

Process Guide

Using the Vital Signs Profile
to Assess the Performance
of Primary Health Care





Logo

Logo

Logo

Logo

Logo

Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder
Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder
Disclaimer Placeholder Disclaimer Placeholder Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer
Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder Disclaimer Placeholder

CONTENTS



INTRODUCTION : INTRODUCTION TO PHC ASSESSMENT USING THE VITAL SIGNS PROFILE **p.4**

1. Key Features of Primary Health Care (PHC) **p.5**
2. The Primary Health Care Performance Initiative (PHCPI) **p.6**
3. PHCPI Measurement Tools **p.7-10**
4. Using this Guide **p.11**

Overview of Assessment Process **p.12**



PHASE 3 : DATA COMPILATION **p.29**

1. Phase 3: Data Compilation **p.30-31**
2. Review VSP Indicators and Measures to Determine Data Availability and Gaps **p.32-36**
3. Identify Data Sources for any Alternative Indicators and for the Progression Model measures **p.37-39**
4. Select any Alternative Quantitative Indicators **p.40**
5. Compile Data for all Quantitative Indicators and for the Progression Model Measures **p.41**
6. Conduct Internal Scoring for the Progression Model **p.42**
7. Summary of Phase 3: Data Compilation **p.43**



PHASE 1 : STARTING OUT **p.13**

1. Phase 1: Starting Out **p.14**
2. Introduce PHCPI and VSP to the Country **p.15**
3. Review the VSP Project with the PHCPI Partnership **p.16**
4. Formalize the Collaboration **p.17**
5. Summary of Phase 1: Starting Out **p.18**



PHASE 4 : GENERATING THE VSP AND VALIDATING THE RESULTS **p.44**

1. Phase 4: Generating the VSP and Validating the Results **p.45**
2. Activate the Technical Review and Validation by PHCPI **p.46**
3. Generate the Formal VSP **p.47-51**
4. Validate Results and Obtain Sign-off by the Ministry of Health **p.52**
5. Summary of Phase 4: Generating the VSP and Validating the Results **p.53**
- 6.



PHASE 2 : PLANNING THE VITAL SIGNS PROFILE ASSESSMENT **p.19**

1. Phase 2: Planning the Vital Signs Profile Assessment **p.20**
2. Define Assessment Objectives and Scope **p.21**
3. Identify the Project Team, Roles and Responsibilities **p.22**
4. Identify Additional Key Stakeholders and Plan for their Engagement **p.26**
5. Prepare a Work Plan and a Project Charter **p.27**
6. Summary of Phase 2: Planning the Vital Signs Profile Assessment **p.28**



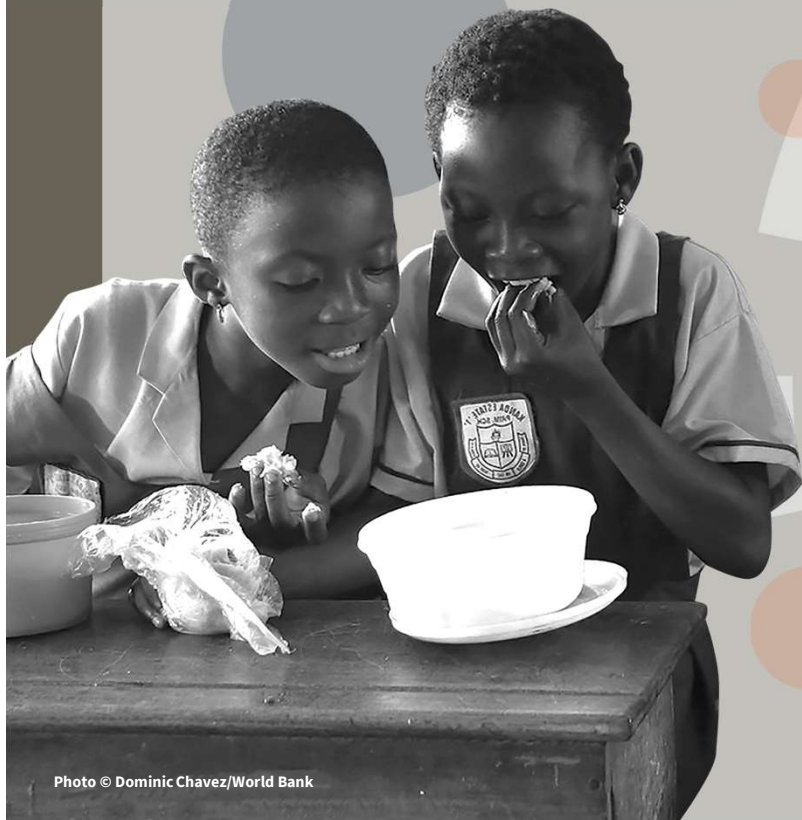
PHASE 5 : ANALYZING AND DISSEMINATING THE RESULTS **p.54**

1. Phase 5: Analyzing And Disseminating the Results **p.55**
2. Prepare Supporting Analyses **p.56**
3. Share the VSP Results and Additional Analyses with Stakeholders **p.57**
4. Determine Where to go Next **p.58**
5. Prepare the Final Report and Close the Assessment Project **p.59**
6. Summary of Phase 5: Analyzing and Disseminating the Results **p.60**

INTRODUCTION

INTRODUCTION TO PHC ASSESSMENT USING THE VITAL SIGNS PROFILE

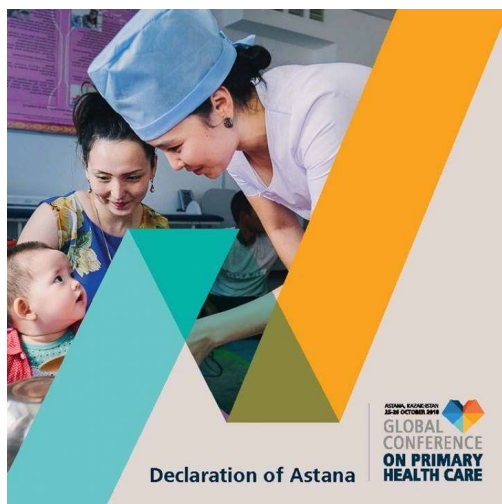
1. Key Features of Primary Health Care (PHC) **p.5**
2. The Primary Health Care Performance Initiative (PHCPI) **p.6**
3. PHCPI Measurement Tools **p.7-10**
4. Using this Guide **p.11**
5. Overview of Assessment Process **p.12**



INTRODUCTION

KEY FEATURES OF PRIMARY HEALTH CARE (PHC)

There has been growing recognition that high performing primary health care is a cornerstone of strong health systems that can address people's complex and varied health needs across the range of challenges presented by everything from non-communicable diseases to tuberculosis and HIV/AIDS. In October 2018, policymakers, advocates, patients and partners convened in Astana, Kazakhstan to commit to strong primary health care as the foundation and future of health for all.



There are common features that form the foundation of strong primary health care:

- **Facilities** located in the right places where people can go to access the primary care services they need when they need them;
- **Health care providers** who are trained, empowered and incentivized to deliver quality primary care; and
- **Systems and policies** that ensure essential medicines, vaccines and diagnostics are available and of high quality.

Adequate funding underpins the success of the entire system and is essential to ensure countries can provide a basic package of primary care services for everyone, at a cost that people can afford. These key features support a system where people and families have access to comprehensive services ranging from family planning and routine immunizations to treatment of illnesses and management of chronic conditions.

What is Primary Health Care?

Primary Health Care is a whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.

Primary Care is a key process in the health system that supports *first-contact, accessible, continued, comprehensive* and *coordinated patient-focused* care.

The organization and delivery of primary care and essential public health services varies across countries. This can have a practical impact on the scope of services, facilities and providers that are considered in the Vital Signs Profile.

INTRODUCTION

THE PRIMARY HEALTH CARE PERFORMANCE INITIATIVE (PHCPI)

The Primary Health Care Performance Initiative is a partnership between the Bill & Melinda Gates Foundation, World Bank Group, and World Health Organization, with technical partners Ariadne Labs and Results for Development. PHCPI was built on the belief that primary health care is the cornerstone of sustainable development, and that improving primary health care begins with better measurement. PHCPI works with governments and development partners who are looking to strengthen primary health care, providing the tools, information and support they need to drive evidence-based improvements. PHCPI uses existing and emerging data to assess primary health care system performance, promote accountability, and help countries and partners drive improvements.

PHCPI supports countries in strengthening primary health care through tools that address the measurement for improvement cycle:



Measurement and decision-making: These include the [PHC Conceptual Framework](#), the [Vital Signs Profile \(VSP\)](#) and the [Progression Model](#). The VSP is the focus of this guide; the other tools are introduced in the section that follows.



Performance improvement: The [Improvement Strategies](#) are an interactive knowledge management tool. Each strategy guides users through the selection of evidence-informed improvement options based on the country's current capacities to deliver on primary health care. The strategies can be used with the VSP to identify relevant opportunities for improvement. The Improvement Strategies modules address topics relevant to strong primary care systems and include an evidence review, case studies, key questions, and infographics to help users identify appropriate strategies. Users can also submit their own experiences, resources, and best practices to facilitate peer-to-peer learning.



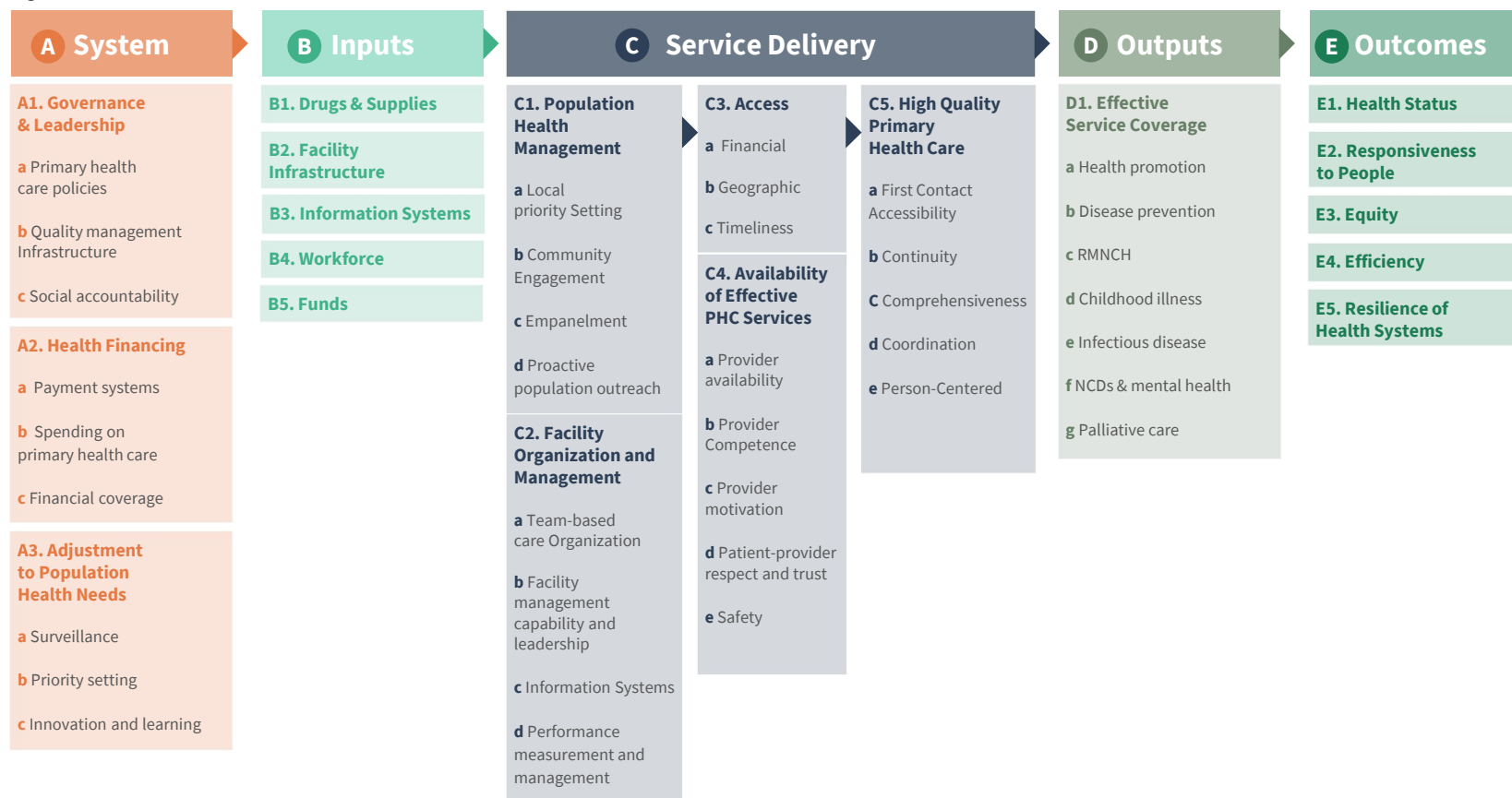
Cross-country learning and engagement: PHCPI provides a platform where countries can share data, knowledge, and experience with measurement and improvement, along with resources to make the case for strong primary health care and the importance of measurement in improving systems.

INTRODUCTION

PHCPI MEASUREMENT TOOLS: THE CONCEPTUAL FRAMEWORK (1/4)

The PHCPI partners developed a Conceptual Framework that lays out the important components of a strong primary health care system, and shows how the different elements of primary health care contribute to a strong system. The framework is based on evidence about the key characteristics and determinants of strong primary health care, building on existing frameworks for health systems performance. It is intended to guide what should be measured to inform and drive efforts to improve primary health care. The conceptual framework is illustrated in Fig. 1, showing how the components and their relationships support strong primary care systems and outcomes. For definitions of the components see the [PHCPI Conceptual Framework](#).

