PRIMARY HEALTH CARE
PROGRESSION MODEL ASSESSMENT TOOL

PRIMARY HEALTH CARE
PERFORMANCE INITIATIVE

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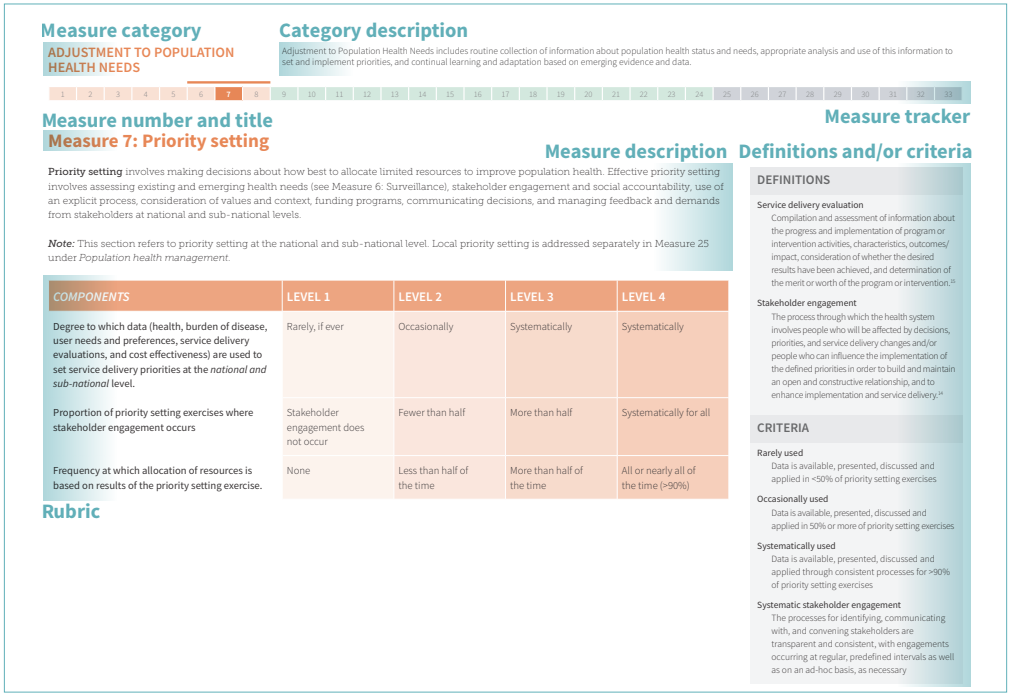
Contents

Orientation to the assessment rubrics



Measure 1: Primary health care policies (1/2)

Primary health care policies are decisions and plans that are undertaken by governments with input from other stakeholders to achieve specific primary health care 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.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Number of elements below that can be answered positively:	2 or fewer	3-4	5-6	All 7
☐ Is there an active National Health Plan or National Strategic Plan in the country?				
☐ Is the 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 embedding of core PHC principles into the Plan?				
☐ Are policies around PHC evidence based?				
☐ Are policies around PHC formulated through a participatory process?				
☐ Are policies around PHC embedded in a legal framework?				
☐ Do policies around PHC include the fundamentals? a. Service package defined b. Financing mechanism c. M&E framework				
☐ Is there a joint review of the progress towards the objectives set out in PHC-related policies?				

DEFINITIONS

Evidence-based policy
Incorporates research-identified effective solutions or approaches, knowledge and experience, and values and goals.

Joint review
A shared approach that includes a diverse range of stakeholders to assess the progress, outcomes, strengths, and weaknesses of a policy.

Measure 1: Primary health care policies (1/2)

CONTEXTUAL INFORMATION

This measure is designed to assess the country's governmental commitment to PHC both in theory and in practice. It refers to policies broadly as the laws, guiding principles, working frameworks and ways of working that guide practice, service delivery decisions, and actions. Countries may strongly prioritize PHC on paper, but this will not translate to effective implementation if there are inadequate systems for acting on these strategies, policies, and/or plans. Formulating policy through broad stakeholder participation and embedding policy with laws and regulation are mechanisms to support the translation of policy into action. Not only is it important for PHC to be prioritized in policies, but the fundamentals of a defined service package, ways of financing PHC, and a system for monitoring and evaluation need to be included.

Note that this measure purposely does not assess whether countries have a "PHC policy." Some countries might, while others instead integrate the functions and principles of PHC into their broader health policy. Policies designed around PHC mean that these polices 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;[2] 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.

Embedding policies in a legal framework means leveraging law and regulation to establish a "roadmap" for the national health policy planning process and the creation of a broad system of rules that serve as "a key implementation mechanism to translate the major policy objectives into action by setting standards and requirements, and using sanctions and incentives to exert leverage over the health system".[3] This may include legally binding instruments (state constitutions, laws, acts, decrees, orders, regulations and ordinances) and legally non-binding instruments (guidelines, standards, operating rules, administrative procedures or rules) and other instruments (protocols, resolutions, and intersectoral or inter-ministerial agreements).[4]

Effective joint review processes should include assessment of the situational analysis and programming, the process, costs and financing, implementation and management arrangements, and results, monitoring and review mechanisms. The inclusion of a diverse range of stakeholders enhances the quality of the assessments and broad confidence in the strategies, as well as improves coordination and alignment moving forward.[5]

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Senior ministry officials, particularly policy and planning leads
- Members of professional associations
- Parliamentary committee members
- Policy advocacy organizations
- Large non-governmental group leaders
- Reports from routine health stakeholders fora

Measure 1: Primary health care policies (1/2)

GUIDING QUESTIONS

- Is there an active National Health Plan or National Strategic Plan? How, if at all, is it referenced in the prioritization, design, implementation, and operations of the health system?
- How is primary health care reflected in national health strategies, policies, and plan?
  - Probe: Is there a specific PHC plan, strategy, or policy?
  - Probe: If not, how, if at all, are core principles of PHC (first point of contact, continuity, comprehensiveness, coordination, and patient-centered care) reflected in the relevant documents?
  - Probe: How would you describe the role that PHC plays in the health system? For example PHC might be a secondary priority after hospitals and tertiary care or it may form the foundation for the design of health services overall.
- What sort of information (experiential, data, peer-reviewed research, published best-practice, etc.) was used to develop the policy? How was it used?
- What stakeholders, if any, are included in the policy formulation process and how are they included?
- To what extent did stakeholders and communities influence or control the policy direction, content or development process?
- What, if any, financing commitments to PHC are included in these strategies/policies/plans? Are these financing commitments sufficient? If not, does the policy identify any additional funding sources?
- Do these strategies/policies/plans include a clear budget for PHC? Do the budgets align with the financing commitments?
- Do these strategies/policies/plans include staff and procedures to implement PHC policies?
  - If yes, what type of staff are included?
  - What types of procedures are outlined?
  - Is there a named agency with responsibility?
  - Do the staff and procedures listed align with the goals and practices identified in the strategies/policies/plans?
- How, if at all, are these strategies/policies/plans embedded in a legal framework?
  - Probe: What, if any, standards and requirements are set to ensure appropriate implementation?
  - Probe: What, if any, sanctions and incentives are in place to ensure appropriate implementation? These may be legally binding such as laws, acts, decrees, orders, regulations, etc. or not, such as guidelines, standards, administrative procedures, protocols, resolutions, etc.
- Are these policies integrated into all relevant national standards and other sectoral commitments? How? Is this effective for realizing the policy?
- How often are these policies reviewed?
  - Probe: At least annually? What is reviewed (ie: progress, impact, goals)?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 2: Primary health care policies (2/2) – Leadership

Policies are decisions and plans that are undertaken by governments with input from other stakeholders to achieve specific health care goals. PHC policies promote, support, or establish system orientation, financing, inputs, and service delivery mechanisms to ensure quality and improve and develop PHC function and outcomes.

This measure is about **leadership for the coordination, monitoring, integration, and implementation of PHC-related policies**. It refers to an identifiable national authority(ies) for primary health care within the government. This person or governmental entity provides stewardship of primary health care and should coordinate, monitor, integrate, and implement national policies related to PHC with defined authority, clear accountability, adequate budget, and sufficiently competent staff. The mandate of this authority should include the public sector as well as oversight and regulation of the private sector, where applicable. The national authority must have accountability for the entire range of comprehensive PHC services defined by national health policies, strategies, and/or plans. The authority must have oversight of all units that are relevant to PHC to ensure active alignment and coordination for the effective and efficient delivery of PHC services.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
A national coordinating authority(ies) (whether an individual or other governmental organizational entity) exists that is accountable for coordinating, monitoring, integrating, and implementing national PHC strategies and policies.	No	Yes, with incomplete accountability	Yes, with clear and complete accountability	Yes, with clear and complete accountability
Sub-national/sub-regional operational capacity and reach of the national coordinating authority(ies)	N/A	Minimal (sub-national)	Moderate at the sub-national level and at least minimal at the sub-regional level	Sufficient (sub-national and sub-regional)
Proportion of time the national coordinating authority(ies) has adequate authority, budget and staff	N/A	Only sometimes	Some of the time, at least at a *national and regional* level	Most or all of the time at the *national, sub-national and regional* level

Measure 2: Primary health care policies (2/2) – Leadership

CONTEXTUAL INFORMATION

This measure assesses a country's ability to follow through on policies and strategies, specifically through the leadership of a national coordinating authority. A national authority(ies) may be an individual or an organization, but the emphasis of this measure is on their ability to steward the country's vision and strategies for PHC; implement strategies and policies; bring together all PHC-related activities to ensure awareness, coordination and alignment between and among them; and oversee implementation at the national, sub-national, and local levels. Through effective stewardship and oversight, a national coordinating authority(ies) can promote effective and efficient PHC service delivery by reducing duplication and resources waste and by identifying gaps in services or coverage. To be effective, the national authority(ies) must have an adequate budget, meaning that sufficient funds are available for them to execute their mandate to coordinate, monitor, integrate, and implement national PHC operationally at the sub-national level.

To qualify as a national PHC authority(ies), it is not required that PHC be the sole focus of this person or entity, though they must have sufficient time and capacity to dedicate to PHC in order to be able to execute on their mandate.

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Senior MOH officials
- MOH policy/planning leads
- Members of professional associations
- Parliamentary committee members
- Policy advocacy organizations
- Public purchasers
- Large non-governmental organization group leaders
- National Health Policy
- National Strategic Plan for Health or National Health Development Plan
- Five-year health sector strategy
- Reports from annual health stakeholders' fora

Measure 2: Primary health care policies (2/2) – Leadership

GUIDING QUESTIONS

- Is there a specific individual or organizational entity that has overall responsibility for stewardship of PHC?
  - Probe: I'm trying to determine who is responsible for tracking, coordinating, and implementing national primary health care strategies and policies at the national level?
- If yes, is this well-known? Named formally?
- If yes, can you describe how this person or organizational entity functions?
  - Does it have a dedicated and adequate budget (to achieve operational objectives)? How much is the budget, and is it sufficient to fulfill their responsibilities?
  - How many people comprise the organizational entity? Do they work there full-time? Is there a clear organizational structure or organogram? What type of people are they (credentials, training, etc.)? Where are they located?
  - Are additional people needed? If yes, what type (qualification, knowledge, experience, location, etc)?
  - What does the agency do to ensure implementation of policies and strategies? Can you share an example? If not, is there someone else we could talk to who could?
  - How are they held accountable for coordinating, monitoring, integrating and implementing national primary health care strategies and policies? Can you share an example that illustrates how well this works? If not, is there someone else we could talk to who could?
- If more than one person or organization has responsibility for PHC, how would you describe how these people/organizations work together?
  - What, if any, duplication of activities occurs around coordinating, monitoring, and implementing PHC?
  - In your opinion, what, if any, important activities related to PHC do not get done by either party>
- At the sub-national level, is there a specific individual or organizational entity that is responsible for tracking, coordinating, and implementing national primary health care strategies and policies?
  - Does it have a dedicated and adequate budget? How much is the budget, and is it usually sufficient to fulfill their responsibilities?
  - How many people comprise the organizational entity? What type of people are they (credentials, training, etc.)?
  - Are additional people needed? If yes, what type?
  - What does the agency do to ensure coordination, monitoring, integration and implementation with the national level of policies and strategies? Can you share an example? If not, is there someone else we could talk to who could?
  - How are they held accountable for coordinating, monitoring, integrating and implementing national primary health care strategies and policies? Can you share an example that illustrates how well this works? If not, is there someone else we could talk to who could?
- When a decision is made at the national level, how is it translated/monitored/implemented at subnational levels? Who is responsible for the communication from national to subnational level? From subnational back to national level? How quickly does this happen?
- Are there any documents you can show me that clarify the structure and function of this entity? For instance, operational plans and procedures, job descriptions, staff terms of reference, proof of budget, or organizational charts? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do* ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 3: Quality management infrastructure

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[6] High-quality health services involve the right care, at the right time, responding to the service users' needs and preferences, while minimizing harm and resource waste. Quality management includes three interlinked concepts, necessary to enhance quality across the health system – quality planning, quality control, and quality improvement. Quality planning includes aims, processes, and goals needed to create an environment for continuous improvement. Quality control entails monitoring established processes to ensure their functionality. Quality improvement is the action of every person working to implement iterative, measurable changes, to make health services more effective, safe, and people-centered.[7] Ensuring quality requires development of **robust quality infrastructure**.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Number of elements of quality management infrastructure, below, that are in place:	2 or fewer	3-4	5-6	7-8
☐ Articulation of national direction on quality, often outlined as a national quality policy or strategy, or integrated with broader health systems planning.				
☐ Identification and implementation of a package (2+ interventions) of appropriate quality interventions to create an enabling systems environment.				
☐ Identification and implementation of a package (2+ interventions) of appropriate quality interventions to reduce harm to patients.				
☐ Identification and implementation of a package (2+ interventions) of appropriate quality interventions to improve clinical effectiveness of health services.				
☐ Identification and implementation of a package (2+ interventions) of appropriate quality interventions to engage patients, families and communities.				
☐ Active systems that routinely collect and publish data on quality health systems.				
☐ A culture of learning on quality across the health system, including development of systems to collect and share learning on quality of care at *facility, sub-national and national* levels.				
☐ Clearly stated leadership commitment to institutionalize quality of care throughout the health system.				

