United States Government

Global Health Principles

Monitoring and Evaluation Resource Guide

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FOREWORD

The U.S. government has long been a leader in global health. We have been proud to contribute to key successes such as the eradication of smallpox and the dramatic reduction of polio, a nearly 50 percent reduction since 1990 in the number of children who die before their fifth birthday, and a tremendous shift in attitudes, access, and use of voluntary family planning methods. With continued and strong support from the U.S. Congress and the American people, one million babies have been born HIV-free and 3.3 million lives have been saved by the scale-up of malaria interventions. We have seen tremendous commitment from host country governments, local communities and their leaders, and our implementing partners to work toward a better, healthier future.

In 2009, President Obama introduced the Global Health Initiative (GHI) to maximize the impact of our investments. This effort capitalized on the strengths of a variety of U.S. agencies and enabled them to collaborate more closely on shared objectives in global health. A key part of the GHI effort was recognizing and embedding seven core principles throughout our work. Drawn from the principles outlined in the Paris Declaration on Aid Effectiveness and the high-quality programming already in place in the field, the GHI principles encouraged us to:

- focus on women, girls and gender equity;
- encourage country ownership and invest in country-led plans;
- strengthen health systems;
- promote global health partnerships;
- increase impact through strategic coordination and integration;
- promote research and innovation; and
- improve metrics, monitoring, and evaluation.

While the value of these principles was clear, we lacked a standard, cohesive, and evidence-based approach to monitoring and sustaining our progress toward these principles. We needed clear definitions, global indicators, and country-level indicators that would gauge whether these principles were being achieved and how they contributed to improvements in health outcomes and systems where we work.

Interagency teams worked together, with MEASURE/Evaluation, to explore existing monitoring approaches, review the evidence, and develop meaningful and specific indicators. We sincerely thank our staff, interagency partners, and external stakeholders who participated in developing this guide. This collaboration was an excellent example of how diverse partners can join together to learn from each other and produce better outcomes. It also demonstrated how a consultative process that engaged those working in the field helps to translate high-level policy into realistic actions.

We hope this guide will be a valuable resource for field offices, implementing partners, the donor community, and our host country counterparts. We look forward to being part of the evolving conversation on how we can best measure and monitor our investments to ensure they represent best-in-class approaches to global health programming.

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ACRONYMS

CDC	Centers for Disease Control and Prevention
F	Office of U.S. Foreign Assistance Resources
FP	family planning
GBV	gender-based violence
GHI	Global Health Initiative
HSS	health systems strengthening
I&PE	institution and policy environment
KBPP	knowledge, beliefs, perceptions, practices
M&E	monitoring and evaluation
NASA	national AIDS spending assessment
NHA	national health accounts
NIH	National Institutes of Health
NTD	neglected and tropical diseases
P&L	participation and leadership
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PPR	Performance Plan and Report
R&I	research and innovation
RH	reproductive health
SER	social and economic resources
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
USG	U.S. government
WGGE	women, girls, and gender equity
WHO	World Health Organization

OVERVIEW

The Global Health Initiative (GHI), introduced by President Obama in 2009, focuses on making maximum use of U.S. government (USG) investments in health and working to use existing resources more effectively. To accomplish this, USG established seven core principles to guide how it engages in global health:

- Focusing on women, girls, and gender equity
- Encourage country ownership and invest in country-led plans
- Health system strengthening
- Promoting global health partnerships
- Increase impact through strategic coordination and integration
- Promote research and innovation
- Improve metrics, monitoring, and evaluation

The underlying concept behind all of the principles is to achieve meaningful health impacts that improve people's lives. Additional information about the seven core principles is available at:

http://www.ghi.gov/principles/index.html#.U_T0ePldVMU

The purpose of this resource guide is to provide ideas for how to measure program-level implementation of the principles. As programs evolve to include the principles, many projects and USG missions have requested information on how to incorporate indicators to measure these aspects of their programs' progress over time.

This resource guide seeks to accomplish this objective by presenting results frameworks for understanding the applications of these principles in global health programs and measurement approaches for monitoring the effectiveness of those applications. This is not meant to be guidance of what has to be done, but a tool for country teams to use and adapt as needed. Results frameworks are important tools that illustrate the hypothesized causal pathway between program inputs, outputs, and outcomes, which lead to documentable health impacts. Such frameworks can aid program planners and monitoring and evaluation specialists who seek to map indicators and data sources or just to help develop a common understanding of program approaches and potential benefits.

Developed by USG interagency working groups for six of the seven principles,[1] this guide summarizes principle papers, results frameworks, and a set of proposed global and illustrative indicators to aid in the monitoring of principle applications in health programs. The global indicators are not meant to add another layer of reporting, but are largely drawn from the existing set of required indicators. They are indicators that are able to be aggregated across countries to give a comprehensive picture at a global level. When none exist, the working groups have suggested possible indicators for this purpose. These have

[1] This exercise did not include the principles of M&E. This guide was a product of the M&E working group.

not been systematically added to the reporting requirements, but are put forward for consideration. The illustrative indicators are only to serve as a reference for programs to consider when designing their own M&E plans. Additionally, this resource guide also describes how these indicators map to the results frameworks for each principle addressed. All information is presented for consideration and adaptation by country teams in their own M&E efforts of health programs applying the GHI principles to their work.

Conceived as an interagency effort, the working groups included representatives with expertise in specific technical areas from the U.S. Agency for International Development (USAID); the Centers for Disease Control and Prevention (CDC); the National Institutes of Health (NIH); and the Department of State, U.S. Office of the Global AIDS Coordinator. The GHI Monitoring and Evaluation (M&E) Interagency Working Group and MEASURE Evaluation staff supported the working groups and shared their specific experiences in monitoring and evaluation.

PRINCIPLE PAPERS, RESULTS FRAMEWORKS, AND INDICATORS

This guide provides an introduction to each principle and presents the results frameworks and indicators developed by each working group. Most of the working groups began by developing a "principle paper"[2]. These papers provide an overview of each principle, synthesize the key literature relating to each principle, as well as a summary of the programmatic and policy considerations that flow from each principle. The groups then, using the paper as a base, turned their attention to thinking through the development of a results framework and indicators, along with indicator reference sheets, to develop a consensus within the expert groups about the best current practice in measurement of the GHI principles. Indicators developed by the groups included so called global indicators and illustrative indicators. Global indicators represent "big picture" indicators that exist or could be incorporated into the PPR process and used to understand, in a very broad way, how the principles are being applied in the field. Illustrative indicators pull from a variety of sources and map to all ranges of the results frameworks. These illustrative indicators will allow program managers who wish to monitor and evaluate the use of these principles in their programming to understand how the principle working groups have approached the design, selection, and application of metrics to the results framework summarizing each principle.

The results framework for six principles addressed in this resource guide lays out the logic behind a health program or intervention outlining the hypothesized flow between program inputs and the potential or expected outputs, outcomes, and impacts. The indicators (both global and illustrative) developed by each principle working group also map to these different levels. The bulk of the work by each principle working group on indicator development or selection gave weight to indicators at the output and outcome level that could be useful for managing programs. Attention was also given to impact level measures and how this could be measured with existing data sources or indicators wherever

[2] A principle paper was not completed for Research and Innovation or Monitoring and Evaluation.

possible. In general, the working groups felt that the impact of the principles is measured through the outcome and impact levels indicators related to specific health interventions. This resource guide seeks to summarize each principle paper and present the results frameworks and indicators developed by each principle working group. A priority for each group was to incorporate as many existing data sources and other existing resources as possible into their work. Areas such as health systems strengthening and gender already had existing indicators and M&E guides to guide program evaluations and to draw upon for GHI principle indicator selection, but some areas have no widely accepted source of knowledge or standardized sets of indicators upon which to draw. The groups with established indicators sorted through these indicators to select indicators appropriate for GHI programs. The working groups with no established indicators, such as those addressing research and innovation, partnerships, and integration, focused on proposing indicators and definitions at the differing levels of the results framework. The groups then posted draft deliverables (principle papers, results frameworks, and indicators) on the Learning Lab (http://usaidlearninglab.org/) to solicit comments from country mission staff, implementing partners, and other stakeholders, and further refine the measurement plans. The Learning Lab received feedback from about 180 individuals who joined the virtual working group. The principle working groups incorporated the feedback from the site and other venues into this document.

USE OF THIS GUIDE

As emphasized above, this resource guide is the beginning of a process for learning and sparking discussions about why these principle areas are important to measure; this version of the guide is not intended to provide definitive guidelines for measuring the effectiveness of the principles. In addition, the guide is not meant to provide the "last word" in M&E relating to the GHI principles, which are expected to continue to evolve and benefit from the lessons learned from the applied M&E of these principles in the field.

More established health areas, such as programs addressing HIV or tuberculosis (TB), have globally agreed upon and accepted indicators set by the Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO), or similar bodies. Specific disease areas also have mature clinical outputs and outcomes that have allowed for more specific and standardized indicators than may be possible for GHI principles, which cut across all health areas. While the international community has agreed that the GHI principles are important, standard definitions have not yet been established. Given this, guidance on how to measure the principles is not yet definitive. The frameworks are not intended to show a fully elaborated causal model. There are varying degrees of evidence for pathways in the framework. It is also possible that there are additional indicators to capture specific activities within a program. Indicators may also be adapted to align with the specific context of a country or program, or for use within the broader M&E system, which is why this guide is still a work in progress. This resource is intended to be a living document that will continually evolve as pilots are conducted, input is received from partners and host country governments, and what is learned over time is used to help refine both the indicators and data collection methods.

