point)</b></p> <p>Facilities have the five basic WASH amenities, including (<i>must meet all of the criteria below to qualify as “Yes”</i>):</p> <ul style="list-style-type: none"> <li>● <b>Water:</b> Available from an improved source on premises, and consistently available (no interruptions of 24+ hours in the past 7 days)</li> <li>● <b>Sanitation:</b> Improved toilet facilities are functional and accessible to outpatient clients, and equipped with menstrual hygiene facilities</li> <li>● <b>Hand hygiene:</b> Functional hand hygiene facility (water with soap and/or alcohol-based hand rub) at all points of care <b>and</b> within 5 meters of toilets</li> <li>● <b>Health care waste:</b> 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             <ul style="list-style-type: none"> <li>○ Safe final disposal of <b>sharps</b> 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.</li> <li>○ Safe final disposal of <b>infectious wastes</b> 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.</li> </ul> </li> <li>● <b>Cleaning:</b> Basic protocols for cleaning are available, cleaning materials (mops, detergent, bleach, etc.) are available, and disinfectants and equipment used for sterilization are available</li> </ul> <p><b>Availability of power (1 point)</b></p> <p>Facilities meet the following criteria for availability of power: (<i>must meet all of the criteria below to qualify as “Yes”</i>):</p> <ul style="list-style-type: none"> <li>● Facilities have a source of electrical power</li> </ul>
----------------------------------	--

	<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="#">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</p>

	<p>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>	

## IN2

## IN2: Health facility density and distribution of PHC care sites

**Measurement Category:** PHC Foundations

**Domain:** Physical Infrastructure

**Subdomain:** Not Applicable

## Indicator IN2: Health facility density and distribution of PHC care sites

<b>Precise Definition</b>	<p>Total number of facilities providing PHC services per 10,000 population, disaggregated by sector, urban/rural, geographic region (subnational coverage), and facility level</p> <p><b>Numerator:</b> Number of facilities in public and private sectors</p> <p><b>Denominator:</b> Total population</p> <p>The total number of PHC facilities divided by the total population of the country, multiplied by 10,000. PHC facilities include: community health posts (staffed by salaried and supervised health care workers (HCWs), PHC clinics (public and private), primary and/or district level hospitals</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data type:</b> Ratio</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #22</p>
<b>Level of Measurement</b>	<p>National (subnational aggregation)</p> <p>Subnational</p>
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	<p>The indicator provides an overall understanding of the PHC availability in a country. Disaggregations help determine variations by geography subregion, urban/rural, sector, and facility level. Availability of health facilities, especially facilities that provide PHC services is critical for achieving universal health coverage. This indicator is also a key measure of equity as it demonstrates the levels of physical access to health services.</p>
<b>Possible Adaptations</b>	<p>The definition of what is considered a PHC facility will need to be adapted to each country's context as will the relevance for inclusion of private sector and other sectors (e.g., faith-based, NGO, etc.)</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 HCWs), PHC clinics (public and private), primary and/or district level hospitals)</p> <p>Sector (public, private, other [faith-based, and NGO]) as relevant</p> <p>Subnational</p>

	Geographic subregion region/area Urban/rural
<b>Data Source(s) and Data Collection Instruments</b>	<b>This indicator should be measured from existing data and analysis. Recommended sources include the following:</b>  <u>Numerator:</u> Routine facility information system (e.g., facility database/master facility list); facility census or other data sources, geospatial modeling (where possible to map out geographic locations of health facilities)  <u>Denominator:</u> Estimated total population
<b>Method of data collection and construction</b>	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. This indicator is usually generated from secondary data extracted from existing government systems and sources. In some cases, a census of facilities or a census of facilities not included in government sources (e.g., private sector facilities) may be required.  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 indicator will be constructed as: (the count of facilities providing PHC service divided by the estimated number of population) x 10,000.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	Government master facility lists or health facility databases may not include all private sector or other sectors health facilities and/or may be out-of-date. If private or other types of facilities are not included in government lists, additional data collection through facility censuses may be required. Updating of master facility lists or databases before calculation of this indicator is recommended.  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 be problematic when, for example, the last census was conducted more than 10 years ago; the census methodology did not meet international standards or there were substantial increases or decreases in the total population, e.g., people migrating into or out of the country. 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 changes in population distribution within the country, e.g., urbanization or displacement.



<b>Data Use</b>	<p>These data will be used early in the project by policymakers and program managers to understand the availability of PHC services in the country at the subnational level. These data will provide insight into the foundational context for where PHC services can be expanded to enhance geographic access. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the availability of PHC services.</p> <p><a href="#">The Data for Impact Indicators Database</a> notes: <i>This standardized indicator measures levels of access to health services by the designated populations, can be used to identify underserved areas, and will allow comparisons within and between countries, regions, sectors, and programs. Geographic mapping will allow identification of where there are coverage gaps for certain populations. Data from multiple time points allow for monitoring progress in improving the population’s access to health facilities.</i></p>
<b>Other Notes, Discussion, and/or Comments</b>	<p>Where possible, geographic information system mapping of sites can be used to help determine facility physical access, distribution, and coverage.</p>
<b>Changes to indicator with date</b>	<p>To be completed in-country</p>
<p><b>This sheet was last updated on: 3/29/2023</b></p>	

## 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 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>	

## IN4

## IN4: PHC human resources for health density and distribution

**Measurement Category:** PHC Foundations

**Domain:** Health Workforce

**Subdomain:** Not Applicable

## Indicator IN4: PHC human resources for health density and distribution

<p><b>Precise Definition</b></p>	<p>Number of health care workers (HCWs) by occupation per 10,000 population</p> <p>The PHC workforce includes all formally trained occupations engaged in providing PHC promotion, disease prevention, and treatment, with a specific focus on physicians providing PHC including general medical practitioners, internists and pediatricians, advanced practice providers (e.g., clinical or medical officers), nurses, midwives, and community health workers (CHWs) [who are paid, supervised, and supported]).</p> <p><b>Numerator:</b> Number of PHC human resources for health (HRH) by occupation/cadre</p> <p><b>Denominator:</b> For national-level estimates: total population as estimated by the United Nations Statistics Division. For subnational estimates: Total estimated population in the area.</p> <p><b>Unit of measure:</b> Number of HCWs</p> <p><b>Data Type:</b> Ratio</p> <p><b>Adapted from:</b> <a href="#">PHC MFI Indicator #27</a></p>
<p><b>Level of Measurement</b></p>	<p>National (subnational aggregation); Subnational</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>From <a href="#">PHC MFI technical specifications document</a>, the concept of a multidisciplinary primary care workforce that was articulated in the Declaration of Alma-Ata is as valid and relevant today as it was 40 years ago. To progress toward universal health coverage, countries will need a health workforce that is aligned with population and community health needs and which can adjust to the growing demand for health care driven by rapid demographic, epidemiological, economic, social, and political changes. Ensuring that all occupations play an effective role in the PHC team, including through role optimization and role substitution (task-sharing), can transform traditional models of service provision. Preparing the health workforce to work toward the attainment of a country's health objectives represents one of the most important challenges for its health system. Methodologically, there are no gold standards for assessing the sufficiency of the health workforce to address the health care needs of a given population. The Sustainable Development Goal (SDG) target 3.c</p>

	sets an index threshold of 44.5 physicians, nurses, and midwives per 10,000 population to achieve UHC.
<b>Possible Adaptations</b>	Countries may need to adapt the types of health care worker occupations considered to be PHC workers to include other cadres of non-physician clinicians (e.g., physician assistants, traditional healers, etc.) and other members of multidisciplinary PHC care delivery teams
<b>Data Disaggregation</b>	<p>Occupation:</p> <ul style="list-style-type: none"> <li>● Medical Doctors <ul style="list-style-type: none"> <li>○ Generalist medical practitioners</li> </ul> </li> <li>● Nursing and midwifery professionals <ul style="list-style-type: none"> <li>○ Nursing professionals</li> <li>○ Midwifery professionals</li> </ul> </li> <li>● CHWs (who are paid, supervised, and supported)</li> </ul> <p>Subnational PHC Facility Type Sector (public/private) as relevant Urban/rural</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator should be measured from existing data and analysis. Recommended sources include the following:</p> <p><u>Numerator:</u> HRH records; Human Resource Information System by occupation</p> <p><u>Denominator:</u> Estimates of population from most recent census</p> <p>Both the numerator and denominator can also be found in the <a href="#">National Health Workforce Accounts</a></p>
<b>Method of data collection and construction</b>	<p>This indicator is usually a compilation of secondary data extracted from existing government systems and sources. In some cases, a census or count of the PHC workforce not included in government sources (e.g., private sector workers) may be required.</p> <p>(Count of PHC human resources for health divided by the estimated number of total population) x 10,000</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>Government HRH records or systems may not include all private sector health facilities and/or may be out-of-date due to staff turn-over, transfers or the like. If private sector HCWs are not included in government lists, additional data collection may be required. Updating HRH databases before calculation of this indicator is recommended.</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 be problematic when, for example, the last census was conducted more than 10 years ago or the census methodology did not meet international standards or there were substantial increases or decreases in the total population, e.g., people migrating into or out of the country. 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 changes in population distribution within the country, e.g., urbanization or displacement.</p>
<b>Data Use</b>	<p>These data will be used to assess numbers of the levels of health care workforce available. Stakeholders (e.g., policymakers, program managers, advocates, donors, etc.) can use the indicator to identify gaps and plan and budget efforts for recruitment, development, training, and retention of PHC workforce.</p>
<b>Other Notes, Discussion, and/or Comments</b>	
<b>Changes to indicator with date</b>	<p>To be completed in-country</p>
<p><b>This sheet was last updated on: 3/28/2023</b></p>	

## 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

<p><b>Precise Definition</b></p>	<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>
<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>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

	<ul style="list-style-type: none"><li>● Ophthalmoscope</li></ul> <p>Oxygen</p> <ul style="list-style-type: none"><li>● Oxygen concentrator or oxygen tank with pressure gauge and regulator</li><li>● Oxygen delivery devices (connecting ties, mask, nasal prongs)</li></ul> <p>Consumable supplies</p> <ul style="list-style-type: none"><li>● Suture, absorbable</li><li>● Needles, suturing</li><li>● Suture, non-absorbable</li><li>● Infusion set, intravenous</li><li>● Intravenous cannula (any size)</li><li>● Intravenous needle, child</li><li>● Needles, sterile (any size)</li><li>● Syringes, single use</li><li>● Splinting set, extremities</li><li>● Casts, set and materials</li><li>● Examination gloves, latex, single use</li><li>● Masks</li><li>● Alcohol swabs</li><li>● Sterile gauze, swabs</li><li>● Adhesive tape</li><li>● Condoms, male</li><li>● Urinary catheter, straight</li><li>● Urine collection bag</li><li>● Endotracheal tube (adult)</li><li>● Endotracheal tube (pediatric)</li></ul> <p>Medical equipment for treatments</p> <ul style="list-style-type: none"><li>● Phototherapy device</li><li>● Incubator, newborn</li><li>● Defibrillator</li><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>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>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.</p>
<b>Possible Adaptations</b>	<p>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.</p>
<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> </ul>

	<ul style="list-style-type: none"> <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>	<p>To be considered in-country</p> <p>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.</p>
<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>	

## IN6

## IN6: Existence of national regulatory mechanism for medicines including PHC essential medications

**Measurement Category:** PHC Foundations

**Domain:** Commodities and Other Health Products

**Subdomain:** Not Applicable

### Indicator IN6: Existence of national regulatory mechanism for medicines including PHC essential medications

<p><b>Precise Definition</b></p>	<p>There are regulatory mechanisms for PHC-related essential medicines, measured against the following in a checklist: (1 point each)</p> <ul style="list-style-type: none"> <li>● National regulatory authority</li> <li>● Marketing authorization</li> <li>● Licensing of manufacturers</li> <li>● Licensing of importers, exporters, wholesalers and distributors</li> <li>● Licensing pharmacies and retail outlets</li> <li>● Registration of pharmacy personnel</li> <li>● Post-marketing surveillance and controls</li> <li>● Control of drug promotion and advertising</li> <li>● Pharmacovigilance</li> <li>● Regulation of clinical trials</li> <li>● Regulatory inspections</li> <li>● Laboratory quality control</li> <li>● Control of narcotics, psychotropic substances and precursors</li> </ul> <p>Countries are assessed on the number of criteria that are met (few, some, many, most/all)—see Method of Data Collection below.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Regulatory standards</p> <p><b>Data Type:</b> Checklist</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #30</p>
<p><b>Level of Measurement</b></p>	<p>National</p>



<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Per the <a href="#">PHC MFI technical specifications document</a>, PHC relies on access to health products, including medicines, vaccines, medical devices, in vitro diagnostics, protective equipment and vector-control tools, and assistive devices. These must be of assured safety, efficacy/performance, and quality. In addition, they must be appropriate, available, and affordable. Poor or inadequate regulation can lead to the prevalence of poor standard, counterfeit, harmful, and ineffective drugs on national markets and in international commerce. This can result in serious harm to the health of individual consumers and even to the health of a wider population. Therefore, countries must continuously strengthen key drug regulatory responsibilities to ensure the safety, quality, and efficacy of drugs and the accuracy of product information.</p>
<b>Possible Adaptations</b>	<p>If a country would like to take a deeper look at their Drug Regulatory System, they can undertake other elements of the WHO Global Benchmarking Tool (GBT) for Evaluation of National Regulatory System of Medical Products.</p>
<b>Data Disaggregation</b>	<p>Not Applicable</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>These data will be collected via document review and/or key informant interview as relevant to the country context. Potential sources of information can include national-level guidance on pharmacovigilance or regulatory documents from national resources, as well as key informants who may work in the drug regulation or supply sectors. If a country has completed the more comprehensive World Health Organization (WHO) Data Collection Tool for the Review of Drug Regulatory Systems, aspects of these data can be used to fulfill this metric.</p> <p>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 component marked as “Yes” receives 1 point. Once the data are collected, the indicator is calculated as a national level score: whether the country meets few (0–3), some (4–7), many (8–10) or most/all (11–13) of the regulatory mechanisms for PHC-related essential medicines as specified in the precise definition.</p>
<b>Method of data collection and construction</b>	<p>National Capacity and Performance Checklist</p>
<b>Data Collection and Reporting Frequency</b>	<p>Early on and two-year review</p>
<b>Data Quality Considerations</b>	<p>To be considered in-country</p>

<b>Data Use</b>	These data will be used early in the project by national policymakers and/or regulatory authorities to understand the current regulatory environment for PHC-related essential medications, identify gaps, and identify areas for strengthening the system. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the country's regulatory system.
<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: 3/28/23</b>	

## IN7

## IN7: Funds allocated for PHC are available and sufficient at subnational and facility levels

**Measurement Category:** PHC Foundations

**Domain:** Financial Resources

**Subdomain:** Not Applicable

### Indicator IN7: Funds allocated for PHC are available and sufficient at subnational and facility levels

#### Precise Definition

#### Subnational level

##### Funds allocated for PHC are available at the subnational level:

*Available means consistently there*

- The flow of health funds (including PHC) to your subnational unit is:
  - Never or rarely available—funds are rarely available to the subnational unit as planned. (0 point)
  - Sometimes available—funds are sometimes available to the subnational level as planned. (1 points)
  - Often available—funds are more often than not available to the subnational level as planned. (2 points)
  - Always available—the flow of funds to the subnational level for health are always available as planned. (3 points)

##### Funds allocated for PHC are sufficient at the subnational level:

*Sufficient means enough funds are available*

- The funds available to your subnational unit for implementing all parts of your PHC plan and/or strategy are (including dispersion of funds to PHC facilities within your subnational unit):
  - Not sufficient—there is a lack of available funds to meet basic PHC functions of the subnational unit. (0 points)
  - Minimally sufficient—available funds are insufficient in achieving implementation of many PHC services across the subnational unit. (1 point)
  - Moderately sufficient—available funds enable implementation of most, but not all, PHC services across the subnational unit. (2 points)
  - Sufficient—available funds enable implementation of all PHC services across the entire subnational unit. (3 points)

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Not Applicable

	<p><b>Data Type:</b> Subnational Score (Categorical)</p> <p><b>Adapted from:</b> <a href="#">WHO Health Financing Progress Matrix</a> Indicator Q2.3 and guiding questions related to Funds found in the <a href="#">PHCPI Progression Model</a></p> <p><b>Facility level</b></p> <p><b>Funds allocated for PHC are available at the facility level:</b></p> <p><i>Available means consistently there</i></p> <ul style="list-style-type: none"> <li>● The flow of health funding (including PHC) to your facility is: <ul style="list-style-type: none"> <li>○ Never or rarely available—rarely delivered and available to the facility unit as planned. (0 points)</li> <li>○ Sometimes available—sometimes delivered and available to the facility unit as planned. (1 point)</li> <li>○ Often available—usually (more often than not) delivered and available to the facility unit as planned. (2 points)</li> <li>○ Always available—always delivered and available to the facility unit as planned. (3 points)</li> </ul> </li> </ul> <p><b>Funds allocated for PHC are sufficient at the facility level:</b></p> <p><i>Sufficient means enough funds are available</i></p> <ul style="list-style-type: none"> <li>● The funds available to your facility for implementing all parts the PHC service package are: <ul style="list-style-type: none"> <li>○ Not sufficient—there is a lack of available funds to meet basic PHC functions at the facility level. (0 points)</li> <li>○ Minimally sufficient—available funds are minimally available and insufficient in achieving implementation of many PHC services at the facility level. (1 point)</li> <li>○ Moderately sufficient—available funds enable implementation of most, but not all, PHC services at the facility level. (2 points)</li> <li>○ Sufficient—available funds enable implementation of all PHC services at the facility level. (3 points)</li> </ul> </li> </ul> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Not Applicable</p> <p><b>Data Type:</b> Facility Score (Categorical)</p> <p><b>Adapted from:</b> <a href="#">WHO Health Financing Progress Matrix</a> Indicator Q2.3 and guiding questions related to Funds found in the <a href="#">PHCPI Progression Model</a></p>
<p><b>Level of Measurement</b></p>	<p>Subnational and Facility</p>

<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Timely flow of public funds to the subnational level, when aligned to the needs and priorities outlined in subnational PHC plans and strategies, and made available positively affects service quantity and quality, as well as rates of utilization. In contrast, a lack of adequate and sustained levels of funding is often identified as the biggest constraint to achieving health outcomes, especially in low-income countries. There can be several inefficiencies in the way that fiscal resources for health are distributed and available for use at the subnational and facility level, that, if addressed, would ensure consistency between projected spending, resources available, and what PHC functions and services can be supported and delivered at facilities. Making available adequate funds for management, coordination, and delivery of essential PHC services at the subnational and facility levels impacts the quality in service delivery as well as core elements of coverage and efficiency.</p> <p>Often, funds flow from the national level to the subnational level for both subnational activities and the distribution of funds to PHC units within a subnational region. PHC units often receive their public funding as distributed by their subnational units. Measuring availability and adequacy is also critical at the facility level to identify where changes in financial flow and levels of funding are needed.</p> <p>This indicator measures the availability and sufficiency of funds; it does not measure decisions made on the allocation of these funds.</p> <p>(Adapted from <a href="#">Assessing Public Expenditure on Health From a Fiscal Space Perspective, Government of Uganda Ministry of Health. Government of Uganda Ministry of Health. Health Financing Strategy 2015/16. Kampala: Uganda; 2016</a>)</p>
<p><b>Possible Adaptations</b></p>	<p>At the subnational level, nomenclature for “subnational unit” should be adapted to the relevant word for your context (e.g., state, district, county, etc.).</p> <p>The scope of PHC being funded and which facilities are included for availability of funds may also need to be adapted.</p> <p>This is meant for facilities which are supported from government funds regardless of sector, so additional adaptations for the private sector may be needed.</p> <p>Basic PHC functions at the subnational and facility levels should be defined according to your country’s context.</p>
<p><b>Data Disaggregation</b></p>	<p>For subnational aggregated facility data as relevant:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/Rural</li> <li>● Sector (public/private)</li> <li>● Variability across facilities</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Subnational Capacity and Performance Checklist and Facility Checklist</p>

<p><b>Method of data collection and construction</b></p>	<p>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 budgets, financial statements and reports or key informants at the subnational and facility levels.</p> <p>The individual or team responsible for collecting and collating the data necessary to complete the measure are guided by the Subnational Capacity and Performance Checklist and Facility Checklist, both of which have been designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. When using the Facility Checklist, 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>Both the subnational and facility levels will be scored individually.</p> <p><b>Subnational Scoring</b></p> <p>Once the data are collected via the tools, the indicator will result in an aggregate score on both the <b>availability</b> and <b>sufficiency</b> of funds at the subnational level:</p> <ul style="list-style-type: none"> <li>● Availability of funds at the subnational level—whether the subnational unit has funds that are rarely available (0 points), sometimes available (1 point), often available (2 points) or always available (3 points) for PHC activities at the subnational unit and distribution to lower levels as specified in the precise definition above.</li> <li>● Sufficiency of funds at the subnational level—whether the subnational unit has funds that are not sufficient (0 points), minimally sufficient (1 point), moderately sufficient (2 points) or sufficient (3 points) for PHC activities at the subnational unit and distribution to lower levels as specified in the precise definition above.</li> <li>● Aggregate subnational score—the overall score for this indicator will be determined by the lowest score achieved in the components related to availability and sufficiency resulting in the following: <ul style="list-style-type: none"> <li>○ Not sufficient and/or available</li> <li>○ Minimally sufficient and/or available</li> <li>○ Moderately sufficient and/or available</li> <li>○ Sufficient and available</li> </ul> </li> </ul> <p>E.g., if a subnational unit scores that funds are always available but only minimally sufficient, it would result in an overall score of minimally sufficient and/or available.</p>
--	--

	<p><b>Facility Scoring</b></p> <p>Once the data are collected via the tools, the indicator will result in an aggregate score on both <b>availability</b> and <b>sufficiency</b> of funds at the facility level:</p> <ul style="list-style-type: none"> <li>● Availability of funds at the facility level—whether the facility has funds that are rarely available (0 points), sometimes available (1 point), often available (2 points) or always available (3 points) for facility-level PHC activities as specified in the precise definition above.</li> <li>● Sufficiency of funds at the facility level—whether the subnational unit has funds that are not sufficient (0 points), minimally sufficient (1 point), moderately sufficient (2 points) or sufficient (3 points) for facility-level PHC activities as specified in the precise definition above.</li> <li>● Aggregate facility score—the overall score for this indicator will be determined by the lowest score achieved in the components related to availability and sufficiency resulting in the following: <ul style="list-style-type: none"> <li>○ Not sufficient and/or available</li> <li>○ Minimally sufficient and/or available</li> <li>○ Moderately sufficient and/or available</li> <li>○ Sufficient and available</li> </ul> <p>E.g., if a facility scores that funds are always available but only minimally sufficient, it would result in an overall score of minimally sufficient and/or available.</p> <p>Facility-level data can be aggregated at the subnational level (i.e., district) to look at 1) the percentage of facilities within the subnational unit that funds that are rarely available, sometimes available, often available or always available; 2) the percentage of facilities within the subnational unit that have funds that are critically insufficient, moderately insufficient, minimally insufficient or sufficient to provide insight into whether or not funds are being appropriately distributed from the subnational unit down to the facility level.</p> </li> </ul>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country Evidence to support the score should accompany information from key informant interviews to self-report used for measurement.
<b>Data Use</b>	These data will be used early in the project to understand whether or not subnational and facility units have available and sufficient funds in place for health, including PHC. This also measures the management of subnational units in disbursing funds to facilities based on country specifics and whether or not these funds are

	reaching PHC facilities and are sufficient. The subnational data can be used by governing officials at the national and subnational levels to understand whether or not funding is appropriately reaching units and meeting needs. Insufficiencies can be addressed or used to advocate for increased funding and more efficient finance systems. Facility data can be used by the subnational unit to understand if funding is being appropriately allocated and distributed to the facilities. Facility managers can also use the data to advocate for their funding needs. These data will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the availability of funds related to PHC at the subnational and facility levels.
<b>Other Notes, Discussion, and/or Comments</b>	To understand budget allocation and execution at the facility and subnational levels, refer to Indicator P6: Existence of facility budgets and expenditures meeting criteria. To understand the existence of financial management information systems, refer to Indicator P7: Existence of Financial Management Information System for PHC facilities/networks.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/21/2023</b>	



## IN8A

## IN8A: Existence and strength of HMIS at facilities that capture integrated data on PHC services

**Measurement Category:** PHC Foundations

**Domain:** Health Information and Surveillance

**Subdomain:** Not Applicable

**Indicator IN8A: Existence and strength of Health Management Information Systems (HMIS) at facilities that capture integrated data on PHC services**

<p><b>Precise Definition</b></p>	<p>Facilities have a HMIS in place (paper-based or electronic) that:</p> <ul style="list-style-type: none"> <li>• Captures data on PHC services provided at the facility (1 point)</li> <li>• Captures data on PHC outreach services provided by facility teams or by CHWs directly connected to this facility (1 point)</li> <li>• Uses standard indicators to report on PHC services (1 point) (standard indicators are typically defined by a higher-level authority, e.g., subnational or national unit)</li> </ul> <p>Facilities are assessed 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 16: Health Management Information Systems.</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>It is important to assess whether facilities have HMIS in place that provide up-to-date, efficient, and interoperable mechanisms to collect and analyze data related to PHC delivered in the facility and through outreach, including, as relevant, CHWs.</p> <p>Adapted from <a href="#">Progression Model</a> Measure 16: HMIS are important data collection systems that can be used to plan, manage, and make decisions in health facilities, including community activities (facility and community-based care) and across a country. This goes beyond simple M&amp;E to facilitate the active collection and assessment of service data and so should be linked with other management activities (quality improvement, HRH management). HMIS systems should be integrated across care delivery areas and into a national/sub-national monitoring framework built on a standardized list of service delivery indicators and definitions. A standardized list of indicators and definitions ensures that all users of an HMIS are</p>

	defining and measuring indicators the same way and therefore are “speaking the same language.”
<b>Possible Adaptations</b>	Adaptation may be needed based on the existence of CBIS and private sector facilities.
<b>Data Disaggregation</b>	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
<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 record whether there is an HMIS at the facility, and if so, whether it meets the criteria in the precise definition. This may involve talking with point people at the facility and reviewing documentation such as facility registers and reports.</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), most (2) or all (3) 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 meet none, some, most or all (respectively) of the criteria for HMIS.</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>	At the facility level, the data will be used by facility managers to identify and act on gaps in facilities' HMIS that are within their control (e.g., a facility might have an HMIS but it does not meet all of the criteria that are considered important for tracking provision of PHC services). When aggregated to the sub-national level, the data can provide an overview of the HMIS strengths and gaps relevant to PHC.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator on the existence of HMIS in Inputs is linked to the downstream indicator on HMIS functioning in Processes. Looking across these indicators will provide insight into HMIS capacity and performance.
<b>Changes to indicator with date</b>	To be considered in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## IN8B

## IN8B: Existence of LMIS that is integrated across vertical programs at national and at subnational levels

**Measurement Category:** PHC Foundations

**Domain:** Health Information and Surveillance

**Subdomain:** Not Applicable

**Indicator IN8B: Existence of Logistics Management Information System (LMIS) that is integrated across vertical programs at national and at subnational levels.**

**Precise Definition**

**National level**

**Existence of Logistics Management Information System (LMIS) at the national level that: (1 point each)**

1. Captures stock on hand data.
2. Captures data on dispensing or consumption—the quantity of stock dispensed to subnational units or used during a particular time period.
3. Captures data on both a) losses and b) adjustments—  
*Required both components to achieve a point for this element otherwise no points allocated*
  - a. Losses are the quantity of stock removed from the national pipeline for any reason other than consumption by subnational units.  
and
  - b. Adjustments include the quantity of stocks issued to or received from other sources at the national level. Adjustments can also be either a positive or negative change if the amount of stock counted is different from that listed or expected.
4. Is integrated across health programs/services at the national level for areas covered by PHC (such as HIV, TB, FP, etc.), meaning, the LMIS for different programs/services are captured in a single system.