DEFINITIONS

Quality interventions to:

Create an enabling systems environment

- Registration and licensing
- External evaluation/accreditation
- Clinical governance
- Public reporting and comparative benchmarking

Reduce harm

- Inspection of institutions for minimum safety standards
- Safety protocols
- Safety checklists
- Adverse event reporting

Improve clinical effectiveness

- Clinical decision support tools
- Clinical standards, pathways and protocols
- Clinical audit and feedback
- Morbidity and mortality reviews
- Collaborative and team-based improvement cycles

Engage patients, families and communities

- Formalized community engagement & empowerment mechanisms
- Health literacy
- Shared decision making
- Peer support and expert patient groups
- Patient experience of care
- Patient self-management tools

Measure 3: Quality management infrastructure

CONTEXTUAL INFORMATION

Quality management infrastructure supports a health system to deliver safe, effective, and efficient care that improves health outcomes and supports healthy populations. It refers to the planning, control activities, and improvement work that underpins the delivery of quality health services. Identification and implementation of appropriate quality interventions as part of quality management infrastructure can have a significant impact on specific health services delivered and on the health system at large. Four key quality intervention categories have been identified for their potential impact on quality by reducing harm to patients; improving clinical effectiveness; creating an enabling systems environment; and engaging patients, families, and communities.[6] Qualifying interventions for each category are provided in the definitions.

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- National Quality Policy and Strategy
- Accreditation officials
- Health professional associations, including private sector associations
- Professional training councils
- Health sector strategy and annual reports
- Clinical guidelines
- Tools for facility quality audits
- Accreditation data/reports

GUIDING QUESTIONS

- How would you characterize the level of commitment from senior leadership to ensuring quality? Why do you say this?
- Is there a national quality policy and/or strategy?
  - If yes, how, if at all, is it integrated into health system planning?
  - If no, what, if any, other mechanism has been used to establish a vision for a national direction for quality?
  - Probe: How, if at all, does this target PHC specifically?
- What interventions or programs, if any, are implemented to ensure an enabling system environment for quality?
  - Probe: Registration and licensing; External evaluation/accreditation; Clinical governance; Public reporting and comparative benchmarking
  - Probe: For any intervention/program mentioned: How does this work in practice? Can you give me an example? How widespread is this practice across the country?
  - Probe: How, if at all, does this target PHC specifically?

Measure 3: Quality management infrastructure

GUIDING QUESTIONS (CONTINUED)

- What interventions or programs, if any, are implemented to reduce harm to patients?
  - Probe: Inspection of institutions for minimum safety standards; Safety protocols; Safety checklists; Adverse event reporting
  - Probe: For any intervention/program mentioned: How does this work in practice? Can you give me an example? How widespread is this practice across the country?
  - Probe: How, if at all, does this target PHC specifically?
- What interventions or programs, if any, are implemented to improve clinical effectiveness of health services?
  - Probe: Clinical decision support tools; Clinical standards, pathways and protocols; Clinical audit and feedback; Morbidity and mortality reviews; Collaborative and team-based improvement cycles
  - Probe: For any intervention/program mentioned: How does this work in practice? Can you give me an example? How widespread is this practice across the country?
  - Probe: How, if at all, does this target PHC specifically?
- What interventions or programs, if any, are implemented to engage patients, families, and communities?
  - Probe: Formalized community engagement & empowerment mechanisms; Health literacy; Shared decision making; Peer support and expert patient groups; Patient experience of care; Patient self-management tools
  - Probe: For any intervention/program mentioned: How does this work in practice? Can you give me an example? How widespread is this practice across the country?
  - Probe: How, if at all, does this target PHC specifically?
- How, if at all, are data on quality collected?
  - Probe: Who is responsible? How frequently does this happen?
- How, if at all, are data on quality published?
  - Probe: Who is responsible? How frequently does this happen?
  - Probe: How is data and learning shared at the national, sub-national, and facility levels?
- How would you describe people's attitudes towards quality at the national, sub-national, and facility levels?
  - Probe: Is there a culture of having an open mindset and eagerness to learn? Is there a culture of being eager to improve?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 4: Social accountability (1/2)

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 (for example, 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, non-governmental organizations, non-health actors, and other stakeholders in health care planning, policy formation, monitoring and evaluation. 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 seeks to amplify or improve government-led PHC efforts. Social accountability at the local level is addressed separately under *Population Health Management*.

Note: Social accountability at the local level is addressed separately under *Population Health Management*.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Engagement around PHC-related issues with the private sector, civil society and/or non-governmental organizations (NGOs) occurs:	Rarely, if ever	On an *ad hoc* basis	Systematically	Systematically
Involvement of the private sector, civil society and/or NGOs in health care planning, policy formation, and monitoring and evaluation	No or minimal	Minimal	Moderate	Significant
Public disclosure on the status of PHC implementation and results occurs:	Does not occur	Rarely	Occasionally	Systematically

CRITERIA

Ad hoc engagement
Hosted or requested for a particular purpose as necessary. The structure and process of engagement changes often and is usually not deliberate.

Systematic engagement
The methods and structure for engagement is established and used consistently at regular intervals and as opportunities for stakeholder consultation and information dissemination arise.

Minimal involvement
Private sector, civil society, and/or non-governmental organizations are informed of relevant health care planning, policy formation, monitoring and evaluation but given few or no opportunities to provide input.

Moderate involvement
Private sector, civil society, and/or non-governmental organizations are informed of relevant health care planning, policy formation, monitoring and evaluation and given the opportunity to provide feedback on the status of implementation and results, alternatives and/or decisions throughout the process.

Significant involvement
Private sector, civil society, and/or non-governmental organizations are collaborators in the health care planning, policy formation, monitoring and evaluation and given equal voice and decision-making power as other stakeholders, such as health system leaders and local government officials.

Measure 4: Social accountability (1/2)

CONTEXTUAL INFORMATION

This measure is related to and often confused with community engagement (Measure 26). In contrast to community engagement which occurs at the local level and involves direct consultation with patients who live in the community served by the local-level facilities, social accountability addresses national-level collaboration and input. Governments and leaders should be held accountable for the content of policies and delivery of health services by the populations they serve. This is facilitated by the establishment of defined processes and mechanisms for the health system to engage stakeholders, and for stakeholders to engage the health system. Beyond engagement, stakeholders should be involved throughout the leadership and governance process—from health care planning, policy formation, and monitoring and evaluation—with the system responsive to their input. The impact of stakeholder engagement on policy priorities is addressed in Measure 7: Priority setting.

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Parliament health committees
- Civil society organization network leaders
- Professional association leaders
- Patient associations
- National policy advocacy organizations

Measure 4: Social accountability (1/2)

GUIDING QUESTIONS

- How, if at all, does the government engage with the private sector, civil society, and non-governmental organizations around health, and primary health care in particular?
  - Probe: For instance, are there specific engagement committees that include representation from these groups? Are all of these groups represented? Regular events designed to get input from these groups?
- If engagement occurs, who does it occur with? What types of groups are represented?
- How, if at all, are these engagements integrated into the country's governance and policy model?
  - Probe: Are there policies and guidelines around how and how frequently engagement should occur?
  - Probe: Does the engagement happen systematically--according to a specific schedule--or only when a particular need arises or when someone thinks to do it?
- How, if at all, does engagement influence planning of policy, priorities, and evaluation? Can you share an example? If not, is there someone else we could talk to who could?
  - Probe: What level of decision-making power is given to the private sector, civil society non-governmental organizations?
- How, if at all, are the results of this kind of engagement shared with the public, for example through the news, radio, or public fora? How often?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 5: Social accountability (2/2) – Multi-sectoral action

Social accountability is a measure of a country's state of being responsive to existing and emerging social concerns and priorities relevant to PHC of internal and external stakeholders (for example, 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, non-governmental organizations, non-health actors, and other stakeholders in health care planning and governance. 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 seeks to amplify or improve government-led PHC efforts. Social accountability at the local level is addressed separately under *Population health management.*

This measure is specifically about multi-sectoral action. Multi-sectoral action—integration across government entities whose work intersects and interacts with Primary Health Care—is an important means of ensuring social accountability and a Health in All Policies approach.[8] Examples of such groups include cross-parliamentary groups on health or other groups who coordinate PHC-related topics across relevant ministries.

DEFINITIONS

Health in all policies approach

"An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity"[9]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Cross-government groups on primary health care	Do not exist	Exist, but roles are not clearly defined	Exist, with clearly defined roles but minimal transparency	Exist, with clearly defined roles and transparent proceedings.
Evidence of cross-sector integrated planning exists.	N/A	No	No	Yes

Measure 5: Social accountability (2/2) – Multi-sectoral action

CONTEXTUAL INFORMATION

Cross-government groups refer to different agencies at the national and/or sub-national level whose mandate and work relate to health. Examples of such groups include cross-parliamentary groups on health, or other groups who coordinate PHC-related topics across relevant ministries. For instance, the Ministry of Health may collaborate with the Ministry of Education, Finance, Housing, or Interior on various health-related issues. It is important that the government as a whole is able to be held accountable for health, including involving those domains that are involved in, impact, or are impacted by health and health services. Sectors which may be included in such groups include but are not limited to Education, WASH, Housing, Finance, Transportation, etc.

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources.
- At least one informant from a non-health Ministry official

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Parliamentary health committee leads
- Patient associations
- National think tanks and policy advocacy organizations
- Key informants in oversight authority bodies
- Annual health sector reports
- Sustainable development agenda
- Meetings minutes and terms of reference for clusters or cross-government groups

GUIDING QUESTIONS

- How, if at all, do groups or ministries within the government engage with the Ministry of Health on issues related to primary health care?
  - Probe: Who is involved?
  - Probe: How frequently does it happen? Is engagement done only around specific issues or is there a routine mechanism established?
  - Probe: Is engagement mandatory or voluntary?
- What are the roles and responsibilities for individuals in these cross-government groups? Who decides? Does this change?
- How, if at all, are these groups held accountable?
- How, if at all, are the proceedings of these groups recorded and shared?
- Can you share an example on when cross-sectoral planning has worked well? Where it was missed? If not, is there someone else we could talk to who could?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 6: Surveillance

Surveillance is the "ongoing, systematic collection, analysis, and interpretation of health-related data essential to the planning, implementation, and evaluation of public health practice."[10] Effective surveillance systems consistently perform the four functions listed below.[11-13]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Number of function(s) of an effective surveillance system (listed below) consistently performed in the majority of sub-national units: ☐ Track health and burden of disease metrics (morbidity, mortality, incidence) ☐ Detect, report, and investigate notifiable diseases, events, symptoms, and suspected outbreaks or extraordinary occurrences ☐ Continuously collect, collate and analyze the resulting data ☐ Submit timely and complete reports from local to higher levels of the system and from higher levels of the system back to lower/community levels	0-1	2	3	4 *Note: to achieve Level 4, all sub-national units must use an effective surveillance system that consistently performs all 4 functions described.*
Format of surveillance systems	Primarily paper-based	Primarily paper-based	Only some parts are electronic	Entirely electronic, and interoperable and interconnected

DEFINITIONS

Interoperable

Interoperability is the ability of different surveillance systems, processes, devices or applications to connect, in a coordinated manner, within and across organizational or geographic boundaries to access, exchange and cooperatively use data amongst stakeholders to respond to disease instances, with the goal of optimizing the health of individuals and populations.[14]

Interconnected

The facilitated linkage or connection of all constituent parts of the surveillance system. This refers to connection of surveillance system components—data systems, detection, reporting and investigative activities, and feedback loops—within a sub-national health system network, and to the linkage between different sub-national health system networks.

Measure 6: Surveillance

CONTEXTUAL INFORMATION

This measure assesses the presence and functioning of health surveillance systems. Strong surveillance systems are dynamic and multimodal networks that inform a country's ability to respond to emerging health needs and build resilience. This goes beyond the collection of data on incidence of communicable diseases of public health significance and notification of emergency response systems, to the dynamic collection of information on population health to inform service delivery. For example, an effective surveillance system would cover both the functions of detection, reporting, and investigation of an incident of viral meningitis, as well as flag a seasonal increase in diabetes complications or increase in road traffic injuries. In order to fill these functions, surveillance systems should track health and burden of disease information for a broad range of diseases, events and symptoms and integrate closely with health management information systems (Measure 16).

Collecting and recording data has little use without mechanisms in place to detect incidences or trends of issue, identified communication channels to report to, and trained staff with the necessary expertise and processes to investigate and respond to these incidences or trends. Recently, the Ebola epidemic underscored the importance of sensitive and robust surveillance systems. Feedback loops between facilities, sub-national regions and the centralized levels of the health system are critical to ensure that the data actually informs action. The flow of information from the national back to facility level is particularly important for response to incidents, with the establishment of communication channels and information system use playing an important role (Measure 31), as well as for overall integration of the surveillance system into population health and facility management.