Treating this guide as a living document allows for further adaptation and incorporation of additional inputs. Feedback is strongly encouraged because that will help in measuring the effectiveness of programs and by revealing what works and what does not. This document will be posted on the Learning Lab (http://usaidlearninglab.org/) and we encourage readers to help us continue to improve it by providing input.

GENDER

INTRODUCTION TO PRINCIPLE

The women, girls, and gender equality (WGGE) principle aims to address gender imbalances that put women and girls at greater risk for poor health and that threaten to undermine continued progress in recent health gains. The principle also works to promote the empowerment of women and girls and to improve health outcomes for individuals, families, and communities. The WGGE principle focuses on women, girls, and enhanced gender equality including adolescent and pre-adolescent girls and boys, in the planning, implementation, and monitoring and evaluation of health and development programs and policies.

The material in this section complements the guidance for gender programming provided in the Global Health Initiative supplemental guidance on women, girls, and gender equality principle, available online at:

http://www.ghi.gov/principles/women/index.html#.Uv5SH_ldWSo

At the time of writing this document, a draft guide for integrating gender into M&E plans had been developed, although it was not yet available publically. This guide uses the WGGE indicators and framework, and the intended audience is USG country offices. In the future, the guide will be piloted to see how it works in application.

RESULTS FRAMEWORK

The gender results framework (figure 1) mirrors the GHI M&E results framework, available at:

http://www.ghi.gov/results/index.html#.U_T1GvldVMU

The gender results framework aims to illustrate pathways by which addressing gender in interventions may affect health outcomes. The framework groups the 10 WGGE program elements of implementation into four distinct but interrelated domains of program activities and highlights the importance of addressing power differentials across the four domains (see: the *Global Health Initiative Supplemental Guidance on Women, Girls and Gender Equality Principle* white paper noted above).

The domains are consistent with a social-ecological approach that treats behaviors, service use, and health as resulting from the interplay of individual, relationship, community, and environmental factors.

The domains are interdependent and together comprise a more comprehensive approach to integrating gender into health programs. For example, staff training (the participation and leadership domain) and service policies (institutional and policy environment domain) are critical inputs for improving access (social and economic resources domain).

The results framework shows pathways from the four interrelated domains through GHI outcomes (e.g., improved FP/RH). The pathways include gender results (e.g., women's leadership in services) and health results as they relate to demand creation (e.g., knowledge of available services), service supply (e.g., access to services), and sustained gender equitable improvements in health behavior and prevention, care, and treatment utilization.

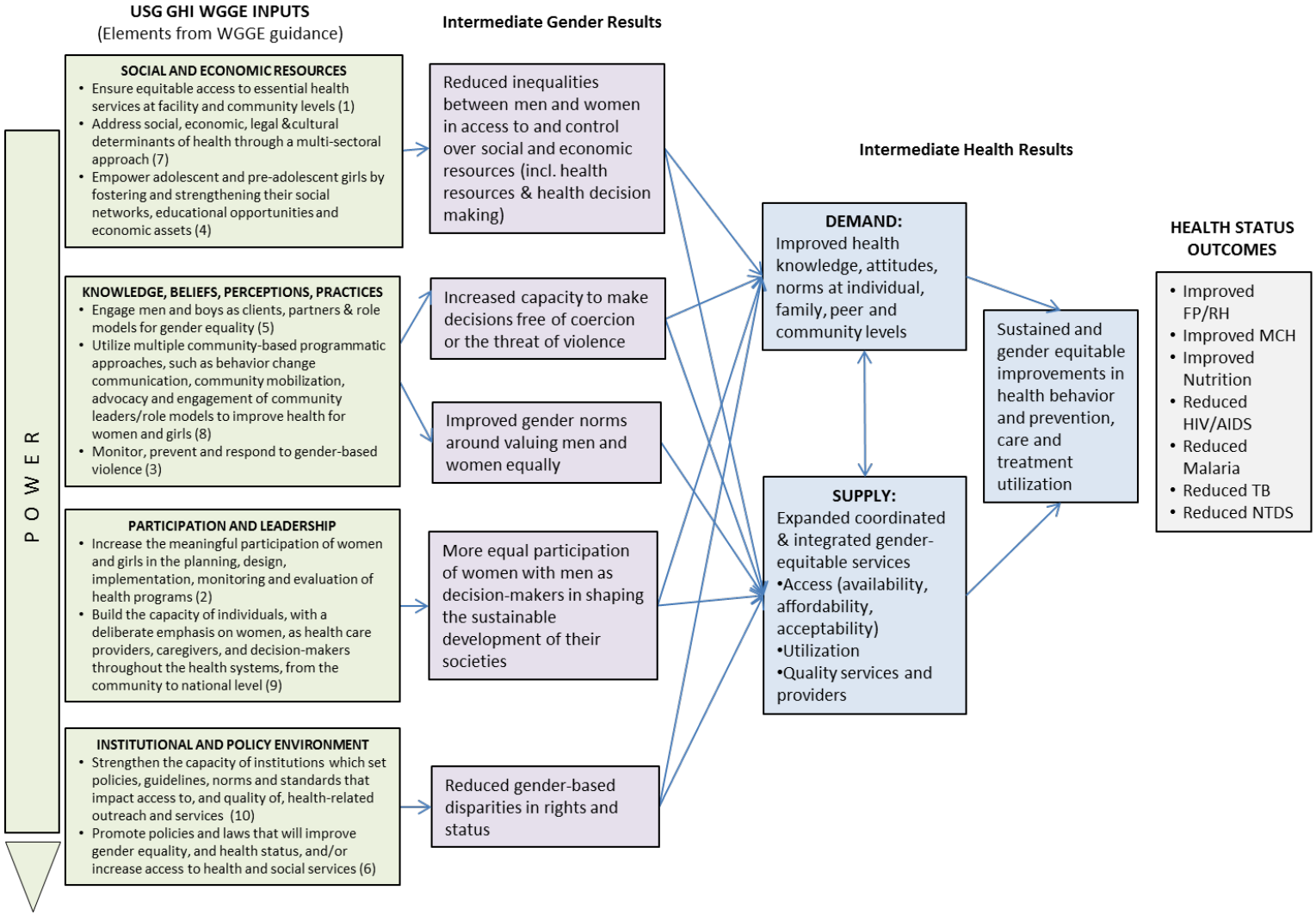
Each domain of program activities should produce changes in at least one dimension of empowerment identified in the literature as contributing to outcomes for girls, women, families, or communities (i.e., gender results). Gender results, in turn, should lead to changes in health behaviors, service use, and health outcomes.

Although programs produce multiple gender results, arrows on the framework show which outcomes are most likely as a result of programs in a particular domain. For example, using behavior change communication approaches may do more to increase knowledge and change attitudes, while empowering adolescents by strengthening their educational and economic opportunities may do more to reduce inequalities between men and women.

The timing and pattern of gender results and health outcomes will not always be clear cut as this "linear" framework suggests (e.g., some health results may occur early on, contributing to gender results that occur later).

The framework is not intended to show a fully elaborated causal model. There are varying degrees of evidence for pathways in the framework. The framework can be complemented by a gender analysis that considers social relationships between women and men, their families and communities, and structural conditions that reinforce gender inequality in a particular country. More rigorous evaluations could be used to provide evidence for the hypothesized causal pathways.

Figure 1: Gender Results Framework*



* The numbers in parentheses reference the 10 WGGE elements explained in the guidance *Global Health Initiative Supplemental Guidance on Women, Girls and Gender Equality Principle*. Under the column heading USG GHI WGGE INPUTAS, the WGGE elements are organized by domain.

GLOBAL INDICATORS

To meet GHI global reporting needs and to reduce this burden on countries, the WGGE working group selected three global indicators, found in table 1. The group drew these from the existing five "required as applicable" gender indicators in the annual Performance Plan and Report (PPR) and Office of US Foreign Assistance Resources (F) reporting system processes used by USAID and the Department of State, across all sectors, since fiscal year 2012. The three indicators selected for GHI address empowerment and use of gender-based violence services, and provide data on gender outputs and gender outcomes.

Annex 1 provides reference sheets on these three global indicators. All data should be collected by programs, via routine program monitoring formats or templates (outputs) or pre-post assessments of program participants (outcome). In addition, the outcome data may be collected periodically via national surveys (e.g., Demographic and Health Surveys) to monitor overall progress in achieving gender results/outcomes.

Table 1: WGGE Global Indicators

Results Framework Element	Indicator	Data Source
WGGE Global Indicators		
Social and economic resources: immediate output	Proportion of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income, or employment)	Program records
Knowledge, beliefs, perceptions, and practices: immediate output	Number of people reached by a USG-funded intervention that provides GBV services (e.g., health, legal, psycho-social counseling, shelters, or hotlines)	Program records
Knowledge, beliefs, perceptions, and practices: gender result	Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities	Survey (pre- and post-intervention)

ILLUSTRATIVE INDICATORS

For each domain of program activities, illustrative indicators for select outputs (not included on results framework), gender and health outcomes were selected. Tables 2-5 provide a complete description of these indicators, organized under the following four domain areas:

- Reduced inequalities in access to and control over social and economic resources (table 2).