Fig. 1 Primary Health Care Conceptual Framework



INTRODUCTION

PHCPI MEASUREMENT TOOLS: THE VITAL SIGNS PROFILE (2/4)

The Four Pillars of VSP

The primary health care Vital Signs Profile (VSP) is a tool for assessing the strengths and weaknesses of a country's primary health care. It is designed to help systematically assess PHC across domains of the conceptual framework in a simpler way. The VSP presents a primary care system profile across four key pillars: Financing, Capacity, Performance, and Equity. The VSP is illustrated in Fig . 2 (Next page)



Financing –

how much PHC is prioritized within the health budget, how much is being spent on PHC, and how much is being provided by the government or other sources



Capacity –

the system has adequate staff, facilities, supplies and drugs; it is well governed with good facility management and effective, proactive management of population health



Performance –

the system delivers primary care that is accessible (minimal financial and geographical barriers) and of good quality (accurate and appropriate diagnosis, treatment and follow up for patient-centered, coordinated, continuous, and comprehensive care), with extensive effective coverage of essential services



Equity –

the system generates better health outcomes, quality of services and access to care for all segments of the population, including the most vulnerable

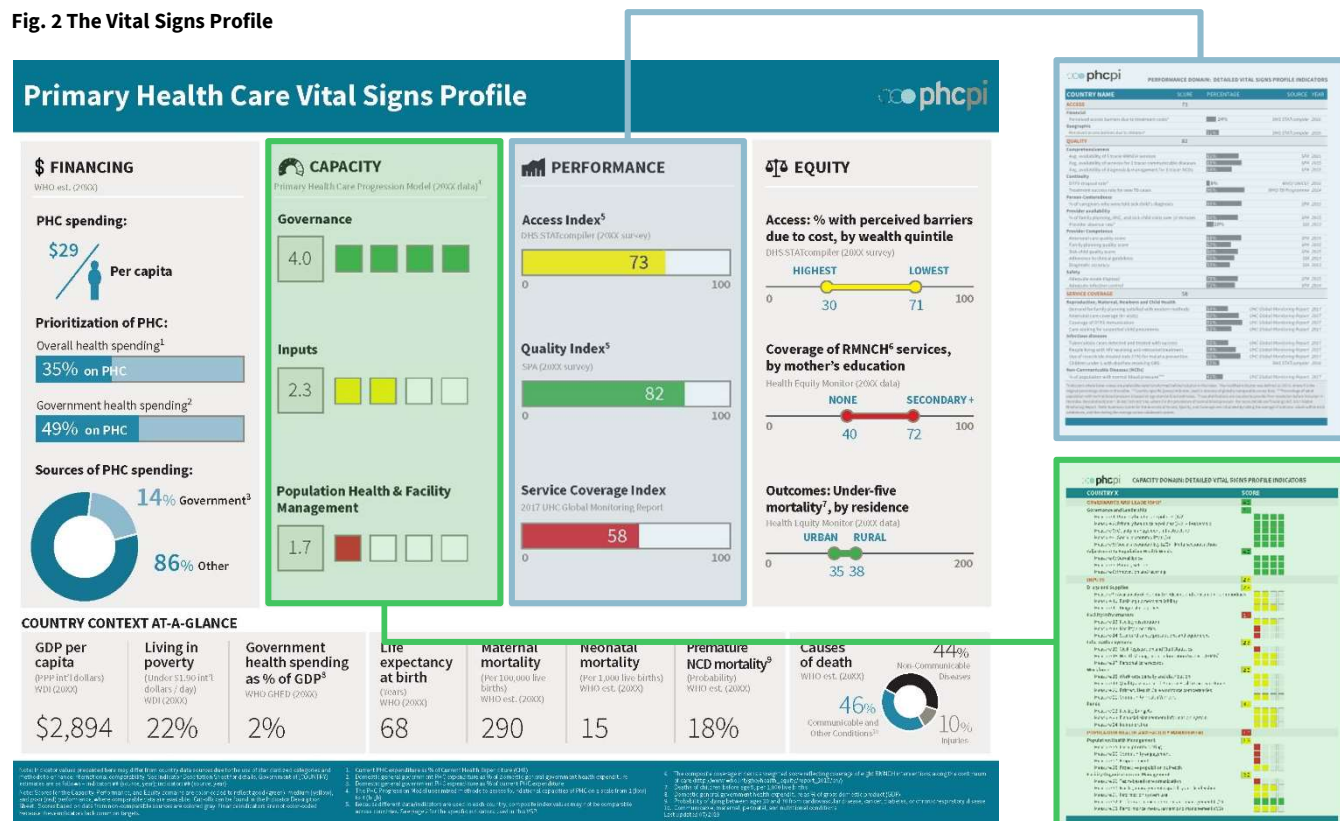
While the VSP offers a systematic approach for measuring PHC, many of the sub-domains of the conceptual framework described on page 7 cannot be assessed due to limited data availability. PHCPI partners with countries and other organizations to improve the availability and quality of data to support increasing capacity for performance measurement.

INTRODUCTION

PHCPI MEASUREMENT TOOLS: THE VITAL SIGNS PROFILE (3/4)

The VSP can be used by policymakers, donors, advocates and civil society to gain further insights into the performance of the country's PHC system, identify priority areas for improvement, and to track and trend improvements over time. The VSP, which includes the main visual and two additional tables with details of the indicators and measures of the performance and capacity pillars, is illustrated in Fig. 2. (References to information on the VSP are included in the list of tools for Phase 1.).

Fig. 2 The Vital Signs Profile



INTRODUCTION

PHCPI MEASUREMENT TOOLS: THE VITAL SIGNS PROFILE (4/4)

There are three categories of information sources used to populate the VSP. These are:



A set of standard indicators covering financing, access, quality, service coverage, equity, context and outcomes, with results coming from the System of Health Accounts 2011 (SHA2011), Service Availability and Readiness Assessment (SARA) and Harmonized Facility Survey (HFS) from the WHO, the Service Delivery Indicators (SDI) from the World Bank Group, the Service Provision Assessment (SPA) and Demographic and Health Surveys (DHS) from USAID, and the Multiple Indicator Cluster Surveys (MICS) from UNICEF



Alternative indicators to be used when the data for standard indicators is not available, too old or not appropriate, for a country. (Phase 3 in this Guide describes methods for assessing data gaps and developing alternative sources and indicators.)



PHC Progression Model populates the capacity pillar. The PHC Progression Model is a mixed methods tool that brings together stakeholders who have different views and complementary knowledge of the multiple aspects of the PHC system in a country to yield an objective, comparable assessment of PHC functional capacities.

Integrating the PHC Progression Model into the Vital Signs Assessment Process

The PHC Progression Model is a mixed methods assessment tool used to measure the Capacity pillar of the Vital Signs Profile. Its aim is to systematically assess core PHC capacities--governance, inputs, and population health and facility management--that are often insufficiently measured by existing quantitative, globally comparable data sources. Therefore, the PHC Progression Model is designed to capitalize on the wealth of information, evidence, and data that is often available in countries but rarely captured in a way that generates usable information for decision-makers or is accessible to external audiences. The goal of the PHC Progression Model assessment is to bring together stakeholders who have varying and complementary knowledge of the functioning of the PHC system in a country to yield an objective, comparable assessment of PHC capacity. (The Progression Model assessment is ideally conducted concurrently/as part of the VSP assessment process.)

This guide describes the process of assessing PHC by creating the full VSP, including references to the implementation of the Progression Model. Yet, given its innovative methodology, a separate guide – PHC Progression Model Assessment Guide – has been developed to support the implementation of the Progression Model. This guide references the Progression Model Guide in the activities where it should be referenced. Both guides are intended to be used to support all of the work of developing a country VSP.

INTRODUCTION

USING THIS GUIDE

The VSP developed by PHCPI is a tool assessing the strength of PHC in a country. While a country's PHC could be assessed in different ways, this guide outlines the process for assessing the strength of a country's PHC through the development of a VSP. ("Preparing a vital signs profile" and "assessing a country's primary health care" are considered synonymous here).

This guide describes the main phases of the process, the key activities, deliverables and outcomes for each phase, and refers to related guides, tools and examples that can help project teams develop a VSP.

The content in this guide, as well as many of the resource materials, were developed through the experiences and lessons learned in developing the first set of VSPs in a number of PHCPI Trailblazer countries in 2018.



The process of assessment described in the guide is valuable in and of itself. The process, together with the completed VSP can fulfill one or more of the following objectives:



Understand strengths and weaknesses of the entire primary care system and how these may be related to health outcomes;



Generate discussion and build consensus among PHC stakeholders on diagnosing system's weaknesses and identifying potential improvement strategies;



Prioritize and align areas for action and investment;



Suggest areas for improvement, and link to improvement tools and pathways; and



Monitor progress over time and evaluate change and effectiveness.

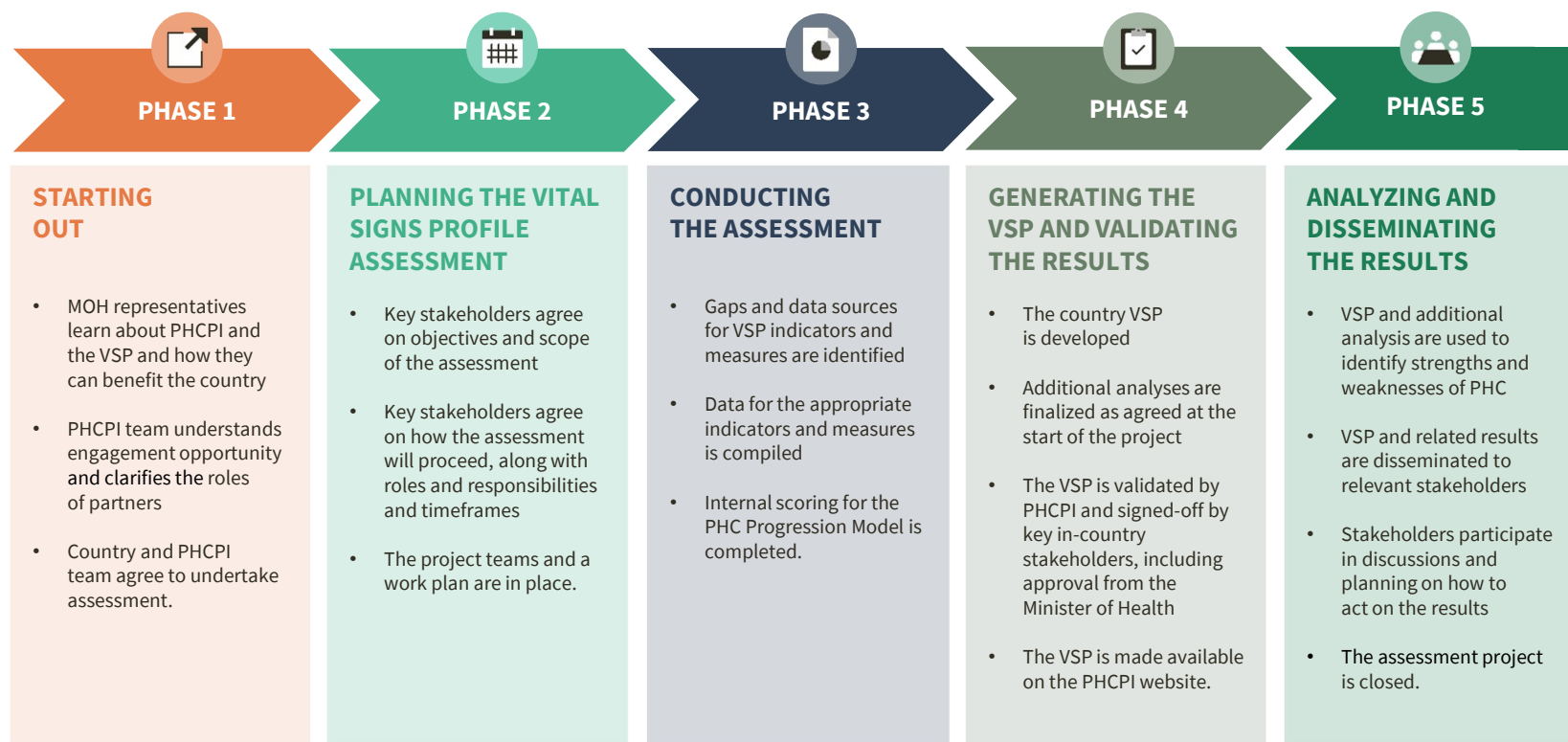
This guide is intended to be used by the project leaders and teams – the individuals ultimately responsible for developing the country VSP. However, different sections of the guide and the resource materials identified provide a reference ore broadly for all participants involved in the project, regardless of their role.

INTRODUCTION

OVERVIEW OF ASSESSMENT PROCESS

The guide presents the assessment as a series of phases, with corresponding objectives and main activities (see Table 1). Each section of the Guide describes the activities, outcomes and objectives in detail and includes references to tools, resources and examples of materials, as well as a “completion checklist”, consisting of items such as documents to be prepared and decisions to be made in order for the phase to be considered complete. It also refers to related guides for a full description of some of the key activities – for example, performing the qualitative assessment for the progression model as well as selecting alternative indicators to fill any data gaps.

OVERVIEW OF PHASES AND OBJECTIVES IN VSP ASSESSMENT



PHASE 1

STARTING OUT

1. Phase 1: Starting Out **p.14**
2. Introduce PHCPI and VSP to the Country **p.15**
3. Review the VSP Project with the PHCPI Partnership **p.16**
4. Formalize the Collaboration **p.17**
5. Summary of Phase 1: Starting Out **p.18**



PHASE 1

PHASE 1: STARTING OUT

Phase 1 includes preparation activities to introduce PHCPI and the VSP to the country's **Ministry of Health (MOH)** and the potential opportunity to support the generation of the country's VSP to the PHCPI partners. There are three key goals to be achieved in this phase:



Ensuring that key MOH representatives and policy-makers are familiar with PHCPI, and understand how the VSP and the process to develop it can help the country, given the specific context.



Ensuring that the PHCPI team is aware of the emerging opportunity to engage in a collaboration with the country and agrees on which role each of the partners will play, if any.



Ensuring that interested parties agree to proceed with the assessment and formalize the collaboration between PHCPI and the MOH.

Outcome of Phase 1

At the completion of this phase, the country representatives (i.e., Minister of Health and other key government contacts) and the PHCPI team should be “signed on” to undertake the assessment – developing a VSP for the country – with a formal sign-off by both the PHCPI partnership and the Minister of Health..

The activities in this phase can be broken into three streams:

1

Initiating a dialogue to provide information about PHCPI and the VSP to key Ministry of Health staff (and other key country contacts as required) to ensure they understand what their commitments will be under the engagement, how PHCPI can support them, and how the country will benefit from the assessment.

2

Consulting with PHCPI partners about the engagement opportunity, discussing the country's context, the potential benefits of undertaking the assessment and potential roles for partners.

3

Formalizing the collaboration between PHCPI and the MOH on the assessment.

Depending on how initial back-and-forth discussions with the PHCPI Team and country Ministry of Health staff proceed, **this phase could take 5 to 6 weeks to complete.**

PHASE 1

INTRODUCE PHCPI AND VSP TO THE COUNTRY

The **expression of interest** for an engagement is initiated by individuals within one of the PHCPI partner organizations or individuals working in organizations that are not currently PHCPI partners, or occasionally by an in-country stakeholders (including the Ministry of Health) who contacts directly the PHCPI team. These individuals could be motivated by their intention to learn more about the initiative before presenting it to their counterparts at the MOH; or by an explicit request from the MOH to participate in the initiative.

If the request is initiated **through one of the PHCPI partners**, it is typically expressed by those who maintain an active dialogue with the country's MOH. For example, these include the World Bank Task Team Leaders (TTL), the Representative of the WHO in the country (WR), the Program Officer of the Bill & Melinda Gates Foundation. These individuals reach out to the PHCPI teams within their organizations to explore how the initiative can contribute to specific MOH requests for support on issues related to strengthening the country's PHC.

If the expression of interest originates through organizations that are **not current PHCPI partners**, the organization that intends to support the MOH in developing a VSP should reach out to the PHCPI team to initiate the process of collaboration with the initiative.

The person that will be supporting the MOH in developing the VSP will be identified as the **"PHCPI Lead"** and will have overall responsibility from the PHCPI

perspective for the VSP assessment project. Typically, each project has only one PHCPI Lead, but it could happen that two people share this role; if this is the case, they will have to explicitly agree on the specific responsibilities of each of them. If possible, the PHCPI Lead should work with at least one other individual from the same organization. This can ensure complementarity of skills and continuity of engagement in case one of the individuals becomes unavailable.