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** National LMIS

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

**Adapted From:** USAID's [Logistics Indicators Assessment Tool](#) (LIAT) Question 103 and [JSI's Supply Chain Handbook](#) Chapter 3—Logistics Management Information System.

**Subnational level**

**Existence of LMIS at the subnational level that: (1 point each)**

1. Captures stock on hand data.

	<ol style="list-style-type: none"> <li>2. Captures data on dispensing or consumption—the quantity of stock dispensed to lower levels within the subnational unit or used during a particular time period.</li> <li>3. Captures data on both a) losses and b) adjustments— <i>Required both components to achieve a point for this element</i> <ol style="list-style-type: none"> <li>a. Losses are the quantity of stock removed from the subnational pipeline for any reason other than consumption within the subnational unit.</li> <li>and</li> <li>b. Adjustments include the quantity of stocks issued to or received from other sources at the subnational level. Adjustments can also be a negative change if the amount of stock counted is different from that listed or expected.</li> </ol> </li> <li>4. Is integrated across care delivery areas at the subnational level for areas covered by PHC (such as HIV, TB, FP, etc.), meaning LMIS for different programs/services is captured in a single system.</li> </ol> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Subnational Logistic Management Information Systems</p> <p><b>Data Type:</b> Subnational Score (Categorical)</p> <p><b>Adapted From:</b> USAID’s <a href="#">Logistics Indicators Assessment Tool</a> (LIAT) Question 103 and <a href="#">JSI’s Supply Chain Handbook</a> Chapter 3—Logistics Management Information System.</p>
<b>Level of Measurement</b>	National and Subnational
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>LMIS perform quantitative data collection through the use of data collection instruments and databases. At a national level, knowing the amount of usable stock available serves as risk management against stockouts, shocks, enabling forecasting, ordering, temperature monitoring, equipment maintenance, and distribution planning. An LMIS captures elements/details within the domains of: Products (unit of measure, pack size, expiry date), Location (facility or store name and address, GPS coordinates), and Status and capacity of storage facility (cubic volume capacity, cold chain equipment functionality). At a subnational and facility level, the LMIS is also used as a monitoring tool for commodity availability and use and to provide supervision over losses and adjustments. Across vertical programs at the subnational level, an LMIS has the capability to monitor the amount of vaccine doses administered, antimalarial nets distributed, packages of oral rehydration salts on hand, STI tests administered, number of oral contraceptives stolen (loss), and more.</p> <p>Digitalization of LMIS records and reports through interoperable mechanisms, as compared to manual/physical data collection, protects against human error in logging, captures data within a single system, and provides supply chain managers</p>

	easy access to data. (Adapted from <a href="#">JSI's Supply Chain Manager's Handbook</a> , USAID <a href="#">Logistics Indicators Assessment Tool</a> [LIAT])
<b>Possible Adaptations</b>	<p>At both the national and subnational level, as there may be variation in the stocks that are monitored and kept track of specific to PHC and which vertical programs are already integrated versus those where work is needed, be sure to take into consideration what is relevant within your context. At the subnational level, nomenclature for “subnational unit” should be adapted to the relevant word for your context (e.g., state, district, county, etc.).</p> <p>The LMIS may capture some medications used in the private sector where private-public partnerships are in place for PHC or vertical programs and so adaptation may also be needed.</p>
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	National Capacity and Performance Checklist and Subnational Capacity and Performance Checklist
<b>Method of data collection and construction</b>	<p>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 LMIS guidance documents, LMIS systems or key informants at the national and subnational levels who are involved in supply chain management including ministry officials and/or non-governmental organizations.</p> <p>The individual or team responsible for collecting and collating the data necessary to complete the measure as guided National Capacity and Performance Checklist and Subnational Capacity and Performance Checklist, both of which are designed for this initiative and largely draw from existing data sources and indicators with adaptations as relevant. Both levels will be scored individually and will not be aggregated. Once the data are collected via the tools, the indicator is calculated as:</p> <ul style="list-style-type: none"> <li>• National-level score: whether the country's LMIS meets few (0–1 points), some (2–3 points) or all (4 points) of the criteria specified in the precise definition above for a functional and integrated system.</li> <li>• Subnational-level score: whether the subnational unit's LMIS meets few (0–1 points), some (2–3 points) or all (4 points) of the criteria specified in the precise definition above for a functional and integrated system.</li> </ul>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review

<b>Data Quality Considerations</b>	To be considered in-country 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 in the project to understand whether or not the national system and subnational units have functional and integrated LMIS in place for supplies related to PHC. Data can be used by both national- and subnational-level stakeholders, including those involved in monitoring and evaluation, information systems or supply chain management, to understand if there is capacity of the system to efficiently track supply and stock across programmatic verticals and in an integrated way. These data can be used to understand where improvements in the tracking and monitoring system may be needed and at what levels. It can also help inform programming and help to identify if there are opportunities to improve the efficiency and integration of the LMIS. These data will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the LMIS system in place at the national and subnational levels.
<b>Other Notes, Discussion, and/or Comments</b>	Mode of data collection and reporting is dependent on the technical capacity of each country and what is relevant within the subnational context should be taken into consideration. Preparing summary and feedback reports is easier and less time-consuming when the LMIS is automated. For digital processes, technology that is feasible to deploy, provide training for, and sustain, would be most effective.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 05/30/2023</b>	

## IN9

## IN9: Existence of effective surveillance system including reporting from PHC

**Measurement Category:** PHC Foundations

**Domain:** Health Information and Surveillance

**Subdomain:** Not Applicable

## Indicator IN9: Existence of effective surveillance system including reporting from PHC

**Precise Definition**

An effective surveillance system (as defined by International Health Regulations (IHR) SPAR) by the level of functionality of early warning functions and a mechanism for event management inclusive of PHC (see below).

The SPAR classifies the levels of functioning for effective surveillance systems as having both an Early Warning Function and a Mechanism for Event Management: (Level 5 indicates highest functionality.)

**C5.1 Early warning function: indicator- and event-based surveillance**

- **Level 1:** The surveillance system for diseases/syndromes/events (reporting, feedback, communication) is under development
- **Level 2:** Standard operating procedures (SOPs) and/or other written technical guidelines for surveillance have been developed and implemented at the national, intermediate and local levels of the surveillance including PHC facilities
- **Level 3:** Surveillance data/information are collected via either indicator-based or event-based surveillance on ad hoc basis and includes data from PHC
- **Level 4:** Surveillance data/information are collected via both indicator- and event-based surveillance with regular reporting and immediate notification taking place in a systematic manner including PHC
- **Level 5:** Surveillance system is regularly evaluated and updated

**C5.2 Mechanism for event management (verification, risk assessment, analysis investigation)**

- **Level 1:** There is unstructured mechanism for event management
- **Level 2:** SOPs and/or other written technical guidelines for event management are developed and disseminated to national, subnational and local levels and include PHC
- **Level 3:** Event verification, risk assessment, investigation and analysis are systematically performed and guide a response by national and subnational



	<p>levels AND include PHC AND Findings are disseminated by production of periodical epidemiological reports</p> <ul style="list-style-type: none"> <li>● <b>Level 4:</b> Event verification, risk assessment, investigation and analysis are systematically performed and guide a response by national, intermediate and local levels AND Results of all events that may constitute potential public health events of international concern are communicated to the World Health Organization (WHO) (or national level for sub-national levels) and epidemiological reports are shared with all relevant sectors, and partners</li> <li>● <b>Level 5:</b> Event management system is evaluated and updated on a regular basis</li> </ul> <p><i>NOTE: These data are pulled directly from IHR SPAR at the national level and exist as an overall combined score for Surveillance, as well as subscores for C5.1 and C5.2.</i></p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Level of functionality</p> <p><b>Data Type:</b> Score from 2–10</p> <p><b>Adapted from:</b> This indicator is not adapted, it is taken directly from <a href="#">IHR SPAR</a>.</p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Public health surveillance is a critical intervention for identifying emerging threats to population health and is an essential public health function and component of the PHC Operational framework. Maintaining an integrated national system for public health surveillance and response is necessary for monitoring, surveillance and investigation of public health threats. The inclusion of PHC as a front-line for surveillance and response is an important lesson from COVID-19.
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	Sub-national levels if measured nationally; Domain of surveillance system, i.e., early warning function/event management mechanism, before summation for score
<b>Data Source(s) and Data Collection Instruments</b>	<b>National level:</b> <a href="#">WHO Electronic State Parties Self-Assessment Annual Reporting Tool</a>

<b>Method of data collection and construction</b>	<b>National level:</b> As reported in SPAR
<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>	These data assess whether a sensitive and flexible surveillance system exists for rapid detection, prompt risk assessment, notification, and response to public health risks and includes PHC at the national level. Data can be used early on for policymakers to identify gaps and areas for improvement. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening national surveillance systems.
<b>Other Notes, Discussion, and/or Comments</b>	<p>Adapted from the <a href="#">PHC MFI</a> Indicator #41</p> <p><u>Indicator-based surveillance</u> is the systematic (regular) collection, monitoring, analysis and interpretation of structured data, i.e., of indicators produced by several well-identified, mostly health-based, formal sources, such as when health care facilities (including primary care settings) regularly report the numbers of cases and deaths caused by certain priority diseases that are predefined and mandated.</p> <p><u>Event-based surveillance</u> is the organized collection, monitoring, assessment and interpretation of mainly unstructured ad hoc information regarding health events or risks which may represent an acute risk to human health. It is a functional component of the early warning and response system (such as media screening that is conducted in a systematized manner to identify events of public health interest).</p> <p>All surveillance data are systematically analyzed for informed decision-making and dissemination.</p>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 5/30/2023</b>	

## IN10

## IN10: Surveillance actively occurring at the PHC system level including community

**Measurement Category:** Monitoring for Change

**Domain:** Health Information and Surveillance

**Subdomain:** Not Applicable

## Indicator IN10: Surveillance actively occurring at the PHC system level including community

<p><b>Precise Definition</b></p>	<p><b>Subnational</b></p> <p><b>Surveillance is actively occurring at the subnational PHC system level (PHC and community) that: (1 point each)</b></p> <ul style="list-style-type: none"> <li>● Tracks health and burden of disease metrics (morbidity, mortality, incidence) across the subnational unit.</li> <li>● Detects, reports, and investigates notifiable diseases, events, symptoms, and suspected outbreaks or extraordinary occurrences within the subnational unit.</li> <li>● Continuously collects, collates, and analyzes the resulting data from the subnational unit.</li> <li>● Submits timely and complete reports from local levels of the system to the national level as required, and from the higher levels of the system back down to lower/community levels.</li> </ul> <p><i>Note: must have bi-directional communication to achieve the point for this component.</i></p> <ul style="list-style-type: none"> <li>● Integrates data from not only PHC facilities within the subnational unit, but also from data collection points within the community (e.g., community health workers, etc.).</li> <li>● Is in formats (electronic or paper-based) that are fully interoperable and interconnected</li> </ul> <p><i>Interoperability is when different surveillance systems and processes connect, in a coordinated manner, to access, exchange and cooperatively use data amongst stakeholders to respond to disease instances. (PHCPI Progression Model)</i></p> <p><i>Interconnectedness refers to the connection of surveillance system components—data systems, detection, reporting and investigative activities, and feedback loops—within a sub-national health system network (e.g., collating data between different levels such as PHC and hospitals). (PHCPI Progression Model)</i></p> <ul style="list-style-type: none"> <li>● Feeds into the national surveillance system (see indicator IN9).</li> </ul> <p><b>Numerator:</b> Not Applicable</p>
----------------------------------	--

	<p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Subnational Surveillance System</p> <p><b>Data Type:</b> Subnational Score (Categorical)</p> <p><b>Adapted From:</b> <a href="#">PHCPI Progression Model Measure 6 Surveillance</a></p> <p><b>Facility</b></p> <p><b>Surveillance is actively occurring at the facility-level within the PHC system, measured by whether the facility: (1 point each)</b></p> <ul style="list-style-type: none"> <li>● Has a mechanism to collect and report new outbreaks of diseases — mechanisms that may include (but are not limited to): <ul style="list-style-type: none"> <li>○ the use of Community Health Workers routinely capturing and reporting information on priority areas; disease-based registries at the facility; staff reviewing active patients with priority conditions who visit the facility; government or other surveys of the community; or routine HMIS</li> </ul> </li> <li>● Has established mechanisms for timely surveillance information exchange with other facilities and local authorities.</li> <li>● Has standard operating procedures for registration or notification of neonatal deaths, stillbirths, pediatric deaths, or maternal deaths.</li> </ul> <p>Facilities are assessed with a checklist as having none, some, most or all elements for an active and functional surveillance system (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 Level Surveillance</p> <p><b>Data Type:</b> Facility Score (Categorical)</p> <p><b>Adapted From:</b> <a href="#">PHCPI Progression Model Measure 6 Surveillance</a></p>
<p><b>Level of Measurement</b></p>	<p>Subnational and Facility</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Surveillance continuously collects, collates, analyzes, and communicates the resulting data between local and national levels for all stakeholders to use to inform responses to health-related situations. The surveillance system ideally includes data from an active surveillance within the PHC level (including both facilities and communities). Surveillance systems serve as live country- and subnational-level data sources for monitoring health metrics. Strong surveillance systems are dynamic networks that inform a country’s ability to respond to emerging health needs and build resilience. A strong surveillance system is characterized by the ability to record metrics of health within an interoperable information system, share information across different levels of the system across geographic areas, community levels, and types of facilities, and have processes in place for investigation and follow-up. This</p>

	<p>goes beyond the collection and recording of data on incidence of communicable diseases of public health significance and notification of emergency response systems. This mechanism should additionally detect trends, identify communication channels to report to, and track a broad range of diseases, events, and symptoms which integrate closely with health management information systems.</p> <p>(Adapted from <a href="#">PHCPI Progression Model Measure 6 Surveillance, Primary Health Care Performance Measurement in World Bank Health, Nutrition and Population Projects</a>)</p>
<b>Possible Adaptations</b>	<p>Notifiable disease lists are often unique to the country context and may also include additional reportable diseases per subnational unit. Be sure to assess surveillance detecting, reporting, and investigation according to the requirements of your country's context and/or subnational unit.</p> <p>Additionally, "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.</p> <p>Please adapt "subnational unit" to the relevant nomenclature for your context (e.g., state, district, county, etc.).</p> <p>The inclusion of private sector facilities in the surveillance system is important but may need to be discussed at country and subnational level.</p> <p>At facility level, the list of mechanisms to collect and report new outbreaks of disease can be adapted depending on the country context.</p>
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	Subnational Capacity and Performance Checklist and Facility Checklist
<b>Method of data collection and construction</b>	<p><b>Subnational</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. Potential sources of information for this measure include surveillance system evidence/documentation, surveillance reports and analyses, protocols and procedures for disease surveillance or outbreak investigation, notifiable disease list, and/or key informants at subnational level who interact with disease surveillance systems.</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. Once the data are collected via the tools, the indicator is calculated as:</p> <ul style="list-style-type: none"> <li>• Subnational-level score: whether the subnational unit has few (0–2 points), some (3–4 points), most (5–6 points) or all (7 points) elements for an active and functional surveillance system as described in the precise definition.</li> </ul> <p><b>Facility</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 person conducting the facility assessment will record whether the facility meets the criteria for an active and functional surveillance system in the Precise Definition above. This will require talking with a key point person/people at the facility and reviewing documentation (surveillance protocols, reports, etc.). Once the data are collected via checklist, the indicator is calculated as:</p> <ul style="list-style-type: none"> <li>• Facility-level score: whether the facility has none (0), some (1 point), most (2 points) or all (3 points) elements for an active and functional surveillance system as described in the precise definition.</li> </ul> <p>Facility-level data will also be aggregated up to the subnational level to understand the percentage of facilities within the subnational unit that have none, some, most or all elements for an active and functional surveillance system.</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>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 to monitor changes in whether or not subnational units and facilities have a functional and effective surveillance system that is integrated across all levels of the system (both higher levels and community levels). These data can be used by subnational officials, including those involved in surveillance and/or monitoring and evaluation, to see if their surveillance system is able to appropriately capture, analyze and act on surveillance priorities within their subnational unit and elevate up or dissemination information down. Facilities are able to use the data to understand if they are able to capture and use data related to surveillance at the facility and community levels. These data can help to identify opportunities for</p>

	strengthening the surveillance system with the PHC-system. The measure will be assessed every 6 to 12 months to continually document progress that has been made in strengthening the surveillance system at the subnational and facility levels.
<b>Other Notes, Discussion, and/or Comments</b>	To get a better understanding of your national surveillance system, please refer to Indicator IN9: Existence of effective surveillance system (IHR SPAR), including reporting from PHC.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/10/2023</b>	

## PROCESSES

### P1A

#### P1A: Facilities have multidisciplinary team-based service delivery for PHC

**Measurement Category:** PHC Foundations

**Domain:** Models of PHC Delivery

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

#### Indicator P1A: Facilities have multidisciplinary team-based service delivery for PHC

<p><b>Precise Definition</b></p>	<p>Facilities have multidisciplinary team-based approaches for the delivery of services in primary care settings, i.e., health care workers work as part of a multidisciplinary team that is characterized by the following attributes:</p> <ul style="list-style-type: none"> <li>• Clearly defined roles and responsibilities for all PHC team members (1 point)</li> <li>• Team includes appropriate cadres to provide the range of PHC services within the facility and its associated communities, per national guidelines (e.g., team includes community health workers for proactive outreach in the community, nurse for frontline care, doctor for comprehensiveness, social worker, mental health provider, etc.—appropriate cadres will vary depending on the country context) (1 point)</li> <li>• Regular team meetings (the frequency defined as “regular” should be defined in-country as appropriate to the local context, but should be at least monthly) (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 below).</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 M53: Multidisciplinary team-based service delivery and <a href="#">Progression Model</a> Measure 29 (Team-based care organization)</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)</i></p>	<p>Adapted from <a href="#">PHC MFI</a> M53: Across-sector or multidisciplinary teams can allow for improved collaboration and knowledge exchange between HCWs working to provide continuity, coordination, and comprehensiveness of care for an individual across the PHC needs. Close collaboration between different primary care professionals optimizes the treatment of individuals and therefore increases the strength of</p>



<b>Assistance Framework)</b>	primary care. Regardless of the mode of teamwork that is applied, there should be some form of structural communication among primary care professionals treating the same individual.
<b>Possible Adaptations</b>	<p>The definition of multidisciplinary care (team composition and scope—appropriate disciplines, per national guidelines) may vary across countries, so the precise definition of this indicator should be adapted to reflect the cadres that are defined as part of the PHC workforce in the country setting. The definition of whether meeting frequency can count as “regular” may also need to be adapted according to country guidelines.</p> <p>From <a href="#">PHC MFI M53</a>: Multidisciplinary teams can range from the basic unit of general medical practitioners/other primary care physicians and nurses to larger, multisectoral teams that engage health and social care workers (which could include other generalist medical practitioners, nurse, social worker, psychologist, dietician, pharmacist or public health professionals). Multidisciplinary care programs can be made available to only a limited number of patients (i.e., those with multiple comorbidity and complex health and social needs or with targeted conditions like diabetes) or to all patients (i.e., patients are registered or empaneled to teams and not to individuals). From <a href="#">Progression Model</a> Measure 29 (team-based care): Note that all team members who work for the same community and on the same team may not be located in the same facility. For example, a community health worker based in the community could be considered part of a multidisciplinary team if he or she is part of a reporting and supervision structure of a larger facility-based team.</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>	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 checklist to record the presence or absence of multidisciplinary team-based service delivery as specified in the precise definition above. This may involve talking with key point</p>

	<p>people at the facility, including PHC team members, in order to assess the extent to which teams meet the attributes of multidisciplinary team-based approaches.</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), most (2) or all (3) 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 meet none, some, most or all (respectively) of the criteria for multidisciplinary teams.</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>	The data will be used by program managers and other relevant stakeholders to determine whether the teams providing PHC at facilities meet the key attributes required for multidisciplinary team-based service delivery, and if not, to support facilities in working toward attaining multidisciplinary team-based service delivery.
<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>	

## 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

<p><b>Precise Definition</b></p>	<p>Categorical score from the number of elements related to the existence of a formal community health worker (CHW) program answered positively (Yes).</p> <ol style="list-style-type: none"> <li>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)</li> <li>2. Is the occupation trained and/or accredited to provide a suite of preventative, promotive, and curative (where appropriate) services to the population? (<i>Accredited means officially being recognized or qualified to perform a particular activity.</i>) (1 point)</li> <li>3. Is the occupation formally employed and officially a part of the health system? (<i>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.</i>) (1 point)</li> <li>4. Is the occupation remunerated? <i>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.</i> (1 point)</li> <li>5. Are individuals in the occupation supported at frequent, regular intervals by a designated supervisor? (e.g., <i>check-ins, reviews, etc.</i>) (1 point)</li> </ol> <p>Countries are assessed on the number of criteria that are met—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> Country/national systems</p> <p><b>Data Type:</b> National Score (categorical)</p> <p><b>Adapted from:</b> <a href="#">PHCPI Progression Model Measure 21</a></p>
<p><b>Level of Measurement</b></p>	<p>National</p>
<p><b>Rationale</b></p>	<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</p>

<b>(and any Link to Foreign Assistance Framework)</b>	<p>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>	<p>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.</p> <p>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</p>

	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>

<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 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>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Every 6–12 months</p>
<p><b>Data Quality Considerations</b></p>	<p>To be considered in-country</p>
<p><b>Data Use</b></p>	<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>
<p><b>Other Notes, Discussion,</b></p>	<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>	

## P2B

## P2B: Existence of systems for proactive population outreach

**Measurement Category:** PHC Foundations

**Domain:** Models of PHC Delivery

**Subdomain:** Active Community Outreach

## Indicator P2B: Existence of systems for proactive population outreach

## Precise Definition

## National Level

## National Systems in place to proactively reach a defined set of populations

- Existence of policies or strategies as well as funding and guidelines for the provision of community based care that outlines:
  - Key activities for outreach activities, including case finding, treatment, and individual/community outreach per national priorities and need (e.g., preventative care programs, vaccination programs, nutrition programs, pregnant women/newborn outreach, etc.). (1 point)
  - Key supplies and systems needed for established outreach activities (e.g., basic equipment for community-based care, Civil Registration and Vital Statistics (CRVS), etc.). (1 point)
  - Key staff and organization strategies needed for successful outreach work (e.g., community health workers, team-based care, etc.). (1 point)

*Note: systems for the remuneration, supervision and training of outreach staff is covered under Indicator P1B—Existence of formal Community Health Worker program.*

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** National Systems

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

**Adapted From:** [PHCPI Progression Model Measure 28](#), [PHCPI Population Health Management Improvement Strategy](#), [WHO Community engagement framework for quality, people-centered and resilient health services](#).