- Improved gender norms and increased capacity to make decisions free of coercion or threat of violence (table 3).
- More equal participation of women with men as decision makers in shaping sustainable development of society (table 4).
- Reduced gender-based disparities in rights and status (table5).

To the extent possible, the working group drew upon existing indicators (e.g., GHI health behavior and service use indicators, U.S. President's Emergency Plan for AIDS Relief [PEPFAR] indicators, Food for Security Indicators Measure Evaluation Family Planning and Reproductive Health Indicators Database). When existing indicators were not available, indicators were created to fill important gaps (e.g., gender outcomes associated with engaging community elders as advocates and role models).

Table 2: WGGE Illustrative Indicators for Social and Economic Resources Domain

Elements and Illustrative Activities or Programs	Immediate Outputs	Reduced Inequalities in Access To and Control Over Social and Economic Resources	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
Element 1: Ensure equitable access to essential health services at facility and community levels. • *Reduce barriers to access (e.g., hours, transportation, financial, language, confidentiality, etc.)* • *Provide alternatives for clients unable to reach facilities* • *Train providers on respectful care & preferences (e.g., type of provider, style of decision making)* • *Integrate service, build robust referral* • *Develop accountability mechanisms, solicit clients' perspectives on services* • *Mobilize communities to support essential health services for all* **Element 7:** Address social, economic, legal & cultural determinants of health through a multi-sectoral approach • *Coordinate with efforts & promote linkages to programs outside health sector that support gender equity, girls/women (e.g., education, economic opportunity, fair & safe employment, legal services, land reform)* • *Raise-awareness among families, communities and government decision-makers about*	• # of trainings by topic (e.g., gender & health,) • # women trained • % women among trainees • # changes to improve access (e.g., hours, confidentiality, referral/integration insurance) • # referrals made • # new community service provision alternatives *(e.g., CHW, health fair)* • # facilities establish QA systems • # QA systems seek feedback • # community-	*Economic empowerment* • % who earn cash* • % women who mainly decide how their own income will be used FPRHIDB, WGSE) * • % target population agree with concept that males & females should have equal access to social economic & political opportunities (SRG)† *Reproductive empowerment* • # communities leaders disavow harmful traditions such as early marriage, FGM/C, etc. • % target population disavow harmful	*Awareness/knowledge* • % target population aware of services (e.g., # aware youth-friendly services) • % target population report fewer barriers to service use • # women/girls receive support from support group/ social network for safer behaviors &/or service use (e.g., % men who are supportive of their partners' RH practices/service use, [FPRHIDB, Male]*; % women who believe that spouse, friends, relatives, and community approve [or	*Knowledge & attitudes* • # health programmers and policy makers who recognize the ways gender affects health • % staff recognize gender barriers to service use • % staff with gender-equitable attitudes • *Staff practice & skill* • % staff who consider clients' preferences for service provision, treatment options, etc. *Organizational/program characteristics* • # service sites/programs maintain modified hours, fees, locations to encourage use • # service sites/ programs maintain	*Health behaviors* • % women make decisions about own health • Increased protective behaviors, e.g.: 1. % 18-24 year olds who have first birth before age 18 (GHI)† 2. % of all birth intervals that are 36 months or longer (GHI)† 3. #people protected from malaria with a prevention measure (ITN, IRS) (GHI)† *Service use* • % change in service use, e.g.: 1. % HIV pregnant women received ARV prophylaxis for PMTCT (GHI)† 2. #adults/children with advanced HIV infection receiving ART (GHI)† 3. Coverage of voluntary medical male

Elements and Illustrative Activities or Programs	Immediate Outputs	Reduced Inequalities in Access To and Control Over Social and Economic Resources	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
determinants of health • *Address harmful traditional practices, (e.g., child/forced marriage, abduction, FGM/C, "honor" crimes) & support traditional practices that promote gender equality* • *Address resource and health needs of women & girls in lowest economic quintiles.* **Element 4:** Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities and economic assets • *Support positive youth development through peer networks and mentorship in & out of schools, foster positive adult-child communication* • *Develop specific programming for out-of-school adolescent and pre-adolescents* • *Involve youth, parents, schools, communities and religious leaders when designing programs* • *Link health activities to education and viable livelihoods programs*	based programs addressing gender equitable access (e.g., *women's health, awareness of services)* • # multi-sectoral interventions addressing social, economic, legal and/or cultural determinants of health (*e.g., land rights, school voucher, economic strengthening)* • % schools that incorporate health & gender into life skills curriculum • % females reached (e.g., % female participants in program to increase access to productive	traditions • % females marry aged 18 or older <u>*Socio-cultural empowerment*</u> • % of families provide adequate nutrition, education, care & protection to children (including girls) is increased (Children in Adversity)† • ratio (boys to girls) in primary & secondary school • school completion rates among girls • % women who have completed at least 10 years of education (FPRHIDB, WGSE)* • sex ratio at birth and at age 5 • *Psychological empowerment*	disapprove] of the practice, [FPRHIDB, BCC]*) <u>*Perceptions of services*</u> • % clients who believe services meet needs • % clients who report receiving quality services and guarantees of confidentiality	integrated services and/or have robust referral system in place • #service sites/programs maintain free or reduced fees (e.g., on sliding scale) • # linkages between facility and community based health service alternatives (e.g., referral systems, health tracking/monitoring systems) • # linkages between facility or community based health programs and livelihood (other economic) programs	circumcision (GHI)† 4. Coverage of diphtheria, pertussis & tetanus (DPT3) vaccines† • % adhere to scheduled appointments • % satisfied with services • % make/keep referrals made

Elements and Illustrative Activities or Programs	Immediate Outputs	Reduced Inequalities in Access To and Control Over Social and Economic Resources	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
	economic resources (assets, income, credit, employment [SRG])†	• % females who report increased self-efficacy at conclusion of training/program (SRG)†			

Notes:

* Denotes an indicator with a well-developed indicator reference sheet and available in MEASURE Evaluation's Family Planning/Reproductive Health Indicators Database, available at: http://www.cpc.unc.edu/measure/index.html/prh/rh_indicators.

† Denotes an indicator with a well-developed indicator reference sheet and used by USG for reporting on cross-agency (e.g., PEPFAR, GHI) or USAID programming. For more detailed information about the indicators indicated by * or †, please contact Joan Kraft at jkraft@usaid.gov.

Table 3: WGGE Illustrative Indicators for Knowledge, Beliefs, Perceptions, and Practices Domain

Elements and illustrative Activities or Programs	Immediate Outputs	Improved Gender Norms and Increased Capacity to Make Decisions Free of Coercion or Threat of Violence	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
Element 5: Engage men and boys as clients, supportive partners, and role models for gender equality. • *Affirm the positive role men and boys can play to improve own health and to support health and rights of women, girls and communities.* • *Provide health services for men* • *Provide couples counseling* • *Mobilize community, and mobilize male religious/ other community leaders and role models to support gender equality, human rights, etc.* **Element 8**: Utilize multiple community-based programmatic approaches, such as BCC, community mobilization, advocacy and engagement of community leaders/role models to improve health for women and girls. • *Incorporate behavior change communication (BCC) activities focused on gender into health programs (e.g., address knowledge; change harmful attitudes and behaviors; and influence social norms and policies)* • *-Engage community leaders,*	*For elements 5&8‡* • Availability of accessible, relevant and accurate information **about gender influences** & health behaviors (# & types of sources) (FPRHIDB, Male)*± • # programs that use multiple community-based approaches • # of health programs that incorporate gender focused BCC activities (e.g., # programs implemented for men and boys that include examining gender and culture norms related to SGBV, [FPRHIDB, SGBV]*; % target population /audience recall hearing/seeing specific message **about gender** FPRHIDB, BCC*)	*Familial/interpersonal empowerment* • # community leaders recognize gender effects on health • % community members recognize gender effects on health • % men hold gender equitable attitudes (on GEM scale) (FPRHIDB, Male)* • % of men and women who share in decision making (*reproductive health issues OR other issue*)with spouse or sexual partner (FPRHIDB, Male)* • % target population that views GBV as less acceptable after participating in or being exposed to USG programming (SRG)† • % ever married or	Awareness/knowledge • % target population/ audience that know of product, practice (e.g. health behavior) or service, FPRHIDB, BCC* • % target population understands links between gender and health issue • % target population can identify one way to overcome gender related barrier to practicing safer behavior or using service • % target population with self-efficacy to change behavior or use service • % men who accompany their partner to ANC **(or type)** visit (FPRHIDB, SD-Male)*	*Staffing knowledge/awareness* • # staff with increased awareness of GBV in general, and role of GBV on other health issues (e.g., attitudes of health care providers towards SGBV survivors or services, [FPRHIDB, SGBV]*) *Staff practices/skill* • % health units with at least one service provider trained to care for and refer SGBV survivors, (FPRHIDB, SGBV)* • #staff follow procedures/ protocol for GBV services *Organizational/program characteristics* • % health facilities with GBV and coercion services available (PEPFAR)† • % facilities that have adequate supplies for GBV services (e.g., kits, test kits, EC) • % facilities have support system (e.g., HR policies, support groups) in place for staff providing GBV services • (e.g., # service delivery points providing appropriate medical, psychological, and legal support for women and men who have been raped or experienced incest, (FPRHIDB, SD-Access)*	*Health behaviors* • Increased protective behaviors, e.g.: 1. % used condoms at last sex with non-martial partner 2. % total condoms supported by PEPFAR (GHI)† 3. #people protected from malaria with a prevention measure (ITN, IRS) (GHI)† 4. modern contraceptive prevalence (GHI)† 5. Mean number of food groups consumed by women of reproductive age (FtF, Dietary Diversity)† *Service use* • # people