REQUIRED DATA SOURCES

» At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

» Availability of data, reports, analysis of trends in priority diseases

Measure 6: Surveillance

GUIDING QUESTIONS

- How, if at all, are health and burden of disease metrics tracked in the country?
  - Probe: Metrics of disease incidence, morbidity, and mortality.
  - How much, if at all, does this system vary by sub-national unit? What proportion of sub-national units have the system you described?
  - What format are these systems in? Paper-based, electronic, etc)
- How, if at all, is information on disease incidence, morbidity, and mortality shared between and across different levels of the system?
  - Probe: What, if any, feedback loops exist between the facility level, regional, sub-national level and national level and how do they function?
  - Probe: Are systems interoperable so that information can be shared across geographic areas, types of facilities, etc?
- How, if at all, are notifiable diseases, symptoms, and potential outbreaks identified and tracked?
  - What health conditions are included in this surveillance system?
  - How much, if at all, does this system vary by sub-national unit? What proportion of sub-national units have the system you described?
  - If systems are reported to be different across sub-national levels: What proportion of [sub-national unit] would you classify as being equivalent to the highest performer? What proportion would you classify as being equivalent to the lowest performer?
  - What format are these systems in? (Paper-based, electronic, etc)
- How does a case make it into the surveillance system? If systems are noted to be inconsistent across sub-national levels, this question may be repeated for both a "high performer" and "low performer."
  - What percentage of cases do you think make it into the system? What evidence supports this hypothesis?
- What happens when a notification is made? What types of investigation and follow-up are undertaken?
  - How much, if at all, does the investigation and follow-up procedure differ by indication or geographic area?
  - How many notifications have occurred in the last 6 months? What proportion were responded to in the manner you just described?
  - If not 100%: How did the process differ in the other examples?
- How, if at all, is information shared between and across facilities, sub-national levels, and the national level?
  - What types of information or analyses are shared?
  - What, if any, feedback loops exist?
  - How would you characterize the speed at which information sharing occurs?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 7: Priority setting

Priority setting involves making decisions about how best to allocate limited resources to improve population health. Effective priority setting involves assessing existing and emerging health needs (see Measure 6: Surveillance), stakeholder engagement and social accountability, use of an explicit process, consideration of values and context, funding programs, communicating decisions, and managing feedback and demands from stakeholders at national and sub-national levels.

Note: This section refers to priority setting at the national and sub-national level. Local priority setting is addressed separately in Measure 25 under *Population health management*.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Degree to which data (health, burden of disease, user needs and preferences, service delivery evaluations, and cost effectiveness) are used to set service delivery priorities at the *national and sub-national* level.	Rarely, if ever	Occasionally	Systematically	Systematically
Proportion of priority setting exercises where stakeholder engagement occurs	Stakeholder engagement does not occur	Fewer than half	More than half	Systematically for all
Frequency at which allocation of resources is based on results of the priority setting exercise.	None	Less than half of the time	More than half of the time	All or nearly all of the time (>90%)

DEFINITIONS

Service delivery evaluation
Compilation and assessment of information about the progress and implementation of program or intervention activities, characteristics, outcomes/impact, consideration of whether the desired results have been achieved, and determination of the merit or worth of the program or intervention.[15]

Stakeholder engagement
The process through which the health system involves people who will be affected by decisions, priorities, and service delivery changes and/or people who can influence the implementation of the defined priorities in order to build and maintain an open and constructive relationship, and to enhance implementation and service delivery.[16]

CRITERIA

Rarely used
Data is available, presented, discussed and applied in <50% of priority setting exercises

Occasionally used
Data is available, presented, discussed and applied in 50% or more of priority setting exercises

Systematically used
Data is available, presented, discussed and applied through consistent processes for >90% of priority setting exercises

Systematic stakeholder engagement
The processes for identifying, communicating with, and convening stakeholders are transparent and consistent, with engagements occurring at regular, predefined intervals as well as on an ad-hoc basis, as necessary

Measure 7: Priority setting

CONTEXTUAL INFORMATION

This measure assesses national and sub-national systems for identifying health priorities and allocating resources appropriately. System-wide priority setting is a complex and inherently political process involving a diverse array of stakeholders, decision-makers, and actors, whose motivations and actions are often imperfectly aligned. Effective priority setting navigates these differing interests and motivations through clear processes, identifying the most appropriate, evidence-based programs and interventions to address the most important needs and demands of a population. This depends on the use of diverse sources of data: health and burden of disease information; service delivery evaluations; cost-effectiveness assessments; and stakeholder input for prioritizing the most appropriate programs and interventions and informing resource allocation. Stakeholder engagement plays an important role in priority setting because it ensures that priorities reflect population needs and that the interventions and programs selected are acceptable, appropriate, and desired.

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources.
- At least one sub-national and/or community representative should be consulted, in addition to any government and non-governmental informants.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Evidence of stakeholder engagement, stakeholder mapping
- Documentation of how priority setting is done—is there a system in place? What criteria are used?

Measure 7: Priority setting

GUIDING QUESTIONS

- How does the country determine service delivery priorities?
- What types of data, if any, are used to support this process?
  - Probe: health, burden of disease, user needs and preferences, service delivery evaluations, cost-effectiveness
  - How is this data acquired?
  - How exactly does it inform decision-making?
- Which stakeholders, if any, are engaged in priority-setting exercises?
  - How are these stakeholders identified?
  - How are their views, concerns or decisions solicited?
  - How frequently does stakeholder engagement occur? Is there a regular schedule or is this done on an ad hoc basis?
- How frequently are resource allocations based on established priorities? Put another way, how often are resource allocations made for personal, political, or other reasons that do not reflect the established priorities?
- How, if at all, does the priority setting process differ at the sub-national level compared to the national level?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 8: Innovation and learning

Innovation and learning is defined as having a system, organization, and culture in place that allows for flexibility and adaptation to modify behavior, practice, priorities, and policies to reflect new knowledge and insights (external or from within the country). This requires routine incorporation of new evidence from research or data and routine reviews and discussion of progress and challenges so that lessons from past events are identified and can be used to predict and/or improve response to future threats or changing health needs.

Innovation and learning can occur across a wide range of areas, including changes in the design of services, products, and production processes (technology element); new or altered ways of organizing or administering activities (organization element); new or improved ways of interacting with other organizations and knowledge bases (system interaction element); and new worldviews, rationalities, missions, and strategies (conceptual element). Innovation involves interrelated changes in technological, organizational and institutional elements of healthcare.[17]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
State of mechanisms to recognize, evaluate, and scale successful innovations	N/A	Nascent and often dependent on individual champions or relationships	Formalized, but may not be systematically implemented and/or transparent	Formalized, systematic and transparent
Engagement of stakeholders (government and private) in innovation and learning in PHC	N/A	Only some stakeholders are engaged	Stakeholders at all levels of the health system are engaged, but roles and responsibilities are not clearly defined	Stakeholders at all levels of the health system are engaged, with clearly defined roles and responsibilities
As a result of the performance of the above components, the occurrence of innovation and learning in PHC and scaling of successful innovations	Does not occur systematically, even at the local or pilot level	Mostly at the pilot level, and successful innovations are rarely if ever scaled	Mostly at the pilot level, and successful innovations are only occasionally scaled	Successful innovations are consistently scaled beyond the pilot level. There are systematic structures in place for sharing learnings across stakeholders at different levels of the health system

DEFINITIONS

Nascent
Newly created or in existence and only just beginning to display signs of future potential.

Formalized
With an agreed upon defined structure, established processes, and endorsement by health system governance and leadership.

Systematic
The methods and structure for recognizing and evaluating success and deciding to scale are established, widely understood, and used consistently as innovations arise.

Measure 8: Innovation and learning

CONTEXTUAL INFORMATION

This measure assesses whether a country has the underlying mechanisms to learn from new evidence, research, and data and to operationalize and incorporate these learnings into changes at scale. This requires mechanisms to recognize and evaluate innovations as well as the operational capacity to scale successful interventions and programs. It is important that innovations are evaluated before decisions to scale are made, rather than scaled as a result of internal or external lobbying. Standards and criteria for consideration as "successful" should be clearly defined and transparent, with standards applied consistently. The decision to adopt and diffuse innovations may be centralized to a small number of key players, or devolved to committees, departments and/or working groups. It is important that these decision-making processes are aligned with national strategy planning and budgetary cycles, in order to incorporate innovations in a sustainable way. The broad involvement of stakeholders supports an overall culture of innovation, and clearly defined roles helps ensure that mechanisms for recognizing success and scaling are not dependent on specific individuals or relationships between individuals, but formalized into a system.

REQUIRED DATA SOURCES

- At least one non-governmental informant (may be development partner, civil society organization, etc.) should be consulted in addition to any relevant government informants/sources.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Existence of national knowledge management and/or evidence review process
- Examples of innovations that have gone to scale recently
- Agencies responsible for supporting or evaluating innovations (i.e. NICE in the United Kingdom)
- Academic advisors to the ministry of health
- National institutes for health research

Measure 8: Innovation and learning

GUIDING QUESTIONS

- In your opinion, how would you describe the predominant culture in the country around learning and innovation in primary health care?
  - How is this demonstrated?
  - How much of a priority is it for the country to review its progress and challenges related to primary health care?
- Can you describe any systems that are in place for health system stakeholders to review progress and challenges and evaluate new data from the country level?
- How, if at all, does the country track pilots and innovations that are occuring?
- What sort of mechanisms exist that identify and recognize successful pilot projects?
  - How, if at all, are pilot projects required to report their findings?
  - How, if at all, are results and lessons from pilots or local level successes shared?
  - How frequently does this happen?
  - Who, if anyone, is responsible for ensuring that this occurs?
- Can you give an example of how research or data from local pilots has been shared and scaled?
  - If yes: What was the process for this? What stakeholders were involved? How were the projects scaled? Have they been sustainable?
- How, if at all, do other countries' progress and challenges inform plans or programming in this country?
  - How is information about other countries' performance obtained?
  - What, if any, formal structures are in place to support this learning? How do these structures function?
- What, if any, formats or venues are set up for sharing successful research, pilot projects or scaled innovations?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 9: Availability of essential medicines and consumable commodities

"**Essential medicines** are those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford."[18] **Essential consumable commodities** are the items and products identified as necessary to treat, cure and/or prevent health system priorities. These may include vaccines, contraceptives, malaria products, sterile gauze, disposable needles, etc.[19]

The **availability** of essential medicines and consumable commodities depends on a functioning supply chain to manage the effective planning, coordination, procurement, inventory management, transportation, distribution, storage, and data collection and reporting, and to ensure the flow of essential medicines and consumables commodities reaches the patient at the primary care facility level.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of primary care facilities that have all primary care-specific essential medicines and consumable commodities available	Fewer than one-third	Between one-third and two-thirds	Between two-thirds and 90%	At least 90% have all primary care-specific essential medicines and consumable commodities consistently available
Variation in availability between subnational areas and/or facility types	Significant	Moderate	Minimal	None

CRITERIA

Significant variation
The maximum absolute difference in availability of essential medicines and consumable commodities between sub-national areas and/or facility types is >30%.

Moderate variation
The maximum absolute difference in availability of essential medicines and consumable commodities between sub-national areas and/or facility types is between 30% to 10%.

Minimal variation
The maximum absolute difference in availability of essential medicines and consumable commodities between sub-national areas and/or facility types is <10%.

Measure 9: Availability of essential medicines and consumable commodities

CONTEXTUAL INFORMATION

The list of essential medicines and consumable commodities should be defined at the country level, and can often be found in a national essential medicines list. This describes the medicines approved to address (treat, cure and/or prevent) the priority health needs of a population. There may be defined essential medicines lists specifically for different levels of care in the health system, and assessment of this measure should focus on primary health care, as defined in Phase 1 of the assessment process. If there is no essential medicines/essential commodities list defined, this measure should be scored as a Level 1.

For essential medicines and consumable commodities to be considered "available" at the primary care facility level, there must be: the correct medicines and commodities present in the appropriate quantities to meet patient needs and priorities, they must be in a safe and viable (ie, non-expired) condition, and able to be dispensed or used as needed. The level of performance for this measure therefore depends on the management of the essential medicines and consumable commodities supply chain.

REQUIRED DATA SOURCES

- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Planning, quality management, and/or pharmacy division/unit
- Central/sub-national/sub-regional medical stores
- Central/sub-national/sub-regional pharmacists
- Drug procurement committee(s)
- Facility audit data
- Health facility assessments such as SARA, SPA, or SDI
- Stock out report
- Commodity supply chain plan
- Logistics management information system

GUIDING QUESTIONS

- What proportion of primary care facilities had all required essential medicines and consumable commodities at the time of the last assessment?
- How does this differ by geography or facility type?
- How does this vary over time? *You should ask to see the three most recent time points, whether monthly, quarterly, yearly, etc. "Consistency" can be determined by looking at whether availability remains constant or varies at the facility level across the three time points. If facility-level data is not available, sub-regional data may be used and relative proportion of availability over time assessed.*
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do* ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 10: Basic equipment

Basic equipment refers to the essential supplies needed for "the safe and effective prevention, diagnosis, treatment and rehabilitation of illness and disease"[20] at all primary care facilities.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of primary care facilities that have all basic equipment present and functioning	Fewer than one-third	Between one-third and two-thirds	Between two-thirds and 90%	At least 90% have all basic equipment consistently available
Variation in availability between subnational areas and/or facility types	Significant	Moderate	Minimal	None

DEFINITIONS

Basic equipment

- scales
- measuring tape
- thermometer
- blood pressure apparatus
- stethoscope*

**This list of basic equipment was extracted from the SARA survey, the SPA survey, the SDI, and the WHO "List of Medical Devices by Facility"*[21-24]

CRITERIA

Significant variation

The maximum absolute difference in availability of basic equipment between sub-national areas and/or facility types is >30%.