The PHCPI lead, in collaboration with others within their organizations (and with partners as appropriate), starts the dialogue with the MOH to explain:

- **What PHCPI is** and what are the measurement and improvement tools available (Conceptual framework, Core Indicators, VSP, Improvement Strategies, Promising Practices)
- **What the VSP is**, including its components and its potential use to identify key bottlenecks and opportunities for improvement
- **The benefits of collaborating with PHCPI**, including being recognized as a leader of and advocate for greater accountability, access to international expertise and technical assistance, and participation in cross-country learning exchanges.

Materials supporting the introduction of PHCPI and its tools to the country's MOH and stakeholders are available in the folder of resources ([Toolkit](#)). These can be adapted to the country context as appropriate.

PHASE 1

REVIEW THE VSP PROJECT WITH THE PHCPI PARTNERSHIP



General Information	
PHCPI Lead	
Project Lead (if different from PHCPI Lead)	
Ministry of Health Focal Point (if already identified)	
CE Note Last Updated	

Engagement high-level points

Background	
Description of Opportunity	
Type of Activities / Interventions	
Description of Expected Results	
Expected timeline for the engagement (tentative)	

Engagement modality

Type of Engagement	
<input type="checkbox"/>	PHC Measurement: Vital Signs Profile
<input type="checkbox"/>	PHC Measurement: Vital Signs Profile + Additional Analytics
<input type="checkbox"/>	PHC Measurement: Participation in Peer-to-Peer Learning / Benchmarking
<input type="checkbox"/>	PHC Measurement: Vital Signs Profile + Subnational Performance Dashboards
<input type="checkbox"/>	PHC Measurement and Improvement: Vital Signs Profile + Improvement Strategies / Policy Recommendations
<input type="checkbox"/>	Implementation support as part of existing lending operations (IS) (World Bank)
<input type="checkbox"/>	Technical assistance as part of new lending operations or GFF investment cases (World Bank)
<input type="checkbox"/>	Technical assistance as part of programmatic Advisory Services and Analytics in country (World Bank)

If the country's MOH expresses interest in moving forward with a VSP assessment, the PHCPI Lead will **notify the PHCPI Team** that there is an opportunity to collaborate with the MOH of the country to support a VSP assessment. This is formally done through the **Country Engagement (CE) Note** (sample provided in the reference materials), prepared by the PHCPI Lead, typically in collaboration with the person who raised the expression of interest. The CE Note is intended to:

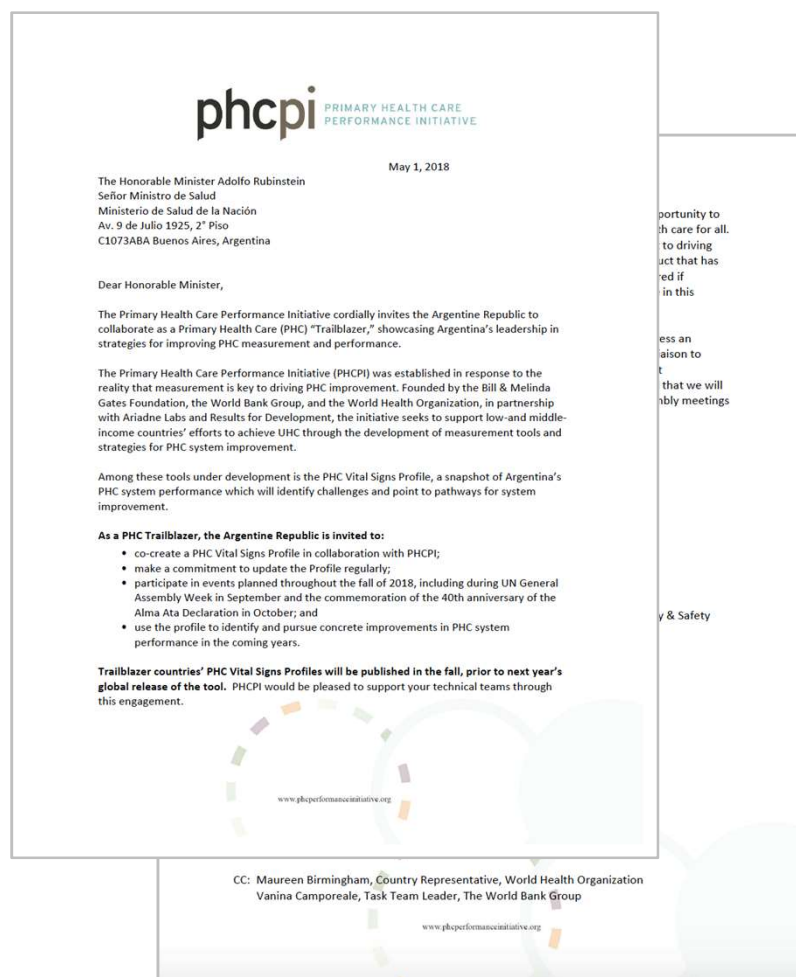
- Raise awareness about the opportunity and provide contextual information about the country situation and the potential benefit of the engagement to the PHCPI partners
- Share the general objectives and overall scope of the assessment with the PHCPI partners
- Give an opportunity to other PHCPI partners to confirm what role they would play in the engagement (if any).

Once the CE Note has been finalized and shared with the PHCPI partners, feedback is expected within a week. If no issues are raised and all partners agree to their respective roles, the partnership agrees for the collaboration to move forward.

This ensures that the PHCPI Lead and the key MOH staff involved in the process have access to adequate support from the PHCPI Team throughout the assessment process.

PHASE 1

FORMALIZE THE COLLABORATION



Following agreement by the PHCPI partners on the new engagement, the PHCPI Team will send a **formal invitation to collaborate** with the Initiative to the Minister of Health, outlining the benefits and the commitments associated with the VSP project. The invitation includes a request to confirm interest in participating and to identify a focal point from the MOH who will act as the technical liaison on the assessment.

While the letter is addressed to the Minister, a number of individuals are copied in the correspondence and should be kept informed about progress with the work, including:

- Key MOH staff who participated in earlier discussions about the involvement of the country with PHCPI
- The individual from PHCPI who liaised with the MOH to introduce the initiative and who will be identified as the PHCPI Lead for the engagement
- Representatives of PHCPI core partners from headquarters, regional office, and country office, as appropriate, and
- Implementing partners who will help conduct the work, if any and if known at this time.

A positive response by the Minister of Health provides the formal agreement for the country to collaborate with PHCPI and to initiate the assessment project.

PHASE 1

SUMMARY OF PHASE 1: STARTING OUT



Completion Checklist

- ☐ PHCPI and VSP concepts have been introduced to the country's Minister of Health and key MOH staff
- ☐ PHCPI sign-off on Country Engagement Note (PHCPI internal)
- ☐ Invitation to collaborate sent to the Minister of Health by the PHCPI Team
- ☐ Minister of Health sign-off on invitation to collaborate with focal point person designated



Resource Material for Phase 1: Starting Out

- Sample PHCPI Country Engagement note
- Sample PHCPI Letter of Invitation to Collaborate
- PHCPI Tool References and Explanations:
 - PHCPI Overview Presentation
 - Vital Signs Profile Report
 - VSP Explainer (4-pager)
 - VSP Detailed Methodology Note
 - VSP Samples
 - Progression Model Overview
 - Improvement Strategy Overview
- Sample Country Briefs
- Process Guide: Using the Vital Signs Profile to Assess the Performance of Primary Health Care (i.e. VSP Process Guide)
- Progression Model Assessment Guide

PHASE 2

PLANNING THE VITAL SIGNS PROFILE ASSESSMENT

1. Phase 2: Planning the Vital Signs Profile Assessment **p.20**
2. Defining Assessment Objectives and Scope **p.21**
3. Identifying the Project Team, Roles and Responsibilities **p.22-25**
4. Identifying Additional Key Stakeholders and Plan for their Engagement **p.26**
5. Preparing a Work Plan and a Project Charter **p.27**
6. Summary of Phase 2: Planning the Vital Signs Profile Assessment **p.28**



PHASE 2

PHASE 2: PLANNING THE VITAL SIGNS PROFILE ASSESSMENT

Phase 2 activities develop the plan for the assessment project. They include identifying in more detail the key project steps with their expected timeframes, and the individuals and teams that will be responsible for performing the work and overseeing the project, along with their roles. Specific objectives include:



Setting expectations and agreeing on the objectives for this project.



Identifying the individuals and teams who will be responsible to deliver the project, those who need to be consulted and those who will have decision authority.



Developing a project workplan/charter.

Outcome of Phase 2

At the end of this phase, stakeholders, partners and project teams should understand and agree on the scope and objectives of the assessment, their roles and responsibilities in the work and should be prepared to commit the time and effort required to the assessment project. The steps and timeframes for developing the VSP for the country will be documented in the assessment project plan. A well-developed project charter provides a reference for all team members as the project moves forward. It helps in assessing the impact of changes in situation, staffing, scope, resources on the project as work progresses.

There are four main activities for this phase:

- 1 Define** the objectives and scope of the assessment
- 2 Determine** the composition of the project teams, their roles and responsibilities
- 3 Identify** additional key stakeholders and plan for their engagement
- 4 Develop** a project charter, documenting the objectives and scope of work and identifying the key steps, the individuals and teams involved in each of these steps, and the expected timeline for delivery.

Planning activities for the Progression Model assessment should also be completed during this phase to ensure that activities and project team are coordinated across activities. See Phase 1, Steps 1-3 of the Progression Model Guide.

These activities will likely proceed in parallel with “back and forth” as key project steps are defined, project team members are identified, and scope and objectives are discussed. Depending on decision-making processes, **the planning phase may require 6 to 8 weeks to complete.**

PHASE 2

DEFINE THE ASSESSMENT OBJECTIVES AND SCOPE

This activity aims to articulate what the country and the PHCPI partners want to achieve with the development of the VSP and how extensive the assessment should be. The objectives and scope should be clear and communicated to all key stakeholders.

Objectives of the assessment

Determination of the objectives will be guided by discussion of questions such as:

- **Why** are we undertaking this work?
- **What** do we want to achieve?
- How do we expect to **use the results**?
- **How** can the results help us in decision-making and planning for PHC?
- By **when** do we need to have the results (e.g., upcoming planning cycle)?
- What are the **gaps** in our understanding of the country's primary care system (e.g., sub-national performance or specific programs)?

The objectives will be closely linked to the impetus behind undertaking the assessment that formed the basis of the discussion in Phase 1. For instance: a Minister could be concerned about the sustainability of the health system and projected levels of funding required; there could be a push from a system failure during a health crisis; a new government might have promised health system reforms; a new policy or funding request from a donor may be under preparation.

Thinking about “how the assessment project came into being” will provide insight into the objectives.

Scope of the assessment

The VSP and related indicators and measures set some broad parameters around the scope. They specify that the assessment looks at the **delivery of services**, but also at how the system is **financed**, what the government **policies** regarding the health system and primary care are, and whether there is **equity** in the system (among other things). However, while it is straightforward to say that the scope of the project is to develop a VSP for the country's primary care system, there are variations in what might be included or specifically excluded from the review. Defining scope is important to develop a project plan with appropriate resourcing and timeframes. The project team will need to consider the impact of resources available on project scope, and vice versa.

The scope of the project will be related to the objectives. Any decisions and assumptions about scope should be documented in project files. A template for documenting project objectives is included in the resource materials.

Examples of objectives and scope of PHC assessments using the VSP

Objectives: *think about what motivated the interest in assessing PHC using the VSP. Examples:*

- **Evaluate** the quality of PHC using national surveys and routine information systems
- **Conduct** detailed analytics on quality of care at sub-national and facility levels
- **Identify** gaps in quality of primary care services and implement quality improvement initiatives
- **Revise** the pay for performance scheme to incorporate best indicators from other global frameworks
- **Create** a subnational monitoring framework of PHC performance for the national UHC Strategy
- **Establish** a participatory process to identify and validate a common PHC monitoring framework

Scope: *think about what will be explicitly included in the analysis. Examples:*

- **National vs subnational.** If it is crucial to look beyond the national VSP, sub-national analysis should be part of the scope and the impact on time and resource needs should be documented.
- **Definition of PHC in the country.** Given the specific delivery system, it should be specified which types of services and providers and which programs (e.g., HIV, TB) are considered part of the primary care system and within the scope.
- **Public vs private.** In some countries, the private sector represents the greatest share of providers, while in others may be negligible; it may form an integral part of the primary care system, or be subject to minimal government oversight. The assessment needs to specify the extent to which services delivered by private providers are in scope.

PHASE 2

IDENTIFY THE PROJECT TEAM, ROLES AND RESPONSIBILITIES

Individuals with a **broad range of skills, expertise and leadership** are needed in a successful assessment team. Team members will include:

- A designated project lead, which would typically, although not always, coincide with the PHCPI Lead
- Other PHCPI partner organizations with roles as outlined in the Country Engagement Note (Phase 1)
- In-country government health policy leaders and decision-makers
- Internal and external experts in data resources and analysis
- Consulting experts to participate in review panels and provide technical expertise at crucial times for decisions to be made
- Consultants who will be tasked to carry out different tasks as appropriate (e.g., data collection, report writing). The project can be supported by external consultants and/or by staff from the MOH if they have time.

These individuals will participate as members of Working Group(s), Steering Committee, or Technical Experts Groups – which are described below.

The Project Lead or, if different, the PHCPI Lead and the Focal Point from the MOH, will work with country representatives and with PHCPI partners to identify the individuals who are suitable for each role and available to work on the VSP, and will secure their commitment to the project. A simplified project organization chart, illustrating the relationships among individuals and groups, is included in the resource materials for this guide. Project organization and roles may be adapted to suit each specific context.

Key roles for the VSP development



PHCPI Lead

From one of the PHCPI partners. Is primarily responsible for the relationship with the country MOH and other country stakeholders



Working Group

Project team composed of individuals with skill sets and resources needed to complete the tasks



Project Lead

Individual who is overall responsible for the VSP project. This may be the PHCPI Lead, but could be a different person depending on resources and needs



Steering Committee

Group of individuals from different stakeholders who oversee and provide interim approvals for the partner country



Focal Point

Designated focal point from the Minister of Health to be responsible for the engagement



PHCPI Team

Designated individuals from PHCPI partner organizations who are responsible for providing technical support to the project and quality review and validation.

PHASE 2

IDENTIFY THE PROJECT TEAM, ROLES AND RESPONSIBILITIES

Examples of Working Group composition

In Argentina,

the Working Group included:

- A lead and three more junior consultants (from a research institution)
- The three focal points from the National MOH:
 - The Director of the Under Secretary of Public Health Care Coverages
 - The Director of Quality in Health Services and Health Regulation
 - A representative of the Office of the General Coordination Unit
- The PHCPI Lead

In Ghana,

the Working Group included:

- The Deputy Director for Policy, Planning, Monitoring and Evaluation of Ghana Health Service (GHS) (Focal Point)
- Three additional representatives from the Policy, Planning, Monitoring and Evaluation of GHS
- One representative from Human Resources of GHS
- Two representatives of the MOH
- A consultant (from academia)
- A representative of the National Health Insurance Authority
- A representative of the Ghana Statistical Service
- A representative of UNICEF in the country

Working Group

The Working Group comprises the individuals who carry out the **day-to-day work** to complete the assessment and who are **responsible for producing the outputs**. Examples of its activities include identifying data gaps and potential sources of alternative indicators, leading the selection of alternative indicators, compiling and analyzing indicator results, and developing the final report.