## Subnational Level

## Subnational Systems and Human Resources for Health (HRH) in place to proactively reach a defined set of populations including:

- Existence of subnational plans and strategies for proactive population outreach including:

	<ul style="list-style-type: none"> <li>○ Established activities defined for outreach activities including case finding and treatment per subnational priorities (e.g., vaccination programs, nutrition programs, case management, etc.) (1 point)</li> <li>○ Established case recognition, referral, and basic treatment pathways for outreach services. (1 point)</li> </ul> <p><i>Case recognition in this measure refers to the identification of persons with health needs relevant to those provided through outreach services.</i></p> <ul style="list-style-type: none"> <li>○ Established staff or teams and roles of health care workers delivering outreach services (1 point)</li> <li>○ Procurement of key supplies needed for established outreach activities (e.g., basic equipment, medicines, etc.). (1 point)</li> </ul> <p><i>Note: systems for the remuneration, supervision, and training of outreach staff is covered under Indicator P1B—Existence of formal Community Health Worker program. Whether or not proactive population outreach is actively occurring is captured through P2A—Facilities provide proactive population outreach at community and household levels according to local health needs and priorities.</i></p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Subnational Systems</p> <p><b>Data Type:</b> Categorical</p> <p><b>Adapted From:</b> <a href="#">PHCPI Progression Model Measure 28</a>, <a href="#">PHCPI Population Health Management Improvement Strategy</a>, <a href="#">WHO Community engagement framework for quality, people-centered and resilient health services</a>.</p>
<p><b>Level of Measurement</b></p>	<p>National and Subnational</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Proactive population outreach involves health systems and HRH actively identifying and reaching out to communities to provide necessary services aligned with local priorities and burden of disease. Identified care needs can be met in homes or communities rather than exclusively in facilities depending on national guidelines. There needs to be an identified health worker or team who has the primary responsibility to conduct these outreach and care activities in the community to meet local population health needs. There may be variability across the titles and cadres of providers, but usually, the staff work in select geographic areas (geographic empanelment). They may conduct health promotion activities like education, prevention (vaccination, education), identification of individuals in need of further diagnosis and care (e.g., malnutrition, malaria, sick newborns), whether care can be delivered in the community or facility (e.g., community-integrated care for common adult and child illnesses, family planning provision, and even palliative care in communities or homes), and identifying individuals needing linkage into facility including pregnant women.</p>

	<p>Some models may also include empanelment (process of assigning individual patients to community-based primary care providers) of individuals with chronic disease who may need support for adherence to care and management and follow-up after visits. For proactive population outreach, responsibilities at the facility and subnational levels include ensuring procurement of key supplies at the national and subnational level. Strategies for supply chain should address commonly used supplies, medicines or products at risk for constraint in times of increased demand, and supply and distribution mechanisms. Proactively, strengthening supply chains allows for preparedness for interruptions and mitigation strategies to maintain the availability of medicines and supplies.</p> <p>HRH and staff responsible for proactive population outreach also require appropriate training, salary, and supervision—this is not covered by this measure, but instead by Indicator P1B (existence of a formal Community Health Worker program).</p> <p>(Adapted from <a href="#">PHCPI Progression Model Measure 28</a>, <a href="#">WHO Community engagement framework for quality, people-centered and resilient health services</a>, <a href="#">Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic</a>)</p>
<b>Possible Adaptations</b>	<p>Subnational outreach activities should be established according to subnational priorities and epidemiology in addition to national guidance; this may include more or less than what is established at the national level.</p> <p>The individuals responsible for the outreach will differ between countries based on national models and policies which need to be taken into consideration.</p>
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	National Capacity and Performance Checklist and Subnational Capacity and Performance Checklist
<b>Method of data collection and construction</b>	<p>These data will be collected via document review and/or key informant interview as relevant to country context. Potential sources of information for this measure include review of national and subnational policies, procedures, and standards for community-based care delivery and/or community outreach. If one cohesive strategy does not exist, it may be useful to identify guidance documents for specific community-based programs (vaccination schemes, disease-specific case management strategies, etc.).</p> <p>An individual or team will be responsible for collecting and collating the data necessary to complete the measure as guided by the National Capacity and Performance Checklist and Subnational Capacity and Performance Checklist, both of which were designed for this initiative and largely draws from existing data sources and indicators with adaptations are relevant. Both levels will be scored individually</p>

	<p>and will not be aggregated. Once the data are collected via the tools, the indicator is calculated as:</p> <ul style="list-style-type: none"> <li>• National-level score: whether the country has none (0 points), some (1 point), most (2 points) or all (3 points) systems in place for proactive population outreach as included in the Precise Definition above.</li> <li>• Subnational-level score: whether the subnational unit has none (0 points), some (1–2 points), most (3 points) or all (4 points) systems in place for proactive population outreach as included in the Precise Definition above.</li> </ul>
<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 the national system and subnational units have the appropriate systems and structures in place to provide a foundation for proactive population outreach. These data can be used by national and subnational policymakers, civil society organizations, and advocates to understand systems in place to foster proactive population outreach. Data can be used to aid policy change and/or advocate for improving structures to better support proactive population outreach and population health management. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening systems and structures for proactive population outreach at the national and subnational levels.</p>
<b>Other Notes, Discussion, and/or Comments</b>	<p><b>Indicator P1B</b> (existence of a formal Community Health Worker program) is also related to these indicators. Community health workers are cadres which are critical in providing proactive population outreach. To better understand the status of this system within your context, please refer to indicator P1B.</p> <p>While this indicator measures the existence of systems and structures for proactive population outreach at the national and subnational levels, whether or not proactive population outreach is actively occurring and taking place at the facility level is measured in <b>indicator P2A</b>. (Facilities provide proactive population outreach at community and household levels according to local health needs and priorities.)</p>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/10/2023</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>	

## P4A

## P4A: Systems in place for community engagement in PHC service planning and organization

**Measurement Category:** PHC Foundations

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

**Subdomain:** Community Engagement in PHC Design

## Indicator P4A: Systems in place for community engagement in PHC service planning and organization

**Precise Definition**

Categorical score measuring the extent to which local PHC service planning is informed by and accountable to community voices and demonstrates involvement of at-risk groups in the planning process. Score is derived from the number of community engagement structures/mechanisms that exist (answered positively, “Yes,” with partial credit possible for the last element #5):

1. In the last two years, has your subnational system conducted a community health needs and asset assessment process? (At least once in two years.) (1 point)
2. Does your subnational system have participatory processes involving communities and local leaders in priority setting? (1 point)

*A participatory process involves the engagement of community members and health care users in priority setting related to the health system. (PHCPI Progression Model)*

3. Does your subnational system have mechanisms for measuring client satisfaction and/or for submitting complaints about care received? (i.e., client exit surveys, community gatherings to discuss health services, etc.) (1 point)
4. Does your subnational system have advisory boards which include membership of community representatives at the local level or in supervisory boards of facilities? (1 point)
5. Do any of the above elements marked as “Yes” include or involve representation from vulnerable groups? (No – 0 points; Yes, some elements – 0.5 points; Yes, all elements – 1 point)

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

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Subnational systems

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

**Adapted from:** [PHCPI Progression Model](#) Measure 26

<b>Level of Measurement</b>	Subnational
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Community engagement is a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes. Stakeholders could include community members and leaders, patients, caretakers, health professionals, policymakers, and other sectors. The desired relationships between communities and the health system are characterized by respect, trust, and a sense of purpose.</p> <p>It is important that systems are in place to effectively empower and engage communities in planning and providing PHC and accountability feedback related to PHC service delivery, including in determining local priority-setting. In addition to the above, it is important for there to be deliberate involvement of at-risk groups and populations in these community engagement mechanisms to better ensure equity in health services. (Adapted from the <a href="#">PHCPI Progression Model</a> Measure 26: Community Engagement)</p> <p>Evidence of engagement is in Indicator P4B “Community engagement in PHC service planning and organization is occurring.”</p>
<b>Possible Adaptations</b>	This indicator will be measured at the subnational level; however, there may be some settings where community engagement mechanisms are managed at the individual facility level, in which case this indicator should also be measured at facility level. In this case, replace nomenclature for “subnational system” with “facility.”
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	Subnational Capacity and Performance Checklist
<b>Method of data collection and construction</b>	<p>These 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 community engagement systems in place, as well as documentation of those systems. We recommend including at least one source, whether key informant or document, from a non-governmental informant, such as a civil society organization or patient association.</p> <p>An individual 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. Element #5 has the opportunity for partial score and can achieve 0</p>

	points, 0.5 points, or 1 point. Once the data are collected via the tool, the indicator is calculated as a subnational-level score: whether the subnational unit has none (0 - <1 points), some ( $\geq 1$ - <4 points) or most/all ( $\geq 4$ -5 points) elements for a system in place for Community Engagement in PHC service planning and organization as specified in the precise definition above.
<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 subnational decision-makers, advocates, and/or implementing partners to understand what community engagement mechanisms are in place and where strengthening is needed. It will be measured again at the two-year review of the project to understand if any progress has been made in expanding community engagement mechanisms and the association with improvement in process, outputs and outcomes.
<b>Other Notes, Discussion, and/or Comments</b>	Note – component 3 on measuring client satisfaction can be aggregated up from data collected through indicator OP9B if a facility checklist is completed.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 05/30/2023</b>	

## P4B

## P4B: Community engagement in PHC service planning and organization is occurring

**Measurement Category:** Monitoring for Change

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

**Subdomain:** Community Engagement in PHC Design

### Indicator P4B: Community engagement in PHC service planning and organization is occurring

#### Precise Definition

#### Subnational Level

Subnational units regularly solicit local input on the design, financing, governance, and implementation of PHC from diverse members of the community through the established systems or other strategies (see indicator P4A “Systems in place for Community Engagement in PHC service planning and organization”) and use this input to inform and implement where changes are needed.

In the past six months, subnational unit has implemented the following community engagement mechanisms: (1 point each)

- Community health needs and asset assessments (subnational only)
- Demonstrated use of participatory processes involving communities and local leaders in priority setting (e.g., community forums or reviews) (subnational only)
- Demonstrated use of mechanisms for measuring client satisfaction and/or for submitting complaints (client exit surveys, community gatherings, etc.) (subnational, facility)
- Participation of community representatives in a meeting of advisory boards or supervisory boards of facilities

Subnational systems are assessed on the number of community engagement mechanisms occurring—see Method of Data Collection.

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Subnational systems

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

**Adapted from:** From [PHC MFI M57](#) and [PHCPI Progression Model](#) Measure 26

#### Facility Level

Subnational units regularly solicit local input on the implementation of PHC from diverse members of the community through the established systems or other strategies.

1. Does the facility have a community advisory board or community management committee that meets regularly?

	<p><i>“Meets regularly” is defined as a frequency appropriate for eliciting and integrating community needs in the local context (e.g., quarterly, twice a year, etc.)</i></p> <ol style="list-style-type: none"> <li>a. Yes (1 point)</li> <li>b. No (0 points)</li> </ol> <p>2. The facility has the following systems for obtaining clients’ feedback about the health facility or it’s services:</p> <ol style="list-style-type: none"> <li>a. Suggestion box (1 point)</li> <li>b. Client survey form (1 point)</li> <li>c. Client interview form (1 point)</li> <li>d. Official meeting with community leaders (1 point)</li> <li>e. Informal discussions with client or community (1 point)</li> <li>f. Other (specify) (1 point)</li> <li>g. No system for feedback (0 points)</li> </ol> <p>Facilities are assessed on the number of community engagement mechanisms occurring—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 systems</p> <p><b>Data Type:</b> Facility Score (categorical)</p> <p><b>Adapted from:</b> From <a href="#">PHC MFI</a> M57 and <a href="#">PHCPI Progression Model</a> Measure 26</p>
<p><b>Level of Measurement</b></p>	<p>Subnational Facility</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>“Community engagement is the inclusion of local health system users and community members in all aspects of health planning, provision, and governance. It is a central component of ensuring that the services delivered are tailored to population needs, priorities and values, which can be achieved through the involvement of communities in the design, financing, governance, and implementation of PHC. To ensure that the needs of all community members are met, it is important that community engagement efforts include representation from diverse members of the community. This may require multiple mediums for engagement, to best capture the needs and opinions of traditionally underrepresented community members.”</p> <p>(From <a href="#">PHC MFI</a> M57 and <a href="#">PHCPI Progression Model</a> Measure 26)</p>

<b>Possible Adaptations</b>	The level at which community engagement activities occur (facility, subnational or both) may vary across country settings, so the level of measurement should be adapted accordingly. For example, one setting may be implementing community engagement activities at the subnational level (e.g., community needs assessments and participatory processes for priority-setting) as well as at the facility level (like implementing patient surveys). In this case, this indicator should be measured at both the subnational and facility levels.
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	Subnational Capacity and Performance Checklist and/or Facility Checklist
<b>Method of data collection and construction</b>	<p>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 key informants who are knowledgeable about the community engagement activities that are occurring, as well as documentation of those activities.</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 and/or Facility Checklist if applicable.</p> <p>Each element will be scored as No or Yes resulting in a numeric value.</p> <p><b>Subnational Level</b></p> <p>At subnational level, the indicator is calculated as a subnational score where none (0), some (1–2), most (3) or all (4) of the activities described in the precise definition above are taking place.</p> <p><b>Facility Level</b></p> <p>If measured at facility level, the indicator is calculated as a facility score where few (0-2), some (3-4), most (5-6), or all (7) criteria in the precise definition are met.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6–12 months
<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 subnational decision-makers and/or facility decision-makers or community advocates to understand the extent to which community engagement is happening in an impactful way and identify opportunities for improvement. It will be regularly monitored every 6–12 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: 5/30/2023</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>	

## P7

## P7: Existence and strength of FMIS for PHC facilities

**Measurement Category:** PHC Foundations

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

**Subdomain:** Budget Allocation and Execution

### Indicator P7: Existence and strength of Financial Management Information System (FMIS) for PHC facilities

<p><b>Precise Definition</b></p>	<p>PHC facilities have a financial management information system (FMIS) that manage and track PHC-related relevant financial categories and expenditures:</p> <ul style="list-style-type: none"> <li>● Expenditures (1 point)</li> <li>● Staff salaries (1 point)</li> <li>● Line-item budgets (1 point)</li> <li>● Internally generated funds (1 point)</li> <li>● Insurance reimbursements or payments (if applicable) (1 point)</li> <li>● Other fund sources (e.g., government funds) (1 point)</li> </ul> <p>A facility is considered to have an FMIS if a) the facility operates and inputs into the FMIS itself or b) the FMIS is maintained for the facility by another entity (i.e., a higher-level facility or subnational administrative unit). For example, a group of health posts might report into a health center which is responsible for financial management and reporting requirements for the full group of health posts.</p> <p>Facilities are assessed via checklist as having an FMIS that meets 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 23: Financial Management Information System</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation, proportion of facilities in each category)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign)</i></p>	<p>It is important to have an FMIS to ensure the flow of funds are integrated to support PHC and integration of services rather than along vertical program areas.</p> <p>From <a href="#">Progression Model</a> Measure 23: FMIS are a tool to improve the strategic allocation of resources, minimize waste, and align spending for operational efficiency, establish credibility of the budgets, and improve service delivery. Tracking</p>



<b>Assistance Framework)</b>	government allocation and use of resources with FMIS helps to increase efficiency and effectiveness, when carried out with principles of comprehensiveness, legitimacy, flexibility, predictability, contestability, honesty, transparency, and accountability. Transitioning from “fragmented and outdated information systems to modern integrated Financial Management Information Systems offers great opportunities for improving public resource mobilization and management, openness and public services.”
<b>Possible Adaptations</b>	<p>PHC facilities are not always required to or have the autonomy to manage their own funds. As noted in the indicator definition, the FMIS for a facility might be maintained for them by a higher-level entity. Other national standards could also be included and adapting of the categories.</p> <p>Note that internally generated funds and reimbursed pooled payments may not be applicable in your context depending on structures for collection of funds at the point of service delivery and/or reimbursement of public facilities through your country's financing structure. If these are not applicable or relevant to your context, please remove those two elements as relevant and adjust scoring . Other funding sources should be added as relevant (e.g., donor, NGO support)</p>
<b>Data Disaggregation</b>	<p>For subnational aggregation:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Geographic</li> <li>● Urban/Rural</li> <li>● Sector (public/private) as relevant</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 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 whether the facility has an FMIS, and if so, whether it meets the criteria in the Precise Definition. This may involve talking with point people at the facility and reviewing documentation, such as facility budgets and financial reports.</p> <p>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, the indicator is calculated as a facility-level</p>

	<p>score: whether the facility meets none (0), some (1–3) or most/all (4–6) of 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 meet none, some or most/all (respectively) of the criteria for FMIS.</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>The data will be used early in the project to assess the existence of an FMIS for PHC as an important function to support effective and quality PHC delivery and service coverage. The indicator will be measured again at the end of the project to understand if any progress has been made in strengthening management space and tools, including FMIS for PHC over the course of the project, and how this influences progress in strengthening PHC. When aggregated to the subnational level, these data can provide an overview of the FMIS strengths and gaps relevant to PHC.</p>
<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: 3/1/2023</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 guidelines when appropriate (for example, if national guidelines indicate that</p>

	supportive supervision should be completed every six months then the desired time period should be adjusted to six months).
<b>Data Disaggregation</b>	For subnational aggregated facility data: <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: Management module
<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>	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 design and implementation of supportive supervision related to performance and quality management and improvement. It

	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)

<p><b>Precise Definition</b></p>	<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>
<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>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>
<p><b>Possible Adaptations</b></p>	<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>
<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>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)

**Adapted from:** This section of the indicator was adapted from the [PRIME tool](#) and the PMA2020 facility survey, Section 4: Facility Management.

	<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</p>

	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.
<b>Possible Adaptations</b>	<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>
<b>Data Disaggregation</b>	<p>PHC facility level</p> <p>Geographic</p> <p>Urban/Rural</p> <p>Sector (public/private)</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Facility Checklist</p> <p>and</p> <p>Subnational Capacity and Performance Tool</p>
<b>Method of data collection and construction</b>	<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),</p>

	<p>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, and/or Comments</b>	<p>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 management and leadership training programs, (7) human resources unit/division or (8) ministry of education.</p> <p>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).</p>

<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/1/2023</b>	

## P9

## P9: Completeness and timeliness of routine PHC data reporting by facilities

**Measurement Category:** Monitoring for Change

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

**Subdomain:** Data Reporting

### Indicator P9: Completeness and timeliness of routine PHC data reporting by facilities

<p><b>Precise Definition</b></p>	<p>Facilities within a subnational unit that use information systems for capturing and reporting comprehensive patient and facility PHC data and report according to subnational and/or national requirements within the required deadline.</p> <p><b>Subnational</b></p> <p><b>Numerator:</b> Number of facilities that submitted Health Management Information System (HMIS) PHC reporting forms which were complete and on time to a higher level for the previous six month period</p> <p><b>Denominator:</b> Number of facilities required to report HMIS data to a higher level for the six-month period</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #34 and <a href="#">MOMENTUM Indicator X-Cut.1</a></p> <p>Primary care facilities may include: community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals</p> <p>The definitions of completeness and timeliness of facility reporting are usually linked to standards defined by the country's HMIS or Ministry of Health authorities.</p> <p><u>Complete</u> refers to having all required inputs and information available.</p> <p><u>On time</u> refers to being submitted to the subnational unit by the required timeline and/or date.</p>
<p><b>Level of Measurement</b></p>	<p>Subnational</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Facilities generate data on a continuous, routine basis that can be used to produce regular (e.g., monthly, quarterly, and/or annual) summary statistics on service availability, utilization and performance; health care resources; and in some cases, individual client care. These data can be used at local, subnational, and national levels for client management, facility management, disease surveillance, sector</p>

	<p>planning, and monitoring and management at all levels. A high level of reporting is required across all health indicators.</p> <p>This is recommended as a core indicator by <a href="#">WHO for analysis and use of facility data</a> and almost all global HMIS guidance. Accurate and timely routine data are needed for countries at the national, subnational, and facility levels to assess the state of a population's health, to establish priorities, and to track progress towards goals and objectives and inform performance management and quality improvement. These data are reported on a regular basis (e.g., monthly or quarterly) from health facilities to subnational levels (e.g., district) and then to the national level of the health system. The HMIS is a primary source of data for assessing health sector performance. The Ministry of Health compiles the data on a regular basis to report on achievements and trends in key health service performance indicators. In addition, HMIS data provide insights into morbidity and mortality patterns that inform policy, planning, and resource allocation.</p> <p>Data on completeness and timeliness of reporting also serve a role in interpreting health service delivery data collected through HMIS; data completeness is an important consideration in how to use and/or interpret other HMIS data.</p>
<p><b>Possible Adaptations</b></p>	<p>This indicator will need to be adapted to the country's HMIS reporting standards and requirements to define completeness and timeliness for PHC and determine which data are being included. If parallel information systems for programs in the country exist that are of interest to assessing PHC (e.g., immunization, HIV/AIDS, tuberculosis, and/or malaria), these systems may need to be included in the assessment and/or indicator calculation in addition to the general HMIS relevant to PHC.</p> <p>In addition, the levels of PHC facilities being included may need to be adapted.</p> <p>If the report cannot be extracted from HMIS or paper records, reporting review during the subnational checklist may be required, and a shorter timeframe and scope of data being reviewed should be considered. Use of Lot Quality Assurance Sampling has also been used when manual review was required. (Hedt et al)</p>
<p><b>Data Disaggregation</b></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>Complete/incomplete reporting</p> <p>Managing authority (public, private)</p> <p>Urban/rural</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>HMIS reports or other information system review.</p> <p>The information required for each facility to construct this indicator is usually compiled within the HMIS or other information system at the facility, sub-national level (district, region, etc.) and the national level and presented in dashboards within the information system and in annual reports. In cases where this information is not</p>

	compiled and calculated directly in the information system, it can be collected at the subnational level through a checklist specifying which and how many facilities reported complete information on time against how many facilities should have reported or reported late or incomplete.
<b>Method of data collection and construction</b>	<p>This indicator should be collected/collated from existing data and analysis available at the national and subnational levels in the online HMIS, other information systems and/or HMIS reports.</p> <p>At the subnational level, the numerator for this indicator is the number of facilities that met the national criteria for timeliness and completeness and the denominator is number of facilities required to report (or being assessed if not from secondary data sources). For the denominator, review the HMIS to extract the number of facilities required to report through the HMIS. Note that facility reports have to be complete AND on time over the previous six-month period.</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>	This indicator will measure and monitor progress in strengthening data completeness and timeliness at facility and subnational level. Program managers can use these data to inform decisions on targeting resources to improve the quality of routine health data reporting by PHC facilities, a key step to increased data use for resource, Human Resources for Health, and other performance management and improvement and accountability.
<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: 5/30/2023</b>	



## P10

## P10: Facility capacity for information system use

**Measurement Category:** PHC Foundations

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

**Subdomain:** Data Reporting

## Indicator P10: Facility capacity for information system use

<p><b>Precise Definition</b></p>	<p>PHC facilities have staff with capacity for information systems use, including the routine and timely collection and reporting of public health data (including surveillance data) and facility PHC data and the use of these PHC data for monitoring service delivery, reporting to community and higher levels in system, and internal performance and quality management and improvement across all areas of PHC delivered at the site or through associated community health workers. This is measured by assessing the facility's ability (possessing the internal technical capacity and resources) to:</p> <ul style="list-style-type: none"> <li>● Input relevant data into information systems. (1 point)</li> <li>● Access data from information systems. (1 point)</li> <li>● Assess quality of data in the systems. (1 point)</li> <li>● Analyze data from information systems. (1 point)</li> <li>● Share data from information systems with appropriate audiences (including facility staff, partners, community members or higher levels). (1 point)</li> <li>● Make decisions based on the data from the information systems. (1 point)</li> </ul> <p><b>Numerator:</b> Not Applicable  <b>Denominator:</b> Not Applicable  <b>Unit of measure:</b> Facility  <b>Data Type:</b> Facility score (categorical)  <b>Adapted from:</b> <a href="#">Progression Model</a> Measure 31: Information System Use</p>
<p><b>Level of Measurement</b></p>	<p>Facility  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 31: Information systems use is the effective utilization of existing information systems and the data they produce at the facility level to support a variety of purposes, including priority setting in day-to-day service delivery, coordinating and tracking patient care, informing management of systems, including supplies, Human Resources for Health, reporting, and identifying gaps to drive quality improvement activities. Effective information systems use involves the compilation and interpretation of data. This effective use requires sufficient staff numeracy and capacity to capture, report, and review data, transform it to relevant</p>

	<p>information, and then leverage that information to support the staff and systems to deliver quality care. The use will also support reporting and communication with community and subnational levels, as well as serving as a frontline for surveillance. For the purposes of this measure, “staff capacity” does not mean that there needs to be a dedicated person at the facility who is solely responsible for information systems use, but that there is at least one person (and ideally many) at the facility with the necessary knowledge and skills needed to use information systems. Routine use of information systems means that information systems are used as part of a regular process of monitoring and improvement rather than only periodically.</p>
<b>Possible Adaptations</b>	The parameters of an information system, the appropriate capacities needed or the expectations related to facility-level data use may need to be modified for the local context.
<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: Management module
<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 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 record whether there is staff capacity for information system use per the criteria in the precise definition. This may involve talking with point people at the facility and reviewing documentation, such as data reports produced by facility staff. Each element will be scored as No (0 point) or Yes (1 point), 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 (1–4), most (5), or all (6) 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 capacity for information system use.</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>	The data will be used early in the project to assess facility capacity for information system data use to ensure routine collection and use of information systems to establish targets, monitor progress, and implement ongoing quality improvement initiatives. The results can be used to strengthen areas within a facility or across facilities at a subnational level to support this core function. It will be measured again at the two-year review to understand if any progress has been made in strengthening information system use for PHC.
<b>Other Notes, Discussion, and/or Comments</b>	Note that this measure is specifically about the use of information systems. Other indicators address the presence and functioning of information systems (see P13 and IN8A).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</b>	

## P11

## P11: Physical or service delivery integration of PHC services

**Measurement Category:** PHC Foundations

**Domain:** Integration and Interoperability of Systems

**Subdomain:** Service Delivery

## Indicator P11: Physical or service delivery integration of PHC services

**Precise Definition**

The level of integration of PHC services is achieved at the facility through a combination of physical integration and service delivery integration. Physical integration refers to the co-location of PHC services at a facility, while service delivery integration refers to the provision of comprehensive PHC during a patient visit.

- **Physical Integration.** Which of the following health services are available within the facility (including prevention, diagnosis, and treatment for the service area)? *Select all that apply (1 point each):*
  - PHC services as defined by your country
  - Reproductive health services
  - Maternal health services
  - Child health services (including immunization and curative care)
  - Malaria services
  - HIV services
  - Tuberculosis services
  - Noncommunicable disease services
- **Service Delivery Integration.** Service delivery integration at the facility is:
  - Non-existent—patient only receives care for only one condition during their visit and requires a separate visit to different clinics or another facility for every condition. (0 points)
  - Minimal—patient receives care for one condition, and is offered screening for other issues during their visit. PHC beyond screening requires an additional visit to a different clinic in the facility or referral outside of the facility. (1 point)
  - Moderate—patient receives care for multiple conditions during their visit, but a minimal number of other needs require a separate appointment or referral within a network of care. (2 points)
  - Complete—patient receives comprehensive care for all PHC-relevant conditions during their visit without a need for separate visits. Referrals to higher level facilities are only done when care is needed at a secondary or higher level facility. (3 points)

**Numerator:** Not Applicable

	<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="#">Commonwealth Fund—Integrating Behavioral Health in Primary Care</a>, <a href="#">Rainbow Model of Integrated Care</a>, <a href="#">WHO Integrating Health Services</a></p>
<b>Level of Measurement</b>	<p>Facility</p> <p>Aggregate to subnational (proportion of facilities in each category)</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>At present, many health systems remain fragmented with vertical programs being separated by location, funding, information systems, and/or providers. This leads to a lack of coordinated, efficient, and person-centered care. This measure is designed to understand the integration of PHC services at the patient and at the facility level, through physical co-location of services and through service delivery integration. The measure provides a progressive scoring, where the highest scores represent the ideal that a system should strive for but likely may not currently be achieving. Given PHC’s function as the point of first contact within the health system, it serves as the right level of the system to integrate and bring together multiple PHC-related services across different health care needs for an individual person.</p> <p>Physical integration refers to the co-location of PHC services at a facility, while service delivery integration refers to the provision of comprehensive PHC during a patient visit. For example, a woman needing HIV care, family planning, and tuberculosis testing should ideally be able to receive each of these essential PHC services within the same location (same facility or space) and during the same visit, achieving both physical and service delivery integration. The degree of integration of services within a facility or network of care is varied—ranging from simple coordination to co-location of services to the existence of fully integrated teams and networks.</p> <p>Integrated PHC services can improve the 5Cs, access to care, and enable higher quality care through better coordination, care continuity, and comprehensiveness and patient-centeredness. There is also evidence suggesting that the integration of PHC services can lead to greater efficiency within the system when it comes to the use of resources, reducing duplicative procedures, and decreasing wait times within the system. The integration of PHC services also serves to improve equity within the system by making care for various needs more accessible and available for patients.</p> <p>(Adapted from the <a href="#">WHO’s Technical Series on Primary Health Care: Integrating Health Services</a> and <a href="#">Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care</a>)</p>
<b>Possible Adaptations</b>	<p>The services that are considered to be a part of PHC may vary depending on country context and should be evaluated according to the national PHC service package and the level of PHC facility being assessed.</p>

	Network of care should be contextualized to the implementing area by taking into consideration the varying levels of PHC Facilities that exist within the country's system.
<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 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 has any form of integration, and if so, which criteria it meets based on the Precise Definition. This may involve talking with point people at the facility and reviewing documentation such as the availability of various PHC services defined in your national health package, as well as any guidance on coordination, referral systems or networks of care.</p> <p>Once the data are collected via the tool, the indicator will result in an aggregate score on both physical and functional integration at the facility level which will be calculated as:</p> <ul style="list-style-type: none"> <li>● Physical integration at the facility level—whether the facility unit has non-existent/limited (1–2 points), minimal (3–4 points), moderate (5–7 points) or complete (8 points) physical integration of PHC services at the facility as specified in the Precise Definition above.</li> <li>● Service delivery integration at the facility level—whether the facility unit has service delivery integration that is non-existent (0 points), minimal (1 point), moderate (2 points) or complete (3 points) for PHC services at the facility as specified in the Precise Definition above.</li> <li>● Aggregate facility score—the overall score for this indicator will be determined by the lowest score achieved in the components related to physical and functional integration resulting in the following: <ul style="list-style-type: none"> <li>○ Not existent/limited physical and/or service delivery integration</li> <li>○ Minimal physical and/or service delivery integration</li> <li>○ Moderate physical and/or service delivery integration</li> <li>○ Complete physical and/or service delivery integration</li> </ul> </li> </ul>

	<p>E.g., If a facility unit scores that complete physical integration but minimal service delivery integration, it would result in an overall score of minimal physical and/or service delivery integration.</p> <p>Facility-level data will be aggregated at the subnational level (i.e., district) to look at the percentage of facilities within the subnational unit that have no integration, integration through coordination, integration through co-location or a fully integrated system.</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 person-centeredness. The results should be used to identify opportunities for changes in where and how services are being delivered to increase integration and help understand results of measures of the 5Cs as well as other quality and equity outcomes. Models of care and facilities which have achieved high levels of integration can also serve as opportunities for cross-subnational and facility learning as well as across the overall initiative.
<b>Other Notes, Discussion, and/or Comments</b>	Related to service integration, it is often helpful to understand the functioning of referral systems when care needs to be provided at higher levels of the system and not within PHC. To better understand referral systems, refer to indicators OP6 and OP8A.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/13/2023</b>	

## P12

## P12: LMIS implements integrated commodity management for PHC

**Measurement Category:** PHC Foundations

**Domain:** Integration and Interoperability of Systems

**Subdomain:** Supply Chain

### Indicator P12: Logistic Management Information System (LMIS) implements integrated commodity management for PHC

#### Precise Definition

#### Facility level

The degree to which LMIS at subnational and facility levels have integrated (as in coordinated, unified or consolidated) commodity storage, commodity distribution, and supply/inventory management to support a streamlined PHC supply chain.