Moderate variation

The maximum absolute difference in availability of basic equipment between sub-national areas and/or facility types is between 30% to 10%.

Minimal variation

The maximum absolute difference in availability of basic equipment between sub-national areas and/or facility types is <10%.

Measure 10: Basic equipment

CONTEXTUAL INFORMATION

Essential equipment is needed in all primary care facilities in order to prevent disease, make diagnoses, monitor, treat and alleviate conditions, and make service delivery decisions. Performance in this measure is influenced by "the proper manufacturing, regulation, planning, assessment, acquisition, and management" of essential equipment.[20] The list of basic equipment above was selected from the WHO list of medical devices by facility[21] because this information can be extracted from data from a SARA[22], SPA[23], and/or SDI survey[24]. If a country has not completed one of these surveys in the last 5 years and/or has more recent data from another source, it is permissible for the exact list of basic equipment assessed to vary slightly—for example, some countries may assess availability of a hand-held light source but not the availability of measuring tape.

If the country has a more robust list of basic equipment, you may also assess progress against that list but a country should not be scored lower because of using stricter requirements. For example, if only 50% of facilities have all equipment as defined through a country's internal, more robust list but 80% of facilities have the five items listed above the facility should be scored as a 3, not as a 2 (assuming conditions re: equity are met).

REQUIRED DATA SOURCES

- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Physical assets management division/unit
- Health facility assessments such as SARA, SPA, or SDI
- Standard equipment lists
- Provider mapping reports

GUIDING QUESTIONS

- What percent of facilities have all basic equipment - including scales, measuring tape, thermometer, blood pressure apparatus, and stethoscope - present and functioning at any given time?
- How does this differ by geography or facility type?
- How does this vary over time? *You should ask to see the three most recent time points, whether monthly, quarterly, yearly, etc. "Consistency" can be determined by looking at whether availability remains constant or varies at the facility level across the three time points. If facility-level data is not available, sub-regional data may be used and relative proportion of availability over time assessed.*
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do* ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 11: Diagnostic supplies

Diagnostic supplies refers to the materials needed to conduct essential diagnostic tests, with the aim of providing information on a patient's condition for diagnosis, monitoring, screening, prediction, or prognosis purposes at the primary care facility level.[25]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of primary care facilities that have all of the supplies needed to conduct the diagnostic tests listed at right.	Fewer than one-third	Between one-third and two-thirds	Between two-thirds and 90%	At least 90% of facilities have all of the supplies needed to conduct the identified diagnostic tests consistently available
Variation in availability between subnational areas and/or facility types	Significant	Moderate	Minimal	None

DEFINITIONS

Diagnostic supplies

The necessary materials to conduct:

- hemoglobin tests
- blood glucose tests
- urine dipsticks for protein
- urine dipsticks for glucose
- urine pregnancy tests
- other tests as defined by local health needs or guidelines (i.e. malaria, syphilis, HIV)*.

These materials may include "reagents, calibrators, control materials, specimen receptacles, software and related instruments or apparatus or other articles."[25]

**This list of diagnostic supplies was extracted from the SARA survey, the SPA survey, the SDI, and the WHO "List of Medical Devices by Facility"*[21-24]

CRITERIA

Significant variation

The maximum absolute difference in availability of diagnostic supplies between sub-national areas and/or facility types is >30%.

Moderate variation

The maximum absolute difference in availability of basic equipment between sub-national areas and/or facility types is between 30% to 10%.

Minimal variation

The maximum absolute difference in availability of basic equipment between sub-national areas and/or facility types is <10%.

Measure 11: Diagnostic supplies

CONTEXTUAL INFORMATION

Diagnostics are a crucial input to service delivery because they provide information on patient and disease conditions and can be used to guide clinical decision-making to determine what sort of services, medicines, or treatment, if any, are needed. The list of diagnostic supplies above was selected from the WHO list of medical devices by facility[21] because this information can be extracted from data from a SARA[22], SPA[23], and/or SDI survey[24]. If a country has not completed one of these surveys in the last 5 years and/or has more recent data from another source, it is permissible for the exact list of diagnostic supplies assessed to vary slightly. In advance of the assessment, you should consult relevant standards for the country to determine whether any additional tests have been deemed necessary by the country and should be added to this list.

Additional diagnostic supplies to be included in the assessment include __.

REQUIRED DATA SOURCES

- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Laboratory services and/or technical support divisions/units
- Central medical stores
- Laboratory outreach and supportive supervision reports
- National Malaria or HIV control programs
- Health facility assessments such as SARA or SPA

GUIDING QUESTIONS

- What percent of facilities have all of the necessary supplies for the following diagnostic tests: hemoglobin tests, blood glucose tests, urine dipsticks for protein, urine dipsticks for glucose, urine pregnancy test, and any other tests as determined by local health needs or guidelines such as malaria, syphilis, and HIV?
- How does this differ by geography or facility type?
- How does this vary over time? *You should ask to see the three most recent time points, whether monthly, quarterly, yearly, etc. "Consistency" can be determined by looking at whether availability remains constant or varies at the facility level across the three time points. If facility-level data is not available, sub-regional data may be used and relative proportion of availability over time assessed.*
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 12: Facility distribution

Ensuring that all populations have timely, geographic access to care requires sufficient facility infrastructure. The number and type of facilities needed depends on many factors such as population distribution and staffing of facilities, among others, and there are therefore no global normative guidelines for facility density or distribution. Instead, it is important for countries to assess their own facility density and distribution needs and set targets that reflect these needs and local context.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Has there been an assessment of primary health care density and distribution in the country?	No	Yes	Yes	Yes
Are there documented targets for optimal health facility density and distribution to meet population health needs?	No	Yes	Yes	Yes
What action has been taken towards achieving targets?	N/A	No or limited action	Action has been taken and progress made, though targets have not yet been met	Action has been taken and the targets have been met

DEFINITIONS

Facility density

The number of primary care facilities per number population. Some indicators base the facility density per 10,000 people, others by 5,000 or 100,000. The denominator should be kept consistent.

Measure 12: Facility distribution

CONTEXTUAL INFORMATION

The density and distribution of primary care facilities refers to the physical locations of primary care facilities. Infrastructural deficiencies pose issues for patient geographic access to care and health system ability to deliver services. The definition of "primary care facility" established at the outset of the assessment should be used for this measure. Because there is no global normative guidance on the optimal facility density and distribution, this measure instead assesses whether countries have conducted their own assessment of facility density and distribution, set targets for optimal density/distribution based on local context and population health needs, and taken steps towards meeting these targets.

In assessing the density and distribution of facilities, it is important to know the number of health facilities, the number of different facility types, the size of the population, and the overlap between where the population lives (population density), and where the facilities are (facility density), disaggregated by sub-national area.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Primary health services development plan
- Estates, hospitals, and/or primary health care division/unit.
- Master facility plan

GUIDING QUESTIONS

- Do you know the ratio of primary care facilities to population in [country]? If so what is it? If not, how many primary care facilities are there in the country?
- Do you have information about how facilities are distributed across regions or districts?
- Do you know how facility distribution compares to population distribution? If no, do you have information about how the population is distributed across regions or districts?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 13: Facility amenities

Facility amenities are features and utilities that enable primary care facilities to be ready and able to provide quality, person-centered primary health care.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of primary care facilities that have all of the identified amenities	Fewer than one-third	Between one-third and two-thirds	Between two-thirds and 90%	At least 90% have all of the identified amenities consistently available
Variation in availability between subnational areas and/or facility types	Significant	Moderate	Minimal	None

DEFINITIONS

Facility amenities

- electricity
- safe water
- exam room with auditory and visual privacy
- light source
- sanitation facilities (toilet/latrine: flush/pour toilets to piped sewer system or septic tank, pit latrine, composting toilet)
- communication equipment (cell phone, landline telephone, and/or shortwave radio)
- computer with internet or network connectivity
- access to emergency transportation*

**This list of facility amenities was extracted from the SARA survey, the SPA survey, and the SDI survey*[22-24]

CRITERIA

Significant variation

The maximum absolute difference in availability of facility amenities between sub-national areas and/or facility types is >30%.

Moderate variation

The maximum absolute difference in availability of facility amenities between sub-national areas and/or facility types is between 30% to 10%.

Minimal variation

The maximum absolute difference in availability of facility amenities between sub-national areas and/or facility types is <10%.

Measure 13: Facility amenities

CONTEXTUAL INFORMATION

Facility amenities are considered a core component of health facility readiness to provide services.[26] The list of facility amenities above is extracted from the SARA survey[22], the SPA survey[23], and the SDI survey.[24] If a country has not completed one of these surveys in the last 5 years and/or has more recent data from another source, it is permissible for the exact list of amenities assessed to vary slightly. If a more robust list of basic amenities required for primary care facilities has been defined by the country, you may also assess progress against that list but a country should not be scored lower because of using stricter requirements. For example, if only 50% of facilities have all amenities as defined through a country's internal, more robust list but 80% of facilities have the amenities listed above the facility should be scored as a 3, not as a 2 (assuming conditions re: equity are met).

REQUIRED DATA SOURCES

- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Planning or physical assets management divisions/units
- Labor Ministry
- Health facility assessments such as SARA, SPA, or SDI

GUIDING QUESTIONS

- What percent of facilities have the following facility amenities: electricity, safe water, exam room with auditory and visual privacy, light source, sanitation facilities (toilet/latrine), communication equipment (cell phone, landline telephone, and/or shortwave radio), computer with internet or network connectivity, and access to emergency transportation?
- How does this differ by geography or facility type?
- How does this vary over time? *You should ask to see the three most recent time points, whether monthly, quarterly, yearly, etc. "Consistency" can be determined by looking at whether availability remains constant or varies at the facility level across the three time points. If facility-level data is not available, sub-regional data may be used and relative proportion of availability over time assessed.*
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do* ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 14: Standard safety precautions and equipment

Standard safety precautions and equipment are the established processes and materials that support safe primary care service delivery and prevent transmission of communicable diseases.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of primary care facilities that have all of the identified standard safety precautions and equipment in place	Fewer than one-third	Between one-third and two-thirds	Between two-thirds and 90%	At least 90% have all of the identified standard safety precautions and equipment consistently available
Variation in availability between subnational areas and/or facility types	Significant	Moderate	Minimal	None

DEFINITIONS

Standard safety precautions and equipment

- sterilization equipment
- safe final disposal of sharps
- safe final disposal of medical waste
- sharps box/container in exam room
- waste bin with lid and liner in exam room
- surface disinfectant (also called environmental disinfectant)
- single-use standard disposable or auto-disposable syringes
- soap (bar or full-concentration liquid) and running water or alcohol-based hand sanitizer
- latex gloves
- guidelines for standard precautions against infection*

** This list of standard precautions and equipment was extracted from the SARA survey, the SPA survey, the SDI, the WHO "Infection Prevention and Control Assessment Framework at the Facility Level", and the WHO "Guidelines of core components of infection prevention and control programmes at the national and acute health care facility level"*[22-24,27,28]

CRITERIA

Significant variation

The maximum absolute difference in availability of standard safety precautions and equipment between sub-national areas and/or facility types is >30%.

Moderate variation

The maximum absolute difference in availability of standard safety precautions and equipment between sub-national areas and/or facility types is between 30% to 10%.

Minimal variation

The maximum absolute difference in availability of standard safety precautions and equipment between sub-national areas and/or facility types is <10%.

Measure 14: Standard safety precautions and equipment

CONTEXTUAL INFORMATION

Standard safety precautions and equipment, sometimes called standard precautions on prevention of infections, are considered a core component of health facility readiness to provide high-quality services and ensure the safety of patients and providers.[26] The list of standard precautions and equipment above is extracted from the SARA survey[22], the SPA survey[23], the SDI survey[24], the World Health Organization's "Infection Prevention and Control Assessment Framework at the Facility Level"[27], and the WHO "Guidelines of core components of infection prevention and control programmes at the national and acute health care facility level".[28] If a country has not completed one of these surveys in the last 5 years and/or has more recent data from another source, it is permissible for the exact list of standard safety precautions and equipment assessed to vary slightly.

If a more robust list of standard safety precautions and equipment has been defined by the country, you may also assess progress against that list but a country should not be scored lower because of using stricter requirements. For example, if only 50% of facilities have all standard safety precautions and equipment as defined through a country's internal, more robust list but 80% of facilities have the standard safety precautions and equipment listed above the facility should be scored as a 3, not as a 2 (assuming conditions re: equity are met).