Given the different aspects of the assessment, the project team may decide to form **one or multiple Sub-Working Groups**.

- One Working Group would allow to take advantage of synergies among the tasks and to ensure consistency in the way activities are conducted. It would also give members more in-depth knowledge of all pillars on the VSP.
- Multiple Sub-Working Groups would allow each to focus on specific parts of the VSP or of the process. For instance, some may gather quantitative data for the financing, performance and/or equity pillar; others may implement the PHC Progression Model for the capacity pillar. Some may be involved in data collection, others in report writing or stakeholder consultations.

The number and types of individuals who will be needed in the Working Groups will depend on a number of factors, including:

- **Scope of assessment.** For example, there will be more work involved in a sub-national analysis than one that is only at the national level, or for an assessment that includes private sector services and delivery.
- **Expertise and knowledge required.** The assessment requires a combination of individuals who:
 - Work in areas related to PHC in the country (e.g., policy development, service delivery, monitoring);
 - Work in areas related to the primary care system (e.g., finance, secondary care delivery, education);
 - Are in-country data experts and with access to data;
 - Have analytical expertise and understand how to work with the data sources;
 - Are consultants with expertise in PHC and understanding of data sources and uses.
- **Time available to complete the VSP.** Consider when the results are needed, and time that the individuals identified can devote to the VSP.

Regular communication and smooth collaboration among Working Group members is key. In addition to bilateral follow-ups, regular team meetings help ensure everyone is on the same page on the work done and on the next steps.

PHASE 2

IDENTIFY THE PROJECT TEAM, ROLES AND RESPONSIBILITIES

Examples of Steering Committee composition

In Argentina, a Steering Committee was not created as a structure. The Working Group engaged selected members of other departments of the National Ministry of Health, including the Director of Health Information and Statistics, and the Chief of Monitoring, Statistics and Reports of the *Programa SUMAR* throughout the process. The Working Group reached out to them to seek input, ask for feedback and participate in the validation of the VSP before the sign-off from the Minister. Even though there was no Steering Committee, an Expert Advisory Group was used to assess the VSP indicators for inclusion in the national monitoring framework for UHC. This Group included representatives of the National MOH, Provincial MOH, professional associations, and unions.

In Ghana,

the Steering Committee consisted of:

- The Minister of Health
- The Director of the Policy, Planning, Monitoring and Evaluation at the MOH
- The Director General of Ghana Health Service (GHS)
- The Deputy-Director General of GHS
- The Chief Executive Officer of Ghana National Health Insurance Authority
- The WHO Country Representative
- The World Bank Task Representative in the country.

The Steering Committee was briefed at the beginning of the assessment process and it was engaged for the validation of the VSP, but not all members participated in this step due to the tight timeline

Steering Committee

While the Working Group is focused on the practical work to deliver the VSP, another set of individuals is generally identified to form the Steering Committee. The Steering Committee is tasked to **provide guidance and oversight** on the process. Its composition is intended **to reflect the multi-stakeholder collaboration** that is needed to complete and obtain buy-in for the assessment.

The **role** of the Steering Committee usually includes:

- Sign-off on assessment objectives and scope
- Bring (or arrange for) resources for the assessment team as needed, including funds, human resources and staffing and data resources
- Review and approve assessment project plan
- Support the engagement of key stakeholders throughout the process
- Monitor the progress of the assessment
- Make decisions on how to deal with issues that arise
- Endorse the VSP before formal approval from the Minister of Health.

The Steering Committee should include representatives of all **key stakeholder groups** that need to contribute to decisions for the assessment. These could include:

- Key national and, if appropriate, subnational institutions and organizations with responsibilities for primary health care (i.e., the Ministry of Health)
- External technical experts
- Representatives from agencies supporting the assessment and health system improvement initiatives in the country (e.g., from PHCPI partners and other development partners).

The Steering Committee members should be **senior** enough to make decisions about the assessment on behalf of their constituency and to commit resources as required.

The Steering Committee should be a formally constituted part of the project team. However, depending on the country situation and composition of the Steering Committee, this group may delegate decision-making to the Project Lead or to the Working Group. In any case, the Minister of Health will be the ultimate decision-maker and will have to provide final approval of the VSP before its release to the public.

PHASE 2

IDENTIFY THE PROJECT TEAM, ROLES AND RESPONSIBILITIES

Technical Expert Advisory Group(s)

The Technical Expert Advisory Groups are special group(s) of established Technical Experts with practical experience in the use of data and indicators to assess the performance of health systems and, specifically, PHC. While the creation of such a group (or groups) may not be required for more straightforward assessments, a Technical Expert Advisory Group could provide useful input and advice in more complex situations.

For instance, in cases where there is limited data available through international databases, this group could support the selection of alternative indicators for the national VSP, using material compiled by the Working Group. In cases where the scope of the assessment goes beyond the national level, the experts could help the Working Group identify appropriate indicators and data sources for the subnational level.

The potential role of this group is described further in Phase 3.

Developing Terms of Reference (TORs) for all project teams and consultants

Terms of Reference should be developed for all the project groups and individual consultants that will contribute to the assessment process. This is crucial to ensure that all those involved understand the membership, responsibilities, and roles of each of the teams and their members in the assessment project.

The following TORs may be required for the project:

- Individual consultants
- Working Group(s)
- Steering Committee
- Technical Expert Advisory Group(s)
- Progression Model Assessment Team(s), if different from the Working Group.

Sample TORs that can be adapted to suit a VSP project are included in the resource tools. Additional resources specific to the PHC Progression Model are available upon request from the PHCPI Lead.

Why to consider a project kick-off event

Depending on the composition of the project team – experience, organizations they represent, place of work – it could be useful to hold a project kick-off event.

Such an event is an opportunity for many of those involved to learn about the project in all its aspects, beyond their individual roles, and to understand how this work fits into the bigger picture. It also provides an opportunity to orient the project team to the PHC Progression Model. (See Step 3 in the Progression Model guide.)

It provides a forum for the team members to meet each other if they haven't already met. Introductions are important for forming working relationships.

The Project Lead can set the stage for the VSP project, ensuring that everyone is on the same page and has the same understanding of the statement of project objectives and organization.

A kick-off event could be the first of on-going series of status and update meetings for the larger team.

PHASE 2

IDENTIFY ADDITIONAL KEY STAKEHOLDERS AND PLAN FOR THEIR ENGAGEMENT

Beyond the groups already identified, there may be other organizations and individuals who have a stake in and will be affected by the outcomes of the VSP assessment. They will need to be involved in the process.

The following questions can help to **identify those stakeholders**:

- Who has an interest in the assessment?
- Who could be affected by the outcomes of the assessment process?
- Who do we need to consult and get information from?
- Who holds the data resources that we will need for the assessment?
- Who can help use the results?

The stakeholders identified will depend on the scope of the project, the organizations and agencies (in-country and external) involved in sponsoring the assessment, the current organization of PHC in the country and governance of the health system.

Once stakeholders have been identified, three key questions should be answered to plan their most effective engagement:

1. What is the **interest** of this group/organization/individual in the outcomes of the assessment?
2. How do they need to be involved in the assessment – **how and when** should they be consulted?
3. What is the best way to **communicate** with them?

Possible ways of engaging these stakeholders include:

- Holding pre- and post-assessment workshops for discussions on priorities and/or results;
- Conducting individual interviews or focus group discussions to obtain perspectives on priorities and performance;
- Provide regular updates on the progress of the assessment, and opportunities for stakeholders to review and comment on data, reports and other outputs.

The list of stakeholders and answers to the questions above should be documented as part of the Project Charter. For further comments on engaging stakeholders see Phase 5, Activities 2 and 3).

Which additional key stakeholders should be engaged?

Examples of **some groups** that would likely be identified as key include:

- Providers of primary care and public health services (public and private, including not-for-profit), professional societies or associations, other organizations representing primary care workers (e.g., physicians, nurses, community health workers)
- District or regional service delivery management, or facility management
- Local or community governance structures
- Patient representatives
- Local and international health advocacy and civil society organizations
- Government ministries, departments and agencies with roles in healthy public policy (e.g., education, labor, environment, safety)
- Organizations holding health-related data (e.g., national statistics agencies, holders of survey data, holders of health registries).

PHASE 2

PREPARE A WORK PLAN AND A PROJECT CHARTER

Work Plan

The Work Plan is intended to provide a guide for activities and to ensure that team members know what is expected of them and when. It can be used to assess overall project progress. It identifies:

- The **activities** to be completed,
- Who is **responsible** for them,
- When the activity is planned and the estimated **time** to complete it, and
- Any required **sequencing** (e.g., activities A and B must be complete before activity C can begin).

The Work Plan template included in the resource materials lists the common activities and tasks for a VSP assessment and suggests how these would be sequenced. However, the assignment of individuals to the tasks as well as the time required to complete them depends on the circumstances of each project and the Work Plan will need to be adapted to fit the situation.

The Work Plan will likely require adjustments as the project proceeds. For example, the scope or available resources may need to be adjusted as the project team starts the assessment or as key stakeholders provide input into the plans. However, a starting point is needed to understand overall project costs, time to complete and output of the assessment.

Project Charter

The project planning documents described in this section – the Work Plan, ToRs, project scope and objectives, identified stakeholders, and the roles and responsibilities of team members, including any budgets and funding sources – should be compiled into a Project Charter document. This material can be shared with all members of the project team and stakeholders as needed. It will be used to steer the assessment work going forward.

Just as the Work Plan is not static, the Project Charter will likely require adjustments as the project moves forward. Situations and circumstances will change, the project team members will learn more about the work involved in completing activities as they progress or project team members may change. However, the Project Charter helps the Steering Committee understand the implications of changes and the effect they may have on the project scope, objectives, timing and resources. The Steering Committee should sign-off on the initial Project Charter and on any significant changes to resources, timing and output.

The Project Charter should be shared with the PHCPI Team.

The **Work Plan template** can be adapted to fit the needs of each country. Where possible, the Progression Model work plan should be incorporated into the overall VSP project plan. This could be done as a 1-2 line reference to the expected timing and resources needed for the Progression Model work, or could be more elaborate with individual Progression Model activities listed as part of the overall work plan.

Phases and Activities	Roles and Responsibilities					Estimated Elapsed Weeks*										
	Leads	Consulted	Contributes	Decides	PHCPI's Role		1	2	3	4	5	6	7	8	9	10
Phase 1: Starting Out						5										
Activity 1: Introduce PHCPI and VSP to the Country						3										
Activity 2: Review the VSP Project with the PHCPI Partnership					PHCPI	1										
Activity 3: Formalize the Collaboration						2										
Prepare Invitation to Collaborate						1										
Sign-off on Invitation to Collaborate					Minister of Health	1										
Phase 2: Planning the Assessment						6										
Activity 1: Define Assessment Objectives and Scope						3										
Activity 2: Identify the Project Team, Roles and Responsibilities						1										
Determine project organization structure						1										
Identify key individuals						2										
Develop the Terms of Reference for Project Teams and Participants						2										
Activity 3: Identify Additional Key Stakeholders and Plan for their Engagement						2										
Activity 4: Prepare a Project Plan and a Project Charter					Steering Committee; PHCPI	3										

PHASE 2

SUMMARY OF PHASE 2: PLANNING THE VITAL SIGNS PROFILE ASSESSMENT



Completion Checklist

- ☐ Terms of reference – Working Group(s), consultant(s), steering committee, including any required for the PHC Progression Model
- ☐ Project Work Plan
- ☐ Project Charter document
- ☐ Sign-off from Project Lead and/or, if different, PHCPI lead and MOH focal point (or Steering Committee if it exists) to activities and time commitments for the development of the entire VSP



Resource Material for Phase 2: Planning the Vital Signs Profile Assessment

- VSP project objectives example
- VSP project organizational chart example
- Example TORs for Working Group, Consultants, Steering Committee
- Example of key stakeholder list
- Work Plan template
- Project charter template
- VSP Process Guide
- Progression Model Assessment Guide

PHASE 3

Data Compilation

1. Phase 3: Data Compilation **p.30-31**
2. Review VSP Indicators and Measures to Determine Data Availability and Gaps **p.32-36**
3. Identify Data Sources for any Alternative Indicators and for the Progression Model Measures **p.37-39**
4. Select any Alternative Quantitative Indicators **p.40**
5. Compile Data for all Quantitative Indicators and Progression Model Measures **p.41**
6. Conduct Internal Scoring for the Progression Model **p.42**
7. Summary of Phase 3: Data Compilation **p.43**

PHASE 3

PHASE 3: DATA COMPILATION (1/2)

Phase 3 activities are focused on identifying and compiling the data and indicator results that will be used to populate the VSP. Specific objectives include:



Identify gaps and data sources for VSP indicators and measures



Collect the data for the appropriate indicators and measures



Conduct steps 4-8 of the PHC Progression Model assessment

Outcome of Phase 3

At the end of this phase, the data and results required for populating the VSP should be compiled and available for validation, analysis and ready to use in developing the VSP.