Elements and illustrative Activities or Programs	Immediate Outputs	Improved Gender Norms and Increased Capacity to Make Decisions Free of Coercion or Threat of Violence	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
role models, gatekeepers (e.g., teachers, religious/tribal leaders, mothers-in-law) to increase knowledge of health consequences of specific behaviors & advocate for community change • *Work with local actors to identify and reinforce cultural norms and practices that support women's and girls' health and gender equality* • *Employ community members in the provision of information and services (e.g., peer educators, community-based distributors or caregivers).* • *-Address resource & health needs of women/girls in the lowest economic quintiles.* **Element 3**: Monitor, prevent and respond to gender-based violence • *-Advocate for laws and policies to monitor, prevent & respond to GBV* • *Support community & mass media efforts around attitudes & behaviors* • *Facilitate discussion (families, community organizations, religious, traditional & other leaders) about human rights, GBV & addressing GBV* • *Support programs to improve women & girls' self-esteem &*	• ratio of local community to external staff • # of community leaders & role models engaged to increase knowledge of health consequences of behaviors, and promote safer behaviors & service use • # people completing an intervention pertaining to gender norms, that meets minimum criteria (GEND_NORMS, PEPFAR) • completed mapping of GBV services (facility, community) • % health units that have documented and adopted protocol for the clinical management of SGBV services, **includes referral** (FPRHIDB, SD-SGBV)*	partnered women (aged 15-49) who experience physical or sexual violence from a male intimate partner in the past 12 months (MERG)† • % 13-24 year olds reporting experience sexual, physical or emotional violence before the age of 18 (Together for Girls) <u>Economic empowerment</u> • % target population reporting increased agreement with the concept that males & females should have equal access to social, economic, and political opportunities (SPG)†	• • # community members aware of GBV services <u>*Perception of services*</u> • % clients believe GBV services (including screening) are confidential • % clients believe GBV services non-stigmatizing		screened for GBV • # people receiving post-GBV care (PEPFAR) • # persons provided with post exposure prophylaxis (PEPFAR)†

Elements and illustrative Activities or Programs	Immediate Outputs	Improved Gender Norms and Increased Capacity to Make Decisions Free of Coercion or Threat of Violence	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
negotiation skills • *Require RH & life skills programs for adolescent and pre-adolescent girls and boys to address healthy relationships, sexual coercion & abuse* • *Build provider capacity to recognize & address GBV as contributor to negative health status & adherence to regimens.* • *- Integrate GBV screening & response into health services (PEP, EC, psycho-social support where feasible)* • *-Link with multi-sectoral programs to increase GBV prevention and response* • *-Promote research on the incidence and impact of GBV on men and boys.*	• % of health facilities with HIV post-exposure prophylaxis available (PEPFAR)† • # CHW/other community outreach programs integrate GBV • # service providers trained to identify, refer and care for SGBV survivors, (FPRHIDB, SGBV)*				

Notes:

* Denotes an indicator with a well-developed indicator reference sheet and available in MEASURE Evaluation's Family Planning/Reproductive Health Indicators Database, available at: http://www.cpc.unc.edu/measure/index.html/prh/rh_indicators.

† Denotes an indicator with a well-developed indicator reference sheet and used by USG for reporting on cross-agency (e.g., PEPFAR, GHI) or USAID programming.

For more detailed information about the indicators indicated by * or †, please contact Joan Kraft at jkraft@usaid.gov.

‡ Elements 5 and 8 may use similar intervention approaches (e.g., community outreach/mobilization, mass media, small group activities) to address underlying gender issues (e.g. harmful practices, women's familial and inter-personal empowerment) that influence a number of health behaviors and service use patterns. Those behaviors and service use patterns, in turn, influence health outcomes central to GHI including maternal and child health, family planning, HIV, TB, malaria, and neglected tropical diseases. Given the similarity of potential activities across health outcomes, "generic" indicators that can be adapted to fit local needs are provided.

Table 4: WGGE Illustrative Indicators for Participation and Leadership Domain

Elements and Illustrative Activities or Programs	Immediate Outputs	More Equal Participation of Women with Men as Decision Makers in Shaping Sustainable Development of Society	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
• **Element 2**: Increase participation in planning, implementation, and M&E of programs • *Grants to CBOs to enhance girls & women's communication, advocacy, networking & leadership* • *Orientation on program design, implementation & M&E ("programming")* • *Participation in and feedback on design, implementation, &M&E* • *Feedback mechanisms for evaluation* • **Element 9**: Build capacity (emphasis on women) as caregivers, providers & decision-makers • *Promote role models, conduct outreach & otherwise support women for pre- & in-service training* • *Implement adult ed. curricula/ training that addresses gender equity & health topic* • *Implement systems for equitable recruitment, retention, & promotion*	• # awards directly to local organizations (SPG)* • # trainees by **sex**, type of personnel & topic (FPRHIDB, TRAINING)† • # participate in health programming - % female • Quick investigation of quality (particularly exit interview) (FPRHIDB, QC)* • # new mechanisms for client reporting • #new/revised pre- & in-service courses that integrate gender • # new/ revised	*Political and socio-cultural empowerment* • # girls/women in leadership role (school, health service, CBO) • #women role models in schools, health service & CBO • # coalitions formed around gender equity • % community members who value efforts to address gender equity in health services • % health programs that actively seek input from community organizations • # new networks for sharing information, mentoring, etc. *Economic empowerment* • # females in paid health positions (government or private; facility or community) • % paid health positions occupied by females	*Perceptions of services* • % community members who cite smaller number of staff or organizational barriers to service use • % clients who believe service providers responsive to articulated concerns or needs • % clients who believe services met needs • % clients provide feedback on services through established quality assurance feedback mechanisms	*Staffing levels* • Gender equity in organizational context (**e.g., % women and men in "non-traditional" cadres**) (Select from menu of indicators, (FPRHIDB, GE/S)* *Staff knowledge & attitudes* • % staff recognize barriers to service use • % staff with gender-equitable attitudes *Staff practice & skill* • % **staff/**trainees competent to provide specific services (FPRHIDB, training)* • % registered/licensed staff *Organizational/program characteristics* • #incentivized community health jobs • #health workers employed by government • # complaints re: discrimination, sexual harassment responded to according to policy • # facilities/communities with task shifting (e.g., CHW distribution Depo)	*Health behaviors* • % women making decisions about own health • # women receive support from support group/ social network for safer behaviors &/or service use *Service use* • modern contraceptive prevalence (GHI)† • # eligible adults/ children provided with a minimum of one (HIV) care service (GHI)† • % change in service use year to year • % adhere to scheduled appointments • % satisfied with services

Elements and Illustrative Activities or Programs	Immediate Outputs	More Equal Participation of Women with Men as Decision Makers in Shaping Sustainable Development of Society	Demand	Supply	Behavior and Prevention, Care, and Treatment Use
	policies on equality/ discrimination • # new entrants in CHW, pre-service training • # in-service advancement trainings • % female	• # women promoted in health occupations			

Notes:

* Denotes an indicator with a well-developed indicator reference sheet and available in MEASURE Evaluation's Family Planning/Reproductive Health Indicators Database, available at: http://www.cpc.unc.edu/measure/index.html/prh/rh_indicators.

† Denotes an indicator with a well-developed indicator reference sheet and used by USG for reporting on cross-agency (e.g., PEPFAR, GHI) or USAID programming.

For more detailed information about the indicators indicated by * or †, please contact Joan Kraft at jkraft@usaid.gov.