REQUIRED DATA SOURCES

- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Planning, statistics, and or quality assurance division/unit
- Health facility assessments such as SARA, SPA, or SDI
- National policy for healthcare quality and accreditation
- Facility accreditation standards

GUIDING QUESTIONS

- What percent of facilities have the following standard safety precautions and equipment: sterilization equipment, safe final disposal of sharps, safe final disposal of medical waste, sharps box/container in exam room, waste bin with lid and liner in exam room, surface disinfectant (also called environmental disinfectant), single-use standard disposable or auto-disposable syringes, soap (bar or full-concentration liquid) and running water or alcohol-based hand sanitizer, latex gloves, and guidelines for standard precautions against infection?
- How does this differ by geography or facility type?
- How does this vary over time? *You should ask to see the three most recent time points, whether monthly, quarterly, yearly, etc. "Consistency" can be determined by looking at whether availability remains constant or varies at the facility level across the three time points. If facility-level data is not available, sub-regional data may be used and relative proportion of availability over time assessed.*
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do* ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 15: Civil Registration and Vital Statistics

All countries should have a well-functioning **Civil Registration and Vital Statistics (CRVS)** system that registers all births and deaths, issues birth and death certificates, and compiles and disseminates vital statistics, including cause-of-death information. It may also record other events such as marriage, divorce, adoption and legitimation. CRVS systems generate administrative data, which serve as the basis for databases, or population registers, across multiple sectors and can be compiled to produce vital statistics.[29]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Completeness of registration of births nationally	Limited (<50%)	50-74%	75-90%	>90%
Completeness of registration of deaths nationally	Limited (<50%)	50-74%	75-90%	>90%

CRITERIA

Completeness

The proportion of the total number of actual births and deaths that were recorded in the civil registration and vital statistics system. A complete system would capture 100% of all births and deaths.

Measure 15: Civil Registration and Vital Statistics

CONTEXTUAL INFORMATION

Information on how many people are born and die each year in a country, as well as the causes of death, is essential for effective health planning and service delivery. "The only way to count everyone and to track all births and deaths is through civil registration. Civil registration provides the basis for individual legal identity but also allows countries to identify their most pressing health issues."[30] Civil Registration and Vital Statistics systems provide routine, up-to-date fertility and mortality data of a population which can be used to establish the foundation for many health policies and provides a meaningful denominator for monitoring and evaluation of burden of disease data. Assessment of the completeness of a CRVS system often compares the number of births and deaths registered with that of the estimated population.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Civil registration and/or social welfare division/unit
- National statistics offices
- Ministry of Education

GUIDING QUESTIONS

- How does the country register births and deaths?
- Are births and deaths that do not take place in a facility included in this system?
  - If no, is there another method to register these births and deaths?
- What percent of births and deaths are registered? Can you show me documentation of this? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do **not** obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 16: Health Management Information Systems (HMIS)

HMIS are routine facility reporting systems used to monitor service data. "Service data are generated at the facility level and include key outputs from routine reporting on the services and care offered and the treatments administered."[26]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of primary health care facilities in which Health Management Information Systems are in place.	Fewer than half	More than half	More than half	Greater than two thirds, and they are interoperable and interconnected.
Format of HMIS	All or primarily paper-based	All or primarily paper-based	Only some parts are digitized	Fully digitized

Measure 16: Health Management Information Systems (HMIS)

CONTEXTUAL INFORMATION

This measure is about the presence and digitization of HMIS. Personal care records are assessed separately in the next measure. HMIS are important data collection systems that can be used to plan, manage, and make decisions in health facilities and across a country. This goes beyond simple monitoring and evaluation, to facilitate the active collection and assessment of service data. HMIS systems should be integrated 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, called a data dictionary in some contexts, ensures that all users of an HMIS are defining and measuring indicators the same way and therefore are "speaking the same language."

REQUIRED DATA SOURCES

- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- HMIS division/unit

GUIDING QUESTIONS

- Please describe the Health Management Information System(s) (HMIS) that are used in the country.
- What proportion of facilities have HMIS?
- What is the format of the HMIS? Are they paper-based or digitized?
  - If digitized, are all elements of the HMIS digital or are some elements still paper-based?
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links?
  *Note: You must ensure that you do **not** obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 17: Personal care records

Personal care records provide a longitudinal health history of patients. Comprehensive personal care records should include the following components:

- Unique patient identification (ID)
- Problem lists
- Care history and notes
- Medication lists and allergies
- Referrals and results of referrals
- Laboratory, radiology and other test results

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Use of personal care records	The majority of primary care facilities do not use personal care records, rely on patients to carry their own paper-based personal care records, or use another paper-based personal care record system which does not record patient information longitudinally.	The majority of primary care facilities use longitudinal personal care records that include 1-4 of the components described above.	The majority of primary care facilities use longitudinal personal care record that include 5-6 of the components described above.	Almost all (<90%) primary care facilities use a comprehensive longitudinal personal care record that includes all six of the components described above.
Format of personal care records	N/A	Nearly exclusively paper-based	Paper based and use a standard format. Some isolated facilities or sub-national units may use nascent electronic records	Fully digitized and interoperable across levels and sub-national areas

DEFINITIONS

Interoperable
Interoperability is the ability of different information systems, devices or applications to connect, in a coordinated manner, within and across organizational boundaries to access, exchange and cooperatively use data amongst stakeholders, with the goal of optimizing the health of individuals and populations.[14]

Longitudinal
Containing information gathered over a long period of time.

Nascent
Newly created or in existence and only just beginning to display signs of future potential.

Measure 17: Personal care records

CONTEXTUAL INFORMATION

Comprehensive personal care records record the history and clinical "story" of a patient, summarizing their experiences with the health system over time in one place. While HMIS and CRVS are invaluable for planning, managing, and decision-making at the facility, sub-regional, sub-national and nation decisions, personal care records play an important role in fostering quality, continuous, and coordinated care. Health care workers in primary care and other levels of the health system and patients can review and act on the complete information in personal care records to better assess, diagnose, monitor, treat, and/or refer a patient. By maintaining relevant information in one place, personal care records make it easier to identify and follow trends, understand chronic conditions, and address any gaps in care.

Personal care records are considered interoperable when the same information is captured in the same or similar format and channels are established such that personal care records can be shared between clinicians and facilities. This means that a patient's care history is then able to follow them as they move geographically or between levels of the health system.

A longitudinal record means that there is a system within the personal care record that allows providers to track a patient's care over time and multiple care encounters.

Electronic personal care records may be considered nascent if they do not have all of the components or functionality of comprehensive personal care records or if clinicians are not fully transitioned to the electronic platform.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

» HMIS division/unit

Measure 17: Personal care records

GUIDING QUESTIONS

- What types of personal care records are used in the country?
  - Probe: Personal care records may include the following: unique IDs, problem lists, care history and notes, medication lists and allergies, referrals and results of referrals, and laboratory, radiology, and other test results.
- How much do personal care records vary from facility to facility or [sub-regional unit] to [sub-regional unit]?
- *[For each type of personal care record in use]* Can you tell me a little bit more about this type of record?
  - Probes:
    - Is it paper-based or electronic? If mixed, what elements are electronic vs. paper?
    - Is it maintained at the facility or kept by patient?
    - Does it include a unique identifier?
    - Which elements are included: problem lists, care history and notes, medication lists and allergies, referrals and results of referrals, and laboratory, radiology, and other tests?
    - Does the record contain information about care delivered at different facilities/different levels of the health system?
    - Is the record accessible at different locations/different levels of the health system
  - Do you have a blank example that I could take with me or have a print-out/take a picture of?
  - What proportion of facilities use this type of record?
  - Can you show me documentation of this? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do **not** obtain any data or information that includes patient information or any other personally-identifiable data.*
- *Repeat the questions above for each format mentioned by the respondent.*

Measure 18: Workforce density and distribution

Achieving effective coverage of health services is dependent on having a sufficient number of skilled health professionals who are equitably distributed and accessible by the population.[31] The World Health Organization has defined a required density of skilled health workers for meeting basic health needs and for achieving coverage of the broad range of primary care services targeted by universal health coverage, where density is measured as the ratio of doctors, nurses, and midwives to the total population.[31,32]

Note: Community Health Workers are considered separately in Measure 21.

DEFINITIONS

Skilled health professional
Doctors, nurses and midwives who are actively providing clinical care

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Workforce density	Critical workforce shortages to meet basic health needs	Insufficient workforce density to achieve high coverage across the broad range of primary care services that are targeted by universal health coverage	Insufficient workforce density to achieve high coverage across the broad range of primary care services that are targeted by universal health coverage	Sufficient workforce density to achieve high coverage across the broad range of primary care services that are targeted by universal health coverage
(Ratio of active skilled health professionals per 10,000 population.)	(<22.8)	(>22.8 but <44.5)	(>22.8 but <44.5)	(>44.5)
Percentage of subnational administrative units that have a health workforce density below 50% of the national median density	N/A	>50%	<50%	N/A

Measure 18: Workforce density and distribution

CONTEXTUAL INFORMATION

The health workforce density and distribution is a "critical starting point for understanding the health system resources situation in a country".[33] For this measure, only **doctors, nurses, and midwives who are actively practicing medicine (i.e., not retired, working in another field, etc.)** should be counted in order to maintain fidelity to the measures recommended by the World Health Organization. Community Health Worker-type cadres are considered separately in Measure 21. The quality of training and practice for all "primary care health workers" are considered separately in Measure 19 and 20.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Human resources and/or planning division/unit
- Census or labour force surveys
- Payroll registrars
- Health professional regulatory bodies

GUIDING QUESTIONS

- Can you provide me with documentation of the current number of active (ie, currently practicing) doctors, nurses and midwives in country that is disaggregated at least to the sub-national unit? May I have a copy, take a photo, and/or can you give me the links?
- Can you provide me with documentation of the current population (or estimated population), disaggregated at the sub-national unit? May I have a copy, take a photo, and/or can you give me the links? *Note: You must ensure that you do* ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 19: Quality assurance of primary health care workforce

This measure is about the functionality and coverage of a continuous system for ensuring that the practicing primary health care workforce has the appropriate training and qualifications, that lists of those appropriately trained and qualified workforce are maintained, and that appropriate measures are taken with respect to workforce members who do not meet established standards.

Note that assessments of workforce competence and quality of care provided during patient interactions are included in the Performance Pillar of the Vital Signs Profile.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Capacity of the system to ensure that the primary health care workforce has the required qualifications.	None	Weak	Moderate	Sufficient
Capacity of the system to ensure that all actively practicing primary health care workforce are qualified, including workforce with foreign credentials.	None	Weak	Moderate	Sufficient
Capacity of the system to ensure that quality standards are met in practice.	None	Weak	Moderate	Sufficient

DEFINITIONS

Mechanisms to ensure that the workforce has the required qualifications
May include established standards for learning outcomes and training institutions, training institution accreditations, and/or a system for licensing or certifying graduates of training institutions.

Mechanisms to ensure that all actively practicing workforce are qualified, including workforce with foreign credentials
May include ensuring all practicing workforce be licensed and/or accredited, and/or a list of all qualified workforce is routinely updated to ensure that it is current.

Mechanisms to ensure that quality standards are met in practice
May include a means of issuing and investigating complaints, continuing professional development including periodic re-validation of credentials/registration/licensing, and/or the capacity to course correct members of the workforce who fail to meet standards, including the possibility of removal if no improvements are made.

CRITERIA

Weak capacity
Coverage of system does not include all occupations of the primary health care workforce and quality assurance mechanisms are not consistently implemented and functioning due to insufficient staff and/or funds within the responsible regulatory bodies.

Moderate capacity
Coverage of system does not include all occupations of the primary health care workforce but quality assurance mechanisms that are in place are consistently implemented and functioning due to sufficient staff and funds within the responsible regulatory bodies.
OR Coverage of system includes all occupations of the primary health care workforce but quality assurance mechanisms are not consistently implemented and functioning due to insufficient staff and/or funds within the responsible regulatory bodies.

Sufficient capacity
Coverage of system includes all occupations of the primary health care workforce and quality assurance mechanisms that are in place are consistently implemented and functioning due to sufficient staff and funds within the responsible regulatory bodies.

Measure 19: Quality assurance of primary health care workforce

CONTEXTUAL INFORMATION

This measure assesses systems for quality assurance of both workforce education and practice, reflecting the need to have a consistency of quality standards, from education to practice, and a continuum of stakeholders working to assure quality at each phase of training and practice. The capacity of systems is assessed as both their level of functionality as well as their coverage. When assessing coverage, you should reference the list of primary health care workforce occupations defined at the beginning of the assessment.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Human resources and/or planning division/unit
- Health professional regulatory bodies
- Health workforce training institutions

Measure 19: Quality assurance of primary health care workforce

GUIDING QUESTIONS

- What mechanisms, if any, does the system use to ensure that the primary care workforce has the qualifications it needs to provide safe, effective care?
  - Probe: What, if any, standards for learning outcomes have been set for workforce training? How were these outcomes established? Are they evidence-based? What occupations of the PHC workforce have learning outcomes? How are these standards enforced?
  - Probe: What, if any, standards exist for PHC workforce training institutions? How were these standards established? Are they evidence-based? What occupations of the PHC workforce have learning outcomes? How are these standards enforced?
  - Probe: How, if at all, are training institutions accredited? Are these standards internationally accepted and/or validated? What proportion of training institutions are accredited? How is accreditation enforced? What proportion of workers have graduated from an accredited institution?
  - Probe: Is there a system for licensing and/or certifying graduates of training institutions? If yes, please describe how the system is designed. What occupations of the PHC workforce are licensed/accredited? How is this system enforced?
- What mechanisms, if any, does the system use to ensure that the practicing primary care workforce is qualified?
  - Probe: What system(s), if any, are there for licensing and/or accrediting practicing workforce? Which occupations of the PHC workforce are covered by this system? How is this system enforced?
  - Probe: How, if at all, are the credentials of foreign workforce confirmed and/or appraised? How is this system enforced?
  - Probe: Is there a list of all qualified individuals that make up the PHC workforce? Which occupations of the PHC workforce are included? How is this maintained to ensure its accuracy and currency? How frequently is it updated?
- What mechanisms, if any, does the system use to ensure that quality standards are met in practice?
  - Probe: What mechanisms, if any, support the periodic re-validation of workforce credentials, registration, and/or licensing? How frequently are credentials updated? What occupations of the PHC workforce are covered by this system? How is the system enforced?
  - Probe: What system, if any, is in place for patients or the public to issue complaints? Who can issue a complaint and how is access to issuing complaints ensured?
  - Probe: What system, if any, is in place to ensure that complaints are investigated? Are complaints recorded? What mechanisms, if any, ensure that investigations are timely and unbiased?
  - Probe: What capacity, if any, does the system have to work on course-correcting efforts with workforce members who fail to meet standards? What occupations of the workforce are covered? If improvements are not made, what capacity, if any, does the system have to remove workforce members from practice? How is this system enforced?
- Can you show me documentation of what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  *Note: You must ensure that you do **not** obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 20: Primary health care workforce competencies

"Competencies are the observable abilities of individual health workers relating to specified activities of work that integrate knowledge, skills, and behaviors. Competencies are durable, trainable and measurable."[34] The primary health care workforce should have competencies related to people-centeredness, communication, decision-making, collaboration, evidence-informed practice, and personal conduct to enable them to provide the PHC service package.