At the facility level, the LMIS is integrated across vertical program as measured by the following elements across three categories:

#### Stock-keeping records (e.g., inventory control cards, bin cards, stock registers)

- Stock-keeping records are separate for all different programs' commodities (HIV, tuberculosis (TB), malaria, FP, immunization, other PHC commodities). (0 points)
- Some program commodity stock-keeping records are integrated. (1 point)
- All program commodity stock-keeping records are integrated. (2 points)

#### Commodity consumption and dispensing records

- Separate stock consumption or dispensing records for all different programs' commodities (HIV, tuberculosis (TB), malaria, FP, immunization, other PHC commodities). (0 points)
- Some program stock consumption and dispensing records are integrated. (1 point)
- All program stock consumption and dispensing records are integrated. (2 points)

#### Requisition (ordering) forms and records

- Separate requisition forms and records for all different programs' commodities (HIV, TB, malaria, FP, immunization, other PHC commodities). (0 points)
- Some program commodity requisition forms and records are integrated. (1 point)
- All program commodity requisition forms and records are integrated. (2 points)

The facility's LMIS is assessed as not integrated (0 pts), partially integrated (1 point) or fully integrated (2 points) for each of the measurement categories detailed above.



	<p>(see Method of Data Construction below for explanation on how the facility composite score is calculated).</p> <p><b>Numerator:</b> Not Applicable <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> USAID’s <a href="#">Logistics Indicators Assessment Tool</a> (LIAT) Question 103 and <a href="#">JSI’s Supply Chain Handbook</a> Chapter 3—Logistics Management Information System.</p>
<b>Level of Measurement</b>	<p>Facility</p> <p>Subnational (aggregated up from facility [percentage of facilities in each category])</p>
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	<p>The effective management of commodities and logistics is crucial to ensuring that health care facilities can provide high-quality PHC services efficiently. The integration of the LMIS across vertical programs at the facility level can ensure more efficient management of commodities, streamline patient care, and improve comprehensiveness and coordination of services, and reduce administrative burden. LMIS integration can improve the availability, accessibility, and affordability of medical commodities in PHC facilities.</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>At the subnational level, there may be variation in the stocks that are monitored and managed by PHC facility level/type and according to which vertical programs are already integrated versus those where work is needed. At the subnational level, nomenclature for “subnational unit” should be adapted to the relevant administrative area for the context (e.g., state, district, county, etc.).</p> <p>The LMIS may capture some medications used in the private sector where private-public partnerships are in place for either PHC or vertical programs, so additional adaptation may be needed.</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>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 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 whether specific elements of a facility's LMIS are integrated, and if so, to what degree according to the criteria in the Precise Definition. This may involve talking with point people at the facility and reviewing documentation such as the paper or electronic LMIS forms.</p> <p>A categorical score of 0 to 2 will be assigned for each measurement category (stock-keeping records, requisition forms and records) according to which of the three elements within each category most accurately describes what is happening in practice at the facility. Facilities are given a total score of 0 (no integration of LMIS), 1-3 (some integration of LMIS), 4-5 (mostly integrated LMIS), or 6 (fully integrated LMIS).</p> <p>If there are no forms or records associated with a measurement category to assess, the data should be indicated as Not Available.</p> <p>Facility-level data will be aggregated at the subnational level (i.e., district) to look at the percentage of facilities which are utilizing LMIS that are not integrated, some integration , are mostly integrated or are fully integrated.</p>
<p><b>Data Collection and Reporting Frequency</b></p>	<p>Early on and two-year review</p>
<p><b>Data Quality Considerations</b></p>	<p>To be considered in-country</p>
<p><b>Data Use</b></p>	<p>The data will be used early in the project by policymakers and program managers to assess the degree to which the LMIS is integrated to support the PHC supply chain at service delivery points. These data will provide foundational context to inform where strengthening is needed and will be measured again at the two-year review to understand the degree to which progress has been made to integrate the PHC supply chain. Variations in subnational performance can provide promising practices for spread and scale.</p>
<p><b>Other Notes, Discussion, and/or Comments</b></p>	<p>To understand the national and subnational level LMIS context, see <b>Indicator IN8B: Existence of Logistics Management Information System (LMIS) that is integrated across vertical programs. Indicators P11, P13A, P13B, and P14 also examine information system integration and interoperability.</b></p>

<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/7/2023</b>	

## P13A

## P13A: Routine PHC data from different electronic information systems are integrated and available through interoperable information architecture

**Measurement Category:** PHC Foundations

**Domain:** Integration and Interoperability of Systems

**Subdomain:** Health Management Information Systems

### Indicator P13A: Routine PHC data from different electronic information systems are integrated and available through interoperable information architecture

<p><b>Precise Definition</b></p>	<p><b>Subnational Level</b></p> <p>District managers are routinely able to routinely view data on PHC services disaggregated to the facility level across the following electronic data systems:</p> <ol style="list-style-type: none"> <li>Electronic data are available from all facilities (either viewed directly or entered into an electronic system at subnational level). (1 point)</li> <li>Health Management Information Systems (HMIS). (1 point)</li> <li>Data from community health workers (e.g., eCHIS) (1 point)</li> <li>Logistics Management Information System (LMIS) or eLMIS. (1 point)</li> <li>Human Resource for Health Information System (HRHIS) or eHRHIS. (1 point)</li> <li>Labs and surveillance. (1 point)</li> </ol> <p>Countries are assessed as having none (0 points), some (1–3 points), mostly (4–5 points) or all (6) elements in place for PHC data interoperability (see Method of data collection and construction below).</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Country/national systems</p> <p><b>Data Type:</b> Subnational Score (categorical)</p> <p><b>Adapted From:</b> Not Applicable</p>
<p><b>Level of Measurement</b></p>	<p>Subnational</p> <p>National (subnational aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Per the <a href="#">Global Partnership for Sustainable Development Data</a>: Interoperability is the ability to access and process data from multiple sources without losing meaning and then integrate that data for mapping, visualization, and other forms of representation and analysis. Interoperability enables people to find, explore, and understand the structure and content of datasets. In essence, it is the ability to “join-up” data from different sources to help create a contextual and holistic picture for</p>

	<p>simpler (sometimes automated) analysis, better decision-making, and greater accountability.</p> <p>Interoperable health information systems can provide a comprehensive picture of the health system at a given point (e.g., district) to improve decision-making by integrating data related to service delivery, human resources, commodities and administrative data, among others. Interoperable health information systems (HIS) contribute to measurement of health system performance by assessing functionality of the health system processes that are imperative for better performance.</p>
<b>Possible Adaptations</b>	<p>Countries may need to adapt criteria and areas depending on national-level policies and subnational differences in how policies and systems for interoperability are implemented and which data streams should be prioritized. Policy and procedural documentation may exist at national and/or subnational levels. All measures need to be examined at subnational level with reference to national level where necessary.</p> <p>In countries where disease- or program-specific (e.g., HIV, malaria, family planning, and reproductive health) information systems exist and are not interoperable, further mapping, assessment, and analyses may be required.</p>
<b>Data Disaggregation</b>	<p>National (aggregated up from subnational)</p> <p>Subnational:</p> <ul style="list-style-type: none"> <li>● Urban/rural</li> <li>● PHC facility level</li> <li>● Sector (public/private) as relevant</li> </ul>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Subnational capacity and performance checklist</p>
<b>Method of data collection and construction</b>	<p><i>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.</i></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 with this indicator based on the criteria specified. The recommended source of information for this measure are key informants from government offices (should be prioritized), implementing partners and/or donors who have insight into data systems at the district level.</p> <p>Once the data are collected via the tool, the indicator is calculated as a subnational score: whether the country meets none (0 points), some (1–3 points), most (4–5 points) or all (6) elements in place for PHC data interoperability as specified in the Precise Definition above.</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 help policymakers and program managers to plan and prioritize HIS activities necessary to build a strong, interoperable national and subnational HIS with attendant subsystems that are able to receive and share data. These data will provide foundational context to inform where strengthening is needed and will be measured again at the two-year review to understand the degree to which progress has been made to improve HIS interoperability. Variations in subnational performance can provide promising practices for spread and scale.
<b>Other Notes, Discussion, and/or Comments</b>	To understand whether facilities and subnational units are reporting health management information across service areas within a single, integrated system refer to indicator <b>P13B</b> . To understand whether functional health management information systems are in place at the facility level, refer to indicator <b>IN8A</b> . To understand facility capacity for information system use, refer to indicator <b>P10</b> .
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 5/30/2023</b>	

## P13B

## P13B: Facilities and subnational units are reporting across service areas within a single system

**Measurement Category:** PHC Foundations

**Domain:** Integration and Interoperability of Systems

**Subdomain:** Health Management Information Systems

### Indicator P13B: Facilities and subnational units are reporting across service areas within a single system

<p><b>Precise Definition</b></p>	<p>Extent to which facilities and subnational units are reporting across service areas within a single system. Integration of reporting on PHC services in a health management information system (HMIS) may exist along a spectrum including:</p> <ul style="list-style-type: none"> <li>• Facility does not report data on PHC services. (0 points)</li> <li>• Facility has separate reports for all PHC service areas. (1 point)</li> <li>• Facility has an integrated report that includes some PHC service areas, and separate reports for other PHC service areas. (2 points)</li> <li>• Facility has a single integrated report that includes most/all PHC service areas. (3 points)</li> </ul> <p>This indicator is measured at facility level, and data are aggregated up to subnational level (not measured separately at subnational level).</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> USAID's <a href="#">MEASURE Evaluation Health Information Systems Interoperability Maturity Toolkit</a></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>Health information systems share critical information about patient care and disease trends across primary care service delivery—playing a critical role in clinical care and population health. But inadequate integration of information systems can undermine the ability of health systems to care for complex and emerging conditions. Traditionally, health management information systems (HMIS) have captured information within specific content areas, such as child health or tuberculosis. An HMIS supportive of PHC allows aggregation and interpretation of data for primary care overall, bringing in service delivery data across contents to provide a lens on the unit's PHC functioning. This may include dashboards that present PHC data in an integrated fashion, rather than population or disease-specific. Improvements to the integration of health information systems, including</p>

	improving the exchange of data between disparate health information systems or the integration of multiple service areas into one system, holds promise for overcoming barriers to data quantity, quality, and accessibility. Consequently, it is important to understand whether facilities and subnational units are reporting across service areas within a single system.
<b>Possible Adaptations</b>	The elements of HMIS integration maturity may vary by local context and should be adapted in accordance with local policies, regulations, and norms.
<b>Data Disaggregation</b>	For subnational aggregated facility data: <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 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 which component of the precise definition most closely aligns with the facility's level of PHC reporting integration. This may involve talking with point people at the facility and reviewing documentation about reporting or health information systems used by the facility.</p> <p>The data collector will choose the one response category that most closely aligns with the facility's HMIS integration. Each element is assigned a numeric value score ranging from 0 to 3. Once the data are collected via checklist, the indicator is calculated as a facility-level score: whether the facility has no integration of reporting (0-1), some interoperability or integration of reporting (2) or high integration of reporting (3) as 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 report none, some or high integration of reporting on PHC services in the health information system integration.</p>



<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country. 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 in the project to understand whether or not facility and subnational units are reporting across service areas within a single system. This indicator also measures the amount of integration that exists across HMIS. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening HMIS integration.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator should be examined in conjunction with others related to information systems including IN8A, P13A, and P13B.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 3/7/2023</b>	

## P14

## P14: Integrated financial management system for PHC funds

**Measurement Category:** PHC Foundations

**Domain:** Integration and Interoperability of Systems

**Subdomain:** Financial Systems

## Indicator P14: Integrated financial management system for PHC funds

<p><b>Precise Definition</b></p>	<p><b>Evidence that a (national) integrated financial management system is enabling integrated flow of funds and financial reporting for PHC is:</b></p> <ul style="list-style-type: none"> <li>• Not integrated—there are numerous parallel systems for managing funds used for different PHC services at the national level with no ability to integrate management or reporting.</li> <li>• Minimally integrated—financial reporting and management of PHC funds remains fragmented across PHC programs/services, reporting areas, and funding types but there is an ability to combine information at the national level for financial management.</li> <li>• Moderately integrated—financial reporting of PHC funds is integrated for some, but not all, aspects of reporting, management or funding types at the national level.</li> <li>• Highly integrated—financial reporting of PHC funds is integrated across all PHC-related programs/services, aspects of financial management, reporting areas, and funding types at the national level.</li> </ul> <p><i>Refer to Indicator P7 to understand standard aspects of Financial Management Information Systems.</i></p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Financial Information System</p> <p><b>Data Type:</b> National Level Score (Categorical)—can be subnational depending on context, see Possible Adaptations.</p> <p><b>Adapted From:</b> <a href="#">WHO Health Financing Progress Matrix</a> Q6.5</p>
<p><b>Level of Measurement</b></p>	<p>National (or subnational depending on context, see Possible Adaptations)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Financial Management Information Systems (FMIS) are a tool to improve the strategic allocation of resources, align spending for operational efficiency, establish credibility of budgets, tracking allocation and spending and improve service delivery for primary health care networks and accountability. Transitioning from fragmented information systems to modern integrated FMIS offers great opportunities for improving public resource mobilization for PHC, including leveraging funds in</p>

	<p>traditionally vertical programs. Fragmentation results in separate accounting systems and financial reporting processes for each funds flow, which causes duplication and operational inefficiency and challenges in management, accountability, and budgeting. Likewise, this problem is exacerbated when facilities with limited human resources are burdened with different systems and administrative requirements. If funds received by PHC facilities are tied to separate FMIS systems and procedures, the fragmentation persists. A solution to this is an integrated and standard financial management system. A good accounting system will track revenue, manage expenditures, report on multiple funds flows, and overall increase efficiency and effectiveness, and transparency. A functional and integrated FMIS system helps to manage the funds flowing into a system from various sources, the funds moving out and being distributed across the system, as well as the funds being spent across the system for all areas related to health and PHC. (Adapted from <a href="#">WHO Health Financing Progress Matrix</a>, <a href="#">WHO, Direct Facility Financing: Concept and Role for UHC</a>)</p>
<b>Possible Adaptations</b>	<p>This indicator can be measured at the subnational level if the country’s financial management system is decentralized. In this case, we recommend replacing nomenclature that says “national” or “country” with the name of the subnational unit or system being evaluated. In this instance, the indicator would be measuring a subnational financial management system.</p> <p>The inclusion of different fund flows as well as the private sector if recipients of national PHC funds may also require adaptation of the criteria for integration. If your context has a national insurance scheme, be sure to include and evaluate the integration of these funds into your FMIS system.</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>	<p>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 Financial Management System guidance documents, Financial Management Systems or key informants at the national and/or subnational levels who are involved in financial management including ministry officials.</p> <p>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 which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. Once the data are collected via the tools, the indicator is calculated as a national (or subnational) score: whether the country/subnational area has evidence of an integrated financial management</p>

	system for PHC funds that is not integrated, minimally integrated, moderately integrated or highly integrated as defined in the precise definition above.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	To be considered in-country 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 in the project to understand whether or not the country has an integrated financial management system for PHC funds and where additional work to strengthen integration would be beneficial as the country moves to strengthen PHC. Stakeholders involved in financial planning, reporting, and monitoring can use these data to identify areas for streamlining system reporting, management, analysis, and data capture. It will be measured again at the two-year review of the project to understand if any progress has been made in strengthening the integration of financial management systems related to PHC.
<b>Other Notes, Discussion, and/or Comments</b>	Note, this indicator measures the integration of FMIS systems related to various PHC funds at the national levels. To understand whether or not your FMIS system has the core components for basic functionality, refer to indicator P7.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</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 integrate into their already existing environment and practices to facilitate their</p>

	<p>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.</p>
<b>Possible Adaptations</b>	<p>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.</p>
<b>Data Disaggregation</b>	<p>For Subnational measurement:</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</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 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>	<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 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 strategic direction. Facility leadership and facility improvement teams drive activity</p>



<b>(and any Link to Foreign Assistance Framework)</b>	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>	

## P17

## P17: Facilities meet criteria for resilient health facilities and services

**Measurement Category:** PHC Foundations

**Domain:** Resilient Health Facilities, Systems, and Services

**Subdomain:** Continuity of Services

## Indicator P17: Facilities meet criteria for resilient health facilities and services

<p><b>Precise Definition</b></p>	<p>Degree to which PHC facilities have systems, mechanisms, and plans in place to ensure the functioning of the facility and continuity of services during emergencies. Criteria include:</p> <ul style="list-style-type: none"> <li>● Defined health facility emergency management plan, including service continuity. (1 point)</li> <li>● Designated team or focal persons for emergency management and service continuity. (1 point)</li> <li>● Prioritized primary care services to be maintained during emergencies are identified (according to national protocols). (1 point)</li> <li>● Up-to-date protocols for case management for priority health emergencies and disasters. (1 point)</li> <li>● Staff trained on emergency and disaster risk management (including prevention, preparedness, response, and recovery) and service continuity. (1 point)</li> <li>● Recent (once in past five years) assessment of risks and structural, non-structural, functionality and preparedness of the facility. (1 point)</li> <li>● Simulation exercises to routinely test the functionality of health facility structures, mechanisms, and functions for emergency management and service continuity. (1 point)</li> <li>● Post-emergency reviews (at facility or subnational level) to evaluate the performance of the facility in emergency management and service continuity and use lessons to effect recovery and strengthen capacities for current and future risks. [Alternatively, if there was no emergency during the recall period, is there a process in place for post-emergency review to do this for the next emergency?] (1 point)</li> </ul> <p>Facilities are assessed using a checklist as meeting none, some, most or all of these criteria (see Method of Data Collection below).</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>
----------------------------------	---

	<b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #61
<b>Level of Measurement</b>	Facility Subnational (facility aggregation)
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Reducing the health risks and consequences of emergencies is vital to local, national, and global health security and to build the resilience of communities, countries, and health systems. There are many cross-cutting, systemwide capacities that contribute to community, health system, and country resilience, including the critical roles of resilient health facilities and their functionality to provide health services in both day-to-day and emergency situations. Various system-wide attributes of resilience can be found in other indicators of this framework.</p> <p>This indicator focuses on emergency and disaster risk management, the continuity of PHC services and functions, and the use of reviews and lessons learned to facilitate recovery and strengthen capacities for current and future risks, as key attributes of resilient health facilities and services.</p>
<b>Possible Adaptations</b>	Countries may adapt the criteria to reflect plans and mechanisms specified in their own national policies for emergency and disaster risk management and ensuring continuity of services and functions, including the frequency of training, the frequency of simulation exercises, types of emergencies that trigger emergency management protocols and require a review of the response, and which facilities should be assessed.
<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>	Facility checklist
<b>Method of data collection and construction</b>	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

	<p>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 the eight resilience criteria in the Precise Definition above. This will involve talking with key point people at the facility, and verifying the existence of plans and procedures through review of documents. Once the data are collected via checklist, the indicator is calculated as a facility-level score: whether the facility meets none (0 points), some (1–5 points), most (6–7 points) or all (8 points) of the criteria specified in the Precise Definition above (or adapted as noted if no emergency in the last year).</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, most or all (respectively) of the resilience criteria.</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>	The ability to respond to emergencies and maintain essential health care services is crucial for the health and wellbeing of communities. This indicator can assist policymakers and program managers at the facility and subnational level to identify gaps in facility resilience early in the project which need addressing, and where policies need adaptation and focused implementation through programs to strengthen health facility capacities. The indicator will be measured again at the two-year review mark 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: 3/31/2023</b>	

## P18

## P18: Facilities and subnational units meet criteria for pandemic preparedness

**Measurement Category:** PHC Foundations

**Domain:** Resilient Health Facilities, Systems, and Services

**Subdomain:** Pandemic Preparedness

## Indicator P18: Facilities and subnational units meet criteria for pandemic preparedness

<p><b>Precise Definition</b></p>	<p><b>Facility</b></p> <p>Degree to which PHC facilities have systems and protocols in place to respond to future pandemics, specifically regarding infection prevention and control (ability to separate patients, environmental ventilation, etc.). This indicator should be interpreted along with indicator P17 on facility level resiliency. Pandemic preparedness is measured by assessing whether the facility has:</p> <ul style="list-style-type: none"> <li>● Physical barriers (e.g., glass or plastic window) in areas where patients will first present, i.e., registration desk at the emergency department or pharmacy window where medication is collected. (1 point)</li> <li>● Protocols/guidelines on quarantine for patients with suspected contagious disease, and isolation for patients with diagnosed condition. (1 point)</li> <li>● Guidelines for managing medical supplies, space, and infrastructure during pandemics. (1 point)</li> <li>● Ability to separate and isolate patients. <ul style="list-style-type: none"> <li>○ Separate triage and waiting areas. (1 point)</li> <li>○ Separate entrance for patients with a suspected contagious disease. (1 point)</li> <li>○ Designated sites (or transport mechanism to higher-level facility) for quarantine of patients with a suspected contagious disease. (1 point)</li> <li>○ Designated sites (or transport mechanism to higher-level facility) for patient isolation with diagnosed condition. (1 point)</li> </ul> </li> <li>● Protocols for the transportation of infectious patients (within this facility and/or to other facility). (1 point)</li> <li>● System to track quarantined or isolated patients upon discharge. (1 point)</li> <li>● Contact tracing protocol and guidelines. (1 point)</li> <li>● Information and data management systems that can be used to manage contact tracing. (1 point)</li> <li>● Disinfection practices:</li> </ul>
----------------------------------	--

- Linens from patients are appropriately washed (at high water temperatures with chlorine followed by mild acid) and/or incinerated. (1 point)
- Surfaces in patient care areas are cleaned with disinfectants at least twice a day. (1 point)
- Management of surge capacity:
  - Designated areas for patient overflow in case of emergency. (1 point)
- Functional hand hygiene facility at points of care, i.e., consultation/exam rooms (A hand hygiene facility is any device that enables staff and patients to clean their hands effectively using running water and soap, such as a sink with tap, water tank with tap, bucket with tap or other similar device. Alcohol-based hand rub dispensers are also hand hygiene facilities, whether they are fixed or portable). (1 point)
- Appropriate method for the final disposal of infectious medical waste (i.e., incinerator, open pit burn, bury). (1 point)
- Facility budget has flexibility to accommodate health emergencies, for example, ability to reallocate funds to procure extra personal protective equipment (PPE) during a pandemic. (1 point)

Facilities are assessed as meeting none, some, most or all of these criteria (see Method of Data Collection below for details).

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Facility

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

**Adapted from:** Service Delivery Indicators Bhutan facility questionnaire—section on Emergency Preparedness and Response (sub-sections on Infection Control, Management of Surge Capacity), also summarized in the World Bank [blog post](#)

### Subnational

Degree to which subnational units have systems and protocols in place to respond to future pandemics, specifically regarding infection prevention and control. This is measured by assessing whether the subnational unit has:

- Functioning subnational infection prevention and control (IPC) program with regularly updated plans and guidance. (1 point)
- Note – the above element is fulfilled only if both the IPC program exists and is regularly updated in accordance with national guidelines.*
- Sufficient human resource capacity to oversee IPC programs during a pandemic or other outbreak. (1 point)
  - Existence of contact tracing protocol and guidelines. (1 point)

	<ul style="list-style-type: none"> <li>● Information and data management systems that can be used to manage contact tracing. (1 point)</li> <li>● Resources and staff capacity to appropriately forecast, budget for, and procure PPE, lab tests, and other supplies to meet demands during a pandemic or outbreak. (1 point)</li> <li>● Guidelines for managing medical supplies, space, and infrastructure in subnational area during outbreaks and pandemics. (1 point)</li> <li>● Guidelines for communication with health facilities, higher-level authorities, and catchment populations during public health emergencies, including about IPC (1 point)</li> <li>● Designated team or focal persons for public health emergency management and service continuity—important to know hierarchical structure and who the focal people are when an outbreak happens (1 point)</li> </ul> <p>Subnational units are assessed as meeting none, some or most/all of these criteria (see Method of Data Collection below).</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> USAID COVID-19 M&amp;E framework, IHR SPAR, <a href="#">WB blog post about Service Delivery Indicators</a>, and PHCMFI M61</p>
<b>Level of Measurement</b>	<p>Facility</p> <p>Subnational</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Pandemic preparedness at the facility and subnational levels is essential in order to mount an effective response to infectious disease outbreaks / pandemics. Lessons learned from COVID-19 have helped to inform the criteria that facilities and subnational units must meet in order to be adequately prepared to respond. Some of these will also help reduce risks of health care-associated infections during and between pandemics.</p>
<b>Possible Adaptations</b>	<p>Existing country policies and guidelines for pandemic preparedness should be reviewed to determine expectations as well based on facility and health care worker role and capacity. Areas of responsibility for pandemic preparedness at subnational level may also exist at facility level, so each country should adapt by including some of the subnational criteria in their facility survey as appropriate. A country will need to adapt “regularly updated” to reflect national guidelines for IPC review and maintenance.</p>



<p><b>Data Disaggregation</b></p>	<p>For facility level:</p> <ul style="list-style-type: none"> <li>● 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</li> </ul> <p>For subnational level:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> <li>● Urban/rural</li> <li>● PHC facility level</li> </ul> <p>Sector (public/private) as relevant</p>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p>Facility checklist</p> <p>Subnational Capacity and Performance Checklist</p>
<p><b>Method of data collection and construction</b></p>	<p><b>Facility-level measurement</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 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 pandemic preparedness elements in the precise definition above. This may involve talking with key point people at the facility, and visual inspection to verify infection control mechanisms.</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 (1–13), most (14–16) or all (17) of the criteria specified in the precise definition above.</p> <p><b>Sub-national level measurement</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. 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 pandemic preparedness protocols and visual inspection of infection control mechanisms. 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 point) or Yes (1 point), resulting in a numeric value. Once the data are collected via the tool, the indicator is</p>

	calculated as a subnational-level score: whether the subnational unit meets none (0 pt), some (1–5 pts), most (6–7 pts) or all (8 pts) elements for pandemic preparedness as specified in the Precise Definition above.
<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 to assess the extent to which facilities and subnational units are prepared to respond to future pandemics and inform where work is needed at the facility and subnational level to address identified gaps and learn from existing strengths in implementation and preparedness.
<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: 3/31/2023</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	
<b>Precise Definition</b>	<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>
<b>Level of Measurement</b>	Subnational (facility aggregation)
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<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>
<b>Possible Adaptations</b>	<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>	

## OP1B

## OP1B: Sources of expenditure on health (and PHC-specific)

**Measurement Category:** PHC Foundations

**Domain:** Access and Availability

**Subdomain:** Accessibility, Affordability, Acceptability

## Indicator OP1B: Sources of expenditure on health (and PHC-specific)

## Precise Definition

Distribution of expenditure on health by source (private [including out-of-pocket], public [domestic government, external]).