There are five main activities for this phase:

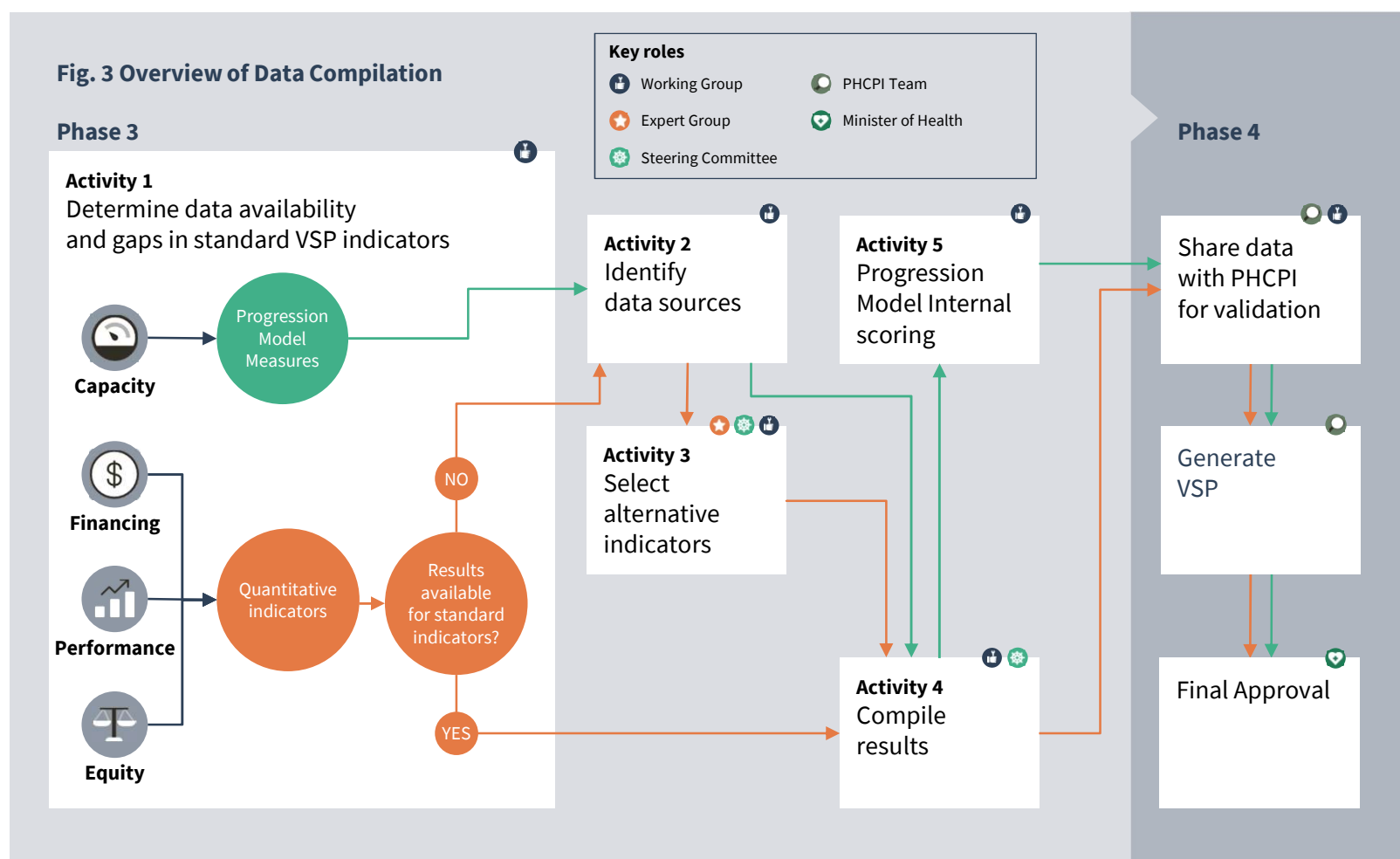
- 1 Review** VSP indicators and measures to determine data availability and gaps
- 2 Identify** data sources for any alternative indicators and for Progression Model measures
- 3 Select** any alternative quantitative indicators
- 4 Compile** data for all the quantitative indicators (standard and alternative) and for the Progression Model measures
- 5 Conduct** internal scoring for Progression Model measures

The work on gathering the quantitative and qualitative data from the different sources is likely to proceed in parallel. While there will be overlap, different individuals and teams may be responsible for assessing and compiling results in the different data categories. This phase can be very resource intensive and is likely to **require roughly 12 to 15 weeks** to complete.

PHASE 3

PHASE 3: DATA COMPILATION (2/2)

Fig. 3 below provides an overview of the process of data compilation, and how it links with the generation and validation of the VSP. It shows the typical steps that should be followed to identify indicators and data sources to complete the VSP. It also outlines who is generally responsible for the different steps in the process. Please note that while validation of the VSP by the PHCPI Team and approval by the Minister of Health (possibly with prior review of the package by the project's Steering Committee) are essential steps before the public release of the VSP, these activities will be discussed in Phase 4.



PHASE 3

REVIEW VSP INDICATORS AND MEASURES TO DETERMINE DATA AVAILABILITY AND GAPS (1/5)

The VSP includes over 30 **standard quantitative indicators** used to assess the pillars of Financing (up to 4), Performance (up to 26) and Equity (up to 3). Another eight quantitative indicators are used to provide information about context and health status outcomes. Page 34 lists the numbers of indicators used to assess the pillars, domains and sub-domains as well as the aspects of context and outcomes, with their data sources. A list of all standard VSP indicators is shown on page 35 and more details can be found in the VSP Detailed Methodology Note in the reference materials.

These standard indicators in the VSP were originally selected, among other objectives, to facilitate **comparisons of results across countries** over the four pillars. These standard indicators are derived from surveys, tools and datasets that are internationally comparable and consistent.

Results for the set of standard indicators for many countries are available through **publicly accessible sources**. Many standard VSP indicators are derived from the following databases and surveys:

- Global Health Expenditure Database (GHED) reported using the SHA2011
- Harmonized Facility Surveys (HFS)
- Service Delivery Indicators (SDI)
- Service Provision Assessment (SPA)
- Service Availability and Readiness Assessment (SARA)
- Demographic and Health Surveys (DHS)
- Multiple Indicator Cluster Surveys (MICS)

PHASE 3

REVIEW VSP INDICATORS AND MEASURES TO DETERMINE DATA AVAILABILITY AND GAPS (2/5)

However, these surveys have **limitations**:

- No single survey covers all quantitative indicator used in the VSP; all surveys currently available are still missing at least some important conceptual measures;
- While many countries may have some of these surveys, not all surveys have been implemented in all countries;
- The results, although available, may be several years old (PHCPI recommends that, outside of exceptional circumstances, all data should be no older than 7 years, and ideally less than 5);
- The results, although available and perhaps even recent, may no longer represent the current situation in the country if major reforms were implemented after the data collection.

The standard indicators are the preferred indicators for the VSP, when available.

They promote international comparability as a potential mechanism for enhancing accountability and cross-country learning. However, results for standard indicators are not always available. Moreover, in some cases, alternative data sources or indicators may be more current or considered to provide a more accurate picture of PHC than the standard indicators. In these situations **alternative indicators may be considered** for use in the VSP.

The use of alternative indicators can support a more current and/or more complete picture of PHC in a country. However, it also implies that indexes calculated from alternative indicators cannot be compared to that for other countries.

Criteria Used to Rate and Select VSP Standard Indicators

The standard VSP indicators were selected from a list of many potential indicators using a phased approach and an *eDelphi* process; for a more detailed description of the process, please refer to the paper [*Better Measurement for Performance Improvement in Low- and Middle-Income Countries: The Primary Health Care Performance Initiative \(PHCPI\) Experience of Conceptual Framework Development and Indicator Selection*](#), published in the Milbank Quarterly and available in the resource materials.

This process started with the identification of indicators related to the domains of the PHCPI conceptual framework. It was followed by electronic surveys through which experts rated potential indicators. Finally, it concluded with expert panel convenings to review the results of the survey and provide advice on indicator selection.

The criteria used in this process were:

Relevance and importance – the extent to which the indicator reflects important aspects of the performance of primary health care

Reliability – the indicator produces consistent results




Validity – the indicator is an accurate reflection of the domain and sub-domain of primary health care systems performance it is supposed to assess

Actionability – the value of the indicator could be improved through implementation of policies and processes designed to improve primary health care system performance

PHASE 3

REVIEW VSP INDICATORS AND MEASURES TO DETERMINE DATA AVAILABILITY AND GAPS (3/5)

Where in the VSP can alternative indicators be used?

Pillars & Sections Of the VSP	Domain	Sub-Domain	# of Standard Indicators	Use of Alternative Indicators?***
 Financing	Total Spending on PHC		1	SHA 2011
	Prioritization of spending on PHC		2	SHA 2011
	Sources of Spending on PHC		1	SHA 2011
 Performance	Access	Financial	1	DHS
		Geographic	1	DHS
	Quality	Comprehensiveness	3	SARA, SPA or HFS
		Continuity	2	GHO
		Person-centeredness	1	SPA or HFS
		Provider availability	2	SPA (1) and SDI (1), or HFS (2)
		Provider competence	5	SPA (3) and SDI (2), or HFS (5)
		Safety	2	SARA, SPA or HFS
	Service Coverage*	RMNCH	4	UHC Global Monitoring Report
		Infectious diseases	3 – 4*	UHC Global Monitoring Report
		NCD	1	UHC Global Monitoring Report
 Equity	Access		1	WHO Health Equity Monitor (or MICS or DHS)
	Quality		1	WHO Health Equity Monitor (or MICS or DHS)
	Outcomes		1	WHO Health Equity Monitor (or MICS or DHS)
Context			3	World Bank WDI (2), WHO (1)
Outcomes			7	WHO
TOTAL			43	

* 9 indicators (or 8, if indicator on use of insecticide-treated nets for malaria prevention is not collected) related to PHC of the 14 used to develop the UHC Service Coverage Index. Results estimated for all countries in the 2017 report. The project team may wish to consider using more current and relevant indicators if available and robust.

** Please reach out to the PHCPI team for any questions or clarifications and to discuss specific cases

PHASE 3

REVIEW VSP INDICATORS AND MEASURES TO DETERMINE DATA AVAILABILITY AND GAPS (4/5)

List of standard VSP indicators by Pillar of the VSP*



PERFORMANCE

Access

Financial Access

- Perceived access barriers due to treatment costs

Geographic Access

- Perceived access barriers due to distance

Quality

Provider availability

- Percentage of family planning, ANC, and sick child visits over 15 minutes
- Provider absence rate (%)

Provider competence

- Antenatal care quality score
- Family planning quality score
- Sick child care quality score
- Adherence to clinical guidelines
- Diagnostic accuracy

Safety

- Adequate waste disposal
- Adequate infection control

Continuity

- DTP3 dropout rate
- Treatment success rate for new TB cases

Comprehensiveness

- Average availability of five tracer RMNCH services
- Average availability of services for three tracer communicable diseases
- Average availability of diagnosis and management of three tracer NCDs

Person-centeredness

- Percent of caregivers told sick child's diagnosis

Service Coverage

RMNCH

- Demand for family planning satisfied with modern methods (%)
- Antenatal care coverage (4+ visits)
- DTP3 immunization coverage (%)
- Care-seeking for suspected child pneumonia (%)

Infectious disease

- TB cases detected and treated (%)
- People living with HIV receiving ART (%)
- Use of insecticide-treated nets for malaria prevention (%)**
- Children under 5 with diarrhea receiving ORS

NCDs

- % of population with normal blood pressure



FINANCING

- Current PHC expenditure per capita (USD)
- Current PHC expenditure as % of Current Health Expenditure (CHE)
- Domestic general government PHC expenditure as percentage of current PHC expenditure
- Domestic general government PHC expenditure as a % of domestic general government health expenditure



EQUITY

Equity in Access

- Perceived barriers due to treatment costs, by wealth quintile

Equity in Coverage

- Coverage of RMNCH services, by mother's education

Equity in Outcomes

- Under-five mortality rate, by residence



OUTCOMES

- Life expectancy at birth (years)
- Maternal mortality ratio (per 100,000 live births)
- Neonatal mortality (per 1,000 live births)
- Premature mortality due to non-communicable disease (NCD)
- Distribution of cause of death



CONTEXT

- GDP per capita (PPP current international \$)
- Population living in poverty (Under \$1.90 int'l dollars / day)
- Government health spending as % of GDP

* See the VSP Detailed Methodology Note for full definitions of these indicators, including numerators and denominators

** If applicable

PHASE 3

REVIEW VSP INDICATORS AND MEASURES TO DETERMINE DATA AVAILABILITY AND GAPS (5/5)

Review PHC Progression Model and Define Key Terms

The VSP includes 33 **standard measures** used to assess **Capacity**. Those measures are pre-defined and collected based on a standardized methodology, the **PHC Progression Model**. The Working Group members should take some time to review the methodology and familiarize themselves with each of the measures, and to agree on the definition of key terms and concepts that will be vital for the assessment (for example how the PC system is defined in the country). A more detailed description of how to review the PHC Progression Model and Define Key Terms for the assessment is included in Phase 3 of the Progression Model Assessment Guide in the resource materials. The figure on the right provides a list of the 33 measures for the Capacity pillar of the VSP. Each of these measures will be assessed based on pre-defined rubrics with evidence derived from multiple quantitative and qualitative data sources.

See p.10 of this guide for an introduction to the Progression Model and use of the Progression Model Guide.

Governance

4.0

Governance and Leadership

- **Measure 1:** PHC Policies (1/2)
- **Measure 2:** PHC Policies (2/2)
- **Measure 3:** Quality management infrastructure
- **Measure 4:** Social accountability (1/2)
- **Measure 5:** Social accountability (2/2)
-

Adjustment to Population Health Needs

- **Measure 6:** Surveillance
- **Measure 7:** Priority setting
- **Measure 8:** Innovation and learning

Inputs

2.3

Drugs and Supplies

- **Measure 9:** Availability of essential medicines
- **Measure 10:** Basic equipment availability
- **Measure 11:** Diagnostic supplies

Facility Infrastructure

- **Measure 12:** Facility density
- **Measure 13:** Facility amenities
- **Measure 14:** Standard safety precautions and equipment

Information Systems

- **Measure 15:** Civil registration and vital statistics
- **Measure 16:** Health management information systems
- **Measure 17:** Personal care records

Workforce

- **Measure 18:** Density and distribution
- **Measure 19:** Quality assurance of PHC workforce
- **Measure 20:** PHC workforce competencies
- **Measure 21:** Community Health Workers

Funds

- **Measure 22:** Facility budgets
- **Measure 23:** Financial management information system
- **Measure 24:** Remuneration

Population / Facility Management

1.7

Population Health Management

- **Measure 25:** Local priority setting
- **Measure 26:** Community engagement
- **Measure 27:** Empanelment
- **Measure 28:** Proactive population outreach

Facility Organization and Management

- **Measure 29:** Team-based care organization
- **Measure 30:** Facility management capability and leadership
- **Measure 31:** Information system use
- **Measure 32:** Performance measurement and management (1/2)
- **Measure 33:** Performance measurement and management (2/2)

PHASE 3

IDENTIFY DATA SOURCES FOR ANY ALTERNATIVE INDICATORS AND FOR THE PROGRESSION MODEL MEASURES (1/3)

Once the gaps in the availability of the standard VSP indicators have been identified, the project team will need to determine if there are **appropriate alternative indicators** that can be used for the VSP, based on the **data sources available in the country** (routine and administrative data, household surveys, facility surveys, patient surveys). The following principles should be used in considering potential alternative indicators:

The proposed alternative indicator must measure the same construct that the original VSP indicator is intended to measure. The indicator should be a valid measure of the domain and sub-domain of PHC performance that it is intended to assess.

For example, if the standard indicator of geographic access is not available, any proposed alternative(s) should measure the experiences of individuals with geographic barriers to primary care services. If the missing indicator is about the availability of reproductive, maternal, neonatal, child health services, any proposed alternative should address the availability of services of this kind.

The **PHCPI conceptual framework** and its guiding questions can be used to identify key areas in which to look for data, and to organize the information, ensuring that key aspects of the framework that relate to the VSP pillars and sub-domains are covered.

If a valid measure of a specific subdomain cannot be found in any alternative data source, then that subdomain will not have any indicators included in the VSP and will be left empty.

Alternative indicators derived from survey datasets with questions similar to those used for the standard indicators are preferred. The Indicator Collection Tool in the resource materials identifies the survey questions from the SPA, SDI, HFS or DHS survey used to define the indicator. In the identification of alternative indicators the Working Group should consider that:

- 1 Questions from the country non-standard surveys should match as closely as possible with **comparable questions** in the standard surveys;
- 2 The question **respondents** should be the same in the standard and non-standard survey where possible. For instance, if the respondent from the SPA survey is a healthcare worker in a primary care facility, then the respondent in the country survey should also be a healthcare worker in a primary care facility;
- 3 Country surveys should ideally be nationally **representative**.