This measure assesses whether evidence-based and locally-adapted competencies relevant to PHC service delivery have been defined for the PHC workforce and whether standards for education outcomes based on these competencies have been established.

Note that assessments of workforce competence and quality of care provided during patient interactions are included in the Performance Pillar of the Vital Signs Profile.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Are competencies specific to the PHC service package established for all occupations of the PHC workforce?	No	Yes	Yes	Yes
Number of elements below that can be answered positively: ❒ Competencies relevant to PHC are evidence-based. ❒ Competencies relevant to PHC are adapted to the country context, meaning that competencies reflect the list of interventions at the PHC level and structure of the PHC workforce in the country. ❒ Competencies relevant to PHC incorporate all key functions of primary health care: first-contact access, continuity, comprehensiveness, coordination, and people-centered. ❒ Standards for education that are based on competencies relevant to PHC have been set for all occupations of the PHC workforce.	N/A	0-2	3	4

Measure 20: Primary health care workforce competencies

CONTEXTUAL INFORMATION

Defining competencies in relation to the PHC service package for all occupations of the PHC workforce is an essential input for aligning education programs and workforce practice with population health needs and ensuring that the PHC workforce is capacitated to deliver on the core functions of PHC (first point of contact, continuity, comprehensiveness, coordination, and person-centeredness). Competencies include people-centeredness, communication, decision-making, collaboration, evidence-informed practice, and personal conduct.[34] Defining these competencies in relation to the PHC service package is a mechanism for ensuring that all occupations of the PHC workforce are able to demonstrate these core competencies to execute their PHC job requirements and deliver the core functions of PHC.

Many different competency frameworks exist that are evidence-based. However, in order to ensure that these competencies are relevant to the country-specific package of PHC services, to the way in which health care providers are organized and their scopes of work defined, it is essential that countries adapt evidence-based competencies to their context.

Note that occupations that make up the PHC workforce in any given country are defined at the outset of the assessment.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Human resources and/or planning division or unit
- Health professional regulatory bodies
- Health workforce training institutions

GUIDING QUESTIONS

- Has the country defined a PHC service package?
- Has the country defined a list of competencies for primary health care workforce?
- *[If competencies exist]* Which occupations of the primary health care workforce have defined competencies?
  - Probe: list of occupations agreed upon at outset of assessment
- *[If competencies exist]* How were these competencies defined?
  - Probe: evidence-based, local adaptation
- *[If competencies exist]* How are these competencies relevant to primary health care?
  - Probe: mention of the core functions of PHC (first-contact access, continuity, comprehensiveness, coordination, person-centered)
- *[If competencies exist]* How, if at all, are these competencies reflected in standards of practice?
  - Probe: Occupations with established standards of practice based on competencies.

Measure 21: Community Health Workers

This measure is about an occupation of health worker whose primary responsibility is to conduct proactive outreach in the community to meet local population health needs. This occupation may be referred to as a Community Health Worker but may have other designations depending on the country.[35]

Note: This type of health worker will also be involved in providing the services described in Measure 27: Proactive Population Outreach.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Is there an occupation of health worker whose primary responsibility is to conduct proactive outreach in the community to meet local population health needs?	No, or only a minimally functioning occupation working only in select geographic areas and/or providing only a limited scope of proactive outreach services.	Yes	Yes	Yes
Number of below criteria the occupation meets ❒ Trained and accredited to provide a suite of preventative, promotive, and curative (where appropriate) health services, tailored to the local population ❒ Formally employed and remunerated appropriately, in accordance with the local health worker salary scale ❒ Supported at frequent, regular intervals by a designated supervisor ❒ Integrated into local health facility service delivery system or teams ❒ Integrated into local health data reporting and feedback systems	N/A	2-3	4	5

DEFINITIONS

Accredited
Officially recognized as having a particular status or being qualified to perform a particular activity.

Formally employed
Having a working agreement or contract

Remunerated appropriately
The World Health Organization recommends that Community Health Workers be remunerated with a financial package that "could take different forms (salary, stipend, honorarium, monetary incentives), in accordance with the employment status and applicable laws and regulations in the jurisdiction."[35]

Measure 21: Community Health Workers

CONTEXTUAL INFORMATION

"CHWs and other types of community-based health workers are effective in the delivery of a range of preventive, promotive and curative health services, and they can contribute to reducing inequalities in access".[35] This measure is about an occupation (cadre) of health worker whose primary responsibility is to conduct proactive population outreach, regardless of what this type of worker is called. The five characteristics assessed in this measure are considered best practices for community-based health workers based on the "WHO guideline on health policy and system support to optimize community health worker programmes."[35]

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Documentation of CHW training and accreditation standards.
- Documentation of CHW employment and payment standards/history.
- Documentation of supervision standards/protocol and, if possible, evidence of implementation of these standards (supervision reports, etc.).
- Documentation of integration of CHWs into service delivery system/teams and data systems, including job descriptions for CHWs and their supervisors, standard operating procedures, and/or policies and strategies describing role of CHWs.

GUIDING QUESTIONS

- Is there an occupation (cadre) of health worker in this country that provides proactive outreach and care to communities? In many contexts, this type of worker is referred to as a Community Health Worker, though this may be different in this country.
  - If yes, what is the name of this occupation?
- *For each occupation mentioned, you should ask the following questions:*
  - Can you please describe to me the main responsibilities of this type of health worker?
  - What types of services do they provide and where? Homes, communities, schools, health facilities, etc?
  - Is this type of worker formally employed in the health care sector? If so, who hires them?
  - How, if at all, are they paid or compensated for their work?
  - How, if at all, are they supervised? Who is responsible for their supervision? How frequently does supervision occur?
  - How, if at all, do they interact with local health care delivery teams and facilities?
  - How, if at all, is data collected by this type of worker integrated into local reporting and feedback systems?
- Can you please show me documents that record this information? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.

Measure 22: Facility budgets

Facility budgets should include:

- Line item funds and/or global budgets as relevant
- Billing/insurance/other patient financial coverage tracked use expenses (if present)
- Internally generated funds from user fees or other fees collected at the point of care.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Maintenance of an annual budget for primary care facilities/primary health care networks	An annual budget is not maintained for the majority (>50%) of primary care facilities/primary health care networks.	An annual budget that includes one or two of the components listed above is maintained for the majority (>50%) of primary care facilities/primary health care networks.	An annual budget that includes all three of the components listed above is maintained for the majority (>50%) of primary care facilities/primary health care networks.	An annual budget that includes all three of the components listed above is maintained for all primary care facilities/primary health care networks.
Proportion of primary care facilities/primary health care networks that use a comprehensive annual budget to engage in a systematic forecasting exercise	N/A	N/A	At least 25%	All

DEFINITIONS

Line item funds
Funding amounts from government sources for specific types of regular expenses such as supplies, equipment, staff, or income such as from service-specific fees.

Global budgets
A pre-specified amount of funds for a given period of time per patient

Billing/insurance/other financial coverage tracked use expenses
Refers most often to reimbursements by government or private insurance mechanisms for services provided to patients

Internally generated funds
Funds generated at and by the facility, most often from user fees or other fees that are collected at the point of care.

Systematic forecasting exercise
Projecting expected costs and income for a future period of time, based on past data, to enable strategic planning.

FUNDS

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.

Measure 22: Facility budgets

CONTEXTUAL INFORMATION

This measure is about the presence and use of budgets only and does not concern the specific amount/sufficiency of cash flow into and out of facilities. Facility budgets set out how much money comes in to the facility, where it comes from, and how much money is spent and on what. 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.

Note that not all facilities may be required or have the autonomy to maintain their own facility budget; this may be done for or in partnership with them by a higher-level facility that is part of the same "primary health care network." "Primary health care network" is a term defined at the beginning of the assessment and refers to a group of facilities that share operational and managerial structures and processes, for example a group of health posts that report into a health center which is responsible for management and reporting requirements for the full group of facilities. Primary health care networks also often share responsibility for patient care, with higher-level facilities in the network providing more advanced or specialized services to support service delivery throughout the network.

REQUIRED DATA SOURCES

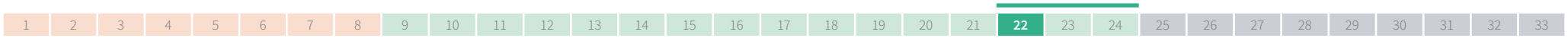
- Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Planning and/or financing division/unit
- Central statistics office
- Auditor general
- Health or financial ombudsman

FUNDS

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.



Measure 22: Facility budgets

GUIDING QUESTIONS

- What type, if any, of primary care facilities are responsible for maintaining their own budget?
- For those that are not, is a budget maintained for them by another facility or administrative unit? If so, which?
- How do facilities that are responsible for maintaining their own annual budget do so?
  - What is included in these annual budgets?
  - What proportion of facilities maintain such a budget?
  - Do facilities use this budget to engage in a systematic forecasting exercise? How does that process work? What percentage of facilities do this? Who is involved in the systematic forecasting exercise?
- In the case where facilities' budgets are maintained for them by another entity, how does this process work?
  - What is included in these annual budgets?
  - What proportion of facilities maintain such a budget?
  - Do facilities use this budget to engage in a systematic forecasting exercise? How does that process work? What percentage of facilities do this? Who is involved in the systematic forecasting exercise?
  - What proportion of facilities do not have any of the systems you've described? How, if at all, do these facilities track revenue and expenditure flows in the absence of such a system?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.

Measure 23: Financial Management Information System

Financial Management Information Systems manage and track expenditure, staff, line item budgets, internally generated funds, and reimbursed pooled payments.[36]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Maintenance of a financial management information system for primary care facilities/ primary health care networks to track revenue and expenditure flows	A financial management information system is not maintained for the majority (>50%) of primary care facilities/primary health care networks.	A financial management information system that includes 1-3 of the components listed above is maintained for the majority (>50%) of primary care facilities/primary health care networks.	A financial management information system that includes 4 of the components listed above is maintained for the majority (>50%) of primary care facilities/primary health care networks.	A financial management information system that includes all 5 of the components listed above is maintained for all primary care facilities/primary health care networks.

FUNDS

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.

Measure 23: Financial Management Information System

CONTEXTUAL INFORMATION

Financial Management Information Systems (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. Underpinning 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.[36] 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."[37]

Note that not all facilities may be required or have the autonomy to maintain their own FMIS; this may be done for or in partnership with them by a higher-level facility that is part of the same "primary health care network." "Primary health care network" is a term defined at the beginning of the assessment and refers to a group of facilities that share operational and managerial structures and processes. For example, a group of health posts that report into a health center which is responsible for management and reporting requirements for the full group of facilities. Primary health care networks also often share responsibility for patient care, with higher-level facilities in the network providing more advanced or specialized services to support service delivery throughout the network.

REQUIRED DATA SOURCES

» Data used to assess this measure should be no more than 5 years old at a maximum.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

» Planning and/or financing division/unit

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.

Measure 23: Financial Management Information System

GUIDING QUESTIONS

- What type, if any, of primary care facilities are responsible for maintaining their own financial management information system? FMIS should include means to track revenue and expenditure, staff and line item budgets, internally generated funds, and reimbursed pooled payments.
- For those that are not, is an FMIS maintained for them by another facility or administrative unit? If so, which?
- How do facilities that are responsible for maintaining their own FMIS do so?
  - What format is this system—paper based? Electronic?
  - Does this system account for staff budgets? Line item budgets? Internally generated funds? Reimbursed pooled payments?
  - Is this consistent across facility types?
- In the case where facilities' FMIS are maintained for them by another entity, how does this process work?
  - What format is this system—paper based? Electronic?
  - Does this system account for staff budgets? Line item budgets? Internally generated funds? Reimbursed pooled payments?
  - Is this consistent across facility types?
  - What proportion of facilities do not have any of the systems you've described? How, if at all, do these facilities track revenue and expenditure flows in the absence of such a system?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

FUNDS

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.