Expenditure on PHC from prepaid sources: Proportion of expenditure from prepaid sources (all sources except out-of-pocket), including change in this proportion over time as a measure of promotion of the use of PHC by making PHC financial accessibility a priority.

Expenditure on health by different sources is defined as:

- **Public sources:** include domestic revenue as internal transfers and grants, transfers, subsidies to voluntary health insurance beneficiaries, as well as social health insurance contributions.
- **Private sector:** includes funds stemming from households, corporations, and non-profit organizations. Such expenditures can be either prepaid to voluntary health insurance or paid directly to health care workers.
- **External sources:** these are composed of direct foreign transfers and foreign transfers distributed by governments encompassing all financial inflows into the national health system from outside the country.
- **Non-profit sources:** Non-Profit Institutions Serving Households (NPISH) or enterprise financing schemes.

PHC-specific: PHC expenditure is calculated as follows based upon data from the [System of Health Accounts \(SHA\) 2011](#):

- General outpatient curative care (HC.1.3.1)—such as visits to a general practitioner or nurse.
- Dental outpatient curative care (HC.1.3.2)—such as visits for regular control and other oral treatment.
- Curative outpatient care not elsewhere classified. (HC.1.3.nec), excluding specialized outpatient care.
- Home-based curative care (HC.1.4), such as home visits by a general practitioner or nurse.
- Outpatient (HC.3.3) and home-based (HC.3.4) long-term health care.
- Preventive care (HC.6), such as immunization, health check-ups, health education, disease detection, monitoring and emergency response programs.

	<ul style="list-style-type: none"> <li>• Part of medical goods provided outside healthcare services (80% of HC.5).</li> <li>• Part of health system administration and governance costs (80% of HC.7).</li> </ul> <p><b>Numerator:</b> Total expenditure on health (and PHC-specific) from each relevant source (government schemes, compulsory contributory health care financing, voluntary health care payment schemes, household out-of-pocket, rest of world financing schemes, other)</p> <p><b>Denominator:</b> Total expenditure on health</p> <p><b>Unit of measure:</b> US dollars</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #17</p>
<b>Level of Measurement</b>	National
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	<p>The distribution of sources for expenditure on health reflects the mix of resources available to support a country's health system.</p> <p>Public sources include domestic revenue (such as internal transfers and grants, transfers, subsidies to voluntary health insurance beneficiaries, NPISH or enterprise financing schemes) as well as compulsory prepayment and social health insurance contributions. All these transfers and subsidies represent public sources for health and <i>indicate the government's overall contribution to funding health care relative to other sources of funding from domestic private and external sources.</i></p> <p>The share of domestic private expenditures on health of the total current health expenditures describes <i>the role of the private sector in funding health care relative to public or external sources, and indicates how much is funded domestically by the private sector.</i> Private sector funds stem from households, corporations, and non-profit organizations. Such expenditures can be either prepaid to voluntary health insurance or paid directly to health care workers. <i>Out-of-pocket expenditure estimates how much households in each country are spending on health directly out-of-pocket.</i></p> <p><i>The share of external sources spent on health as a percentage of total current health expenditures indicates how much the health system is dependent on external funding sources relative to domestic sources.</i> External sources include direct foreign transfers and foreign transfers distributed by government encompassing all financial inflows into the national health system from outside the country.</p>
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	<p>PHC-specific expenditure</p> <p>Source: out-of-pocket, domestic government, external</p>

<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator should be measured from existing data and analysis. Recommended sources include the following:</p> <p>National Health Accounts (NHA)</p> <p><a href="#">Guidelines for the implementation of the SHA 2011 framework for accounting health care financing</a></p> <p><a href="#">Global Health Expenditure Database</a></p>
<b>Method of data collection and construction</b>	<p>Per <a href="#">WHO GHO</a>, NHA indicators are based on expenditure information collected within an internationally recognized framework. NHAs synthesize the financing flows of a health system, recorded from the origin of the resources (sources), and the purchasing agents (financing schemes), which distribute their funds between health care workers, to pay for selected health goods and services to benefit individuals. Beneficiaries are analyzed across geographical, demographic, socioeconomic and epidemiological dimensions. Total expenditure on health (THE) is measured as the sum of spending of all financing agents managing funds to purchase health goods and services. The NHA strategy is to track records of transactions, without double counting and in order to reach a comprehensive coverage. Monetary and non-monetary transactions are accounted for at purchasers' values. Guides to producing NHAs exist. (<a href="#">OECD, 2000</a>; <a href="#">WHO-World Bank-USAID, 2003</a>).</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>	<p>These data will be used early in the project by policymakers and program managers to understand the funding sources of expenditure on PHC-specific health and health more broadly and if and how they contribute to the relative strengths and weaknesses of their health systems, make informed decisions about resource allocation, and improve overall health outcomes. This is particularly important for PHC services, which are often the first point of contact for people seeking health care and play a crucial role in promoting health and preventing illness. These data will be measured again at the two-year review of the project to understand if any progress has been made in collecting accurate and up-to-date expenditure data, which will allow policymakers and health managers to identify gaps in PHC budgets, allocate resources more effectively, and ultimately improve PHC services.</p>
<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: 4/12/2023</b>	

## OP1C

## OP1C: Patient-reported experience of acceptability

**Measurement Category:** Monitoring for Change

**Domain:** Access and Availability

**Subdomain:** Accessibility, Affordability, Acceptability

## Indicator OP1C: Patient-reported experience of acceptability

<p><b>Precise Definition</b></p>	<p>PHC facilities deliver care that is acceptable to patients through assessment of patient satisfaction and whether or not they would recommend the facility to others. 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>● Were you satisfied with the care received at this facility? <ul style="list-style-type: none"> <li>○ Yes (1 point)</li> <li>○ No (0 points)</li> </ul> </li> <li>● Would you recommend this facility to others? <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></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>Assessment of patient acceptability has become increasingly important in the design and evaluation of care delivery at the facility level. Patient-reported acceptability can help to understand the critical patient perspective, providing a lens into whether patient expectations are being met when seeking care. Assessment of patient acceptability will provide insight into how effectively the provider addressed their health concerns and whether the patient felt satisfied with their care when leaving the facility. If care is not being seen as adequate or effective, the likelihood of adherence to treatment plans as well as the return to a facility to seek care can be adversely affected.</p> <p>(Adapted from <a href="#">PHC MFI</a> and <a href="#">Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework</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), the 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 can be collected through a facility client exit survey to better understand the patient’s satisfaction with care immediately after receiving PHC services. The client exit survey will be conducted at the end of a visit to the facility with the patient (caregiver if for a child). The client exit survey may be conducted at the same time as a visit to complete a facility checklist. The individual or team at the facility will ask the respondent about satisfaction with service provision and whether they would recommend the facility. If not done during the visit, the survey can be conducted at an earlier or later date, but not by someone who is providing care or management at the facility. If relevant, there is growing experience collecting this data through phone surveys dependent on the context. Completion of this measure will result in an overall score for acceptability at the facility level. In order to calculate the score, the points from each question will be summed up for each respondent and result in a categorical value in which:</p> <ul style="list-style-type: none"> <li>● Score of 2 = Acceptable</li> <li>● Score of 1 = Somewhat acceptable</li> <li>● Score of 0 = Not at all acceptable</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 acceptability of care.</p>

	Facility-level data will be aggregated at the subnational level (e.g., district) to look at the average rating of facilities across the subnational context. 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
<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 acceptability of patient experience when receiving care or treatment at the facility, based on previous or anticipated expectations when it comes to engagement with the PHC system. It can identify where work is needed to understand low ratings and where change is needed in the PHC delivery and environment. This indicator will be measured every 6 to 12 months to understand if any progress has been made in meeting patients' needs and expectations when seeking care.
<b>Other Notes, Discussion, and/or Comments</b>	<p>Refer to indicators OP1A and OP1B for data on accessibility and affordability.</p> <p>This indicator will be measured through a client exit survey along with the remaining patient-reported experience measures of first-contact accessibility (OP4), 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> (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>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 04/11/2023</b>	

## OP2A

## OP2A: Facilities offer services according to national defined service package (availability)

**Measurement Category:** Monitoring for Change

**Domain:** Access and Availability

**Subdomain:** Service Availability and Readiness

### Indicator OP2A: Facilities offer services according to national defined service package (availability)

#### Precise Definition

Facility score measuring the extent to which the facility offers services according to a national defined service package, i.e., service availability. Per [SARA](#), the facility is asked whether they offer each service (i.e., whether the service has been available in the past 3 months; if desired, countries can further refine the definition of “offering” the service, e.g., specifying a minimum frequency). Specific services depend on the country context and should align with the nationally determined core package of services. National PHC package of services often, but not always, includes some level of care (preventive, diagnostic, curative), and some may be available through networks of care with referral systems. Main areas which are often covered include, but are not limited to:

- **Communicable diseases**
  - Communicable disease prevention (e.g., immunization).
  - Communicable diseases diagnosis and management (excluding neglected tropical diseases) (e.g., HIV testing/counseling, antiretroviral therapy management, sexually transmitted infection diagnosis and treatment, tuberculosis services including diagnosis, treatment and treatment follow-up, malaria diagnosis and treatment, diagnosis and treatment of childhood respiratory infections and diarrheal diseases, etc.).
  - Neglected tropical diseases.
- **Growth monitoring services** (e.g., infant, child and adolescent growth and development, nutrition, special considerations for older people, etc.).
- **Noncommunicable diseases** (e.g., cardiovascular diseases, cancer screening, chronic respiratory disease, endocrine disease, congenital abnormalities, selected genitourinary disorders, skin and hair diseases, etc.).
- **Other non-communicable diseases including mental health, neurological and substance use disorders.**
- **Reproductive and sexual health** (e.g., antenatal care, prevention of mother-to-child transmission of HIV; basic emergency obstetric and neonatal care (BEmONC); essential newborn care; family planning).
- **Care and/or referral for victims of gender-based violence.**
- **Minor surgical services.**

	<ul style="list-style-type: none"> <li>● <b>Emergency services available 24 hours a day</b> with either a health care worker present at the facility at all times or officially on call for the facility at all times.</li> <li>● <b>Nutrition services.</b></li> </ul> <p>Facilities are assessed with a checklist as offering none, some, most or all of the services defined in the national defined service package for their PHC facility-level (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 services</p> <p><b>Data Type:</b> Facility score</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #66, <a href="#">SARA</a></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>Availability of health services should be aligned with a country’s defined package of essential health services and public health functions and for each level of PHC facility assessed as well as the network of care (services available through referral as appropriate). This measure assesses the extent to which specific PHC services are offered and available within the relevant PHC service delivery points.</p>
<b>Possible Adaptations</b>	<p>Countries need to adapt the health services assessed to their nationally defined package of essential health services that should be provided at each type/level of health facility. Within each service area, additional, detailed types of services may be collected if of interest as well as contributing to measures of integration. For example, within antenatal care services, questions such as if the facility offers preventative treatment of malaria in pregnancy or offers diagnosis and treatment of hypertension in HIV clinics can be included. Countries may also adapt the definition of “offering” services to specify a minimum frequency (e.g., at least once a week, on a routine basis but less frequently than once a week).</p> <p>If desired, countries can also look at the percentage of services offered at the facility out of the total services that should be available per national guidelines.</p>
<b>Data Disaggregation</b>	<p>Service area</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>For subnational aggregated facility data:</p> <ul style="list-style-type: none"> <li>● PHC facility level</li> </ul>

	<ul style="list-style-type: none"> <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>Facility checklist</p> <p>Estimates of the components of this indicator can also be extracted for subnational areas from health facility assessments, such as the <a href="#">HHFA</a>, <a href="#">DHS SPA</a>, <a href="#">World Bank Service Delivery Indicators</a>, or others, if they have been conducted recently and cover all relevant PHC facilities.</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 if the facility offers specific services as outlined in the detailed definition and adapted to the country's essential package of services. Collecting these data requires asking the facility in-charge about the services normally offered at the facility.</p> <p>Once the data are collected, the indicator is calculated as follows: the facility will receive 1 point for each service offered, and a facility score will be calculated for whether the facility offers none, some, most or all of the services defined in the national service package for their PHC facility level. The scoring ranges for each category will vary depending on the number of services in the national service package. For example, if there are 10 services, facilities would be scored as offering none (0), some (1–7), most (8–9) or all (10) services.</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the percentage of facilities that offer none, some, most or all services according to the national defined service package.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months
<b>Data Quality Considerations</b>	The stated availability of each service at the facility is limited in that it does not assess if the facility has the proper equipment, staff, and commodities to provide the service and does not assess the quality of that service. If the service is available by referral, the functionality of referral is not assessed here but rather in indicators OP6 and OP8A.
<b>Data Use</b>	This indicator can help policymakers and health managers (facility and subnational) better understand the strengths and weaknesses of the availability of nationally

	defined scopes of PHC services and where there are gaps which need to be addressed. The data can also be used to understand if resources are being used effectively, services are being delivered according to national guidelines, and patients have access to the care they need and where strengthening is needed.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator falls under the cross-concept of Quality, which is also covered in multiple other output indicators.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/10/3023</b>	



## OP2B

## OP2B: Facilities meet minimum national standards to deliver tracer services (readiness)

**Measurement Category:** Monitoring for Change

**Domain:** Access and Availability

**Subdomain:** Service Availability and Readiness

## Indicator OP2B: Facilities meet minimum national standards to deliver tracer services (readiness)

**Precise Definition**

Facility level readiness score defined as whether the facility has appropriate levels of staff and guidelines, equipment, diagnostics, and medicines/commodities for tracer PHC services (detailed below), per minimum national standards. This indicator should be assessed and interpreted separately for each tracer service.

Tracer PHC services include: family planning, antenatal care, labor and delivery, newborn care, child health, child immunization, malaria, tuberculosis, and HIV. An illustrative list of elements for each service is below, and more details on standard readiness indicators for country level adaptation are available within the [WHO Harmonized Health Facility Assessment Inventory](#). Of note, there are other components of service readiness, such as IPC and funding, that are covered in other PIRS (e.g., OP12A: Facilities compliant with selected IPC measures).

- Family planning (FP) (e.g., staff trained on FP, blood pressure apparatus, and injectable contraceptives).
- Antenatal care (ANC) (e.g., ANC check-lists and/or job aids, hemoglobin diagnostic capacity, and iron tablets).
- Basic obstetric and newborn care (e.g., guidelines for essential childbirth care, emergency transport, and skin disinfectant).
- Child health (e.g., guidelines for integrated management of childhood illness (IMCI), staff trained in IMCI, child and infant scale, malaria diagnostic capacity, zinc, amoxicillin DT, and ORS packet).
- Immunization (e.g., staff trained in child immunization, cold chain, auto-disable syringes, and DTP vaccine).
- Malaria (e.g., guidelines for IPT, malaria diagnostic capacity, and first-line antimalarial in stock).
- Tuberculosis (TB) (e.g., guidelines for diagnosis and treatment of TB, TB microscopy, and first-line TB medications).
- HIV (e.g., staff trained in HIV counseling and training, visual and auditory privacy, HIV diagnostic capacity, and condoms).

Facilities are assessed with a checklist as meeting criteria for staff and guidelines, equipment, diagnostics, and medicines/commodities for each tracer PHC service per national guidelines (see Method of Data Collection).

**Numerator:** Not Applicable

	<p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facility</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #68</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>One of the goals of universal health coverage is the ability to provide quality health services to the population that meet their needs without financial hardship. Service readiness (as defined by facilities meeting minimum standards to deliver services) is a necessary component of quality health services. The ability of facilities to provide quality services to those accessing care is dependent on the facility having adequate supplies and staffing. Some of the components of these indicators are measured separately as part of this framework. However, this measure combines the different components to give a combined measure of service readiness as well as examining separately the different components to see where minimum standards are (or are not) being met.</p>
<b>Possible Adaptations</b>	<p>Countries should adapt the facility checklist as appropriate based on the country's minimum standards/readiness criteria for each tracer condition. The addition of noncommunicable diseases should also be considered based on country priorities and scope. Facility surveys which capture these data are included in <a href="#">WHO Noncommunicable disease facility-based monitoring guidance</a>.</p>
<b>Data Disaggregation</b>	<p>Tracer Services</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>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>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 has the recommended staff, guidelines, equipment, diagnostics, medicines, and commodities to provide tracer services for FP, ANC, basic obstetric and newborn care, child health, immunization, malaria, TB, and HIV according to national guidelines. Once the data are collected, the indicator is constructed by scoring each tracer services as 1 (have all of the appropriate staff, guidelines, equipment, diagnostics, medicines, and commodities according to national guidelines) or 0 (does not meet all of these criteria). A facility-level score is then calculated by adding up the number of points awarded; for example, if there are 8 tracer services, the facility score could range from 0–8.</p> <p>Facility-level data will also be aggregated at the subnational level (e.g., district) to look at the average and range of facility scores for tracer service readiness, and will be disaggregated for each tracer service to identify specific gaps.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months (note: due to seasonal variation in service uptake, we recommend this indicator only be measured every 12 months to compile annual data).
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	These data will allow facilities to identify gaps in meeting the national standards for service readiness, and help policymakers and program managers develop targeted interventions needed to address challenges in service readiness. The data can be used to monitor progress over time, ensuring that improvements are sustained over time and facilities are providing quality 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: 4/10/2023</b>	

## OP3

## OP3: Overall service utilization rate

**Measurement Category:** Monitoring for Change

**Domain:** Access and Availability

**Subdomain:** Utilization of Services

## Indicator OP3: Overall service utilization rate

<p><b>Precise Definition</b></p>	<p>Rate of outpatient department visits to facilities providing PHC services during a specified time period (e.g., 6 or 12 months) per 10,000 population in the catchment area. Outpatient visits are defined as contact with a health care worker, such as physician, nurse, midwife, etc., where the person is not admitted to any health care facility and does not occupy a hospital bed for any length of time. This indicator uses total number of outpatient department visits irrespective of types of service provided and whether first or subsequent visits, because it is assumed that perception of improved service quality due to quality improvement activities will improve overall facility utilization of services.</p> <p><b>Numerator:</b> Total number of annual outpatient department visits at a PHC facility during the specified time period</p> <p><b>Denominator:</b> Estimated total population served by the PHC facility (e.g., catchment population)</p> <p><b>Unit of measure:</b> Visits to outpatient department</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> <a href="#">USAID PPR HL-6</a>, <a href="#">MEASURE Evaluation</a>, <a href="#">Data for Impact</a></p>
<p><b>Level of Measurement</b></p>	<p>Facility Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>PHC facilities should be the first contact access for conditions which do not require hospitalizations; therefore, strengthening PHC outpatient service delivery and increasing utilization are fundamental to improving health status and outcomes. This standardized indicator shows the levels of utilization of outpatient primary health care services and can be employed to examine trends and variations in use of services by type of facility and healthcare service, geographic districts and urban/rural locations.</p> <p>This indicator can also be a proxy measuring progress of the government's commitment and efforts to improve quality of health services for better health outcomes and effectiveness of care.</p>
<p><b>Possible Adaptations</b></p>	<p>If possible, countries may want to look at outpatient utilization numbers in addition to overall rate, and also disaggregated data by health care service (e.g., reproductive</p>

	<p>health and family planning visit; maternal, neonatal, and child health visit; malaria treatment, non-communicable diseases management, etc.)</p> <p>Countries will need to decide which facilities and which services are included.</p>
<b>Data Disaggregation</b>	<p>Gender, others as available (wealth, age, etc.)</p> <p>Facility type</p> <p>Urban/rural (as relevant)</p> <p>Sector (public/private) as relevant</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>Numerator:</b> Information extracted from the HMIS or other information system review.</p> <p>Where HMIS or other information systems do not contain these data, data can be collected via facility checklist by reviewing existing HMIS reports.</p> <p><b>Denominator:</b> Existing estimates or calculation by the project</p>
<b>Method of data collection and construction</b>	<p><b>Numerator:</b> The information required to construct this indicator is usually compiled from within the Health Management Information System or other information system for each facility and is aggregated to the sub-national level (district, region, etc.) and the national level. In cases where this information is not compiled and calculated directly in the information system, it can be collected at the facility level through an extraction of all or a sample of outpatient department registers or at the district level through review and extraction of facility reports.</p> <p>If collected semiannually, will need to determine impact of seasonality.</p> <p><b>Denominator:</b> The information on facility catchment population can be obtained from existing estimates or it can be determined directly by the project. This will depend in part on how the facility catchment population is defined and calculated in the country context. Some examples might include: population in a geographic catchment area (which may be an existing estimate) or list of enrolled patients from general empanelment.</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> <p>This is a count or rate of outpatient visits and does not represent the actual number of unique individuals utilizing services. Within this count/rate, there may be people in the population who make multiple visits.</p> <p>An accurate count requires complete and reliable recording and reporting of the number of outpatient department visits by staff at public and private facilities.</p>

<b>Data Use</b>	This standardized indicator shows the levels of utilization of outpatient health care services and can be employed to examine time trends and variations in use of services by type of facility and health care service, geographic districts, and urban/rural locations, and will allow comparisons between regions and programs; especially when standardized to a rate per population. The results should inform areas where additional exploration is needed for potential barriers to access, uptake or availability of outpatient PHC services.
<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: 4/10/2023</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 (and any Link to Foreign Assistance Framework)</b>	<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 where work is needed to understand low ratings and where change is needed in the</p>

	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 1<sup>st</sup> 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</p>

<b><i>(and any Link to Foreign Assistance Framework)</i></b>	also reflects facility efforts of engaging clients for improving compliance with 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 1 <sup>st</sup> vs 4 <sup>th</sup> 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. (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 be 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>

<b>Method of data collection and construction</b>	<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>
<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>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>  <i>(and any Link to Foreign)</i></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 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</p>

<b>Assistance Framework)</b>	<p>PHC systems to capitalize on the ability to deliver a wider range of services when a patient first accesses care and is closely tied 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>
<b>Possible Adaptations</b>	<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>
<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 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</p> <p><b>Unit of measure:</b> Individual rating</p> <p><b>Data Type:</b> Binary (yes/no)</p> <p><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)</p> <p>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 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-</p>

	<p>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.</p> <p>Completion of this measure will result in an overall score for coordination at the 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</p>

	<p>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>	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.
<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 responsiveness and trust in care (OP9A).

	<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>
<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)
  - Good (3 points)
  - Fair (2 points)



	<ul style="list-style-type: none"> <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> <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> </ul>
--	---

	<ul style="list-style-type: none"> <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 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</p>

	<p>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>
<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 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 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>	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 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 Subnational (facility aggregation)</p>
<p><b>Rationale (and any Link to Foreign)</b></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</p>

<b>Assistance Framework)</b>	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.
<b>Possible Adaptations</b>	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.
<b>Data Disaggregation</b>	For subnational aggregated facility data: <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 or Health Management Information System
<b>Method of data collection and construction</b>	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: $z_i = (x_i - \min(x)) / (\max(x) - \min(x)) \cdot 100$ where $z_i$ =the $i$ th normalized value in the dataset; $x_i$ =the $i$ th value in the dataset for that indicator; $\min(x)$ =the minimum value in the dataset for that indicator; and $\max(x)$ =The maximum value in the dataset for that indicator.
<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.
<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>	

## OP11

## OP11: Adherence to clinical standards for RMNCH tracer conditions

**Measurement Category:** Monitoring for Change AND Measuring for Impact

**Domain:** Quality PHC

**Subdomain:** Effectiveness

### Indicator OP11: Adherence to clinical standards for reproductive, maternal, newborn and child health (RMNCH) tracer conditions

#### Precise Definition

#### Facility Level

Adherence to clinical guidelines/standards for essential PHC tracer conditions refers to the technical quality of services provided (as opposed to readiness to provide these services (Indicator OP2B) or experiential quality (Indicator OP9A)). This indicator is defined in two ways, depending on the measurement time point:

**Monitoring for Change (every 6 - 12 months):** whether the facility has done a formal assessment of technical/clinical quality of care in the past 6 - 12 months (yes or no). Facilities must show documentation that the assessment has been done.

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Facility

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

**Adapted from:** Not Applicable (new)

**Measuring for Impact (early on, two-year review):** Technical quality of services, i.e., the percentage of clinical service encounters for a specific tracer condition in which clinical guidelines/standards for that specific service are met. Depending on the tracer condition, this could include whether the health care worker asked relevant history and physical examination questions, provided appropriate and relevant information to the patient, and/or conducted a physical exam including appropriate/relevant clinical elements like taking the patient's blood pressure, etc.

#### Example RMNCH tracer conditions:

- % of clients selecting contraceptive methods who were informed: (1) about side effects or problem of method used, (2) of what to do if they experienced side effects or problems with the method used, (3) of other methods of contraceptive that could be used, and (4) that they could switch to another method if they wanted or needed to ([FP 2030 Method Information Index Plus](#)—collected through surveys).
- % antenatal care (ANC) clients receiving minimal elements of physical examination and screening appropriate for ANC visit including a) height (first visit only), b) weight, c) examination for dates (e.g., fundal height), d) fetal

	<p>heartbeat, e) auscultation of heart and lungs (first visit only); f) blood pressure measured [ANC visit 1 only for height and auscultation of heart and lungs] and screening for g) anemia/hemoglobin, h) syphilis, and i) HIV.</p> <ul style="list-style-type: none"> <li>• <u>% women with maternal vital signs (blood pressure, temperature, pulse) and fetal vital signs (fetal heart tones) taken and documented at admission to labor and delivery.</u></li> <li>• <u>% of sick children under 5 years of age who visited the health facility for medical care and received essential physical and clinical assessment in accordance with integrated management of childhood illness algorithm (weight, mid-upper arm circumference [&gt;6 months], weight for height calculation, respiratory rate, temperature, pulse, cough, difficult breathing/chest indrawing, diarrhea/dehydration status, and palmar/conjunctival pallor/nails checked for anemia).</u></li> </ul> <p><b>Numerator:</b> Total number of clinical service encounters assessed for a specific tracer condition in which required elements were covered by the provider</p> <p><b>Denominator:</b> Total number of clinical service encounters assessed for a specific tracer condition</p> <p><b>Unit of measure:</b> Number of service encounters</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #77</p>
<p><b>Level of Measurement</b></p>	<p>Facility Subnational (facility aggregation)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Measuring adherence to practice guidelines is a measure of quality of care. Adherence to clinical guidelines improves patient outcomes. However, there is often a gap between clinical standards and actual provider practice. Examining adherence to clinical guidelines for a tracer set of commonly occurring diseases and conditions (services involving women and children and noncommunicable diseases) demonstrates if providers are providing health services according to standards. If providers have difficulty in meeting the clinical standards for these commonly presenting diseases and conditions, they will likely also have problems with other, less-common diseases.</p>
<p><b>Possible Adaptations</b></p>	<p>Clinical standards will need to be adapted for each country's national clinical protocols, including confirming which tracer conditions to be assessed, and whether all guidelines or a prioritized set of guidelines will be part of the measurement. Data sources (direct observation, clinical vignettes or extraction of records) will need to be customized by each country depending on resources available, availability of complete patient records, and other considerations.</p>

<p><b>Data Disaggregation</b></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>The chosen tracer conditions will need to be adapted based on data availability and country priorities.</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> <li>● Health worker cadre (if possible)</li> </ul>
<p><b>Data Source(s) and Data Collection Instruments</b></p>	<p><u>Monitoring for Change (whether a formal assessment of technical quality has occurred):</u> Facility Checklist</p> <p><u>Measuring for Impact (technical quality of services):</u> Many countries now have national quality directorates or monitoring and evaluation departments, which would be a preferred source of information.</p> <p>Ideally, countries should use existing sources. Possible sources can include:</p> <p>Patient-provider observation (<i>recommended if feasible</i>)</p> <p>Clinical vignettes (<i>recommended if feasible</i>)</p> <p>Register/record extraction</p> <p>Household surveys</p> <p>Exit surveys or other client surveys</p> <p>Facility Checklist can also be used if primary data collection is needed.</p>
<p><b>Method of data collection and construction</b></p>	<p><u>Monitoring for Change (whether a formal assessment of technical quality has occurred):</u> 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 use a checklist to indicate whether a formal assessment of technical/clinical quality of care has been conducted at the facility in the past 6 - 12 months. The interviewer should ask to see documentation (e.g., a report) to confirm the assessment has occurred.</p>

Once the data are collected, the indicator is calculated as a facility-level binary score: whether a formal assessment of technical/clinical quality has been conducted during the specified time period (yes/no).