Any differences in question wording, context, sampling, or respondent used in the country's survey compared to the standard surveys must be documented.

PHASE 3

IDENTIFY DATA SOURCES FOR ANY ALTERNATIVE INDICATORS AND FOR THE PROGRESSION MODEL MEASURES (2/3)

If it is not possible to **derive alternative indicators from survey questions that are similar to those from which standard indicators are derived (i.e. if it is not possible to fulfill any of the criteria above), other indicators may also be considered as alternative for the VSP.**

This is the case if, for example, there are no suitable survey datasets, or if the survey datasets available are not of acceptable quality. In these cases, the Working Group would consider any routine and administrative data that is relevant to measure the concept of interest. Strategies used in some countries to identify these indicators are described in the resource material associated with this phase (see box).

Limitations of using alternative indicators for the VSP:

Choices on the selection of alternative indicators have implications on the presentation of the VSP, **on the interpretation of results, and on the comparability of results across countries.**

In the standard VSP presentation, indexes of performance for the sub-domains and domains within the pillars can be color-coded – green for relatively good results, yellow for relatively (nearly) acceptable results, and red for poor results. For examples, any of the indexes of the Performance pillar will be marked red if the index value is **0-59**, yellow if it is **60-79**, and green if it is **80 or more**. This allows the user of the information to visually and more easily grasp whether a country is performing better or worse than a pre-defined standard in a specific index.

If alternative indicators have been used in the calculation of the index for a domain or sub-domain, then the result for the index cannot be compared to the standard and hence cannot be color-coded; the result is therefore colored grey. Information on the composition of the index should be made explicit and documented in the VSP.

Possible strategies to identify alternative Indicators

Interview:

- Staff in government statistical agencies
- Health insurance providers and agencies
- Ministry of Health staff responsible for strategic planning and implementation of government programs
- Staff of international organizations or development partners in the country
- Academics or staff in prominent research institutions in the country.

Review documents related to:

- National health strategies
- Monitoring and evaluation frameworks
- Statistical reports (annual, quarterly, monthly, etc.)
- Health Insurance reports
- Performance-based incentive programs.

Look to the following resources for ideas:

- WHO 100 Core Health Indicators
- PHCPI Diagnostic Indicators
- Joint Learning Network PHC Indicator Inventory.

PHASE 3

IDENTIFY DATA SOURCES FOR ANY ALTERNATIVE INDICATORS AND FOR THE PROGRESSION MODEL MEASURES (3/3)

Document Potential Alternative Indicators and Data Sources

Documenting any potential alternative data sources and indicators is key to this process. This information will be used to select the indicators that will eventually be included in the VSP and to assess the quality and coverage of the data sources from which the indicators can be derived. Below are guides to how alternative data sources and indicators can be documented:

Data Source Documentation

Data source name	The name used in the country to refer to the data source
Type of data source	Indicate if the data source is: <ul style="list-style-type: none"> • Routine information system (e.g., administrative data)? • Household survey? • Facility survey? • Provider survey? • Other?
Representativeness of data	How well does the data source represent the country? Remark on the following items as appropriate: <ul style="list-style-type: none"> • National or for specific region(s) only? • Urban and rural areas? • Public and private sectors? • Is it for a specific target population (e.g., age, disease, ethnic or gender-based)? • Time period of data collection (e.g., were all areas surveyed at the same time, or were some regions done one year and others the following year)? • Sample size? • Level of facilities (e.g., acute care only, health stations, community health centers, etc.)? • Other comments on representativeness
Data quality reviews and results	Describe if data quality reviews have been done and what is known about: <ul style="list-style-type: none"> • Completeness of data • Investigation of outliers • Internal consistency across related indicators • Believability of trends • Consistency with other data sources
Is data source expected to continue?	If a survey is it: <ul style="list-style-type: none"> • One-time or planned to be ongoing? • If ongoing, what is the planned frequency? • If an operational or administrative system is the system planned to continue being used?
Include the following documentation or references	<ul style="list-style-type: none"> • Data collection instrument • Dataset (if available and permissible) • Reports or publication where the data have been used or cited • Information of funders of survey, as appropriate, and any conflict of interest

Alternative Indicator Documentation

Indicator Name	Reference name for the indicator
Indicator definition	Include definitions of: <ul style="list-style-type: none"> • Numerator • Denominator Refer to specific survey questions and responses in the definitions if appropriate
Use in the VSP	What pillar, domain and sub-domain will the indicator be used to measure? (For example, Performance / Quality / Access) <p>Describe how the indicator would be used in the calculation of VSP indexes. What standard VSP indicator would this indicator replace?</p>
Rationale	Describe how the indicator relates to the PHC construct of interest and why it is a valid measure
Importance and relevance	How does the indicator add important and relevant information for assessing PHC in the country?
Data source	Indicate the survey or other data source that is used to calculate the indicator
Time period	When was the source data collected?
Limitations and caveats	Note any concerns or limitations due to representativeness, wording of the survey question(s) or other factors.

PHASE 3

SELECT ANY ALTERNATIVE QUANTITATIVE INDICATORS

Once potential alternative indicators have been identified, they should be **vetted through a defined and agreed upon process** to ensure their suitability for use in the VSP. Although the process of selection of alternative indicators to be included in the VSP varies across countries, such a process is typically defined by the Working Group and endorsed by the country's Steering Committee (if existing) and by the PHCPI Team.

The process should identify the individuals or group that will be providing advice and input, and those that will make the final *decision* on the recommended alternative indicators. The documentation of the alternative data sources and indicators will inform the process.

PHCPI Support

The PHCPI Team should be consulted throughout the assessment process, starting from Phase 1. Based on prior experience assisting countries with the creation of VSPs, the PHCPI Team can specifically provide advice and guidance on the process of selecting alternative data sources and indicators to ensure that choices across countries are made consistently. The proposed list of alternative indicators must be reviewed by PHCPI prior to proceeding with compiling results for these indicators.

While the process used to select alternative indicators **may vary** depending on the country and circumstances, the following steps are suggested to ensure that different perspectives can be heard:

1. Request a **group external to the Working Group to rate the indicators against established criteria** – e.g., validity, importance/relevance, measurability, and actionability. This could be done by the Steering Committee or an ad-hoc Experts Advisory Group of national and ideally international experts in PHC measurement. In the latter case, TOR for the group should be developed in Phase 2.
2. Convene the Expert Advisory Group (or the Steering Committee), including representatives from the MOH and other country stakeholders to **discuss the suitability of each indicator and the recommended selection**, in cases where more than one indicator could be used to measure the same construct. The discussion can be informed by the ratings assigned in step 1, if done.
3. Based on the Expert Advisory Group's feedback, the Working Group develops recommendations for the use of alternative indicators and presents these to the PHCPI Team for sign-off and to the Steering Committee (where appropriate) for final **approval**. In case that changes are made by the Steering Committee, the PHCPI Team is informed (where appropriate) for endorsement.

Each alternative indicator should be selected with a view to replacing a specific standard indicator that is not available, hence it needs to measure a similar construct (i.e. it needs to answer the same question). In the VSP, a number of standard indicators are combined (averaged) to calculate the sub-indexes and indexes that will be included in the VSP (as described in Phase 4 Activity 1 and in Annex 2 of the VSP Detailed Methodology Note).

However, it may happen that no potential alternative indicators can be identified for a particular domain or sub-domain, or that none of the potential alternatives are considered suitable. If so, VSP indexes may still be calculated as the **average of the remaining indicators** included. Examples of alternative indicators used in published VSPs are included in the resource materials and available on the PHCPI website.

PHASE 3

COMPILE DATA FOR ALL QUANTITATIVE INDICATORS AND PROGRESSION MODEL MEASURES

Results for all quantitative indicators (standard and alternative) and for all Progression Model measures should be compiled by the Working Group and endorsed by the Steering Committee and by the PHCPI Team (as it will be explained in Phase 4).

Quantitative Indicators:

These should be compiled into a standardized excel data collection tool [Indicator Collection Tool]. This guide was developed to provide a standard format and ensure consistency in recording results for both standard and alternative indicators.

1. **Country results for the standard VSP indicators** (where available) can be found in the PHCPI dataset. This dataset is available through the PHCPI team. It contains the most recent results for all VSP indicators for all countries and is regularly updated.
2. **Country results for the alternative VSP indicators** will need to be calculated (see box) and recorded in the Tool.

Quality Review and Sign-off on Data Compiled

The compiled results should be reviewed and endorsed by the Steering Committee. As explained in Phase 4, the results will be reviewed and signed-off on by the PHCPI Team to ensure that the selected alternative indicators are consistent with the construct they should measure and that data sources and indicators' definitions and results can be verified.

Progression Model Measures

As described in Steps 6 and 7 of the Progression Model Guide, during this phase, the Working Group should:

1. **Gather data:** the data required to complete the assessment – quantitative documentation as well as interviews with key informants – is collected, organized and stored, ready for synthesis; and
2. **Synthesize data:** all relevant evidence from quantitative data, document reviews, and key informant interviews for each measure of the PHC Progression Model is extracted for use in the scoring of performance levels. Evidence is compiled and organized by measure to facilitate the scoring (see next activity).

Obtaining Results for Alternative Indicators

Results may be obtained from different sources depending on the definition of the alternative indicator:

- **Calculated from primary survey data sets by the project team.** This would apply if results for an indicator have not previously been calculated from an existing survey dataset. If this is the case, it is good practice to have the result verified independently by a second analyst.
- **Obtained from existing reports.** An indicator result may have been reported previously by the government or other body. In this case, the source report should be referenced and a copy kept in the project files for documentation.
- **Obtained via special request from the data holder.** Ministries of Health or government statistical departments may hold the data needed and supply to the project team on request. In this case detailed technical specifications should be supplied, and the name, position and department of the individual supplying the result should be documented, along with the specifics of the request and kept in the project files.

PHASE 3

CONDUCT INTERNAL SCORING FOR THE PROGRESSION MODEL

Once evidence has been gathered and appropriately synthesized by measure, the Working Group conducts the internal scoring. This consists in **assigning a performance level of 1 through 4 to each of the 33 measures**, using all of the relevant collected and synthesized evidence. The internal scoring is based on the standardized rubrics. It is typically done by the assessment team together with in-country stakeholders who were key informants during data collection and/or individuals with extensive knowledge of the organization and delivery of primary care in the country. Step 8 of the Progression Model guide describes this activity in detail and provides significant guidance and resources.

First, following precise scoring rules, a score is attributed to each component of each of the 33 measures.

Then, the Progression Model score sheet summarizes and aggregates the scores for all the measures by subdomain.

PRIMARY HEALTH CARE PROGRESSION MODEL						
Appendix 15: PHC Progression Model Score Sheet for [COUNTRY]						
Measure 1: Primary health care policies (1/2)						
Components	Internal Score	External Score	External Score Notes	Consensus?	Final Score	Final Score Notes
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?						
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, financing mechanism, and M&E framework?						
Is there a joint review of the progress towards the objectives set out in PHC-related policies?						
Measure 1 Score						

PRIMARY HEALTH CARE PROGRESSION MODEL				
Appendix 15: PHC Progression Model Score Sheet for [COUNTRY]				
Last updated on [date]				
Category	Measure	Internal Score	External Score	Final Score
Governance and Leadership	1: Primary health care policies (1/2)	0	0	0
	2: Primary health care policies (2/2) - Leadership	0	0	0
	3: Quality management infrastructure	0	0	0
	4: Social accountability (1/2)	0	0	0
	5: Social accountability (2/2) - Multi-sectoral action	0	0	0
Adjustment to Population Health Needs	6: Surveillance	0	0	0
	7: Priority Setting	0	0	0
	8: Innovation and Learning	0	0	0

PHASE 3

SUMMARY OF PHASE 3: DATA COMPILATION



Completion Checklist

- ☐ Review of VSP indicators list and PHC Progression Model measures
- ☐ Data mapping complete for Progression Model measures
- ☐ Review of data availability for internationally comparable indicators
- ☐ Documentation of data sources and definitions for potential alternative indicators
- ☐ Documentation of sources of results for selected alternative indicators (Indicator Descriptive Sheets)
- ☐ Completed indicator collection spreadsheet containing results for all (standard and alternative) indicators
- ☐ Compiled list of indicators with values endorsed by PHCPI and Steering Committee
- ☐ Supporting Progression Model evidence and documentation organized and stored
- ☐ Completed internal Progression Model scoring



Resource Material for Phase 3: Data Compilation

- PHCPI Complete Indicators and Progression Model Measures List
- PHCPI VSP Indicators Checklist
- VSP Indicator descriptive sheets for standard indicators and template for documenting alternative surveys
- Alternative data source documentation template
- Alternative indicator documentation template
- Documents describing possible alternative indicators (JLN list, WHO 100 list, PHCPI diagnostic indicators)
- Alternative indicator selection process examples
- E-survey for indicator rating example
- Analysis of e-survey results for indicator rating example
- VSP Detailed Methodology Note
- Indicator Collection Tool
- Examples of alternative indicators used
- Indicator compilation example
- VSP Process Guide
- Progression Model Assessment Guide

PHASE 4

GENERATING THE VSP AND VALIDATING THE RESULTS







1. Phase 4: Generating the VSP and Validating the Results **p.45**
2. Activate the Technical Review and Validation by PHCPI **p.46**
3. Generate the Formal VSP **p.47-51**
4. Validate Results and Obtain Sign-off by the Ministry of Health **p.52**
5. Summary of Phase 4: Generating the VSP and Validating the Results **p.53**

PHASE 4

PHASE 4: GENERATING THE VSP AND VALIDATING THE RESULTS

In this phase, the results of the quantitative indicators and progression model measure scores compiled in Phase 3 are used to generate the Vital Signs Profile document and to prepare material for release and sharing beyond the project team and PHCPI. This requires a technical review and validation by the PHCPI Team, a review by the Steering Committee, and approval by the Minister of Health (as described in the invitation to participate).

Specific objectives of this phase include:

-  Calculating indexes and obtaining aggregate measures from the individual indicators.
-  Generating the Vital Signs Profile document and related presentation materials.
-  Obtaining validation of the VSP by PHCPI and in country stakeholders, including approval from the Minister of Health (or designate).
-  Publishing the VSP.

Outcome of Phase 4:

At the end of this phase, PHCPI, the project team and any relevant country stakeholders should be prepared to release the country VSP results. The VSP and its underlying indicators, measures and indexes, are uploaded on the PHCPI website.

There are three main activities for this phase:

- 1 Activate** the technical review and validation by the PHCPI Team.
- 2 Generate** the formal VSP.
- 3 Validate** the results within the country and obtain the formal sign-off by the Ministry of Health for public release.

These activities are typically sequenced and, importantly, if any changes are made to the VSP after approval from the Minister of Health (or designate), formal approval will need to be obtained again. This phase may **require 4 to 6 weeks of elapsed time**.

PHASE 4

ACTIVATE THE TECHNICAL REVIEW AND VALIDATION BY PHCPI

Once all the data for the **VSP has been compiled**, this **has to be reviewed by PHCPI**.