Table 5: WGGE Illustrative Indicators for Institutional and Policy Environment Domain

Elements and illustrative Activities or Programs	Immediate Outputs	Reduced Gender-Based Disparities in Rights and Status	Demand	Supply	Behavior and Prevention, Care and Treatment Use
Element 10: Strengthen institutions which set policies, guidelines, standards and norms standards that impact access to & quality of health-related outreach/services to improve health & promote gender equality • *Training & mentoring on gender equality & health needs of women/youth* • *Address harassment, violence and discrimination.* • *Support civil society organizations participation* • *Capacity to collect & use data* **Element 6:** Promote policies and laws that will improve gender equality and health status, and/or increase access to health and social services • *Advocacy activities* • *Develop and enforce laws, guidelines, norms, operational policies, other policies and standards to increase gender equality and empowerment (e.g., discrimination, child marriage, gender-based violence, trafficking in persons, inheritance)* • *Champions promote gender equality & safeguard women's and girl's health*	• # trainees by sex, type of personnel & topic (FPRHIDB, TRAINING)* • gender analysis/ assessment done by MOH (or other org) • policies harmonized • accountability system established • # advocacy trainings • # organizations & # people trained • % female trainees • # & type of advocacy activities (e.g., awareness-raising) • # policies on select topics (including for health care facilities) (e.g., # laws, policies, or procedures drafted, proposed or adopted to promote gender equality at the regional, national or local level;† # laws, policies or procedures…to improve prevention of or response to S/GBV [SPG]†; existence of national laws, regulations or policies that limit access to effective FP for unmarried and/or young people) [FPRHIDB, SD Access]*)	*Political empowerment* • % government officials & other policy makers who hold gender equitable attitudes • % community members participate in advocacy events (e.g., awareness raising, meetings) • % target population reporting increased agreement with the concept that males & females should have equal access to social, economic, and political opportunities (SPG) • % program participants know legal rights of children, women and men	*Awareness/ knowledge* • % target population who believe women and men should have equal access to health care services, at facility and community level • % of non-use of services related to gender (or psycho-social) barriers ((FPRHIDB, SD-Access)* • % target population who know relevant policy, law, regulation regarding health & access to services	*Access* • Gender sensitivity in service delivery environment (e.g., gender sensitive services), select from menu or indicators, (FPRHIDB, GE/S)* • % of health care facilities that provide full range (TBD) of health services for women, girls, men and boys, in one place or through robust referral (e.g., % of facilities were x% of clients receive service that meets the expected standards for Gender sensitivity & health, [FPRHIDB, QC]*) *Quality* • % health care facilities that follow new/revised policies, regulations, standard procedures (e.g., percent of facilities w/non-medical restrictive eligibility criteria for contraception, (FPRHIDB, SD-Access*) • % facilities/decision making bodies use data on implementation and outcomes to revise policies, procedures, etc.	

Notes:

* Denotes an indicator with a well-developed indicator reference sheet and available in MEASURE Evaluation's Family Planning/Reproductive Health Indicators Database, available at: http://www.cpc.unc.edu/measure/index.html/prh/rh_indicators.

† Denotes an indicator with a well-developed indicator reference sheet and used by USG for reporting on cross-agency (e.g., PEPFAR, GHI) or USAID programming.
For more detailed information about the indicators indicated by * or †, please contact Joan Kraft at jkraft@usaid.gov.

HEALTH SYSTEMS STRENGTHENING

INTRODUCTION TO PRINCIPLE

A health system is all people, institutions, resources, and activities whose primary purposes are to promote, restore, or maintain health. As shown in the health systems strengthening (HSS) results framework (figure 2), the six critical functions of a health system are leadership and governance; financing; information; human resources; medical products, vaccines, and technologies; and service delivery. These functions cut across public and private sectors and are relevant to service delivery and health promotion and disease prevention.

HSS is defined as strategies, interventions, and activities designed to sustainably improve country health system performance as defined by financial protection, access to essential services, equitable population coverage, and responsiveness to people's expectations. HSS identifies and addresses the complex interconnections and dynamic relationships among the six functions of a health system.

Following are brief definitions for each of the six HSS results framework functions:

- **Leadership and governance:** This refers to robust oversight, regulation, and accountability for health activities and results in the public and private sectors, as well as incentives that reward good and sanction poor performance.
- **Financing:** Financing refers to sufficient revenue to pay for health needs; allocation of resources efficiently, effectively, and equitably; pooling resources when possible to foster efficiency and to spread risks and costs; and purchase of packages of high quality, high-impact services.
- **Information:** The collection, analysis, dissemination, and use of timely and high quality information on health status, financial risk protection, health service use, client satisfaction with services, health behavior, and health system performance are the aspects of this function.
- **Human resources:** Human resources refers to a healthy, accessible, technically competent, adequately resourced, motivated, and well-deployed health workforce provides services (across health system functions and levels) in accordance with standards in a timely, patient-centered manner, without discrimination.
- **Medical products, vaccines, and technologies:** Sustained access to and appropriate use of essential medical products that are safe, effective, and of assured quality, and managed in accordance with best practices, local laws, policies, and regulations, and containment of antimicrobial resistance are aspects of this function.

- **Service delivery:** This refers to effective, safe, and high quality public and private sector services to those who need them, when and where they are needed, with maximum efficiency and patient choice.

The GHI principal paper on HSS provides insights into the opportunities and challenges for health system strengthening for staff implementing GHI programs. The paper is available at:

http://www.ghi.gov/principles/docs/principlePaperHSS.pdf

RESULTS FRAMEWORK

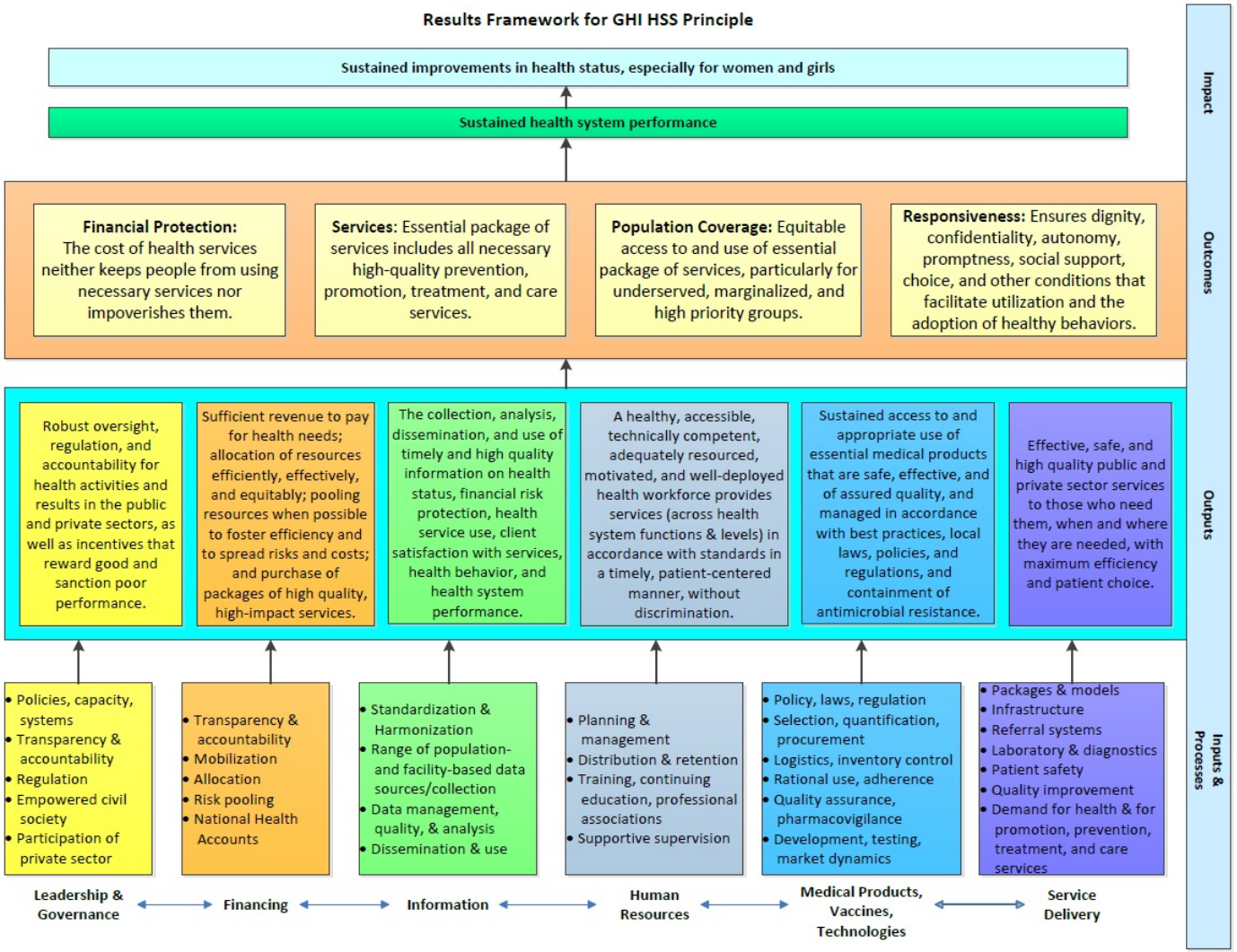
The HSS results framework illustrates that strengthened health system functions operating independently and in combination contribute to improved health system performance, as defined by financial protection, access to essential services, equitable population coverage, and responsiveness to people's expectations. These outcomes, in turn, contribute to sustained improvements in health status, defined by GHI as an AIDS-free generation, ending preventable child and maternal deaths, and countering ancient diseases and emerging threats.

Of the four outcomes shown in figure 2, three (financial protection, essential services, and equitable population coverage) are key dimensions of universal health coverage. The fourth outcome (responsiveness) refers to how a health system interacts with people to meet their needs and expectations.

Improved health system performance among these four outcomes includes:

- ensuring that the cost of health services does not keep people from using necessary services or impoverishing them (financial protection);
- providing an essential package of services that includes all necessary high-quality prevention, promotion, treatment, and care services (essential services):
- ensuring equitable access to an essential package of services, and to its use, particularly for underserved, marginalized, and high-priority groups (population coverage); and
- guaranteeing dignity, confidentiality, autonomy, promptness, social support, choice, and other conditions that facilitate the use and adoption of health behaviors (responsiveness).