Facility-level data will also be aggregated at the subnational level (i.e., district) to look at the breakdown of facilities conducting formal assessments of technical/clinical quality of care.

Measuring for Impact (technical quality of services): The indicator is typically measured through clinical vignettes (e.g., Service Delivery Indicators ) or direct observation (e.g., SPA, supportive supervision), though could alternatively be measured through exit interviews or record reviews or household surveys, or data could be extracted from a register or patient record (e.g., partograph for labor and delivery or sick child recording form for integrated management of childhood illness). As noted above, data should ideally be pulled from existing sources (e.g., recent assessment reports conducted through formal government processes).

If there is no existing data, data can be collected during a facility visit, ideally using existing country-specific assessment tools. 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.

The individual or team conducting the facility assessment will use a checklist to indicate whether clinical standards were met for the specific tracer service (e.g., relevant history and examination questions were asked by the health worker during a patient interaction or clinical vignette or recorded by the health worker in the patient records; the health care worker provided appropriate and relevant information; the health worker conducted a physical exam including appropriate/relevant clinical elements including diagnosis and treatment and follow-up instructions).

Once the data are collected, the indicator is calculated as a facility-level score: whether the health worker met none (0), some (1%–50%), most (51%–99%) or all of the clinical standards for the tracer condition. Score ranges for each category will need to be tailored for each specific tracer condition, depending on the number of clinical standards that it includes. For example, the indicator on “% ANC clients receiving minimal elements of physical examination and screening appropriate for ANC visit” includes 9 clinical standards (some of which are only relevant at the 1st ANC visit), so the scoring for the ANC1 indicator would be none (0), some (1–5), most (6–8), all (9).

Facility-level data will also be aggregated at the subnational level (i.e., district) to look at the range and average percentage of adherence to each of the clinical standards at facilities and by cadre.

<b>Data Collection and Reporting Frequency</b>	Monitoring for Change (whether a formal assessment of technical quality has occurred): Every 6 to 12 months  Measuring for Impact (technical quality of services): Early on and two-year review
<b>Data Quality Considerations</b>	To be updated in-country.  Household surveys and exit surveys may be subject to recall bias and social desirability bias. Record extraction is unlikely to capture something if it was done during a visit (relevant for labor and delivery) – clinical vignettes or patient-provider observations are recommended for data quality, but are resource-intensive; in some cases, direct observations will be invasive and potentially socially/ethically unacceptable.
<b>Data Use</b>	Policymakers and program managers should use these data to identify gaps in quality of care and feed into quality improvement and performance management to address identified gaps. Similarly, facilities which score high on quality can serve as positive outliers to share best practices for learning across facilities and more broadly. The goal is ensuring that health providers are following evidence-based guidelines and that patients are receiving safe, effective, and appropriate care.
<b>Other Notes, Discussion, and/or Comments</b>	<i>See also indicator OP9A for experiential quality (as measured through responsive and people-centered care)</i>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/7/2023</b>	



## OP12A

## OP12A: Facilities compliant with selected infection prevention and control (IPC) measures

**Measurement Category:** Monitoring for Change AND Measuring for Impact

**Domain:** Quality PHC

**Subdomain:** Safety

### Indicator OP12A: Facilities compliant with selected infection prevention and control (IPC) measures

#### Precise Definition

Degree to which PHC facilities meet standards for infection prevention and control (inadequate, basic, intermediate, advanced) based on selected high-priority core components of the [Infection Prevention and Control \(IPC\) Assessment Framework \(IPCAF\)](#). The indicator is a score for the facility. The selected components of the score are described below: IPC Guidelines present; water, sanitation and hygiene; and personal protective equipment availability.

- IPC guidelines
  - Evidence-based facility-adapted standard operating procedures (SOPs) based on the national IPC guidelines. (1 point)
  - Routine monitoring of the implementation of at least some of the IPC guidelines/SOPs. (1 point)
- IPC education and training
  - All front-line clinical staff and cleaners must receive education and training on the facility IPC guidelines/SOPs upon employment. (1 point)
- Built environment, materials, and equipment for IPC at the facility level
  - Water should always be available from a source on the premises. (1 point)
  - Functional and accessible, improved sanitation facilities should be available onsite equipped with menstrual hygiene facilities. (1 point)
  - Functional hand hygiene facilities should always be available at points of care/toilets and include soap and water, or alcohol-based hand rub. (1 point)
  - Clearly labeled bins to allow for health care waste segregation. (1 point)
  - IPC supplies and equipment for environmental cleaning (for example, mops, detergent, disinfectant, and sterilization equipment). (1 point)
  - Personal protective equipment (gloves, gowns, masks). (1 point)

Facilities are assessed with a checklist as inadequate, basic, intermediate or advanced IPC. (See Method of Data Collection below).

	<p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Facilities</p> <p><b>Data Type:</b> Score</p> <p><b>Adapted from:</b> <a href="#">PHC MFI</a> Indicator #69</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>Preventing harm to patients, health workers, and visitors due to infection in health care facilities is fundamental to achieve quality care, patient safety, health security, and the reduction of health care-associated infections and antimicrobial resistance.</p>
<b>Possible Adaptations</b>	<p>The IPC criteria stated above may need to be adapted to the national Ministry of Health IPC policies.</p> <p>If using the <a href="#">WHO IPC facility assessment framework</a> comprehensive tool, the scoring will be calculated according to this tool: At the facility level: each answer choice in the questionnaire is assigned a point value and summed at the end for each section. Score 0–200 is labeled as inadequate, 201–400 as basic, 401–600 as intermediate, and 601–800 as advanced.</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> </ul> <p>Variability across facilities</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Facility checklist (unless a recent HFA has been conducted, such as the <a href="#">HHFA</a>, <a href="#">DHS SPA</a>, <a href="#">World Bank Service Delivery Indicators</a>, or others, in which case data can be extracted for subnational areas)</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 the presence or absence of IPC measures at the facility that meet the criteria in the Precise Definition. Collecting these data will require making observations, talking with key point people, and verifying responses using documentation.</p> <p>Scores are unweighted sums of criteria points for criteria met. Facilities are classified as having inadequate (0–1 points), basic (2–4 points), intermediate (5–7 points) or advanced (8–9 points) IPC.</p> <p>Facility-level data will also be aggregated at the subnational level (i.e., district) to look at the percentage of facilities at that level that are (respectively) inadequate (0–2 points), basic (3–5 points), intermediate (6–7 points) or advanced (8–9 points) IPC measures. For further analysis and actionability, facility-level data can be aggregated separately for each criterion to look at the percentage of facilities that meet standards for IPC program, IPC guidelines, IPC education and training, etc.</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>This indicator can help facilities and managers identify areas of strength and weakness in IPC (when looking at data disaggregated by criterion) and implement strategies to improve IPC and overall performance. Facility and subnational estimates may help program managers identify geographic areas and IPC measures that require additional resource allocation to improve IPC within PHC services.</p>
<b>Other Notes, Discussion, and/or Comments</b>	
<b>Changes to indicator with date</b>	<p>To be completed in-country</p>
<p><b>This sheet was last updated on: 4/3/2023</b></p>	

## OP12B

## OP12B: Facilities conduct maternal, perinatal, and pediatric death audits

**Measurement Category:** Monitoring for Change

**Domain:** Quality PHC

**Subdomain:** Safety

## Indicator OP12B: Facilities conduct maternal, perinatal, and pediatric death audits

<p><b>Precise Definition</b></p>	<p>Facilities with any qualifying institutional deaths (maternal, perinatal or pediatric under 5 deaths) in the prior six months that conducted at least one audit of one of those deaths during that time frame.</p> <ul style="list-style-type: none"> <li>● Maternal death: women who die in the facility within six weeks of giving birth</li> <li>● Perinatal death: stillbirths and live births who die within 7 days of birth</li> <li>● Pediatric death: children under 5 who die in the facility</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 (binary)</p> <p><b>Adapted from:</b> MOMENTUM PIRS MNH.HFA.8</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (aggregated from facility)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Maternal, perinatal, and pediatric death audits by facilities are an indication of the extent to which facilities attempt to identify preventable factors contributing to deaths which can be addressed by the health system. Maternal, perinatal, and pediatric death audits are important because they can help identify underlying causes of deaths, improve the quality of care, enhance accountability, inform policy and practice, and facilitate communication and collaboration among health care workers. Audits should result in a plan of action that is implemented to prevent a further death, if feasible. Over time, the number of deaths should decline or stabilize and decrease amenable causes of mortality as a result of continuous improvements in care stimulated by these audits. (<a href="#">WHO HMIS RMNCAH guidance</a> 2019)</p>
<p><b>Possible Adaptations</b></p>	<p>Country standards may vary for which level of facilities should be doing maternal, perinatal and/or pediatric death audits.</p>

	The <a href="#">WHO HMIS guidance</a> also recommends calculating the percentage of maternal and perinatal deaths reviewed for each facility and district, so countries may decide to calculate this indicator in addition to or instead of the current indicator.
<b>Data Disaggregation</b>	Facility type (as relevant to context): including community health posts (staffed by salaried and supervised health care workers), PHC clinics (public and private), primary and/or district level hospitals. 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 (or alternatively can be extracted from national HMIS or other records)
<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 record whether the facility had any institutional deaths (maternal, perinatal and/or pediatric death) in the past six months, and if so, whether the facility conducted a maternal, perinatal, and/or pediatric death audit for the relevant group(s) during that time frame, as confirmed by documentation such as audit reports.</p> <p>Once the data are collected via checklist, the indicator is calculated as a facility-level binary indicator (Yes/No). If a facility had any institutional deaths (maternal, perinatal, and/or pediatric) in the past 6 months, the facility must have audited at least one of the institutional deaths (maternal, perinatal, and/or pediatric) that occurred in the past six months in order to be classified as “Yes.” A facility without any qualifying institutional deaths in the past six months will be classified as Not Applicable for this indicator.</p> <p>Facility-level data are then aggregated at the subnational level (i.e., district) to calculate the percentage of facilities with a qualifying institutional death that conducted a death audit in the previous six months.</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>	Program managers can use this indicator to measure the extent to which facilities are attempting to determine underlying causes of death, and therefore implement processes to improve the quality of maternal newborn and child health services at the facility level over time.
<b>Other Notes, Discussion, and/or Comments</b>	This indicator falls under the cross-concept of Quality, which is also covered in multiple other output indicators.
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/11/2023</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



	<ul style="list-style-type: none"> <li>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 <ul style="list-style-type: none"> <li>i. Consider: met needs for FP</li> </ul> </li> <li>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 <ul style="list-style-type: none"> <li>i. Consider: women delivering in a facility</li> </ul> </li> <li>c. Child immunization: Percentage of infants receiving three doses of diphtheria-tetanus-pertussis-containing vaccine <ul style="list-style-type: none"> <li>i. Consider: vaccination rate</li> </ul> </li> <li>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 <ul style="list-style-type: none"> <li>i. Consider: diarrhea incidence</li> </ul> </li> </ul> <p>2. Infectious diseases</p> <ul style="list-style-type: none"> <li>a. TB: Percentage of incident TB cases that are detected and initiated on treatment.</li> <li>b. HIV/AIDS: Percentage of adults and children living with HIV currently receiving antiretroviral therapy.</li> <li>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]. <ul style="list-style-type: none"> <li>i. Consider: % children with fever tested for malaria</li> </ul> </li> <li>d. Water, sanitation and hygiene: Percentage of population using at least basic sanitation services.</li> </ul> <p>3. Noncommunicable diseases</p> <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> </ul>
--	--

	<p>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>).</p> <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>
<b>Level of Measurement</b>	National Subnational
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<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 coverage of these tracer services as a reflection of the strength of PHC service coverage.</p>
<b>Other Notes, Discussion, and/or Comments</b>	<p>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.</p>
<b>Changes to indicator with date</b>	To be completed in-country

This sheet was last updated on: 4/7/2023

## OC2

## OC2: Effective service coverage: coverage of services delivered according to technical quality standards for tracer PHC functions

**Measurement Category:** Measuring for Impact

**Domain:** Effective and Equitable Coverage

**Subdomain:** Not Applicable

### Indicator OC2: Effective service coverage: coverage of services delivered according to technical quality standards for tracer PHC functions

<p><b>Precise Definition</b></p>	<p>Effective service coverage is defined as population-level <b>coverage of essential PHC services</b> (tracer interventions including reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases) <b>that are delivered in an evidence-based way and in adherence to established national technical quality standards</b> (Effectiveness). Effective service coverage rates are most useful when looked at separately for each specific service, but an overall average effective service coverage rate for essential PHC services can also be calculated.</p> <p><b>Numerator:</b> Number of people who have received a specific essential PHC service (for tracer condition) that meet technical quality standards</p> <p><b>Denominator:</b> Total population in need of the specific essential PHC service (i.e., those who are eligible for the services)</p> <p><b>Unit of measure:</b> Individuals</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted From:</b> <a href="#">Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019</a></p>
<p><b>Level of Measurement</b></p>	<p>National, Subnational if possible</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Effective coverage is important and needed, as mortality from poor quality services is now a greater problem than lack of access (Kruk et al). Effective service coverage reflects the recognition that services without quality will not achieve the gains needed for SDG 3. There is increased global interest in using effective coverage for universal health coverage monitoring.</p>
<p><b>Possible Adaptations</b></p>	<p>Data sources and specific tracer services should be customized by country depending on existing data sources and standard operating procedures.</p> <p>Countries may already have data from household surveys which focus on tracer conditions (reproductive, maternal, newborn and child health). Countries may also be using modeled estimates of an Effective Service Coverage Index (<a href="#">Lancet article</a>). This approach uses estimates and imputed data using 23 effective coverage</p>

	<p>indicators across five health service domains (promotion, prevention, treatment, rehabilitation and palliation) and five population-based age groups (i.e., reproductive and newborn, children &lt;5 years, children and adolescents aged 5–19 years, adults aged 20–64 years, and adults aged ≥65 years).</p> <p>Other sources may be emerging or already existing as countries invest in measuring quality and coverage (phone surveys for example)</p>
<b>Data Disaggregation</b>	Sex, age, service as available, subnational/geography as feasible
<b>Data Source(s) and Data Collection Instruments</b>	Demographic and Health Surveys, Multiple Indicator Cluster Surveys, Countdown to 2030 or other population-based surveys
<b>Method of data collection and construction</b>	<p>The goal is for countries to leverage existing data or other sources for this indicator, using national-level data and disaggregating at subnational level where possible. Effective service coverage is measured separately for each specific area of care delivery, and is typically done through household surveys assessing self-reported receipt of the service that meets key technical quality standards. For example, women with a pregnancy in the last three years are asked whether they attended antenatal care (ANC) and if so, whether the recommended elements of ANC were received (did the provider measure blood pressure, take urine and blood samples, listen to the baby's heartbeat, etc.). Effective service coverage for ANC is then calculated as the percentage of women with a pregnancy in the past three years receiving recommended services during ANC visit. See <a href="#">Colombia VSP</a> for examples of other effective service coverage indicators for specific tracer services.</p>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	This indicator is limited by the availability and quality of data on health service coverage and on the quality of those services. Data may be missing or unreliable, particularly for denominators at the subnational level.
<b>Data Use</b>	The data will be used to understand the extent to which populations are receiving effective PHC services, i.e., services that are of sufficient technical quality to make a difference in health outcomes, and where gaps in effective service coverage may exist.
<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: 4/11/2023</b>	

## OC3

## OC3: Disaggregated service utilization data for FP, MNHC, TB, HIV, Malaria

**Measurement Category:** Monitoring for Change

**Domain:** Effective and Equitable Coverage

**Subdomain:** Not Applicable

**Indicator OC3: Disaggregated service utilization data for Family Planning (FP), Maternal, Newborn and Child Health (MNHC), Tuberculosis (TB), HIV, Malaria**

**Precise Definition**

Service utilization data (receipt of services) for FP, MNCH, TB, HIV, and Malaria, disaggregated by age, sex or key populations can be examined for specific demographic inequities in accessing or receiving PHC services, **when compared to the anticipated/expected service uptake for these sub-populations.** For example, if the number of adolescents receiving FP services is typically in a standard range (e.g., 500 per every 6 to 12 months) but is considerably lower during a specified time period (e.g., 100 per the last 6 to 12 months), that might be an indication of an equity gap for the sub-population of adolescents.

*Note: this indicator does NOT measure equity gaps in service coverage at a population level (that concept is measured separately in indicator IMP1B – Reduction in equity gaps in service coverage).*

Countries can obtain and examine disaggregated service uptake data from existing reports that are already routinely submitted, such as data for USAID PPR indicators and PEPFAR (U.S. President’s Emergency Plan for AIDS Relief). Countries can examine disaggregated data for a core set of service utilization indicators that align most closely with their priority service areas, especially service areas where there may be existing concerns about equity gaps in utilization. An illustrative list of service delivery indicators below has been adopted from the [US Government Foreign Assistance Standard Indicators](#), [WHO guidance for RMNCAH facility data](#) and [malaria facility data](#), [PEPFAR MER Indicators](#), and [PMI Reporting Plan](#). (see country adaptations). U.S. government (USG) standard indicators are identified by their indicator number/name).

- Number of FP visits, disaggregated by age, urban/rural (where possible).
- Number of ANC 1 during the first trimester, disaggregated by women’s age, urban/rural (where possible).
- Number of ANC 4 visits, disaggregated by woman’s age, urban/rural (where possible).
- Number of children who received their first dose of measles-containing vaccine (MCV1) by 12 months of age (**USAID HL.6.4-2**), disaggregated by child’s sex, urban/rural (where possible).
- Number of cases of child diarrhea treated in USG-supported programs (**USAID HL.6.6-1**), disaggregated by child’s sex, urban/rural (where possible).



	<ul style="list-style-type: none"> <li>● TB detection rate: Number of new and relapse TB cases (and cases with unknown previous TB treatment history) that were reported in the last year (<i>USAID HL.2.1-6</i>), disaggregated by sex, age, people living with HIV (PLHIV), where possible.</li> <li>● Number of individuals who received HIV Testing Services (HTS) and received their test results (<i>PEPFAR HTS_TEST</i>), disaggregated by sex, age, key populations where possible.</li> <li>● Number of adults and children living with HIV currently receiving antiretroviral therapy (ART) (<i>PEPFAR TX_CURR</i>), disaggregated by sex, age, key populations where possible.</li> <li>● Number of malaria cases treated with first line antimalarial/artemisinin-based combination therapy, disaggregated by sex, age, urban/rural (where possible).</li> </ul> <p><b>Unit of measure:</b> Patients/clients—count of individuals from each sub-population receiving the specific service(s)</p> <p><b>Data Type:</b> Service statistics</p> <p><b>Adapted from:</b> <a href="#">US Government Foreign Assistance Standard Indicators</a>, <a href="#">WHO guidance for RMNCAH facility data</a> and <a href="#">malaria facility data</a>, <a href="#">PEPFAR MER Indicators</a>, and <a href="#">PMI Reporting Plan</a></p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p>
<p><b>Rationale</b> (and any Link to Foreign Assistance Framework)</p>	<p>PHC service delivery statistics are important to monitor for several reasons. PHC statistics can help measure the <i>access</i> of people to health care services, a critical component of achieving universal health coverage. They can help identify the <i>types of services people are using and how often they are using them and the distribution of service use by demographics of recipients</i>. By understanding where gaps in service uptake exist across demographic groups, policymakers and program managers can use these data to allocate resources to areas where they are most needed. By disaggregating utilization of services by sex, age or key populations at the patient level and facility type and geography at the subnational or national level, program managers and health workers can identify avoidable, unfair or remediable differences (inequities) among groups of people for access to or delivery of needed services across the PHC continuum (promotion, prevention, diagnosis, and curative) of services. Note that some of these analyses of equity in service utilization is only possible if comparing to expected numbers for service uptake—e.g., program managers expected 1,000 children under 5 to receive treatment for diarrhea and only 500 children under 5 actually received this service.</p>
<p><b>Possible Adaptations</b></p>	<p>Countries should select the most pertinent service delivery indicators and disaggregation categories for their PHC programs and those available in their routine</p>

	<p>health information systems. While noncommunicable diseases are not explicitly included, countries should consider including as guidance emerges.</p> <p>Results and trends for the disaggregated service utilization indicators will need to be interpreted within each country's epidemiological and demographic context as well as seasonal variation if timing of measurement changes.</p>
<b>Data Disaggregation</b>	<p><u>For facility and subnational levels:</u> specified above in precise definition for each service area: age, sex, key populations when looking at services directed for PLHIV</p> <p><u>For subnational levels:</u></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>Sector (public/private)</p> <p>Urban/rural</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>In most cases, these data will be extracted from existing information systems or reports. Existing data sources and reports should be identified to avoid as possible new data extraction and compilation unless new priority areas are identified where this work is needed.</p> <ol style="list-style-type: none"> <li>1. <u>Subnational and facility level:</u> In most cases, this indicator should be compiled/extracted from existing reports of data that are compiled within the national health management information system (HMIS) and/or other information systems, such as DATIM (Data for Accountability, Transparency and Impact) or TB program databases. Within these information systems, the appropriate indicator/data elements, geographic area or facility, disaggregation and time period should be selected as feasible and the data extracted. Health authorities at the subnational level are usually in the best position to extract and share these data. When often facility data are only reported in aggregate, additional work may be needed if disaggregation is the goal.</li> <li>2. <u>Subnational level:</u> These data can also be extracted from quarterly, biannual or annual reports, such as the national health "statistics" report, implementing partner reports, etc. for subnational units. However, these reports often do not provide all the recommended disaggregation and do not include facility-level data.</li> <li>3. <u>Facility level:</u> In cases where these data or selected indicators are not available through electronic information systems, they can be extracted from paper registers or service delivery summary reports at the facility level during a facility visit using a register extraction form. Archived paper service delivery summary reports including the indicators above for each facility may be available at the subnational level and the data could be extracted from these reports for each facility at the subnational level.</li> </ol>

<b>Method of data collection and construction</b>	<p>As noted above, in most cases these data will be drawn from existing reporting for USAID PPR indicators, PEPFAR, etc. If data are not available through existing sources, the data can be collected during a facility visit by asking to see paper registers or summary reports.</p> <p>An individual or team will be responsible for collating the data from the HMIS, other information systems, and/or existing reports and/or extracting from registers or summary reports for the facilities and subnational level (aggregated data from the facilities in that subnational unit). Ideally data will be available for a census of facilities, but can also use a representative sample of facilities to follow over time.</p> <p>Any comparisons of count indicators between facilities and subnational units should be standardized per the estimated population in the facility or subnational catchment area as well as by season of collection and reporting.</p>
<b>Data Collection and Reporting Frequency</b>	Every 6 to 12 months, depending on country context (reporting frequency for indicators varies as noted above in “Method of data collection and construction”). Depending on the country context, the disaggregated indicators can be examined monthly, quarterly, biannually or annually and compared over time within each facility or subnational unit.
<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	This indicator may help identify inequities in receiving services among specific sub-populations (i.e., adolescents, key populations for HIV). Policymakers and program managers can use these data to ensure that health services are equity-oriented, where additional strategies are needed and all groups of people have equal access to or delivery of needed services across the PHC spectrum.
<b>Other Notes, Discussion, and/or Comments</b>	Note that equity gaps in <b>service coverage</b> at a population level are assessed separately in indicator IMP1B (Reduction in equity gap in service coverage).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/24/2023</b>	

## OC4

## OC4: Financial protection from catastrophic expenditure

**Measurement Category:** Measuring for Impact

**Domain:** Effective and Equitable Coverage

**Subdomain:** Not Applicable

## Indicator OC4: Financial protection from catastrophic expenditure

<p><b>Precise Definition</b></p>	<p><b>National level</b></p> <p>Proportion of the population with large household expenditure on health as a share of total household expenditure or income. Two thresholds are used to define “large household expenditure on health”: greater than 10% and greater than 25% of total household expenditure or income.</p> <p>Household expenditure on health is defined as any expenditure (formal or informal) incurred at the time-of-service use to get any type of care (promotive, preventive, curative, rehabilitative, palliative or long-term) including all medicines, vaccines, and other pharmaceutical preparations as well as all health products, from any type of provider and for all members of the household. These payments include the part not covered by a third party, such as the government, health insurance fund or private insurance but exclude insurance premiums as well as any reimbursement by a third party. They might be financed by income, including remittance, savings or borrowings. With this definition, health expenditures are labeled out-of-pocket payments in the classification of health care financing schemes of the international Classification for Health Accounts.</p> <p>Total household consumption expenditure is generally defined as the sum of the monetary values of all items consumed by the household on domestic account during a reference period. It includes monetary expenditures on food and non-food non-durable goods and services consumed as well as the imputed values of goods and services that are not purchased but procured otherwise for consumption (value of in-kind consumption), the value use of durables, and the value use of owner-occupied housing.</p> <p><b>Numerator:</b> Household expenditure on health &gt;10% and &gt;25% of total household expenditure</p> <p><b>Denominator:</b> Total household consumption expenditure or, when unavailable, income</p> <p><b>Unit of measure:</b> Household expenditure</p> <p><b>Data Type:</b> Percentage of households above the threshold in spending</p> <p><b>Adapted from:</b> <a href="#">WHO GHO/SDG 3.8.2</a></p>
<p><b>Level of Measurement</b></p>	<p>National</p>

<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Financial protection is at the core of universal health coverage and one of the final coverage goals. The concern is with all people and communities receiving the quality health services they need (including medicines and other health products), without financial hardship. Financial hardship is a key consequence of inadequate financial risk protection mechanisms and can be experienced in any country, regardless of the income level and type of health system. Health financing policy directly affects financial protection. Reducing financial hardship in health is important on the global development agenda as well as a priority of the health sector of many countries across all regions. Per <a href="#">WHO GHO</a>: Health expenditures are likely to expose households to financial hardship in particular when they exceed a predefined threshold of a household's ability to pay; when this happens, they are characterized as being catastrophic. Within the SDG monitoring framework (SDG indicator 3.8.2), the proportion of the population facing catastrophic expenditures is measured as the population weighted average of the number of households with “large household expenditures on health” as a share of total household expenditure or income (household’s budget).</p>
<b>Possible Adaptations</b>	<p>None</p>
<b>Data Disaggregation</b>	<p>10% vs. 25% out-of-pocket expenditure  Age composition of household  Gender composition of household  Urban/rural  Quintiles of the household welfare measures  Subnational (if feasible)</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources include the following:</b>  <a href="#">WHO/SDG GHO</a></p> <p>This indicator is calculated from population-based health surveys with a module on household expenditures, such as household budget surveys, household income and expenditure surveys, and household socioeconomic and living standards surveys.</p>
<b>Method of data collection and construction</b>	<p>Countries should locate existing estimates for this indicator from the data sources identified above.</p>
<b>Data Collection and Reporting Frequency</b>	<p>Early on and two-year review</p>