Measure 24: Remuneration

Remuneration is the payment(s) made to the primary care workers for their work or services. This measure refers to the payment of wages and salaries (including benefits and allowances) and consultancy fees, where applicable.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Stability of primary health care staff remuneration	Highly unstable	Moderately unstable	Moderately stable	Highly stable
Timeliness of primary health care staff remuneration	Almost always delayed	More often delayed than on time	More often on time than delayed	Always on time
Predictability of primary health care staff remuneration	Highly unpredictable	Moderately unpredictable	Moderately predictable	Highly predictable
Differences in in reliability (stability, timeliness, and predictability) of remuneration across sub-national areas and/or facility type.	N/A	Significant differences	Few differences	No differences

DEFINITIONS

Formally employed
Having a working agreement or contract

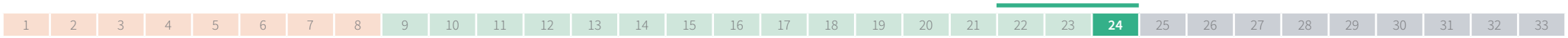
Stable
Consistent in quantity with amount specified in the working agreement or contract.

Predictable
The timing and mechanism of delivery can be anticipated

Timely
Occurring promptly and when specified in the working agreement or contract

FUNDS

This set of measures focuses on the appropriate management of funds at the facility level to address recurrent and fixed costs incurred at the facility, including payment of staff salaries.
Note: Payment mechanisms are not assessed through the Progression Model.



Measure 24: Remuneration

CONTEXTUAL INFORMATION

This is a measure of how reliably and dependably primary care staff are remunerated. It is not a measure of how adequate the amount of payment is. It is important that funds in a health system are managed in such a way that remuneration of primary care staff happens reliably. This means that the amount of remuneration expected is paid in its entirety, that it is predictable when and how the remuneration is delivered to staff, and that it is made on time. You should use the definition of "primary care staff" established by the country at the beginning of the assessment.

REQUIRED DATA SOURCES

» If relying on interviews to assess this measure, at least one non-governmental stakeholder should be interviewed.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

» Human resources, payroll, and/or accounting division/unit

GUIDING QUESTIONS

» How frequently are primary care staff supposed to be paid?

» How frequently are payments typically made in reality?

» How often are primary care staff paid an amount other what was agreed in their working agreement or contract (for example, because of budget shortfalls)?

» Are there variations in staff payment by geographic area or facility type? How so?

» May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 25: Local priority setting

Local priority setting entails the translation of national or sub-national policies into local strategic action plans that respond to the burden of disease and the needs and preferences of the population.

Note: Priority setting at the national and sub-national levels is covered under *Adjustment to Population Health Needs, Measure 7: Priority Setting*.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of sub-regional units that collect and use data to effectively translate national and/or subnational policies into local PHC priorities and strategic action plans on at least an annual basis (or more frequently, if stipulated by national guidelines)	<25%	25-50%	51-75%	>75%
Involvement of communities and local leaders in data interpretation and priority setting	None or minimal	Minimal	Moderate	Significant

CRITERIA[40]

Minimal involvement
Communities are informed of relevant data and resulting priorities but given few or no opportunities to provide input

Moderate involvement
Communities are informed of relevant data and given the opportunity to provide feedback on analysis, alternatives and/or decisions throughout the priority-setting process

Significant involvement
Communities are collaborators in the data interpretation and priority setting process and given equal voice and decision-making power as other stakeholders, such as health system leaders and local government officials.

Measure 25: Local priority setting

CONTEXTUAL INFORMATION

Local priority setting is the process of identifying health priorities specific to the local community and developing action plans informed by community needs as well as national or regional priorities.[39] Just like priority setting at the national and sub-national levels, local priority setting should be an evidence-based and participatory process. Community member and health care user engagement in priority setting helps the health system to be more efficient, improves relevance of services offered and community health status, and can facilitate stronger patient-provider respect and trust. The involvement of communities and local leaders in data interpretation and priority setting is best when the engagement empowers the community as partners in the identification of and decision-making around problems and solutions.[40]

The measure refers to priority setting at the sub-regional level, as defined at the beginning of the assessment, but in some countries local priority setting may occur at a level even closer to the community.

REQUIRED DATA SOURCES

- Informants should include at least one representative of the sub-regional level and one non-governmental informant, such as CSOs or patient associations.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Local government
- Administrative head of council
- Civil society organizations
- Health facility, community, and religious leaders
- Local action plans and/or documentation of priority setting exercises

Measure 25: Local priority setting

GUIDING QUESTIONS

- How, if at all, do sub-regions identify local PHC priorities and strategic action plans?
- How frequently, if ever, does sub-regional priority setting occur and how frequently, if ever, are these priorities reviewed?
- What types of data, if any, are used to support this process?
  - Probe: health, burden of disease, user needs and preferences, service delivery evaluations, cost-effectiveness
  - How is this data acquired?
  - How exactly does it inform decision-making?
- Which stakeholders, if any, are engaged in priority-setting exercises?
  - How are these stakeholders identified? How, if at all, do sub-regional leaders ensure a diversity of perspectives are included?
  - How are their views, concerns or decisions solicited?
  - How frequently does stakeholder engagement occur? Is there a regular schedule or is this done on an ad hoc basis?
- What role(s) does each party play in the priority setting process?
  - Probe: providing input; reviewing data; making recommendations; establishing priorities
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 26: Community engagement

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.[41] Stakeholders could include community members, patients, caretakers, health professionals, policy-makers, and other sectors. The desired relationships between communities and the health system are characterized by respect, trust, and a sense of purpose.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of sub-regional units that regularly solicit local input on the design, financing, governance and implementation of PHC from diverse members of the community	<25%	25-50%	51-75%	>75%
Impact of community engagement/input on the way in which services are structured and delivered	Almost none	Minimal	Moderate	Significant

CRITERIA[40]

Minimal impact
Community input on how PHC is structured and delivered is taken into consideration and feedback is provided on whether and how feedback impacted decision making.

Moderate impact
Community input on how PHC is structured and delivered is often directly incorporated into decisions and solutions, but final decision-making power resides with non-community representatives.

Significant impact
Communities are collaborators in determining how PHC is structured and delivered and are given equal voice and decision-making power as other stakeholders, such as health system leaders and local government officials.

Measure 26: Community engagement

CONTEXTUAL INFORMATION

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.

REQUIRED DATA SOURCES

- Informants should include at least one representative of the sub-regional level and one non-governmental informant, such as CSOs or patient associations.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Local government
- Administrative head of council
- Civil society organizations
- Health facility, community, and religious leaders
- Documentation of community engagement plans and committees
- Documentation of the meetings / engagements with community members

Measure 26: Community engagement

GUIDING QUESTIONS

- How, if at all, do sub-regions solicit input from communities on the way PHC services are financed, governed, and implemented?
  - Probe: For instance, are there community health committees, complaint lines or boxes, or community gatherings to discuss health services, ballots on priority decisions? Do facilities have an identified point of contact at the facility?
  - Is the feedback representative of all community members? How may its design limit or enhance the perspectives of the community captured?
- On what elements of the health system do sub-regions solicit community feedback?
  - Probe: For instance, do they seek feedback specifically on financing, governance, and implementation of services?
- How, if at all, does community engagement influence the structure and delivery of PHC services?
  - Are there any systems in place to ensure that feedback translates into changes in service delivery?
- How would you characterize the level of trust between communities and health facilities/local health administration?
- How, if at all, does all of the above vary by sub-region?
  - What proportion of sub-regions do this?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 27: Empanelment

"**Empanelment** (sometimes referred to as rostering) is a continuous, iterative process to identify and assign populations to facilities, care teams, or providers who have a responsibility to know the individuals in their assigned population and to proactively deliver coordinated primary health care to them... Both patients and providers must be aware of their relationship, and the resulting panels (patient lists) must be regularly reviewed and updated."[42]

There are different methods for assigning people to panels, including geographic empanelment, insurance-based empanelment, and individual choice. The most critical thing is that individual people—not just the number of people—are known, tracked, and managed over time. Importantly, geographic catchment areas are not the same thing as geographic empanelment, which requires that all specific individuals within a catchment area are known and can be tracked.

CRITERIA

Patient panel
The list of individuals assigned to a provider/ facility/care team

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Proportion of the population that is empaneled to a provider, care team or facility	Minimal (<25%)	Fewer than half (only for specific categories of patients, i.e. based on insurance status, based on specific diagnoses, or patients in specific geographic areas only)	The majority (>50%)	Complete or nearly complete (>90% of the population)
Frequency at which patient panels are updated	N/A	N/A	Patient panels are not regularly updated	Patient panels are updated at least annually
Patient choice	N/A	N/A	N/A	Patients are able to choose and/or switch the facility/provider/ team to which they are empaneled

Measure 27: Empanelment

CONTEXTUAL INFORMATION

Empanelment is more than the identification of a facility's catchment population; it means that facilities/providers/care teams know not just how many people they are responsible for, but exactly who all the individuals in that group are. Empanelment establishes a list (panel) of individuals for whom facilities/providers/care teams are responsible, regardless of whether or not those individuals actively seek out care in a facility. Empanelment is the organizational foundation for population health management; it establishes a point of care for individuals and simultaneously holds providers and care teams accountable for actively managing care for an enumerated panel of individuals. Empanelment also provides a population denominator for measurement efforts to track performance and effectively plan services. Finally, empanelment is not a static process; panels must be regularly reviewed and updated to account for births, deaths, relocations, etc.

Empanelment can take many forms. In some countries, empanelment is insurance-based, in which an insurance scheme assigns patients to a primary provider/facility/care team responsible for their care. In other countries, the population is empaneled geographically, meaning that everyone within a certain catchment area is empaneled to a health team/provider who is responsible for their care. Note that this goes beyond simply demarcating catchment areas to the actual identification of individuals (not just a denominator of patients) and active assignment of these individuals to the specific responsibility of care team/provider/facility.

Some countries have empaneled their entire population, but most have not. Empanelment can also occur for select groups of patients—for example, in some countries people living with HIV may be empaneled to a care team for ongoing, continuous care.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Policies and policymakers at the national & sub-national levels
- District management teams

Population health management is defined as "an approach [that] focuses on interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations."[38]

Measure 27: Empanelment

GUIDING QUESTIONS

- I'd like to ask you about the system for empanelment in your country. Empanelment is a continuous, iterative process to identify and assign groups of individuals to facilities, care teams, or providers who have a responsibility to know the individuals in their assigned population and to proactively deliver coordinated primary health care to them. Empanelment is more than the identification of a facility's catchment population; it means that facilities/providers/care teams know not just how many people they are responsible for, but exactly who all the individuals in that group are. Empanelment establishes a list of individuals (panels) for whom facilities/providers/care teams are responsible, regardless of whether or not those individuals actively seek out care in a facility. It implies a dual responsibility for patient care and outcomes between an individual and their care team/provider/facility, whether or not the patient actively seeks care or not.
- By this definition, what proportion of the population in the country is empaneled?
  - Probe for specific sub-populations such as people living with HIV, people with a specific insurance, or specific geographic areas.
- Empanelment is not a static process. Because people are born, die, move, get married, change disease status or insurance status, and many other life events, high functioning empanelment systems must include some means of periodically reviewing and updating panel lists. In this country, how often, if at all, does this occur?
- If individuals are empaneled in the country, how does this empanelment occur?
  - Probe: by geographic area, insurance status, disease status, etc.
  - Do individuals have the ability to choose and/or change the person or facility to which they are empaneled?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Population health management is defined as "an approach [that] focuses on interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations."[38]

Measure 28: Proactive population outreach

Proactive population outreach involves health systems actively reaching out to communities, particularly those that are underserved or marginalized, to provide necessary services aligned with local priorities and burden of disease, and link those in need to primary health care. Examples of proactive population outreach interventions include mobile health units, transport systems, home based care, telemedicine, and proactive follow-up with patients with chronic illness.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of sub-regional units which provide proactive population outreach according to local health needs and priorities	<25%	25-50%	51-75%	>75%
Percentage of sub-regional units that have registries or lists to identify relevant patients for proactive outreach (i.e. HIV/TB patients; NCD patients; pregnant women; vulnerable geographies; etc.)	<25%	25-50%	51-75%	>75%

DEFINITIONS

Underserved or marginalized[43]

Person(s) and/or communities excluded from mainstream life based on race, religion, sex, culture, or financial status. Examples may include

- the chronically ill and disabled;
- low-income and homeless communities;
- lesbian, gay, bisexual, transgender and queer (LGBTQ) communities;
- geographically underserved communities (remote or rural);
- immigrants;
- indigenous groups etc.

Measure 28: Proactive population outreach

CONTEXTUAL INFORMATION

Proactive population outreach is the active provision of care in homes and communities rather than exclusively in facilities. These services are often preventive or promotive (though may also be curative) and initiated by the health system rather than by patients. Such services are often provided by community health workers (CHW) or similar occupations. Examples of common proactive outreach services include health promotion activities, health education, identification of acute cases and pregnant women needing referrals to health facilities, family planning provision, and chronic disease adherence follow-up.

"Sub-regional unit" was defined for the country at the beginning of the assessment. Note that the relevant types of registries will differ based on context and burden of disease.