It is important that PHCPI Team looks at the VSP document and verifies that the indexes and information displayed in the document have been developed according to the VSP methodology. This ensures consistency in the application of the methodology and in the generation of the VSPs across countries. Regular and close coordination with the PHCPI Team throughout the data compilation phase will facilitate this activity and ensure that it straightforward.

The PHCPI team will be looking to ensure that:

- 1 The indicator results as documented are reflected in the VSP indexes
- 2 The external verification of the internal scoring of the measures for the Capacity Pillar obtained through the PHC Progression Model is done
- 3 Indexes are calculated from the individual quantitative indicators based on a standardized methodology
- 4 Any color-coding of VSP results is appropriate, based on comparability of indicators
- 5 Indicator choices and limitations in the VSP results are appropriately documented.

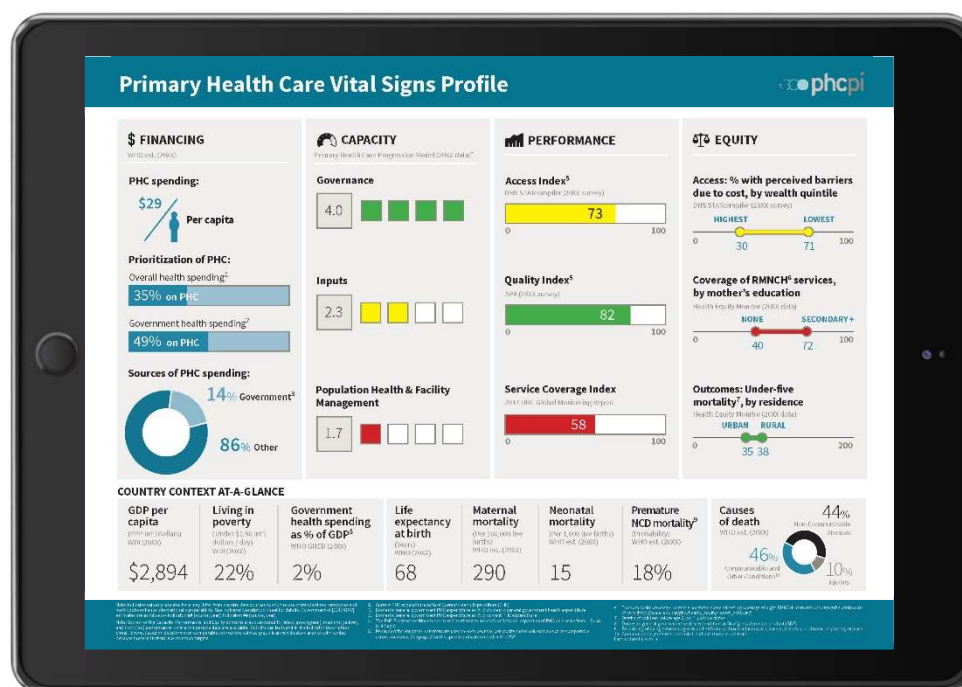
PHASE 4

GENERATE THE FORMAL VSP

The individual quantitative indicator results (standard and alternative) and the Progression Model measure scores were compiled and agreed upon in Phase 3. These results are now **combined into the indexes** that are used to **generate the VSP document**. The VSP includes:

1. The main front page with the aggregate results of the four Pillars, and
2. Two pages with the details of the individual indicators / measures and the aggregate sub-domain indexes / scores – one page each for the Capacity and Performance pillars.

The VSP Detailed Methodology Note provides more detailed explanations of how to combine the results to determine the indexes and aggregate scores. The process of aggregating the quantitative indicators into indexes will be taken care of by PHCPI. The PHCPI Lead will contact the PHCPI Team to activate this process. The notes below briefly describe the process for each of the pillars of the VSP.



Indicators of Context and Outcomes

The estimates for context and outcomes indicators displayed at the bottom of the VSP front page are taken from comparable global databases derived using a consistent methodology across countries (WHO and WB sources). These indicators, although only estimates, may not be replaced by other measures or

or country-generated data in order to maintain comparability. In case any discrepancies between the values of these indicators in the international databases with the nationally available data is a cause of concern for the country stakeholders, the PHCPI Lead will liaise with the PHCPI Team on a case-by-case basis.

PHASE 4

GENERATE THE FORMAL VSP: FINANCING PILLAR

The **Financing Pillar** presents the results of the 4 standard (or alternative) indicators that will have been collected by the Working Group in Phase 3. They reflect the level of spending on primary health care and the source of funding. For this pillar, there are no targets or consensus benchmarks, so the results are simply presented without color coding and not compared to those for other countries. If alternative indicators measuring these concepts have been used the results can be illustrated in a similar fashion.

Indicators

- Current PHC Expenditure per capita
- Current PHC expenditure as % of current health expenditure
- Domestic general government PHC expenditure as % current PHC expenditure
- Domestic general government PHC expenditure as % domestic general government health expenditure



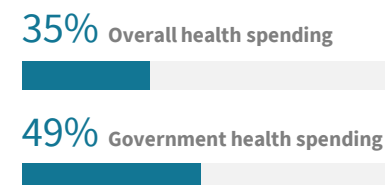
Financing

WHO est. (20XX)

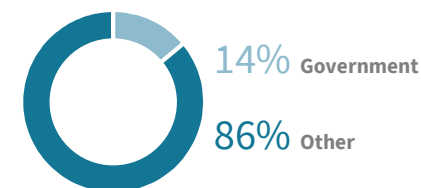
PHC spending



Prioritization of PHC



Sources of PHC spending



PHASE 4

GENERATE THE FORMAL VSP: CAPACITY PILLAR

The **Capacity Pillar** is created by combining the scores from the PHC Progression Model measures of the Governance, Inputs, and Population Health and Facility Management domains, as shown in the front page of the VSP.

In Phase 3, individual scores have been attributed to each measure by the Working Group through an internal scoring exercise (see PHC Progression Model Guide for additional details on this step). The score for each measure is given on the basis of specific evidence gathered through multiple data sources for that measure. The score identifies a specific level of maturity of the system that ranges from 1 (lowest) to 4 (highest), following the pre-specified rubric for that measure. At this point, the scores” for the measures are **verified** by the PHCPI Team, which reverts back to the Working Group in case of any discrepancies or requests for clarification.

The individual scores are combined into the summary indexes in a 2-stage approach. Results from the 33 measures are first rolled up into nine sub-domain scores. These sub-domain results are then rolled up to the 3 summary indexes (see Table 4 below). For example, to get to the overall score for Population Health and Facility Management, first the aggregate scores for Population Health Management (4 measures) and for

Facility Organization and Management need to be calculated (5 measures); then the score for Population Health and Facility Management will be calculated from the two aggregate scores.

The sub-domain scores and the individual measures are displayed on page 2 of the VSP. The color-coding of the results in the Capacity Pillar reflects the value of the total score, where green is assigned to scores of 4, yellow to scores of 2 and 3 and red to scores of 1. Results of the Capacity Pillar are comparable across countries because they are derived using the same methodology (PHC Progression model).

Population Health and Facility Management	
Population Health Management	1.0
Measure 25: Local priority setting	● ● ● ●
Measure 26: Community engagement	● ● ● ●
Measure 27: Empanelment	● ● ● ●
Measure 28: Proactive population outreach	● ● ● ●
Facility Organization and Management	2.4
Measure 29: Team-based care organization	● ● ● ●
Measure 30: Facility management capability and leadership	● ● ● ●
Measure 31: Information system use	● ● ● ●
Measure 32: Performance measurement and management	● ● ● ●
Measure 33: Performance measurement and management	● ● ● ●



Capacity

Primary Health Care
Progression Model (20XX data)

Governance and Leadership

4.0



Inputs

2.3



Population Health & Facility Management

1.7



PHASE 4

GENERATE THE FORMAL VSP: PERFORMANCE PILLAR

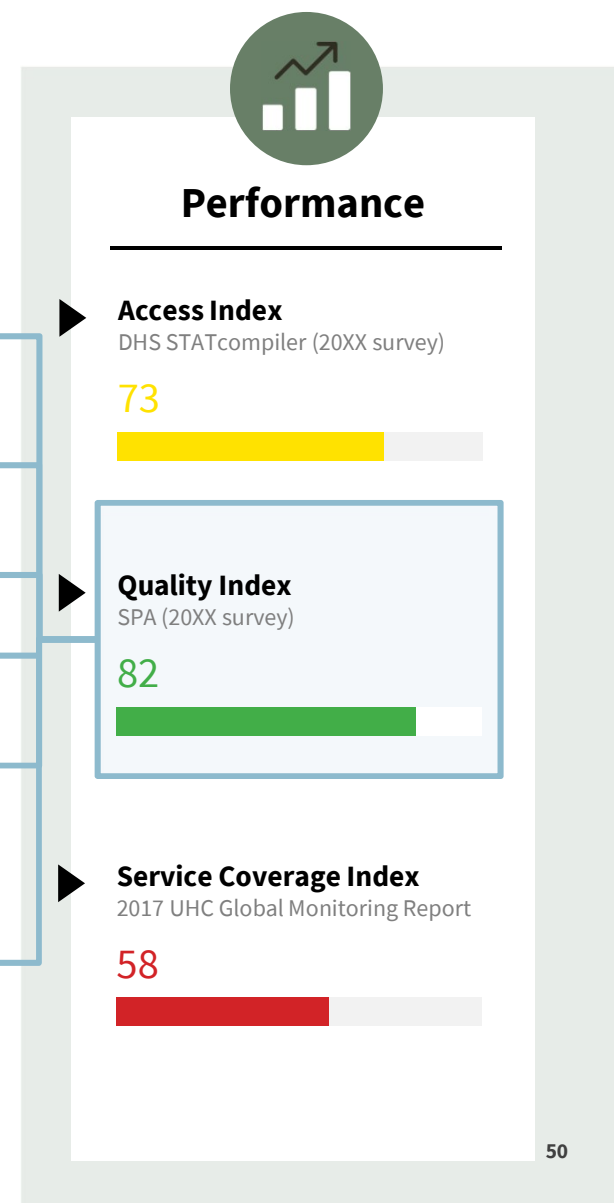
The main page of the VSP displays the results for the indexes of Access, Quality and Service Coverage within the **Performance Pillar**. The results for these indexes are derived from the individual quantitative indicators – standard or alternative -- compiled by the Working Group in Phase 3. The individual indicators are **rolled up into sub-indexes** that reflect specific sub-domains of the PHCPI conceptual framework. For instance, to calculate the Quality Index, it is necessary to first calculate 6 sub-indexes: comprehensiveness (3 indicators), continuity (2 indicators), person-centeredness (1 indicator), provider availability (2 indicators), provider competence (5 indicators), and safety (2 indicators). (Note, the numbers of indicators reference here apply to the use of the standard indicators. They may be different if alternative indicators have been used.)

The PHCPI team will generate the indexes automatically based on the data provided by the Working Group through the PHCPI Lead, using standardized tables.

An index result (number between 0 and 100) can be color-coded green, yellow or red to illustrate different levels of performance, but only if the standard VSP indicators have been used to determine the index – i.e. if the indicators used are derived from data sources that ensure their comparability across countries. Otherwise results will be displayed in grey.

In addition to the Access, Quality and Service Coverage Indexes on the front page of the VSP, results for the sub-domain indexes and individual indicators are shown on page 2 of the VSP.

Quality	
Comprehensiveness	78
Avg. availability of 5 tracer RMHCH services	81%
Avg. availability of 3 tracer communicable diseases	89%
Avg. availability of diagnosis & management for 3 tracer NCDs	64%
Continuity	94
DTP3 dropout rate*	8%
Treatment success rate for new TB cases	96%
Person-Centeredness	89
% of caregivers who were told sick child's diagnosis	89%
Provider availability	81
% of family planning, ANC and sick child visits over 10 minutes	80%
Provider absence rate*	18%
Provider Competence	76.7
Antenatal care quality score	88%
Family planning quality score	62%
Sick child quality score	80%
Adherence to clinical guidelines	70%
Diagnostic accuracy	59%
Safety	75.5
Adequate waste disposal	79%
Adequate infection control	72%



PHASE 4

GENERATE THE FORMAL VSP: EQUITY PILLAR

The front page of the VSP displays the results for the 3 indicators of the **Equity Pillar**. These look at equity in access, quality and outcomes. They are based on the individual indicators – standard or alternative – collected by the Working Group in Phase 3. The PHCPI team will generate the indicators automatically based on the data provided by the Working Group through the PHCPI Lead, using standardized tables.

If the standard indicators and disaggregations listed have been used, then the results may be color-coded green, yellow or red to reflect the levels of performance – less absolute difference between disaggregated scores is more desirable, and scores closer to 1 (or 100) are more desirable. If other indicators or disaggregations have been used, then results will be displayed in grey.

Specifically, the results will be color-coded as follows:

For equity in access by wealth quintile: red if absolute difference in scores is greater than 50, yellow between 50 and 5, and green less than 5

For equity in coverage by mother's education: red if absolute difference in scores is greater than 30, yellow between 30 and 3, and green less than 3

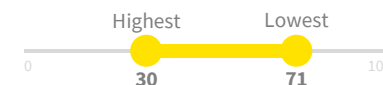
For equity in outcomes by residence: red if absolute difference in scores is greater than 40, yellow between 40 and 3, and green less than 3



Equity

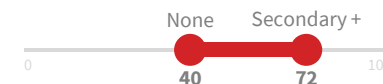
► **Access: % with perceived barriers due to cost, by wealth quintile**

DHS STATcompiler (20XX survey)



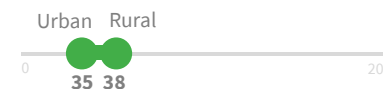
► **Coverage of RMNCH services by mother's education**

Health Equity Monitor (20XX survey)



► **Outcomes: Under-five mortality, by residence**

Health Equity Monitor (20XX survey)



PHASE 4

VALIDATE RESULTS AND OBTAIN SIGN-OFF BY THE MINISTRY OF HEALTH

A key part of the country commitment to assessing PHC using the VSP methodology is to **publicly release the VSP results**. This commitment is spelled out in the letter from PHCPI inviting the country to participate. The letter also guarantees that results will not be released without first receiving **authorization from the Minister (or designate)**. Although the Ministry responsible for the country's health system signs off on the VSP, reviewing results with country stakeholders – ensuring that they understand the results and agree that the results present a fair picture of the state of PHC in the country – is a critical component of obtaining this authorization.

Normally this is done through a review of the VSP results and a more complete Validation Package by the **Steering Committee**; however, it could also happen through the involvement of a broader set of stakeholders and representatives than the ones included in the Steering Committee. While other stakeholders may not have a formal role in authorizing the release of the VSP, the review and validation of results with these individuals provides an opportunity to generate further buy-in and raise any potential concerns or issues prior to release.

Any concerns should be documented and followed up for resolution by the Working Group or the Steering Committee as appropriate. The Minister of Health or MOH Focal Point may want to ensure that any substantial concerns have been resolved prior to authorizing results for release.