Figure 2: HSS Results Framework



GLOBAL INDICATORS

To meet GHI global reporting needs, the HSS working group selected the four global indicators for the GHI HSS principle listed in table 6. Where possible, the working group drew from existing indicators and data sources. Details about these indicators are provided in the global indicator reference sheets found in annex 2.

Table 6: HSS Global Indicators

Results Framework Element	Indicator	Data Source
Financial protection	Ratio of household out-of-pocket payments for health to total expenditure on health	Preferred source is National Health Accounts (NHAs) if conducted within the past 5 years; secondary source is the Global Health Expenditure Database maintained by WHO
Essential services	Service-specific readiness	Service Availability and Readiness Assessment
Population coverage	Development stage for an essential package of health services in the host country	USAID Performance Plan & Report
Responsiveness	Responsiveness as measured by client satisfaction	USAID Performance Plan & Report

ILLUSTRATIVE INDICATORS

A detailed list of 33 illustrative indicators for HSS is found in tables 7-12. These indicators include a mix of both input- and output-level indicators. These indicators are intended to provide country programs with a menu of optional indicators to support HSS program monitoring, and should be selected based on and adapted to country/program-specific context, and used within a broader system of HSS monitoring and evaluation.

Table 7: Illustrative Indicators for Health Systems Strengthening in Financing

Results Framework Element	Indicator Description	Data Source
Output	**Indicator:** Total health expenditure per capita, in international and US dollars **Description:** This indicator reflects the average amount of resources spent on health per person. It is a standard measure that can indicate whether spending on health is adequate to achieve appropriate access and quality. Countries with relatively low per capita spending (e.g., below USD 30 per capita) are likely to have poor access, a low quality of health care, or both. This indicator is best interpreted with a health index indicator to provide a better understanding of health efficiency. **Supporting Documentation:** Page 6 from: http://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_Financing.pdf	National Health Accounts (NHAs). The NHA is designed to capture the full range of information contained in resource flows and reflects the main functions of health care financing, such as resource mobilization and allocation, pooling and insurance, purchasing of care, and the distribution of benefits.
Output	**Indicator:** Benefit incidence of government health expenditure, by wealth quintile **Description:** This indicator measures the relative share of the public expenditure captured across different income quintiles in the public sector. When possible this indicator would also be useful to disaggregate by gender, region and/ or urban/rural. This indicator is most commonly used to analyze public expenditures on health and health reform initiatives. Incidence analysis can identify how well public services are targeted to certain groups in the population, including women, the poor, and residents of particular regions. **Supporting documentation:** http://www.levyinstitute.org/pubs/wp_748.pdf	• Household surveys • NHAs (see above) • Software exists to help analyze benefit incidence, e.g. the World Bank's ADePT tool.
Output	**Indicator:** Percent of population enrolled in a health scheme **Description:** Financial protection is one of the goals of a health system and financial coverage is one of the three dimensions of universal health coverage. It is possible to achieve universal health coverage through risk pooling of funds or insurance. This indicator reflects the breadth of self-reported insurance coverage across the population and captures individuals' perception of whether they are insured. Because this indicator is a self-reported measure, correlation with registered affiliation with a particular scheme, or up-to-date payments, is not guaranteed; the usefulness of this metric depends on individuals having accurate information about their and their family's health care coverage at the time of the survey. **Supporting Documentation:** This indicator is a mandatory PPR indicator for USAID HSS bureau, please see indicator reference sheet.	The measurement tool is a nationally representative household survey that includes appropriate questions to measure enrollment in a health insurance scheme. Existing mechanisms include the Living Standards Measurement Surveys (LSMS); the World Health Survey; and the Demographic and

Results Framework Element	Indicator Description	Data Source
	http://www.healthsystems2020.org/userfiles/Indicators%20for%20UHC%20Draft%20Report_Sept27.pdf	Health Survey (DHS) with the Out of Pocket Health Expenditures Module added to the questionnaire.
Input	**Indicator:** National Health Accounts published within the last three years **Description:** NHA is a tool designed to assist policy-makers in their efforts to understand their health systems and to improve health system performance. NHA constitute a systematic, comprehensive and consistent monitoring of resource flows in a country's health system for a given period and reflect the main functions of health care financing: resource mobilization & allocation, pooling and insurance, purchasing of care and the distribution of benefits. Health financing policy requires decisions on how to raise funds, how to pool them, and how to use them equitably and efficiently. Informed decision-making requires reliable information on the quantity of financial resources used for health, their sources and the way they are used. National Health Accounts (NHA) provides evidence to monitor trends in health spending for all sectors- public and private, different health care activities, providers, diseases, population groups and regions in a country. It helps in developing national strategies for effective health financing and in raising additional funds for health. Information can be used to make financial projections of a country's health system requirements and compare their own experiences with the past or with those of other countries. **Supporting Documentation:** http://www.who.int/nha/en/	National Health Accounts (NHAs) records
Input	**Indicator:** Level of capacity in country to produce and publish NHA: 1. NHA produced and published by external technical assistance with no support from a local institution(s) 2. NHA produced and published by external technical assistance with support from a local institution(s) 3. NHA produced and published by local institution(s) with support from external technical assistance 4. NHA produced and published by local institution(s) without external technical assistance Please comment on the use of NHA results **Description:** This indicator provides a metric of the capacity of partner countries to implement NHA, and thus is an indicator of progress toward institutionalization of NHA for routine health resource tracking. **Supporting Documentation:** http://www.who.int/nha/docs/en/NHA_concepts_datasources_methodology.pdf	USG Team, as observed during estimation of National Health Accounts (NHA)

Results Framework Element	Indicator Description	Data Source
Input	**Indicator:** Government health expenditure as a proportion of general government expenditure **Description:** This indicator measures the proportion of total domestic government expenditure that goes to health. It reflects the priority that partner governments place on the health sector in execution of their budgets. **Supporting Documentation:** http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=93 and http://data.worldbank.org/indicator/SH.XPD.PUBL	National Health Accounts (NHAs) records
Input	**Indicator:** Government expenditure on priority health programs as a share of total government expenditure on health, by programmatic area **Description:** This indicator measures the proportion of domestic government expenditure on health that goes to priority programs. It enables analysts to assess the extent to which domestic government funding on health is consistent with GHI targets and local patterns of disease. **Supporting Documentation:** http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/policy/percent-of-government-health-budget-allocated-to and http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/hss/total-health-expenditure-the-per-capita-in as examples to review	NHAs using SHA 2011, or previous NHA with subaccounts

Table 8: Illustrative Indicators for Health Systems Strengthening in Governance

Results Framework Element	Indicator Description	Data Source
Output	**Indicator:** Number of community-based organizations that formally participate in government decision making at the national, state, and local level **Description:** Community-based organizations play a systematic, organized role in advocacy, policy and decision making, and in creating and maintaining an enabling environment that supports people's health and reduces the effects of poverty and discrimination. "Formally participate" should include consultation or making position contribution in decision making. For instance, community based organization that just attended a meeting on the location of a health facility with letter of invitation or consultation or making inputs on preference for particular location should be counted but not CBO attending without contribution or consultation. **Supporting documentation:** http://www.who.int/tb/dots/comm_hss.pdf	Administrative records
Input	**Definition**: Number of countries/provinces in which USG is supporting capacity building in health sector financial management **Description:** There is a strong need to strengthen the health sector capacities and skills in developing realistic budgets and financial plans by estimating resource needs, projecting revenues and closing resource gaps. In many developing countries, annual budgets are not fully executed due in part to a lack of capacity and operational systems to effectively absorb and utilize funds. For example, there can be a lack of expertise in contracting arrangements and grant-making limiting developing countries' ability to program and disburse funds to implementing partners. Cumbersome procurement procedures and poor cash flow management can impact the ability of implementers to get the drugs, medical supplies, and equipment they need to effectively carry out their programs. **Supporting documentation:** http://www.healthsystems2020.org/section/topics/capacity	Review of project/program documents
Output	**Indicator:** Policy Index Score, comprised of: • Existence of an up-to-date national health strategy linked to national needs and priorities, including health promotion as well as health services • Existence and year of last update of a published national medicines policy • Existence of updated policies on medicines procurement that specify the most cost-effective medicines in the right quantities; open, competitive bidding of suppliers of quality products • Tuberculosis: existence of an up-to-date national strategic plan for tuberculosis that reflects the six principal components of the Stop-	Interviews with expert respondents who have been carefully selected for their professional and in-depth knowledge in the ten component areas.