REQUIRED DATA SOURCES

- At least one non-governmental informant (development partner, civil society organization, etc.) with insight into how community engagement happens in practice.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- Community leaders (health, religious, political, etc.)
- District / sub-national leaders / policy-makers

GUIDING QUESTIONS

- In this country, what care, if any, is proactively provided in homes and communities?
  - Who receives this care?
  - How are decisions about what services to provide and who to provide them to made?
- How, if at all, does this vary by sub-region?
  - What proportion of sub-regions provide proactive care?
- What mechanisms, if any, are used to identify patients with specific health needs such as HIV/TB patients, patients with NCDs, and pregnant women, patients in vulnerable areas?
  - Probe: Are there registries to identify these patients? What communication between the health system and other sectors exists to identify, develop and reach out to patients using registries?
  - What percentage of sub-regional units have these registries? How often are these registries updated?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 29: Team-based care organization

Team-based care is a strategic redistribution of work among members of a practice team. Team-based care means that all members of the team play an integral role in providing patient care and share responsibilities for better patient care.[44] Care teams are characterized by:

- A team identity
- Regular team meetings
- Clearly defined roles and responsibilities that are uniformly understood by all team members
- Shared goals of providing quality patient care that individual teammates cannot achieve on their own
- Mutual accountability structures in which each team member can be held accountable by any other team member

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of facilities (or primary health care networks, if teams are split across physical locations) where all primary health care providers work as part of a team, defined as when all 5 characteristics above are present	<25%	25-50%	51-75%	>75%

DEFINITIONS

Team identity
: Having a team identity means that team members see themselves as part of one larger, cohesive unit with shared methods, ideals, and goals.

Measure 29: Team-based care organization

CONTEXTUAL INFORMATION

As defined above, having care teams means more than just having multiple personnel working at the same location. Effective care teams operate as a single unit with a shared identity to provide effective, coordinated care. This is facilitated by teams meeting regularly to discuss their goals and progress towards them and to identify patients about whom they are concerned and agree to a plan for how to support the patient. Team members have a shared responsibility to provide quality patient care that no individual team member could achieve on their own.

Note that all team members may not work in the same facility. For instance, a community health worker who is based in the community would be considered a member of a team-based care organization if he or she is part of a reporting and supervision structure of a larger facility-based team. "Primary health care network" is a term defined at the beginning of the assessment and refers to a group of facilities that share operational and managerial structures and processes, for example a group of health posts that report into a health center which is responsible for management and reporting requirements for the full group of facilities. Primary health care networks also often share responsibility for patient care, with higher-level facilities in the network providing more advanced or specialized services to support service delivery throughout the network. In some countries, the primary health care team may be considered to span across the primary healthcare network.

REQUIRED DATA SOURCES

» At least one non-governmental informant (development partner, civil society organization, etc.) with insight into how primary care facilities are generally operated and perform.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

» District health management teams

» PHC team members at the facility and community level

Measure 29: Team-based care organization

GUIDING QUESTIONS

- In this country, do providers work together as a team to deliver care to patients? By team, I mean multiple providers working together with a shared team identity and clearly defined roles and responsibilities towards the shared goal of providing better patient care than any one person could provide alone.
- If yes, how are these teams structured at the primary care level?
  - Probe: Where are teams located? Who is part of teams?
- How are roles and responsibilities defined and monitored?
  - Probe: Who is accountable to whom in the team?
- What structures are in place to promote team culture?
  - Probe: regular meetings, team-building exercises, communication channels, etc.
- How do team members share tasks with one another?
- What percentage of primary care facilities employ this model of team-based care?
  - If not 100%; Is there another model of team-based care used in this country?
  - If yes, repeat questions from above.
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 30: Facility management capability and leadership

Facility management capability and leadership are essential for facilitating the continuous delivery of high-quality health services.[45] Many of the tasks and functions that good managers perform are described elsewhere (See Measure 26: Community Engagement, Measure 29: Team-based Care Organization, Measure 31: Information Systems Use, and Measure 32: Performance Measurement and Management). This measure instead focuses on the degree to which facility management is professionalized and whether or not facility managers are regularly evaluated based on their management capabilities and performance.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of primary care facilities that are led by a manager(s) who has official management training (for example, a certification, diploma, or degree).	<25%	25-50%	51-75%	>75%
Percentage of primary care facility managers that receive an annual review and feedback on their management capabilities and performance	<25%	25-50%	51-75%	>75%

Measure 30: Facility management capability and leadership

CONTEXTUAL INFORMATION

Training on facility management can take many forms. Ideally, training would include a focus on the core functions of management, such as organizing facility operations; engaging, motivating, and managing staff; managing budgets and deploying resources; and reacting to new challenges. These competencies can be defined as a combination of knowledge, motive, skill, and self-image. Review of training curricula is, however, outside the scope of this assessment. Management training should be defined at the country level.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- District health and/or facility management teams
- Training records
- Curriculum and coursework documents
- Supervision records
- Professional associations
- Civil society organization management and leadership training programs
- Human Resources unit/division
- Ministry of Education

GUIDING QUESTIONS

- How are decisions made about who manages primary care facilities?
- Are their training or accreditation standards that managers must have?
  - How, if at all, does this vary by facility type?
  - What topics are covered in this training?
  - How are competencies measured at the end of training?
- What proportion of primary care facilities are led by a manager with some sort of training in management?
  - How is this tracked and enforced?
- How, if at all, is the quality of facility management measured and monitored?
  - How frequently does this happen?
  - How, if at all, does it vary by geographic area or facility type?
  - What proportion of managers of primary care facilities would you estimate have received an annual review and feedback specific to their management capabilities and performance in the last year?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 31: Information system use

Information systems use includes the routine and timely collection and reporting of public health data (including surveillance data) and facility data and the use of this data for clinical purposes and quality improvement across all levels of PHC. Effective data use is dependent on sufficient staff capacity to capture, report, and review data using available information system infrastructure. At higher levels of performance, it can drive quality improvement.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of primary care facilities/primary health care networks that have staff capacity for information systems use	<25%	25-50%	51-75%	>75%
Percentage of primary care facilities/primary health care networks that routinely use information systems for capturing and reporting comprehensive patient data and facility data in a timely manner	<25%	25-50%	51-75%	>75%
Percentage of primary care facilities/primary health care networks that routinely use information systems for conducting quality improvement activities.	<25%	25-50%	51-75%	>75%

DEFINITIONS

Staff capacity for information systems use
Staff ability to input data into information systems and subsequently access, interpret, analyze, understand and make decisions based on the information systems content

Routine
Performed as part of a regular procedure rather than for a special reason

Measure 31: Information system use

CONTEXTUAL INFORMATION

Information systems use is the effective utilization of existing information systems and the data they produce at the facility level to coordinate and track patient care and drive quality improvement activities. Note that this measure is specifically about the **use** of information systems. By contrast, Measures 14, 15 and 16 address the presence and functioning of information systems. Effective information systems use involves the compilation and interpretation of data, and can support a variety of purposes ranging from priority setting in day-to-day service delivery to clinical tasks and education. This requires sufficient staff literacy and capacity to capture, report, and review data, transforming it to relevant information and then leveraging that information to deliver quality care. 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 knowledge and skills to use information systems. Routine use of information systems means that information systems are used as part of regular procedure rather than for a special reason.

Note that not all facilities may be expected or have the autonomy to enter their own information. "Primary health care network" is a term defined at the beginning of the assessment and refers to a group of facilities that share operational and managerial structures and processes. For example, a group of health posts that report into a health center which is responsible for management and reporting requirements for the full group of facilities. Primary health care networks also often share responsibility for patient care, with higher-level facilities in the network providing more advanced or specialized services to support service delivery throughout the network. In some countries, information system use may be a joint effort of multiple facilities in a network—that is acceptable for this measure as long as the lower level facilities are active partners in the use of information systems and not passive recipients of information or outputs.

REQUIRED DATA SOURCES

- At least one non-governmental informant (development partner, civil society organization, etc.) with insight into how primary care facilities are generally operated and perform

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- District management teams
- Information systems division/unit

Measure 31: Information system use

GUIDING QUESTIONS

- What types of health management information systems are in place in primary care facilities here? *Note: this information is also collected under Measure 16. This information may be used to prompt respondents, and the goal of asking this question is not to fully document HMIS systems but to prime respondents to think about these systems.*
- What proportion of primary care facilities have staff who are trained in how to use the information systems? This means not only collecting data, but also collating data and interpreting data.
  - Do these staff typically have dedicated time allocated for using information systems and interpreting data? How many of the trained staff have time dedicated to using information systems? Are the information systems accessible to these individuals?
  - How are facility staff trained to use information systems? Are these capacities covered in their degree coursework? Is there in-service training or mentorship in information systems use? How often is this updated?
- How do staff at primary care facilities use these information systems?
  - Probe:
    - Capturing and reporting patient data
    - Capturing facility/service delivery data
    - Frequency of reviewing data internally
    - Monitoring performance
    - Informing quality improvement activities
    - Setting priorities
    - Reporting to higher level facility/office
    - Receiving feedback from higher level facility/office
  - Is this done in "real-time"?
  - How if at all does information system use inform patient care?
  - What percent of primary care facilities use information systems in this way?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 32: Performance measurement and management (1/2)

Performance measurement and management includes both supportive and continuous supervision of staff *(see Measure 33)* as well as the routine establishment of performance targets, monitoring of progress towards these targets, and implementation of quality improvement initiatives to address identified gaps.[44,46]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of primary care facilities/primary health care networks that use established performance indicators for PHC	<25%	25-50%	51-75%	>75%
Percentage of primary care facilities/primary health care networks that conduct routine monitoring of these performance indicators	<25%	25-50%	51-75%	>75%
Percentage of primary care facilities/primary health care networks that have documented quality improvement work linked to underperforming areas	<25%	25-50%	51-75%	>75%

DEFINITIONS

Established performance indicators
: Carefully chosen metrics that are recognized and accepted by staff across the facility, designate facility targets and indicate how progress towards targets will be tracked.

Routine
: Performed as part of a regular procedure and embedded into the existing environment and practices.

Measure 32: Performance measurement and management (1/2)

CONTEXTUAL INFORMATION

Performance measurement and management involves a continuous process of establishing targets, monitoring performance against those targets, and implementing and adapting improvement efforts. 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 routine collection. Once facility performance data is received, health systems stakeholders must have processes in place to interpret data and use results to drive adaptation and improvement processes.

Note that not all facilities may have the autonomy to set their own targets. "Primary health care network" is a term defined at the beginning of the assessment and refers to a group of facilities that share operational and managerial structures and processes. For example a group of health posts that report into a health center which is responsible for management and reporting requirements for the full group of facilities. Primary health care networks also often share responsibility for patient care, with higher-level facilities in the network providing more advanced or specialized services to support service delivery throughout the network. In some countries, performance measurement and management may be a joint effort of multiple facilities in a network—that is acceptable for this measure as long as the lower level facilities are active partners in the process and not passive recipients of information or outputs.

REQUIRED DATA SOURCES

- At least one non-governmental informant (development partner, civil society organization, etc.) with insight into how primary care facilities are generally operated and perform.

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- District management or health facility teams
- Supervision logs / reports
- Performance reports

Measure 32: Performance measurement and management (1/2)

GUIDING QUESTIONS

- How, if at all, do primary care facilities define performance targets?
  - Are these typically set at a national, sub-national, or sub-regional level or left to the discretion of the facility?
- What percent of primary care facilities have performance targets?
- How, if at all, do primary care facilities monitor progress towards targets?
  - Is this considered routine?
  - Who assesses the data on progress?
- What percent of primary care facilities monitor their progress?
- How, if at all, do primary care facilities implement quality improvement activities?
  - How are the objectives of quality improvement activities set?
  - Who initiates these activities?
  - Who monitors them?
- What percent of primary care facilities have implemented quality improvement activities?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

Measure 33: Performance measurement and management (2/2) – Supportive supervision

Performance measurement and management includes both supportive and continuous supervision of staff as well as the routine establishment of performance targets, monitoring of progress towards these targets, and implementation of quality improvement initiatives to address identified gaps.[44,46]

This measure is specifically about supportive supervision, a component of performance measurement and management. **Supportive supervision** is characterized by collaborative problem solving and open dialogue. Supervision routinely includes mentoring to address gaps in performance, knowledge, and skills and setting individual goals and reviewing progress towards their achievement.[47,48]

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Percentage of primary care facilities that implement or receive supportive supervision on at least an annual basis (or more frequently if stipulated by national guidelines)	<25%	25-50%	51-75%	>75%

Measure 33: Performance measurement and management (2/2) – Supportive supervision

CONTEXTUAL INFORMATION

Supportive supervision of individual providers is a key component of performance measurement and management. Rather than using punitive or corrective action, supportive supervision is focused on collective problem solving and identifying gaps and opportunities to fill them. This approach strengthens relations between staff and builds pathways to improvement through active collaboration between providers and supervisors.

REQUIRED DATA SOURCES

- At least one non-governmental informant (development partner, civil society organization, etc.) with insight into how primary care facilities are generally operated and perform

EXAMPLES OF WHERE YOU MAY FIND NEEDED EVIDENCE

- District management and/or health facility teams
- Facility performance management plans
- District monitoring plans
- Policies at national and sub-national levels

GUIDING QUESTIONS

- How, if at all, do providers receive supervision in their roles? If multiple methods mentioned, repeat questions below for each:
  - Who conducts supervision? What sort of support of qualifications do these individuals have?
  - Who receives supervision? Who does not?
  - Where do supervisory visits take place and how long do supervisory visits last?
  - What sort of activities do supervisory visits cover?
    - Probe: observation of clinical interactions, teaching/coaching, goal setting, progress review, collaborative problem solving
  - How frequently does supervision occur?
  - Is there an established schedule for supervision, or do visits need to be requested?
  - What percent of facilities employ this method?
- How, if at all, does the quantity, quality, or content of supervision depend on occupation, sub-national region, and/or facility type?
- May I see documentation that supports what we have discussed? May I have a copy, take a photo, and/or can you give me the links?
  Note: You must ensure that you do ***not*** *obtain any data or information that includes patient information or any other personally-identifiable data.*

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