Depending on the numbers and types of stakeholders identified, it may be possible for these individuals to meet as a group in a **workshop** where results can be presented and discussed in person. It can be useful to include country technical experts who have been involved in the VSP project and other members of the Working Group to answer questions and explain the results. This approach has been taken in other countries and sample workshop agendas and materials are available. Depending on the participants and time available, such a workshop could also be used to start off a “what’s next” phase – to explore and understand the main drivers behind the results and to begin the discussion of improvement strategies. (see also Phase 5).

Validation Package

In order for the VSP to be approved by the Minister of Health, a validation package is typically created by the Working Group, reviewed and endorsed by the Steering Committee and delivered to the Minister of Health by the MOH Focal Point. Such a validation package generally includes:

1. The finalized VSP, consisting of the main page and the break down of the measures of the capacity pillar and of the indicators of the performance pillar.
2. A short briefing note to explain how the VSP was generated and what are the key results, including a reminder that the VSP will be published once approved.
3. A standardized table containing each of the quantitative indicators, their definitions, numerators and denominators, their values, their data sources and the year.

Once stakeholders have had an opportunity to review and comment on the VSP and any additional analytical work, everything is ready for the public release of the VSP.

A plan for public release should be developed as ministry stakeholders are engaged throughout the VSP project.

Public release of the VSP, following authorization by the Minister of Health, was a commitment made at the outset of the project.

PHASE 4

SUMMARY OF PHASE 4: GENERATING THE VSP AND VALIDATING THE RESULTS



Completion Checklist

- ☐ VSP document completed
- ☐ VSP review and validation by PHCPI Team
- ☐ VSP review and validation by country stakeholders
- ☐ Formal country sign-off on VSP results



Resource Material for Phase 4: Generating the VSP and Validating the Results

- VSP Detailed Methodology Note
- Progression Model Scoring sheet for external verification (refer also to Step 9 in the Progression Model guide for other materials needed for the external validation)
- Template for in-country validation workshop agenda
- Validation package, including briefing notes
- VSP Process Guide
- Progression Model Assessment Guide

When this phase is complete, the VSP document will be ready for release. The PHCPI Team will have completed its review and signed off on the VSP document, including its indicators and measures. The results will have been reviewed and validated with the key country stakeholders, and the Ministry of Health will have signed off on the VSP document, authorizing its public release.

PHASE 5

ANALYZING AND DISSEMINATING THE RESULTS

1. Phase 5: Analyzing and Disseminating the Results **p.55**
2. Prepare Supporting Analyses **p.56**
3. Share the VSP Results and Additional Analyses with Stakeholders **p.57**
4. Determine Where to go Next **p.58**
5. Prepare the Final Report and Close the Assessment Project **p.59**
6. Summary of Phase 5: Analyzing and Disseminating the Results **p.60**



PHASE 5

PHASE 5: ANALYZING AND DISSEMINATING THE RESULTS

The activities in Phase 5 support the broader dissemination of the results of the VSP and dialogue among stakeholders around PHC performance. They are focused on analyses to provide stakeholders a deeper understanding of the findings from the VSP. The analyses and discussion should refer to the objectives of the assessment and to the key questions identified at the start of the project (see Phase 2).

The main objectives of this phase include:



Using the VSP results and any additional analysis to identify strengths and weaknesses of the country's PHC.



Disseminating the results of the work done to all relevant stakeholders in the country.



Generating a participatory process to start discussing and planning on how to act upon the results of the work.



Closing the assessment project.

Outcome of Phase 5:

At the end of this phase, any of the additional analyses to complement the VSP that were agreed upon at the start of the project will have been completed. The country stakeholders and internal and external partners should be familiar with and have had an opportunity to discuss the results presented in the VSP and accompanying analysis, and there should be some preliminary discussion among the stakeholders of where to go from here.

There are four main activities for this phase:

1

Prepare additional analyses to answer key questions on PHC performance.

2

Sharing the VSP results and additional analyses with stakeholders for comment and discussion. This may include a workshop to review and discuss results.

3

Identify where to go next – both in terms of how to address any data gaps and how to strengthen areas of weaker performance.

4

Develop a final report and close the assessment project.

These activities are typically sequenced, although the same forum can be used for the dissemination of the results and discussions on how to act upon the results of the analyses. It is likely that the analytical work (#1) will proceed in parallel with activities in Phases 3 and 4. However, this phase **may require 16 to 18 weeks of elapsed time total**.

PHASE 5

PREPARE SUPPORTING ANALYSES

The VSP provides a snapshot of the performance of a country's primary health care system performance. Yet, the VSP itself is not likely to answer some of the questions that policy-makers, government agencies, and internal and external partners may have about performance and where to focus improvement efforts. As the VSP indicator results are compiled, the project team will have collected much information about various aspects of performance that can be used to help answer those questions. It may not be possible to do additional analytical work within the scope of the VSP project, given time and resources; however other questions may be identified as priorities for investigation in future work. Where VSP results suggest, it can be worthwhile to collect more specific or detailed data related to a specific domain or sub-domain to support further analysis.

Examples of such analyses are included in the resource materials. PHCPI does not provide specific guidance on how to conduct such analyses, which are normally discussed and agreed between the MOH and the project team.

The VSP presents results for a country at a point in time. While some of the indexes may be presented in a way that compares results to those from other countries (if standard indicators have been used), to place the results in context and better understand where to target improvement, it is useful to consider the following key questions:

- 1 Are there specific components of some of the indexes that are driving relatively better or poorer results?** A low score on a high level index may be mostly due to one of the sub-domains or one specific indicator within the index. For example, within the quality Index, the sub-domains of Safety or Comprehensiveness may have relatively low scores and be dragging down the rest of the index, or there may be missing indicators that skew results. This suggests that further investigation or improvements targeting those sub-domains should be a priority.
- 2 How have results changed over time?** If results for indicators are available historically, the trend can show whether results are getting worse or stagnating, suggesting priorities for interventions; or whether they are improving, suggesting that current strategies should continue and maybe even scaled-up.
- 3 How much variation is there across sub-national results or regions?** If there are different pockets showing good and poor results, the variation suggests that efforts be focused on the geographical areas with suboptimal performance, to bring it up to the level of higher performing regions. One should also look at the interventions or factors that are driving better results and determine their applicability to lower performing regions.
- 4 How do results compare to targeted comparator countries?** One could identify comparator countries, facing similar demographic challenges or with a similar economic context. The comparison can help identify areas of relatively lower performance, suggesting priorities for improvement, as well as targets or goals.

PHASE 5

SHARE THE VSP RESULTS AND ADDITIONAL ANALYSES WITH STAKEHOLDERS

Although it is not a mandatory step for the approval of the VSP, the VSP results and supporting analytical materials should be shared with in-country and external stakeholders (as identified in Phase 2) prior to the release of any material publicly. This provides them an opportunity to absorb and understand the results and to provide comments and feedback to influence the policy dialogue. When thinking about stakeholders to involve in this activity, it is also useful to identify other stakeholders who may benefit from information unearthed during the VSP process and consider including them in the dissemination and feedback processes.

Key stakeholders should have already been **engaged at key points** throughout the assessment process. For instance:

- At project initiation to explain the objectives of the assessment and the VSP, the methodology behind it, and how it can benefit the country (see Phase 1);
- During the selection of alternative indicators to obtain input from stakeholders on ideas for and suitability of alternative indicators (see Phase 3);
- During the validation phase to consider the results and their implications (Phase 4).

There are different **options** for sharing the results with a broad range of stakeholders. The methods used may be a combination of options and will depend on the nature of the findings of the assessment, the resources available to the project team, and on the diversity and level of engagement with the stakeholders throughout the project. Some options are:

- Electronic sharing of materials;
- Ad-hoc meetings with key individuals;
- Video conferences or webinars;
- Workshops (typically between half a day and two days).

A workshop can bring together a variety of stakeholders. It would allow them to discuss the results together and think about how to develop strategies to respond to the findings of the assessment. This should consider both how to address data gaps identified as well as potential strategies for improvement.

This activity could also have been included as a part of Phase 4. Regardless of when it is done, it is critical that results are shared with key stakeholder groups and there is an opportunity to **include different perspectives when considering the results and their implications** for greater ownership and transparency.

Note that the formal VSP document may be launched on the PHCPI website following approval by the Minister of Health. This could occur prior to the scheduling of dissemination workshops with stakeholders.

PHASE 5

DETERMINE WHERE TO GO NEXT

Regardless of what specific “next steps” are identified, these should be **documented and agreed upon** (or at least discussed) with as many stakeholders as possible. There should be clarity on following-up on the implementation of these next steps to maintain the momentum created with the work on the VSP project. Depending on the format of stakeholder discussions and meetings, and the degree of consensus on how to move forward, “next steps” may range from doing more analytical work into some of the key bottlenecks identified and reconvening for additional discussion, to identifying responsibilities to begin work on improvement strategies.

A commitment to identify next steps is outlined in the invitation to collaborate – where the Ministry of Health is invited to use the VSP to identify and pursue concrete improvements in the country’s PHC over the coming years and to join a network of PHCPI partner countries that are sharing lessons learned on assessing and improving PHC – which could be supportive of the use of data for decision-making.

There are several possibilities for moving forward from the VSP assessment. The PHCPI collaborative has developed tools – **Improvement Strategies** – to support improvement efforts at the country level by synthesizing best practices and evidence of strategies for strengthening PHC. The project team and the Ministry of Health may wish to consider those as one of the inputs to the process of determining how to move from the results of the assessment into planning what interventions to implement to improve performance.

The Improvement Strategies Modules consist of suggestions and summaries of evidence for improving the strength of PHC. The strategies include summaries of and links to external resources and are available on the [PHCPI website](#). They are presented in a format that allows users to navigate to the content most relevant to their context, based on their VSP results. The Improvement Strategies can be used as a starting point for discussion among stakeholders and partners to consider where to prioritize efforts to build on the results of the VSP assessment and improve country systems.

Improvement Strategies

The Improvement Strategy Modules developed by PHCPI are one of the resources (among others) that the country and/or other development partners have at their disposal to think about how to strengthen PHC based on the diagnosis offered by the VSP and the additional analysis. The modules currently available include:

- **Population Health Management** – integrating active outreach and engagement with the community in care delivery, shifting service delivery from reactive to proactive management of a segment of the population.
- **Facility Organization and Management** – supporting the effective organization of facility management, including such areas as multidisciplinary teams, information systems, performance monitoring, quality improvement processes, etc.
- **Access** – strategies to support providing the right care at the right place at the right time, without barriers (financial or otherwise) to the patients.
- **Availability of Effective PHC Services** – strategies that support the presence of competent, motivated health workers when patients seek care, where safe practices are routinely followed in the delivery of care.
- **High Quality Primary Health Care** – strategies focusing on the systems, policies, and infrastructure that should be in place to ensure the delivery of high-quality PHC services.

PHCPI is working on expanding the current list of available improvement strategies. (Please check the [website](#) for regular updates.)

PHASE 5

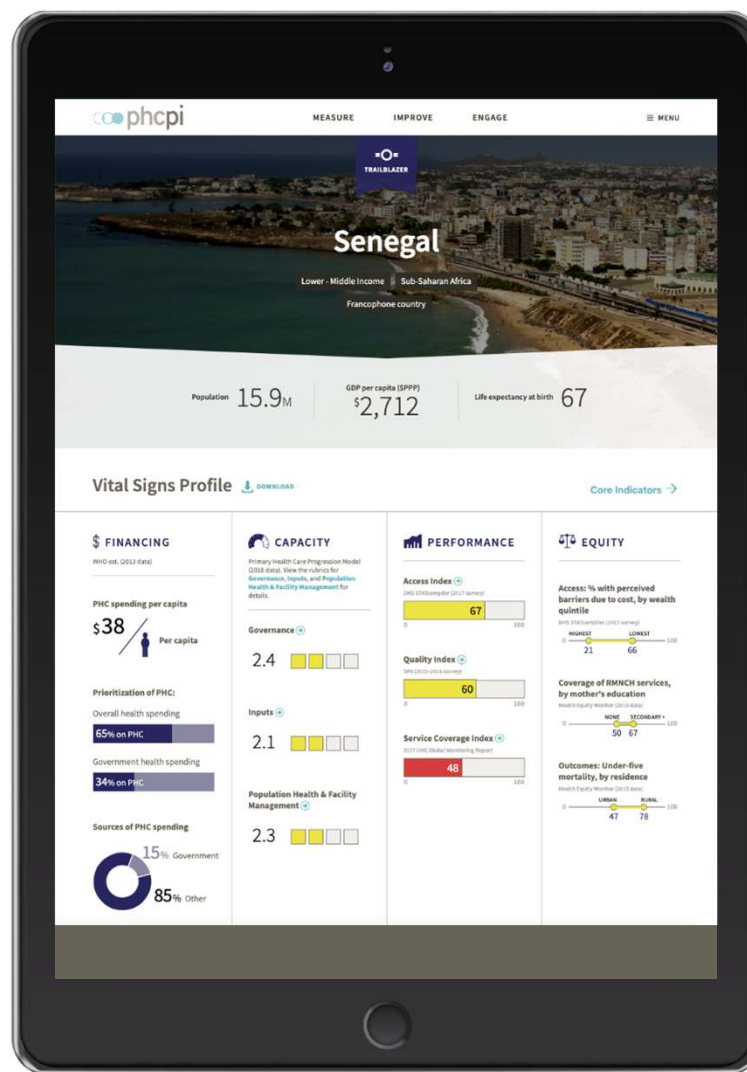
PREPARE THE FINAL REPORT AND CLOSE THE ASSESSMENT PROJECT

The final step of the assessment process is to formally close out the VSP project. PHCPI expects that the VSP will be updated in the future to be able to capture any differences in performance that may result from the implementation of improvement interventions. In order to support the periodic update of the VSP, it is critical to document and file descriptions of the processes, data resources, references, and key contacts that were used to develop the VSP.

Therefore, before the project can be considered closed, normally a final report is produced. The report describes the methodology followed and the findings from the VSP, any highlights of the analytical work, and outcomes from discussions with stakeholders, including any planned work going forward.

In addition to the final report, any copies of the relevant electronic materials and references – additional analysis (if agreed), reports used for obtaining indicator values – should be shared with PHCPI.

The final steps include closing and signing off on any financial aspects of the project, including contracts for consultants and other resources.



PHASE 5

SUMMARY OF PHASE 5: ANALYZING AND DISSEMINATING THE RESULTS



Completion Checklist

- ☐ Supporting analytical materials finalized
- ☐ Workshop/discussion of results and next steps with country stakeholders and partners
- ☐ Final report and project files
- ☐ Agreement on project closure



Resource Material for Phase 5: Analyzing and Disseminating Results

- Template of presentation of synthesis of results
- VSP Process Guide
- Progression Model Assessment Guide
- Sample of additional analyses
- Example of analytical report
- Template table of content of analytical report
- Improvement strategies (IS) on the PHCPI website
- IS Overview and User Guide

When this phase is complete, the MOH and key stakeholders will be able to better understand the results of the VSP and initiate discussions about the implications and how to address those. These will include actions to be taken on the prioritization of strategies to improve PHC performance, as well as decisions on how to address some of the data gaps highlighted during the assessment process. They should also include a plan for periodic updates to the VSP.