<b>Data Quality Considerations</b>	To be considered in-country
<b>Data Use</b>	Policymakers and program managers are able to identify areas of financial vulnerability and develop strategies to mitigate the impact of catastrophic health care costs on individuals and families. This indicator along with other health care spending data can inform development of mechanisms and strategies to ensure access to affordable and quality health care for all.
<b>Other Notes, Discussion, and/or Comments</b>	Two thresholds are used for global reporting to identify large household expenditure on health as share of total household consumption or income: a lower threshold of 10% (3.8.2_10) and a higher threshold of 25% (3.8.2_25). With these two thresholds the indicator measures financial hardship ( <a href="#">see section on comments and limitations</a> ).
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/8/2023</b>	

## OC5

## OC5: Financial risk protection, including PHC

**Measurement Category:** PHC Foundations

**Domain:** UHC Financial Protection

**Subdomain:** Not Applicable

## Indicator OC5: Financial risk protection, including PHC

<p><b>Precise Definition</b></p>	<p>Percentage of population enrolled in USAID-supported financial protection schemes in areas of the country receiving USAID financial or technical assistance.</p> <p><u>A financial protection scheme</u>, such as health insurance, is a public or private prepaid risk pooled health financing scheme designed to limit the risk of high health out-of-pocket (OOP) expenditures that can push people into poverty.</p> <p><u>USAID support provided either through financial or technical assistance</u> (or both) in the design or implementation of risk protection schemes.</p> <p><u>USAID-supported areas</u> are those areas where USAID is supporting other health projects. If the assistance is at the national level and USAID-supported areas could not be identified, then use the national population.</p> <p><b>Numerator:</b> Number of people enrolled in financial protection schemes in geographic areas that USAID supports with technical or financial assistance</p> <p><b>Denominator:</b> Total population in USAID supported area(s)</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="#">USAID HIRS</a></p>
<p><b>Level of Measurement</b></p>	<p>Subnational (if data allows); national</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>USAID's Office of Health Systems (OHS) promotes financial risk protection schemes, such as health insurance, to reduce high OOP expenditures that can push people into poverty or further into poverty. The purpose of financial risk protection is to reduce financial barriers in access to health care when people need it and is linked to improving equity by shrinking health disparities between people in the lowest and highest wealth quintiles. Reducing financial barriers to access should increase utilization of preventive services and enable people to seek early treatment, which leads to better health outcomes and health status and reduces overall costs of health care.</p>
<p><b>Possible Adaptations</b></p>	<p>None</p>

<b>Data Disaggregation</b>	Not Applicable
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources include the following:</b></p> <p><u>Numerator:</u> USAID administrative/program records</p> <p><u>Denominator:</u> Estimated population in USAID-supported areas from the national DHIS2/Health Management Information System (HMIS) or government projections</p> <p>If administrative records are not reliable or available, a household survey in USAID-supported areas could estimate this percentage.</p>
<b>Method of data collection and construction</b>	<p><u>Numerator:</u> Count the number of people enrolled in financial protection schemes in geographic areas that USAID supports with technical or financial assistance (Source: administrative records from risk protection schemes)</p> <p><u>Denominator:</u> Total estimated population in USAID supported area(s) from census projections (can usually be extracted from the DHIS2/HMIS for sub-national areas) or population estimate from most recent census</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>	<p>This indicator can be used to:</p> <ul style="list-style-type: none"> <li>● Assess USAID's support to improving access to care, reducing OOP expenditures and reducing health disparities among social groups.</li> <li>● Monitor government's commitment and efforts to reduce financial barriers to reduce access to health services for poor, marginalized, and vulnerable populations and contribute to universal health care.</li> <li>● Monitor progress towards sustainability by contributing to increased commitment of inclusive development (gender and health equity) and increased capacity (government effectiveness, private sector, and civil society involvement).</li> <li>● Develop recommendations for adaptive management.</li> <li>● Facilitate USAID reporting.</li> </ul>
<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: 4/7/2023</b>	

## OC6

## OC6: Existence of health emergency management plans/protocols

**Measurement Category:** Monitoring for Change

**Domain:** Health Security

**Subdomain:** Not Applicable

## Indicator OC6: Existence of health emergency management plans/protocols

## Precise Definition

## National Level

## Extent of planning for health emergencies:

- **Level 1:** All-hazard risk informed health emergency plan is not available or under development
- **Level 2:** All-hazard risk informed health emergency plan is developed but not being implemented
- **Level 3:** All-hazard risk informed health emergency plan is developed and being implemented at the national level
- **Level 4:** All-hazard risk informed health emergency plan is developed and being implemented at the national and intermediate levels
- **Level 5:** All-hazard risk informed health emergency plan is developed and being implemented at national, intermediate and local levels and exercised, reviewed, evaluated, and updated, with improvements based on [Simulation Exercise Manual \(SimEx\)](#) and lessons learned from real-world events, e.g., [Intra-Action Reviews \(IARs\)](#) or [After Action Reviews \(AARs\)](#)

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Level of planning for health emergency management

**Data Type:** Score (1–5)

**Adapted from:** [IHR SPAR Tool](#) Indicator C7.1

## Subnational Level

Subnational unit has an emergency response plan that includes the following (1 point each):

- A risk assessment section with risk prioritization and description of main risk scenario/impact (to be used for planning assumptions).
- A resource/capacity section (both health facility and catchment area).
- Continuity plan(s) for essential services describing any changes in service delivery modalities and resources needed.

	<ul style="list-style-type: none"> <li>• Response plan(s) for surge in health needs, describing coordination mechanisms, specific activities, logistics, communication, etc.</li> <li>• An action plan for overcoming identified deficiencies and resource gaps for continuity and response.</li> <li>• A response communication coordination matrix (e.g., a plan for informational communication during emergencies among stakeholders).</li> </ul> <p>Subnational units are assessed with a checklist as having none, some, most or all elements for a facility emergency preparedness plan (see Method of Data Collection).</p> <p><b>Facility Level</b></p> <p><b>Extent of emergency preparedness planning at facility level.</b> Facility has a written emergency preparedness plan for health emergencies, like outbreaks of Ebola, meningitis, SARS, COVID-19, cholera, etc.</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> MOMENTUM Integrated Health Resilience</p>
<p><b>Level of Measurement</b></p>	<p>Facility</p> <p>Subnational (facility aggregation)</p> <p>National (from IHR SPAR)</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>Ensuring risk-based plans for emergency preparedness and response at the facility and national levels, as well as robust emergency management structures and mobilization of resources during an emergency are critical for a timely response to public health emergencies.</p> <p><a href="#">WHO guidance on preparing for national response to health emergencies and disasters</a>: A <b>national health emergency response</b> is based on the emergency and disaster country risk profile and builds on existing capacity development plans, including the National Action Plan for Health Security, focusing on an all-hazards approach. This alludes to the recognition that there are common elements and common capacities required in the management of risks and in the responses to virtually all types of emergencies.</p> <p>According to International Health Regulations (IHR)/State Party Self-Assessment Annual Reporting Tool (SPAR), health emergency risk profiles should be based on a strategic multisectoral and multi-hazard health emergency risk assessment and updated on a regular basis. A health emergency plan is defined as a plan for coordinating emergency preparedness measures, which includes multisectoral, multi-hazard emergency response plans, contingency plans, and business continuity</p>

	plans for specific hazards or risk scenarios. Plans should be multisectoral, multidisciplinary, and interoperable. These plans should be linked to a hazard-specific plan, such as for chemical events or radiation emergencies. There should be a chemical/radiation event response plan describing procedures, roles, responsibilities, and requirements to ensure an adequate response to a chemical release with the aim of minimizing the impact of the release on human health and the environment.
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	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)  Subnational  Urban/rural
<b>Data Source(s) and Data Collection Instruments</b>	<b>National level:</b> <a href="#">IHR SPAR tool</a> <b>Subnational level:</b> Subnational Capacity and Performance Checklist <b>Facility level:</b> Facility checklist
<b>Method of data collection and construction</b>	<b>National:</b> All countries are required to complete IHR/SPAR and these results should be used for this indicator. Based on the descriptions of each maturity level, countries will select the one which reflects their level of health emergency management planning.  <b>Subnational:</b> 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. 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 emergency management plans and protocols. An individual or team will be responsible for collecting and collating the data necessary to complete the measure as guided by the 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 score: whether the subnational unit meets none (0 points), some (1-3 points), most (4-5 points), or all (6 points) elements for a health emergency management plan/protocol as specified in the precise definition.  <b>Facility:</b> 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

	<p>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 facility checklist to record whether the facility has an emergency preparedness plan. Once the data are collected, the indicator is calculated as a binary facility-level score (yes/no).</p> <p>Facility-level data will be aggregated to look at the percentage of facilities in the subnational area that have emergency preparedness plans.</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>	This indicator allows policymakers and program managers to identify gaps which need to be addressed and make decisions and mobilize resources towards being prepared and operationally ready for response to any public health event.
<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: 4/8/2023</b>	

## OC7

## OC7: Sum of SPAR Capacity Scores for USAID-supported technical areas

**Measurement Category:** PHC Foundations

**Domain:** Health Security

**Subdomain:** Not Applicable

## Indicator OC7: Sum of SPAR Capacity Scores for USAID-supported technical areas

<p><b>Precise Definition</b></p>	<p><b>National level</b></p> <p>The State Party Self-Assessment Annual Reporting Tool (SPAR) is an annual assessment of capacities needed to implement the International Health Regulations (IHR) (2005). The World Health Organization (WHO) compiles the annual scores in a <a href="#">publicly available website</a> (WHO SPAR).</p> <p>USAID-supported technical areas: The technical areas targeted with USAID support include: Laboratory, Surveillance, Health Emergency Management, Antimicrobial Resistance (including Infection Prevention and Control), Risk Communications and Community Engagement, and Zoonotic Diseases. All USAID Missions must report the Zoonotic Disease score, and USAID Missions should report scores for each additional USAID-supported technical area for which activities are implemented; USAID Missions and implementing partners should list Not Applicable for technical areas that are not supported by USAID.</p> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Capacity level</p> <p><b>Data Type:</b> Integer</p> <p><b>Adapted from:</b> <a href="#">e-SPAR</a> (not modified)</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>Countries should have the ability to prepare for, prevent, identify, conduct risk assessment for, and report health concerns at the human-animal-environment interface. Mechanisms and documented procedures among all relevant sectors, particularly those responsible for human, animal (livestock, pets, wild animals), and environmental health should be in place to ensure operational coordination in preparedness, planning, surveillance, and response to zoonotic diseases and other health events existing or emerging at the human-animal-environment interface.</p> <p>Laboratory mechanisms are critical to surveillance, preparedness, and response. Mechanisms to ensure a functioning laboratory process and system should be maintained. A sensitive surveillance system is needed to ensure early warning</p>

	<p>function and to provide information for an informed decision-making process during public health events.</p> <p>Ensuring risk-based plans for emergency preparedness and response, robust emergency management structures, and mobilization of resources during an emergency is critical for a timely response to public health emergencies.</p> <p>Strong, effective Infection Prevention and Control (IPC) programs allow safe health care and essential services delivery and prevention and control of outbreaks throughout the health system. It is critical to initially ensure that at least the minimum requirements for IPC are in place, at both the national and facility level, and to gradually progress to the full achievement of all requirements within the World Health Organization (WHO) IPC core components recommendations.</p> <p>Risk Communications and Community Engagement (RCCE) have proven to be vital in all public health emergencies. Its ultimate purpose is that everyone at risk is able to make informed decisions to mitigate the effects of the threat and take protective and preventive action.</p>
<b>Possible Adaptations</b>	None recommended
<b>Data Disaggregation</b>	Technical area: Zoonotic; Laboratory (if applicable); Surveillance (if applicable); Health Emergency Management (if applicable); IPC (Antimicrobial Resistance) (if applicable); RCCE (if applicable)
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources include the following:</b></p> <p><a href="#">WHO IHR SPAR reporting</a></p>
<b>Method of data collection and construction</b>	Each USAID-supported technical area score should be calculated, then be summed together and entered as one score. For technical areas with more than one indicator, the average value for that technical area should be calculated to determine the overall score for that technical area. The value entered should be the sum of these four scores. The range for each SPAR technical area is 1–5 and total summed score cannot exceed 30.
<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 allows policymakers and program managers to understand the current state of USAID-supported activities (proactive and reactive) to minimize the danger and impact of acute public health events that endanger people’s health across geographical regions. These measures are relevant to the role of PHC in ensuring health security. This indicator will track capacity scores specific to the emergency preparedness for zoonotic events technical area as well as other technical areas prioritized by Mission investments, and will be used to track improvements 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: 4/10/2023</b>	



# IMPACTS

## IMP1A

### IMP1A: Level of disruption in essential health services

**Measurement Category:** Measuring for Impact

**Domain:** Equitable and Resilient Health Systems

**Subdomain:** Not Applicable

#### Indicator IMP1A: Level of disruption in essential health services

##### Precise Definition

##### Subnational level—disruption of essential health services

Level of disruption in essential PHC service areas is rated on a 3-point ordinal scale (1: Completely disrupted / Suspended; 2: Partially disrupted (Limited access); 3: Not disrupted (functioning as normal)) for the most recent shock or stress experienced, among facilities in an area experiencing a shock or stress in the previous six months or year (as relevant to context).

Stressors or shocks may include:

- Natural disasters (like floods, fires, earthquakes, volcanic eruptions, tsunamis, droughts).
- Pandemics/outbreaks of infectious diseases (such as COVID-19, measles, cholera or VD-polio).
- Conflict (intercommunal and internal anti-government, ethnic violence).
- Population displacement.
- Protests or strikes, including of health workers.
- General strikes or protests.
- Insecurity (such as post-election violence, terrorism, violent extremism, civil conflict).
- Economic shocks (such as price shocks/spikes).
- Currency devaluation or economic recession).
- Shocks to food supply (such as locusts or livestock disease outbreaks).

Disruption to essential PHC services (or on the flip side, Maintenance of Essential Health Services) during stresses or shocks is measured at the **subnational level** as follows: (Adapted from the [WHO COVID Pulse Survey](#))

1. For the most recent shock experienced in the area in the past 1–2 years: Which of the following services were disrupted due to the shock, and to what extent were they disrupted? For each service: 1=Completely disrupted/ Suspended; 2=Partially disrupted (Limited access); 3=Not disrupted (Functioning as normal)
  - a. Family planning and contraception

- b. Antenatal care
- c. Facility based births
- d. Routine immunization services in health facilities
- e. Routine outreach immunization services
- f. Sick child services
- g. Management of moderate and severe malnutrition
- h. Outbreak detection and control (for non-COVID diseases)
- i. Continuation of established antiretroviral treatment
- j. Tuberculosis case detection and treatment
- k. Malaria diagnosis and treatment
- l. Implementation of planned campaigns for distribution of insecticide treated nets
- m. Implementation of planned preventive campaigns, e.g., for indoor residual spraying or seasonal malaria chemoprevention campaigns
- n. Noncommunicable disease diagnosis and treatment (e.g., hypertension, diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease)
- o. Treatment for mental health disorders
- p. Cancer diagnosis
- q. 24-hour emergency room/unit services
- r. Access to surgery for essential services

**Numerator:** Not Applicable

**Denominator:** Not Applicable

**Unit of measure:** Level of service disruption

**Data Type:** Subnational score (ordinal)

**Adapted from:** [WHO Pulse Survey](#)

### National level—Policies for maintaining essential services during shocks

This is measured as the presence of policies at the national level to ensure maintenance of essential health services during a shock or stressor. Even if these policies are not being implemented during shocks, it is helpful to know whether the policies exist or not. This indicator is measured as follows: (Adapted from the WHO Covid Pulse Survey)

2. During the shock, are there government policies for maintaining the following? (1 point for each policy in place)
  - a. Outpatient services (1 point)
  - b. Inpatient services (1 point)

	<ul style="list-style-type: none"> <li>c. Emergency unit services (1 point)</li> <li>d. Prehospital emergency care services (e.g., ambulance transport) (1 point)</li> <li>e. Community based care (1 point)</li> <li>f. Mobile clinics (1 point)</li> </ul> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Number of policies</p> <p><b>Data Type:</b> National score</p> <p><b>Adapted from:</b> <a href="#">WHO Pulse Survey</a></p>
<b>Level of Measurement</b>	<p><b>Service disruption:</b> Subnational, National (subnational aggregation)</p> <p><b>Policies:</b> National</p>
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Equitable and resilient health systems are needed to be able to provide quality services before, during, and aftershocks to ensure healthy lives and promote well-being for all at all ages. Tracking access to essential health services during shocks and stresses is critical in order to achieve the optimal balance.
<b>Possible Adaptations</b>	Countries may adapt the list of shocks/stressors as well as service delivery settings and tracer service areas as appropriate.
<b>Data Disaggregation</b>	<p>Service delivery setting</p> <p>Tracer service area</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>Subnational Checklist (or <a href="#">WHO Pulse Survey</a> if further rounds are conducted but this is not currently planned)</p> <p>and</p> <p>National Checklist</p>
<b>Method of data collection and construction</b>	<b>Service disruption (subnational):</b> 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. These 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 disruption to services in the subnational area, as well as documentation of service disruption. An individual or

	<p>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 question is rated on Likert scale (1 being completely disrupted and 3 being not disrupted) with an option for don't know.</p> <p>Once the data are collected via the tool, the indicator is calculated as an unweighted mean score (ranging from 1.0 to 3.0) for service disruption in the subnational area. Subnational areas service disruption during the most recent shock / stressor is classified as little or no disruption—functioning as normal (2.5–3.0), moderately disrupted—limited access (1.5–2.4) or completely disrupted/suspended (1.0–1.4). “Do not know” answers are unscored and are not included in the average. If a subnational area has not experienced any shocks or stressors during the specified time period, this indicator cannot be calculated for that subnational area.</p> <p><b>Policies (national)</b> for maintaining essential health services: Data collection will be carried out using the National Capacity and Performance Checklist, which is designed for this initiative and largely draws from existing data sources and indicators with adaptations as relevant. These data will be collected via document review and/or key informant interview/survey as relevant to country context as part of the National Capacity and Performance Checklist. Potential sources of information for this measure include key informants who are knowledgeable about policies for maintaining essential services, as well as policy documents. An individual or team will be responsible for collecting and collating the data necessary to complete the measure as guided by the National Capacity and Performance Checklist. 1 point is awarded per policy in place, and the country is assessed as having none (0), some (1–3), most (4–5) or all (6) key policies in place for maintaining essential health services.</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 allows policymakers and program managers to understand the readiness (policies) and resilience of essential health services to the impact of different stresses and shocks, recover services, and strengthen health service resilience over time. It can support decision-makers in systematically taking stock of organization and resilience of essential services and flagging common issues to be addressed as workforce task-shifting, resource allocation, and supply chains are diverted or burdened to respond to the current shock or strengthen preparedness to future events.
<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: 4/24/2023</b>	

## IMP1B

## IMP1B: Equity gaps for selected PHC coverage

**Measurement Category:** Measuring for Impact

**Domain:** Equitable and Resilient Health Systems

**Subdomain:** Not Applicable

## Indicator IMP1B: Equity gaps for selected PHC coverage

**Precise Definition**

An equity gap in PHC coverage is defined as differential/inequitable coverage of essential PHC services among specific sub-groups. Equity gaps are measured for specific tracer conditions, with examples shown below from [Countdown 2030](#). Countries will need to choose which tracer services to include, based on country priorities and data availability as well as disease burden/epidemiology. Examples include:

- Demand for family planning satisfied with modern contraceptive methods.
- Antenatal care (four or more visits).
- Institutional delivery.
- Postnatal care for all babies.
- Postnatal checkup for mother.
- DPT3 immunization coverage.
- Oral rehydration salts for children under 5 with diarrhea.
- Care-seeking for children under 5 with suspected pneumonia.
- Treatment of children with fever by antimalarial medicines.
- Use of intermittent preventive treatment by women during pregnancy.
- Composite coverage index 2030: Weighted average of the coverage of eight interventions: (1) family planning coverage with modern methods; (2) skilled birth attendant; (3) at least four antenatal care visits by a skilled provider; (4) BCG vaccination; (5) three DTP vaccinations; (6) measles vaccination; (7) Oral rehydration salts therapy for infant diarrhea; and (8) care-seeking for childhood pneumonia.
- HIV 90–90–90 cascade: Individuals with HIV know their diagnosis, are on treatment, and achieve suppression of their virus.
- Tuberculosis indicators: diagnosis and successful treatment.
- Hypertension cascade, i.e., patients with hypertension are treatment, have blood pressure controlled.

Equity stratifiers include the following examples from [Countdown 2030](#):

- Wealth quintiles.
- Woman's age / maternal age.

	<ul style="list-style-type: none"> <li>• Woman’s education / maternal education.</li> <li>• Geographic area (urban/rural residence) or subnational unit.</li> <li>• Region of the country.</li> <li>• Sex of the child (for relevant services).</li> </ul> <p><b>Numerator:</b> Not Applicable</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Individuals</p> <p><b>Data Type:</b> Absolute rate difference</p> <p><b>Adapted from:</b> <a href="#">Countdown 2030</a></p>
<b>Level of Measurement</b>	National, Subnational if possible
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Progress towards universal health coverage for populations across the lifespan must be assessed not only in terms of national averages, but also on how well such gains benefit all subgroups living in a country. National averages can hide persistent inequities that need to be addressed. In recognition of the importance of equity for overall country progress, the Sustainable Development Goal (SDG) target 17.18 calls for the disaggregation of national statistics according to income, gender, place of residence, ethnicity, and other relevant variables. Disaggregated analyses of service coverage are important for ethical and practical reasons. Such analyses help identify which populations are being left behind—information that countries can use to design better and more inclusive policies and programs.
<b>Possible Adaptations</b>	Specific indicators and stratifiers should be adapted depending on country priorities and data availability.
<b>Data Disaggregation</b>	Countries should compare equity gaps based on the different strata for a component of care (i.e., compare the wealth gaps vs the geographic-area gap for ANC4 coverage), and equity gaps across components of care within a specific stratification (e.g., wealth gap for ANC4 coverage vs. wealth gap for DPT3 coverage).
<b>Data Source(s) and Data Collection Instruments</b>	This indicator should be generated from existing data and analysis. Recommended sources of equity gaps include the following: <ul style="list-style-type: none"> <li>• <a href="#">Countdown 2030</a></li> <li>• Household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys or other relevant nationally representative surveys with focus on women, children and adolescent health, and PHC more broadly).</li> </ul>

<b>Method of data collection and construction</b>	<p>This indicator needs to be calculated using existing data, for example from <a href="#">Countdown to 2030</a> Equity Analysis Center which maintains and updates a large dataset with indicators for the SDGs related to reproductive, maternal, newborn, and child health, which can be stratified by various equity dimensions, such as wealth quintiles and maternal education.</p> <p>Countries will need to choose which tracer services to include, based on country priorities and data availability. For each tracer service/condition of interest:</p> <ol style="list-style-type: none"> <li>1. Determine the service coverage rate for that service (i.e. rate of ANC4 coverage in the population).</li> <li>2. Disaggregate the service coverage rate by equity stratifiers, as data availability allows (i.e., rate of ANC4 coverage stratified by wealth quintile, maternal education, subnational unit, etc.).</li> <li>3. Assess the equity gap for each equity stratifier for the specified service (i.e., ANC4 coverage is 95% among women in the highest wealth quintile but only 70% among women in the lowest wealth quintile—an equity gap of 25%).</li> </ol>
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	This indicator is limited by the availability and quality of data on health service coverage and relevant equity stratifiers. Data may be missing or unreliable, particularly for denominators at the subnational level.
<b>Data Use</b>	These data will be used to help identify which sub-groups of populations are being left behind in accessing essential PHC services, in order for countries to design better and more inclusive PHC policies and programs.
<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>	



## IMP2A

## IMP2A: Number of child and maternal deaths prevented

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP2A: Number of child and maternal deaths prevented

<b>Precise Definition</b>	<p><b>Numerator:</b> Number of child and maternal deaths prevented</p> <p><b>Denominator:</b> Not Applicable</p> <p><b>Unit of measure:</b> Number of deaths</p> <p><b>Data Type:</b> Integer</p> <p><b>Adapted from:</b> taken directly from <a href="#">LiST Tool</a> guidance</p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Modeling the number of child and maternal deaths prevented can quantify the direct effects of primary care interventions aimed at saving lives. It is hard to have mortality data for 3–5 year health programs; LiST (Lives Saved Tool) helps provide estimated mortality data to help with decision-making to assess impacts when large scale measurement is not feasible.
<b>Possible Adaptations</b>	There are many adaptations and assumptions that can be made to the LiST model. See below for caveats and the <a href="#">LiST Tool</a> website for guidance.
<b>Data Disaggregation</b>	<p>Maternal and under-five deaths</p> <p>Age of child (neonatal [0–28 days]; infant [0–11 months]; under-five [0–59 months]), maternal</p> <p>Type of PHC intervention</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator needs to be calculated using the <a href="#">LiST Tool</a>, which is based on the following underlying data:</p> <ul style="list-style-type: none"> <li>• Intervention coverage data modeled from household surveys (<a href="#">DHS</a>, <a href="#">MICS</a>, <a href="#">WHO/UNICEF JMP</a>)</li> <li>• Default effectiveness values: systematic reviews, meta-analyses, Delphi estimations, and randomized control trials based upon the Child Health Epidemiology Reference Group guidelines</li> </ul>

	<ul style="list-style-type: none"> <li>● Baseline mortality: country-level estimates from the World Health Organization, UNICEF, United Nations Population Fund, World Bank Group and the United Nations Population Division and United Nations Inter-Agency Group for Child Mortality Estimation</li> </ul>
<b>Method of data collection and construction</b>	<p>Countries should use the online LiST tool to calculate child and maternal deaths averted, using country-specific inputs for intervention coverage, etc. The calculation method is summarized below. Additional details about the LiST modeling methods are available in the <a href="#">LiST</a> tool methods document.</p> <ul style="list-style-type: none"> <li>● <b>Child mortality:</b> The number of deaths averted is determined by applying the reduction in the overall mortality rates to the number of children in each age band. The reduction in all-cause mortality is the modeled number of reduction from all interventions acting on a single cause of death multiplied by the proportion of all deaths due to that cause. The number of children is provided by the demographic projection module in Spectrum. The number of deaths averted by an intervention is calculated as the product of the total number of deaths averted and the proportional contribution of each intervention. Because an intervention frequently has an impact on several causes of death, LiST sums the deaths averted by an intervention across the several causes of death to determine the total impact of each intervention.</li> <li>● <b>Maternal mortality:</b> LiST also includes the capacity to calculate reductions in maternal mortality. The calculation for this runs in parallel to those for child mortality. All interventions for child mortality and maternal mortality are scaled up in the same editors assuring consistent estimates of all outcomes. The calculation for maternal mortality does not require turning on special features. It is calculated automatically when LiST is implemented.</li> </ul>
<b>Data Collection and Reporting Frequency</b>	At two-year review
<b>Data Quality Considerations</b>	This estimate is based on modeled data and thus, there are many layers of data quality considerations. The quality and precision of the underlying demographic projections, intervention coverage estimates, cause of death estimates, as well as the assumptions programmed into the model all affect the estimates.
<b>Data Use</b>	Data from the LiST tool can be used for advocacy, evaluation, and strategic planning. Policymakers and program managers can assist in the decision-making process, identifying priority interventions by empirically showing what is going to make the greatest impact on lives saved.
<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: 4/5/2023</b>	