Results Framework Element	Indicator Description	Data Source
	TB strategy as outlined in the Global Plan to Stop TB 2006–2015 • Malaria: existence of an up-to-date national malaria strategy or policy that includes drug efficacy monitoring, vector control and insecticide resistance monitoring • HIV/AIDS: completion of the GARPR questionnaire for HIV/AIDS • Maternal health: existence of an up-to-date and comprehensive reproductive health policy consistent with the ICPD action plan • Child health: existence of an updated comprehensive, multiyear plan for childhood immunization • Existence of updated national M&E plan, policy or platform • Existence of key health sector documents that are disseminated regularly (such as budget documents, annual performance reviews and health indicators) • Existence of mechanisms, such as surveys, for obtaining opportune client input on appropriate, timely and effective access to health services **Description**: Health policies are important because they guide the actions and plans to achieve health goals. More experience will be needed with this indicator to understand how it is best constructed whether as a checklist or index and how the results are interpreted. **Supporting Documentation:** http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf page 27	
Output	**Indicator:** Number of civil society organizations (CSOs) receiving USG assistance engaged in health advocacy Participation by citizens, including those from disadvantaged or marginalized social groups, in both public policymaking and its implementation, can improve service delivery, ultimately impacting health outcomes. By promoting advocacy and participation in the governance of the health system, CSOs ensure that citizens have the means to express their preferences, engage in dialogue with policy makers, and affect public policy decisions. After governments establish policies, CSOs perform critical oversight of state performance by demanding accountability in the allocation and management of public resources. This indicator sheds light on the extent to which Missions are working with civil society to assist them in having a voice in the health arena. Missions could use this indicator to report on how they are supporting local civil society to play a key role in the host countries' health governance. **Supporting Documentation:** This indicator is a mandatory PPR indicator for USAID HSS bureau, please see indicator reference sheet.	Data source may include local partners' PMPs or annual reports, or keeping record of press releases or advocacy campaign materials, etc.

Table 9: Illustrative Indicators for Health Systems Strengthening in Medical Products, Vaccines, Technologies

Results Framework Element	Indicator Description	Data Source
Output	**Indicator:** Average (or median) availability of a set of selected essential medicines in public and private health facilities **Description:** This indicator can be used to assess the availability of essential medicines. Availability may be influenced by various factors in the pharmaceutical management systems, including practices in selection, procurement, distribution and use of these medicines. Moreover, this indicator can serve as a proxy for service quality, as represented by the presence of non-expired stock. Essential medicines are defined as those that satisfy priority health care needs of the population and are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage form, with assured quality, and at a price that individuals and the community can afford. Most countries have Essential Medicines Lists which also indicate the level of service where the medicines are expected to be present at all times. This indicator measures availability of essential, non-expired medicines geographic distribution and quality of services with medicines can only be measured using a range of indicators that provide data on medicine procurement, storage, prices, distribution and travel time to medicine outlets, quality, safety, and rational use including appropriate prescribing, dosages, and dispensing practices. The range of the findings should be reported, and if appropriate the facilities should be stratified by type/level. **Supporting Documentation:** This indicator is a mandatory PPR indicator for USAID HSS bureau, please see indicator reference sheet. http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/hss/percent-of-facilities-that-have-all-tracer	The information required to calculate this indicator is found on inventory stock cards in facilities or by direct visual inspection. In consultation with staff from the MOH, a set of 10 to 20 essential medicines (can include vaccines and other health commodities) that are normally to be stocked at each level must be defined.
Output	**Indicator:** Public and private per capita expenditure on medicines **Description:** This indicator is also known as the total pharmaceutical expenditure (TPE). It may be defined as the total consumption of pharmaceuticals, regardless of the distribution mean, the place or condition of consumption or its type (prescription or over-the-counter). Per capita data are obtained from the whole population. As much as possible, this indicator is disaggregated into two components to reflect public and private sector financing. Public financing refers to social security, territorial governments, and extra budgetary entities combined, while private financing includes out-of-pocket spending, finances related to private insurance, nongovernmental organizations, and corporations (excluding social security). **Supporting Documentation:** http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_section4_web.pdf page 8	National Health Accounts (NHAs). The NHA is designed to capture the full range of information contained in resource flows and reflects the main functions of health care financing, such as resource mobilization and allocation, pooling and insurance, purchasing of care, and the distribution of benefits.

Results Framework Element	Indicator Description	Data Source
Output	**Indicator:** The National Medicines Regulatory Authority (NRA) uses regulatory decisions, reports (inspection, evaluation, vigilance), guidance, or information from other NRAs or international bodies **Description:** National Medicines Regulatory Authorities (MRAs) are responsible for the regulation and control of medical products such as medicines, vaccines, blood products and medical devices. They contribute to promoting and protecting public health by ensuring that: • medicines are of the required quality, safety and efficacy, • health professionals and patients have the necessary information to enable them to use medicines rationally, • medicines are appropriately manufactured, stored, distributed and dispensed, • illegal manufacturing and trade are detected and adequately sanctioned, • promotion and adverting is fair, balanced and aimed at rational drug use, • Access to medicines is not hindered by unjustified regulatory work. Intensification of international commerce and increasing technological complexity of manufacturing and product specifications have created additional challenges for national regulatory authorities and manufacturers, particularly to those of developing countries. This requires that national regulatory capacity is regularly assessed, areas of weakness are identified and appropriate, necessary measures are taken. **Supporting Documentation:** http://www.who.int/medicines/areas/quality_safety/regulation_legislation/assesment/en/index.html	Interview with NRA authorities and review of documentation.
Input	**Indicator:** National medicines policy implementation plan exists (Y/N), if Yes, please cite most recent date it has been updated **Description:** The policy may otherwise be known as the national drug policy. The policy should express and prioritize the medium- to long-term goals set by the government for the pharmaceutical sector. The accompanying implementation plan should provide a framework within which the activities of the pharmaceutical sector can be coordinated. It should cover both the public and the private sectors, and involves all the main actors in the pharmaceutical field. A national drug policy implementation plan presented and printed as an official government statement, is important because it serves as a formal record of aspirations, aims, decisions and commitments. Without such a formal policy document there may be no general overview of what is needed; as a result, some government measures may conflict with others, because the various goals and responsibilities are not clearly defined and understood. **Supporting Documentation:** http://www.who.int/medicines/areas/coordination/Empty_English_Questionnaire.pdf	A national medical policy should be available at the federal ministry of health (or country equivalent).

Results Framework Element	Indicator Description	Data Source
Input	**Indicator:** SOPs developed for all levels of the supply chain based on *WHO Guidelines for Good Storage Practices for Pharmaceuticals* **Description:** A Standard Operating Procedure is a document which describes the regularly recurring operations relevant to the quality of the investigation. The purpose of a SOP is to carry out the operations correctly and always in the same manner. A SOP should be available at the place where the work is done. At each storage site, there should be an adequate number of qualified personnel to achieve pharmaceutical quality assurance objectives. National regulations on qualifications should be followed. All personnel should receive proper training in relation to good storage practice, regulations, procedures and safety. All members of staff should be trained in, and observe high levels of, personal hygiene and sanitation. Personnel employed in storage areas should wear suitable protective or working garments appropriate for the activities they perform. All of this would be based on standard operation procedures and clearly articulated in the SOPs. The implementation of clear and efficient Standard Operating Procedures (SOPs) is an integral part of a successful supply chain management system. **Supporting Documentation:** World Health Organization WHO Technical Report Series, No. 908, 2003	Checklist of minimum criteria for adequate conservation conditions and survey of sample of pharmacies, dispensaries, drug outlets, and warehouses.
Input	**Indicator:** There is a formal committee or other equivalent structure for the selection of products on the National Essential Medicines List (Y/N) **Description:** Careful selection of a limited range of essential medicines results in a higher quality of care for patients, better management and use of medicines and more cost-effective use of health resources. Clinical guidelines and lists of essential medicines may improve the availability and proper use of medicines within health care systems. Selection of medicines follows market approval of a pharmaceutical product which defines the availability of a medicine in a country. An essential medicines list may then be developed based on disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness. A formal and well qualified committee should be in place to develop and update such a list. **Supporting Documentation:** http://www.who.int/selection_medicines/en/	MOH, other government Ministries/authorities

Table 10: Illustrative Indicators for Health Systems Strengthening in Service Delivery

Results Framework Element	Indicator Description	Data Source
Input	**Indicator:** Percent of HIV and Tuberculosis laboratories that are accredited according to national or international standards **Description:** This indicator monitors the scale up of accreditation practices in labs and assesses the quality systems of a lab and its ability to maintain quality. A laboratory can be counted as being accredited if it has received national and international accreditation that meets the WHO Accreditation of Public Health Laboratory Networks standard. Laboratories may also be assessed using the WHO/AFRO Laboratory Accreditation checklist. Accreditation provides documentation that the laboratory has the capability and the capacity to detect, identify, and promptly report all diseases of public health significance that may be present in clinical and research specimens. The accreditation process further provides a learning opportunity, a pathway for continuous improvement, a mechanism for identifying resource and training needs, and a measure of progress. **Formula**: Number of laboratories accredited to perform quality-assured clinical laboratory testing for HIV and TB /Total number of laboratories) x 100 **Supporting Documentation:** PEPFAR Direct Indicator: H1.2.D http://www.pepfar.gov/documents/organization/81097.pdf page 102	PEPFAR APR annual reporting system through FACTS info
Input	**Indicator:** Number of facilities per 500,000 providing basic and comprehensive emergency obstetric care **Description:** This indicator measures the existence of life-saving obstetric care services (access, availability, coverage). The number of facilities providing basic and comprehensive obstetric services (known as signal functions) at least once in the previous three months per 500,000 population. If a facility has performed each of six previously standardized functions in the past three months, it qualifies as providing basic EOC. If it has provided all eight of the functions, it qualifies as a "comprehensive" EmOC facility. It distinguishes between "basic" and "comprehensive" care services to emphasize that maternal lives can be saved not only in hospitals providing all the services listed above, but also at health centers or smaller hospitals that do not. **Supporting Documentation:** http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/sm/number-of-facilities-per-500-00-providing-basic	Facility surveys that examine medical records or service statistics. Ideally, records should provide the emergency obstetric signal functions. Personal interviews with knowledgeable staff who attend obstetric patients are a second, albeit, potentially more biased source of information than written records are.