## IMP2B

## IMP2B: All-cause U5 mortality rate

**Measurement Category:** Measuring for Impact**Domain:** Improved Health Status**Subdomain:** Not Applicable

## Indicator IMP2B: All-cause U5 mortality rate

<b>Precise Definition</b>	<p>All-cause child mortality rate, ages 0–4 years, expressed as deaths per 1,000 live births</p> <p><b>Numerator:</b> Number of deaths among children aged 0–4 years (0–59 months of age)</p> <p><b>Denominator:</b> Number of live births</p> <p><b>Unit of measure:</b> Deaths per 1,000 live births</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> Not Applicable, taken directly from <a href="#">WHO GHO/SDG Indicator 3.2.1</a></p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Under-five mortality rate measures child survival. It also reflects the social, economic, and environmental conditions in which children (and others in society) live, including their health care. Because data on the incidences and prevalence of diseases (morbidity data) frequently are unavailable, mortality rates are often used to identify vulnerable populations. It is a closely watched public health indicator because it reflects the access of children and communities to basic health interventions such as vaccination, medical treatment of infectious diseases, and adequate nutrition. A strong PHC system can prevent and treat diseases, detect and manage childhood illnesses and manage malnutrition in a timely manner, and provide health services, which all contribute to reducing U5 mortality.</p>
<b>Possible Adaptations</b>	<p>For countries with adequate trend of data from civil registration, the calculations of under-five and infant mortality rates are derived from a standard period abridged life table. For countries with survey data, under-five mortality rates are estimated using the Bayesian B-splines bias-adjusted model. Predominant type of statistics: adjusted and predicted.</p>
<b>Data Disaggregation</b>	<p>Age (Neonatal, infant [0–11m], child/under-five [0–59m])</p> <p>Sex of child</p> <p>Urban/rural</p> <p>Socioeconomic status (as feasible) such as wealth, maternal education</p>

	Sub-national
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources of estimates for U5MR include the following:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">UN IGME estimates</a> (The United Nations Inter-Agency Group for Child Mortality Estimation) based on household surveys, census, etc.—updated annually)</li> <li>• <a href="#">IHME estimates</a> (Institute for Health Metrics and Evaluation) (interactive data visualization tool)</li> <li>• <a href="#">Global Health Observatory</a> (includes UN data)</li> <li>• Civil registration with complete coverage of births and deaths</li> <li>• Household surveys (e.g., <a href="#">DHS</a>, <a href="#">MICS</a>)</li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of all-cause under-5 mortality rate from the data sources identified above.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	Any comparisons of this indicator over time or geographic areas should take into consideration estimates of uncertainty (presented in IGME estimates) and the retrospective nature of under-5 mortality estimates derived from Demographic and Health Surveys (DHS) birth/pregnancy history methods. Differences in the IGME estimates over 1–2 years are unlikely to represent actual change from programming, unless there are new survey or census data driving the estimates. Under-5 mortality from birth/pregnancy history is usually presented for the last 5 years nationally and last 10 years at the regional level.
<b>Data Use</b>	These data will help policymakers and program managers identify regions with higher mortality rates and causes of death that contribute the most to under-five mortality. This will help in the decision-making process to design programs that can target specific age groups, areas, and diseases.
<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: 4/5/2023</b>	

## IMP2C

## IMP2C: Neonatal mortality rate

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP2C: Neonatal mortality rate

<b>Precise Definition</b>	<p>Probability that a child born in a specific year or period will die during the first 28 completed days of life if subject to current age-specific mortality rates, expressed per 1000 live births.</p> <p><b>Numerator:</b> Number of deaths during the first 28 completed days of life per 1,000 live births in a given year or other period.</p> <p><b>Denominator:</b> Number of live births in the indicated year</p> <p><b>Unit of measure:</b> Newborn deaths</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> taken directly from <a href="#">WHO GHO/SDG Indicator 3.2.2</a></p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	Mortality during the neonatal period accounts for a large proportion of child deaths and is considered to be a useful indicator of maternal and newborn neonatal health and care. PHC plays a crucial role in reducing the neonatal mortality rate by providing essential health care services to women during pregnancy, skilled attendance during childbirth, essential newborn care, treatment of possible serious bacterial infection, Kangaroo mother care, postnatal care, and immunization services. By ensuring that women and newborns receive comprehensive and quality care, PHC can significantly reduce the neonatal mortality rate.
<b>Possible Adaptations</b>	Some countries are working to include stillbirths
<b>Data Disaggregation</b>	<p>Sub-national</p> <p>Sex</p> <p>Urban/rural</p> <p>Maternal education level</p> <p>Socioeconomic status as feasible</p>

<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources of estimates for neonatal mortality rate include the following:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">UN IGME</a></li> <li>• <a href="#">IHME estimates</a> (interactive data visualization tool)</li> <li>• <a href="#">Global Health Observatory</a> (includes UN data)</li> <li>• Civil registration with complete coverage of births and deaths</li> <li>• Household Surveys (e.g., <a href="#">DHS</a>, <a href="#">MICS</a>)</li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of neonatal mortality rate from the data sources identified above.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	Any comparisons of this indicator over time or geographic areas should take into consideration estimates of uncertainty (presented in IGME estimates) and the retrospective nature of neonatal estimates derived from DHS birth/pregnancy history methods. Differences in the IGME estimates over 1–2 years are unlikely to represent actual change from programming, unless there are new survey or census data driving the estimates.
<b>Data Use</b>	These data will be used to track progress in reducing neonatal mortality, identify areas where interventions are needed, and evaluate the effectiveness of maternal and child health programs. It can also be used to monitor disparities in neonatal mortality rates among different groups and guide efforts to address those disparities.
<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: 4/5/2023</b>	



## IMP2D

## IMP2D: Maternal mortality ratio

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP2D: Maternal mortality ratio

<p><b>Precise Definition</b></p>	<p>Maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period. It depicts the risk of maternal death relative to the number of live births and essentially captures the risk of death in a single pregnancy or a single live birth.</p> <p><u>Maternal deaths:</u> The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period.</p> <p><u>Live births:</u> The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (ICD-10)</p> <p>For the purpose of international reporting of maternal mortality, only those maternal deaths occurring before the end of the 42-day reference period should be included in the calculation of the various ratios and rates. The recording of later deaths is encouraged to inform national, regional, and global understanding of these events.</p> <p><b>Numerator:</b> Number of maternal deaths in a given time period</p> <p><b>Denominator:</b> Number of deliveries/women who gave birth in a given time period</p> <p><b>Unit of measure:</b> Maternal deaths</p> <p><b>Data Type:</b> Ratio (per 100,000 live births)</p> <p><b>Adapted from:</b> Not Applicable, taken directly from <a href="#">WHO GHO/SDG Indicator 3.1.1</a></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>Per <a href="#">WHO GHO</a>: In 2015, in anticipation of the launch of the Sustainable Development Goals (SDGs), the World Health Organization (WHO) and partners released a consensus statement and full strategy paper on ending preventable maternal mortality (EPMM). The EPMM target for reducing the global MMR by 2030 was adopted as SDG target 3.1: reduce global MMR to less than 70 per 100 000 live births by 2030. WHO leads the UN Maternal Mortality Estimation Interagency Group</p>

	(MMEIG) composed of WHO, UNICEF, United Nations Population Fund, the United Nations Population Division, and the World Bank Group. The MMEIG is tasked with generating internationally comparable estimates of maternal mortality for the purposes of global monitoring, having done so for Millennium Development Goal reporting and will continue to do so under the SDGs framework. Monitoring maternal health is widely seen as one of the most complicated health indicators within global frameworks. Significant unfinished business and challenges remain with estimating MMR; primarily due to the availability and usability of population-based data on maternal death.
<b>Possible Adaptations</b>	Not Applicable
<b>Data Disaggregation</b>	Not Applicable
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources for MMR estimates include the following:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">UN MMEIG</a>; 2000–2020 estimates available in the most <a href="#">recent report</a> (January 2020)</li> <li>• <a href="#">WHO</a></li> </ul> <p>Estimates from stand-alone surveys, census or civil registration are not generally recommended and should be used with great caution due to the differing methodologies and MMR estimates' sensitivity to data quality issues.</p>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of the MMR the data sources identified above.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	MMEIG global, regional, and country MMR estimates are released every 3–5 years and due to the methodology are retrospective in nature; therefore, any comparisons over recent time will be difficult. Any use of alternative data sources for comparisons 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>	Tracking changes in the MMR over time is an important way to assess progress in access to and quality of maternal health care services, a key part of PHC. A decrease in the MMR over time indicates that efforts to improve maternal health and access to health care services are working.

<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: 4/5/2023</b>	

## 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>
<p><b>Data Disaggregation</b></p>	<p>When possible and relevant, by sex, by urban/rural, and by cause of death</p>

<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>	

## IMP3A

## IMP3A: 95%–95%–95% HIV Testing and Treatment Targets

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP3A: 95%–95%–95% HIV Testing and Treatment Targets

<b>Precise Definition</b>	<p>95–95–95 testing and treatment targets achieved within all subpopulations and age groups (per <a href="#">UNAIDS report on 2025 targets</a>):</p> <ul style="list-style-type: none"> <li>• 95% of people living with HIV (PLHIV) know their HIV status</li> <li>• 95% of PLHIV who know their status initiate treatment</li> <li>• 95% of PLHIV on treatment are virally suppressed</li> </ul> <p>Numerator: Not Applicable Denominator: Not Applicable Unit of measure: Individual Data Type: Percentage Adapted from: Not Applicable, taken directly from <a href="#">UNAIDS 2025 targets</a></p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>From <a href="#">UNAIDS 2025 targets</a>: “As the Fast-Track era draws to a close, a global effort to plot the future course of the HIV response has developed a set of interim targets for 2025 that need to be achieved to reach the 2030 HIV targets within the Sustainable Development Goals. The braiding together of efforts to achieve all three categories of targets for HIV diagnosis, access to care, and viral suppression is critical to successful and sustainable scale-up and will reflect work to address barriers as well as integration into sustainable PHC. The 2025 targets also recognize that the HIV response sits within a wider effort to end poverty, fulfill the right to health and other human rights, and other goals within the 2030 Agenda for Sustainable Development. Frameworks and concepts for the achievement of the Sustainable Development Goals cut across the 2025 targets.”</p>
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	Age, key populations

<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator should be measured from existing data and analysis. Recommended sources for 95–95–95 HIV testing and treatment target estimates include the following:</p> <ul style="list-style-type: none"> <li>• <a href="#">UNAIDS</a></li> <li>• National HIV System</li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of 95–95–95 targets from the data sources identified above.
<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 to assess the association of USAID’s PHC work with the 95–95–95 targets, since strengthening and integration of HIV education (health promotion), prevention, related outreach, testing, and treatment services in primary care settings may contribute to achieving the 95–95–95 targets.
<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: 4/5/2023</b>	

## IMP3B

## IMP3B: Prevalence of HIV

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

Indicator IMP3B: Prevalence of HIV	
<b>Precise Definition</b>	<p><b>Numerator:</b> Total number of HIV infections in a defined population at a specific time</p> <p><b>Denominator:</b> Total population</p> <p><b>Unit of measure:</b> Individual</p> <p><b>Data Type:</b> Percentage</p> <p><b>Adapted from:</b> Not Applicable, taken directly from <a href="#">WHO Global Health Observatory</a></p>
<b>Level of Measurement</b>	National
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	From <a href="#">WHO Global Health Observatory</a> : HIV and AIDS remains a major public health problem in many countries and monitoring the course of the epidemic and impact of interventions is crucial. Both the Millennium Development Goals and the United Nations General Assembly Special Session on HIV and AIDS have set goals of reducing HIV prevalence. The work to strengthen PHC should include a focus on ongoing work to prevent HIV through better education and outreach, prevention and treatment.
<b>Possible Adaptations</b>	At-risk populations for countries with limited generalized epidemic—would see what PEPFAR suggests
<b>Data Disaggregation</b>	As feasible, by at-risk populations, sex, age
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources for HIV prevalence estimates include the following:</b></p> <ul style="list-style-type: none"> <li>● <b>Preferred:</b> General population surveys with HIV testing in high-burden epidemics, HIV case-based surveillance, and surveys determining proportions of HIV population undiagnosed, sample-based surveys with HIV-testing in key populations and size estimates of key populations.</li> <li>● <b>Alternate:</b> Modeled estimates using Spectrum, a Joint United Nations Programme on HIV and AIDS (UNAIDS)-supported software tool. UNAIDS supports most countries to produce estimates of HIV prevalence annually using Spectrum.</li> </ul>



<b>Method of data collection and construction</b>	Countries should locate existing estimates of HIV prevalence from the data sources identified above.
<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 HIV prevalence 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>	The data will be used to assess the association of USAID's PHC work with the HIV burden, since HIV promotion and prevention services in primary care settings may contribute to achieving a slower increase in HIV prevalence. Caveat: Strong PHC would likely result in an initial increase in HIV prevalence as more people would be diagnosed, started on treatment, and retained on treatment. HIV prevalence may not go down for a while, as people living with HIV survive longer.
<b>Other Notes, Discussion, and/or Comments</b>	Other possible data sources: Active facility-based surveillance system with key population estimates
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/5/2023</b>	

## IMP3C

## IMP3C: HIV incidence-mortality ratio

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP3C: HIV incidence-mortality ratio

<b>Precise Definition</b>	<p>The HIV incidence-to-mortality ratio (IMR) is the ratio of the number of new HIV infections to the number of people infected with HIV who die (from any cause).</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> Ratio</p> <p><b>Adapted from:</b> Not Applicable, taken directly from <a href="https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002678">https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002678</a></p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>Per <a href="#">KFF</a>: PEPFAR’s definition of epidemic control is when “the total number of new HIV infections fall below the total number of deaths from all causes among HIV-infected individuals.” When the incidence-to-mortality ratio is greater than one or when there are more new infections than deaths, the size of the population of people living with HIV grows; when it is less than one, the size of the population shrinks.</p> <p>Also see this article for a description of the IMR: <a href="https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002678">https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002678</a></p>
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	None
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources for the HIV IMR include the following:</b></p> <ul style="list-style-type: none"> <li>• <b>Preferred source:</b> Empirical data on HIV incidence and all-cause mortality among PLHIV. See <a href="#">Ghys et al 2018</a> for description of data availability for HIV</li> </ul>

	<p>incidence (General Population and Key Populations) and all-cause mortality among PLHIV.</p> <ul style="list-style-type: none"> <li>● <b>Alternate source:</b> Modeling</li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of HIV incidence-mortality ratio from the data sources identified above.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	Any use of alternative data sources HIV IMR 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>	The data will be used to assess the impact of USAID's PHC work, since HIV promotion, prevention, testing, and treatment services in primary care settings may ultimately contribute to achieving reduced HIV incidence and mortality.
<b>Other Notes, Discussion, and/or Comments</b>	<p>Per <a href="#">KFF</a>: It is important to note that using the IMR by itself may not paint a complete picture, since having an IMR below one is possible with high levels of mortality. Consequently, PEPFAR has noted that decreases in the IMR must also occur within the context of treatment coverage that is greater than 70%.</p> <p>Per <a href="#">Ghys et al 2018</a>: This indicator "applies to epidemics of all sizes, regardless of the level of incidence or mortality."</p> <p>It is mentioned in PEPFAR strategies.</p>
<b>Changes to indicator with date</b>	To be completed in-country
<b>This sheet was last updated on: 4/5/2023</b>	

## IMP4A

## IMP4A: Malaria prevalence in children under 5

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP4A: Malaria prevalence in children under 5

<p><b>Precise Definition</b></p>	<p>Percentage of children ages 6–59 months with detectable malaria parasites in their blood, determined by rapid diagnostic test (RDT) or microscopy.</p> <p><b>Numerator:</b></p> <ol style="list-style-type: none"> <li>1. Number of de facto* children tested using RDT who are positive for malaria</li> <li>2. Number of de facto children tested using microscopy who are positive for malaria</li> </ol> <p><b>Denominator:</b></p> <ol style="list-style-type: none"> <li>1. Number of de facto children tested using RDT</li> <li>2. Number of de facto children tested using microscopy</li> </ol> <p><b>Unit of measure:</b> Number of children</p> <p><b>Data Type:</b> Percentage</p> <p>*De facto eligible population refers to children younger than 6 years of age who had complete records and were tested for malaria infection during the household survey. Children who were not tested and those children whose values were not recorded are excluded from both the denominator and the numerator.</p> <p><b>Adapted from:</b> Not Applicable, taken directly from <a href="#">DHS Guidance</a></p>
<p><b>Level of Measurement</b></p>	<p>National, Subnational if possible</p>
<p><b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i></p>	<p>The parasite prevalence among children aged 6–59 months is an indicator of malaria burden within populations and provides a guide to the level of malaria transmission and effectiveness of prevention. Knowing the level of malaria transmission can inform the most effective strategies for preventing and treating the disease and tailor strategies to each context. PHC services are often the first point of contact for individuals who are experiencing malaria symptoms, and they play a critical role in identifying and treating cases of the disease. In addition to providing services, PHC also plays a crucial role in community engagement and education to raise awareness about the importance of malaria prevention measures and promote behavior change that can reduce the transmission of the disease.</p>

<b>Possible Adaptations</b>	This indicator may be less relevant in contexts with low or no burden of <i>P. falciparum</i> malaria and very low burden of other Plasmodium species. This may also underestimate rates where coverage of testing and access to care is low.
<b>Data Disaggregation</b>	Age Sub-national Urban/rural Where feasible: Socio-economic status Mother's education level
<b>Data Source(s) and Data Collection Instruments</b>	This indicator should be measured from existing data and analysis. Recommended sources of under 5 malaria prevalence include the following: <ul style="list-style-type: none"> <li>Household surveys, such as <a href="#">MIS</a>; <a href="#">DHS</a>; <a href="#">MICS</a> or other representative household surveys</li> <li>Secondary data sources such as the <a href="#">WHO World Malaria Report</a>; <a href="#">Malaria Atlas Project</a></li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of under 5 malaria prevalence from the data sources identified above.
<b>Data Collection and Reporting Frequency</b>	Early on and two-year review
<b>Data Quality Considerations</b>	<u>Per DHS</u> : Parasite prevalence can fluctuate dramatically throughout the course of a year with the seasonality of malaria, and thus values of the indicator may be influenced by the timing of a survey in relation to peak transmission. Accordingly, parasite prevalence should not be used for tracking the short-term impact of scaling up prevention efforts, as the prevalence rates may merely reflect differences in the timing of surveys in relation to within-year variation in parasite prevalence. Parasite prevalence is better suited to measuring changes in malaria burden over a longer term during which changes in parasite prevalence are expected to be much greater and outweigh within-year variation. To demonstrate a reliable trend, no more than four data points within a 10-year span are generally needed.  Although malaria RDTs are a suitable alternative to microscopy for estimating prevalence in certain circumstances, the method of measuring parasite prevalence should be considered (microscopy or RDT) when interpreting this indicator.

<b>Data Use</b>	These data, taken together with other childhood mortality and morbidity indicators, can be used to determine malaria control activities' contributions to reductions in malaria-associated mortality and the association with work to strengthen PHC including malaria control, diagnosis and management.
<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>	

## IMP4B

## IMP4B: Malaria incidence

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP4B: Malaria incidence

<b>Precise Definition</b>	<p>Number of new cases of malaria per 1,000 people at risk each year. A case of malaria is defined as the occurrence of malaria infection in a person in whom the presence of malaria parasites in the blood has been confirmed by a diagnostic test. The population at risk of the disease is determined according to the country context (e.g., all adults and children in a malaria endemic area). (<a href="#">SDG metadata indicator 3.3.3</a>) and incidence is determined through diagnosis.</p> <p><b>Numerator:</b> Number of new cases of malaria</p> <p><b>Denominator:</b> Total population at risk</p> <p><b>Unit of measure:</b> Cases per 1,000 population at risk</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> Not Applicable, taken directly from <a href="#">SDG Indicator 3.3.3</a></p>
<b>Level of Measurement</b>	National, Subnational if possible
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	To measure trends in malaria morbidity and to identify locations where the risk of disease is highest. With this information, programs can respond to unusual trends, such as epidemics, and direct resources to the populations most in need. These data also serves to inform global resource allocation for malaria such as when defining eligibility criteria for Global Fund finance.
<b>Possible Adaptations</b>	<p>Most low-incidence countries combine malaria confirmed cases from in- and outpatient settings. Any person with a positive result from a parasite based test (microscopy or rapid diagnostic test) would be considered a malaria (confirmed) case.</p> <p><b>Other country-level relevance sources should also be considered.</b></p>
<b>Data Disaggregation</b>	<p>Age</p> <p>Urban/rural</p> <p>Season (year and month)</p> <p>Subnational</p>

<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator should be measured from existing data and analysis. Recommended sources of malaria incidence include the following:</p> <ul style="list-style-type: none"> <li>• <a href="#">WHO World Malaria Report</a></li> <li>• <a href="#">Malaria Atlas Project</a>, which contains estimates of country-level malaria incidence on an annual basis, based on data provided by each country</li> <li>• National Demographic Household Survey or Malaria Indicator Survey</li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of malaria incidence from the data sources identified above.
<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>	These data can assist policymakers and program managers in resource mobilization, planning, and programming for malaria control programs. Examining changes over time can evaluate the effects of malaria control programming and whether PHC integration activities have been associated with improvement. This is an indication of strong PHC for prevention, promotion, and diagnosis.
<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>	



## IMP4C

## IMP4C: Malaria-specific mortality (modeled)

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP4C: Malaria-specific mortality (modeled)

<b>Precise Definition</b>	<p>Rate of deaths due to malaria in a specific year per 100,000 population</p> <p><b>Numerator:</b> Number of adult and child deaths due to malaria in a specific year</p> <p><b>Denominator:</b> Total population in a specific year</p> <p><b>Unit of measure:</b> Deaths per 100,000 population</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> <a href="#">WHO GHO</a></p>
<b>Level of Measurement</b>	National
<b>Rationale (and any Link to Foreign Assistance Framework)</b>	To measure trends in malaria mortality and to identify locations where the burden of disease is highest. With this information, programs can respond to unusual trends, and direct resources to the populations most in need. These data also serve to inform global resource allocation for malaria, such as when defining eligibility criteria for Global Fund finance.
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	Age (all, under 5)
<b>Data Source(s) and Data Collection Instruments</b>	<p><b>This indicator should be measured from existing data and analysis. Recommended sources for malaria-specific mortality include the following:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">WHO World Malaria Report</a>; <a href="#">Malaria Atlas Project</a>; <a href="#">WHO GHO</a></li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of malaria-specific mortality from the data sources identified above.

<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 malaria-specific mortality 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>	These data can help policymakers, program managers, and advocates estimate the burden of disease, evaluate the impact of current control activities over time, and revise future plans according to the data available.
<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: 4/5/2023</b>	

## IMP4D

## IMP4D: TB incidence rate

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP4D: Tuberculosis (TB) incidence rate

<b>Precise Definition</b>	<p>New TB cases during the specified time period, expressed as rate per 100,000 population</p> <p><b>Numerator:</b> Number of people newly diagnosed with TB during the specified time period</p> <p><b>Denominator:</b> Total population</p> <p><b>Unit of measure:</b> Cases per 100,000 population</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> Not Applicable, taken directly from WHO/SDG indicator <a href="#">2.1 TB Incidence</a> (we do not have a USAID PIRS for this indicator)</p>
<b>Level of Measurement</b>	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	TB causes a considerable global burden of disease, and USAID's PHC work in facility- and community-based TB promotion and prevention may contribute to a reduction in the rate of new TB cases. TB incidence has been designated by USAID as an essential indicator to track across countries (per Global Health (GH) Common Indicators presentation), in addition to the GH Common Indicators of health service coverage index and index population mortality.
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	Age, sex
<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator should be measured from existing data and analysis. Recommended sources of TB incidence rates include the following:</p> <ul style="list-style-type: none"> <li>Existing data from TB prevalence surveys.</li> <li>National studies on underreporting of detected TB cases.</li> <li>Administrative data on TB case detection.</li> </ul>

	<ul style="list-style-type: none"> <li>Existing USAID TB reporting.</li> </ul>
<b>Method of data collection and construction</b>	Countries should locate existing estimates of TB incidence from the data sources identified above.
<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 to assess the association of USAID's PHC work with the TB burden, since TB promotion and prevention services in primary care settings may contribute to achieving a reduction in new TB cases.
<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>	

## IMP4E

## IMP4E: TB mortality rate

**Measurement Category:** Measuring for Impact

**Domain:** Improved Health Status

**Subdomain:** Not Applicable

## Indicator IMP4E: Tuberculosis (TB) mortality rate

Precise Definition	<p>Deaths caused by TB, expressed as rate per 100,000 population.</p> <p><b>Numerator:</b> Number of deaths from TB during the specified time period</p> <p><b>Denominator:</b> Total population</p> <p><b>Unit of measure:</b> Deaths per 100,000 population</p> <p><b>Data Type:</b> Rate</p> <p><b>Adapted from:</b> Not Applicable, taken directly from WHO/SDG indicator <a href="#">2.2 TB Mortality</a> (we do not have a USAID PIRS for this indicator)</p>
Level of Measurement	National
<b>Rationale</b> <i>(and any Link to Foreign Assistance Framework)</i>	<p>TB contributes significantly to the global burden of mortality, and USAID’s PHC work in facility- and community-based TB promotion, prevention, diagnosis, and treatment may contribute to a reduction in TB mortality. TB mortality has been designated by USAID as an essential indicator to track across countries (per Global Health (GH) Common Indicators presentation), in addition to the GH Common Indicators of health service coverage index and index population mortality.</p>
<b>Possible Adaptations</b>	None
<b>Data Disaggregation</b>	<p>Age, Sex, urban/rural, subnational as feasible</p> <p>HIV status—for consistency with international standards, there is a clear distinction between TB deaths in HIV-negative people (classified as deaths caused by TB) and TB deaths in HIV-positive people (classified as deaths from HIV, with TB as a contributory cause).</p>
<b>Data Source(s) and Data Collection Instruments</b>	<p>This indicator should be measured from existing data and analysis. Recommended sources include the following:</p> <ul style="list-style-type: none"> <li>National vital registration systems and mortality surveys or other existing TB mortality reporting or estimates.</li> </ul>

<b>Method of data collection and construction</b>	Countries should locate existing estimates of TB mortality rate from the data sources identified above.
<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 to assess the association of USAID's PHC work with the TB burden, since TB promotion, prevention, diagnosis, and treatment services in primary care settings may contribute to achieving reduced mortality from TB.
<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>	