Results Framework Element	Indicator Description	Data Source
Outcome	**Indicator**: Percent of women who gain weight in the last two trimesters of pregnancy within the recommended range for their weight status **Description*:*** This indicator measures weight gain during pregnancy, one of the most critical factors in determining both birth outcomes and maternal nutritional outcomes of pregnancy. Gestational weight gain (GWG) is particularly important for women who are underweight prior to pregnancy and for women who are pregnant during times of acute nutritional stress, such as famines or seasons of food scarcity. Conversely, the prevalence of overweight has been increasing worldwide during the past two decades resulting in a "double burden" of health concerns stemming from the co-existence of under- and over-nutrition in many regions. Given the rising numbers of overweight and obese women of reproductive age, recommended GWG for normal to overweight women and concerns with excess GWG need to be taken into consideration. **Formula:** Number of women by weight category gaining in recommended kg/month range in second and third trimesters of pregnancy / Total number of pregnant women in weight category) x 100 **Supporting Documentation:** http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/womens-nutrition/percent-of-women-who-gain-weight-in-the-last-two-trimesters-of-pregnancy-within-the-recommended-range-for-their-weight-status	Service statistics, antenatal care (ANC) cards, or other clinic-based records; samples of home or community-based records reviewed
Input	**Indicator:** Documented evidence of a national policy and/or Ministry of Health (MOH) guidelines for a recommended minimum package of services to be provided by antenatal care (ANC) facilities **Description:** This indicator measures whether there is documented evidence of a national policy and/or Ministry of Health (MOH) guidelines for a recommended minimum package of services to be provided by antenatal care (ANC) facilities. Variations exist among recommended essential and minimum care packages, and can be attributed to the types of health risks prevalent in different settings (e.g., areas of endemic malaria or generalized HIV epidemic). This indicator measures the level of national commitment provision of quality ANC services through the health system. **Supporting Documentation:** http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/sm/minimum-package-of-antenatal-care-services-defined	National policy documents and/or MOH written guidelines for ANC; interviews with key informants
Output	**Indicator:** Provider compliance with national guidelines/standards for labor and delivery visits at USG-supported facilities **Description:** This indicator measures the degree to which providers follow national clinical guidelines/standards for labor and delivery visits, and is a proxy for measuring the quality of health services overall.	A sample of randomly selected clinical records for labor and delivery services is selected. Each clinical record is reviewed against the

Results Framework Element	Indicator Description	Data Source
	Compliance with national standards/guidelines is an indicator of the quality of health services. Low levels of compliance indicate the need for quality improvement efforts. *Numerator:* Average number of tasks completed in compliance with national guidelines/standards for labor and delivery visits *Denominator:* The total number of tasks in the national guidelines/standards for labor and delivery visits **Supporting Documentation:** This indicator is a mandatory PPR indicator for USAID HSS bureau, please see indicator reference sheet.	standardized review form, and then the average level of compliance across all medical records reviewed is calculated.

Table 11: Illustrative Indicators for Health Systems Strengthening in Human Resources

Results Framework Element	Indicator Description	Data Source
Output	**Indicator:** Number of new health care workers who graduated from a USG supported pre-service training institution within the reporting period, by select cadre **Description:** It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up health services. The lack of a sufficient workforce in countries presents a serious challenge to every area of health. A health information system with a strong human resources component can help build the evidence base to plan for the availability of required health workers of desired quality in the right place, at the right time. Planning requires knowledge of the numbers and characteristics of health workers who are active in the health sector, of those being trained and added to the human resources pool. Pre-service training is an essential component of human resources for health that is planned as part of an overall HRH strategy, which links the production of new health workers with service delivery needs and health systems capacity to recruit and retain newly trained health workers. This indicator does not measure the quality of the pre-service training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals from their host country. **Supporting Documentation:** This indicator is a mandatory PPR indicator for USAID HSS bureau, please see indicator reference sheet.	MOH Human Resource Information Systems (HRIS), pre-service training institutions, professional associations, Ministry of Education, Public Service, and/or private sector HRIS, Ministry of Social Welfare HRIS, professional boards and councils, alumni or graduates networks, Health Sector or HRH Strategic Plans, Implementing partners.
Output	**Indicator:** Distribution of health workers, by occupation/specialization, region, place of work and sex **Description:** Health workers are defined as all persons eligible to participate in the national health labor market by virtue of their training, accreditation, skills, and, where required, by age. The most complete and comparable data currently available on the health workforce globally pertain to physicians, nurses and midwives. However, the health workforce includes a wide range of other categories of service providers (e.g., dentists, pharmacists, physiotherapists, community health workers), as well as management and support workers. Information should be captured on all of these categories of human resources for health. **Formula: (**The number of health workers with a given characteristic / Total number of health workers in a designated area) x 100 This indicator provides information on the distribution of health workers by their occupations and areas of specialty and can be subset by district, sex, age and other categories to examine coverage and demographics of the health care workforce. The additional information on health workers' demographic characteristics may be important for policy and planning, for instance, the age distribution can lend insights into the	Health facility records; human resource information system (HRIS); database maintained by the ministry of health or other mandated agency; maps and/or computerized mapping systems; facility surveys, such as the SARA

Results Framework Element	Indicator Description	Data Source
	numbers of workers approaching retirement age and whether sufficient numbers of younger health workers are coming into the system. At least four main typologies for monitoring the distribution of health workers should be considered: imbalances in occupation/specialty; geographical representation; institutions and services; and demographics. The impact on the health system varies for these different types of imbalances and, consequently, there is a need to monitor and assess each of these dimensions of workforce distribution (WHO, 2010). **Supporting Documentation:** http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/hss/distribution-of-health-workers-by-occupation	
Input	**Indicator:** Costed/prioritized HRH Operational Plan that includes detailed M&E plan with indicators and targets and most recent updated date **Description:** Operational planning is related to describing strategies that are implemented on a day-to-day basis. For example, if training more staff is the strategy selected for improving staffing in remote facilities, the operational planning would include the details of implementation such as the start date for training courses and the number of trainers needed, etc. The overall aim of a costed/prioritized HRH Plan is to ensure an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality services. Prioritizing and including an M&E plan are integral parts of an HRH operational plan to ensure accountability, and aid in decision making given countries limited resources. **Supporting Documentation:** http://www.intrahealth.org/files/media/human-resources-for-health-strategic-planning/techbrief_9.pdf http://www.who.int/workforcealliance/countries/hrhcountryplans/en/	Government reports and/or interviews with key informants
Input	**Indicator:** Nationally-implemented HRIS whose data are used to generate HRH Strategic Plan (Yes/No), if yes, please cite most recent date it has been updated **Description:** HRIS is a system for collecting, processing, managing and disseminating data and information on human resource for health (HRH). Depending on the level of development of a country's health care system and the organization of its workforce, an HRHIS can be computerized or paper-based, and including information on numbers and distribution of health workers and track their career information. It is usually an integral part of a comprehensive health management information system, and may be used to monitor and assess the performance of the overall health system. Human Resources for health is defined as "all people engaged in actions whose primary intent is to enhance health". In many countries there is simply insufficient human capacity at all levels to absorb, deploy and use efficiently the financing	Government reports and/or interviews with key informants

Results Framework Element	Indicator Description	Data Source
	for scaling up health services delivery offered by recent initiatives. Still, an HRIS that informs an HRH plan is paramount in creating health work-force information systems, to improve research, and to develop capacity for data management in order to institutionalize evidence-based decision making and enhance shared learning". **Supporting Documentation:** http://www.who.int/workforcealliance/knowledge/toolkit/25.pdf	
Input	**Indicator:** National HRH Stakeholder Leadership Group functioning in accordance with four leadership measures: (*1*) *Work group commitment:* The work group is committed to the organization's mission and to continuous learning, improvement, and innovation *(2)* *Leadership focus:* The work group has identified priority challenges and selected actions that address barriers to achieving results *(3)* *Contextual understanding*: The work group can provide valid and relevant evidence about the nature of its internal and external environments, quality and extent of its performance, and resources available on best practices, and can identify challenges within and facing the team *(4)* *Alignment and mobilization:* Work group responsibilities and resources are internally aligned and work group goals are externally aligned in order to address selected challenges and meet stated objectives. **Description:** This composite indicator examines four key components to a well-organized and strategic leadership group for human resources for health at the national level. This indicator should be calculated based with a Y/N per sub component. And then the overall score of Y/N where if any of the 4 are no—the entire indicator would be no. **Supporting Documentation:** http://erc.msh.org/toolkit/toolkitfiles/file/LM_Indicator_Menu_Not_Prgm_Specific_20072.pdf	Government reports and/or interviews with key informants
Input	**Indicator:** Country policy (s) in place that recognize the role of community health workers **Description:** Community health workers are known by many different names in different countries. The umbrella term "community health worker" (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come. A widely accepted definition was proposed by WHO: Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers. Successful and	Government reports and/or interviews with key informants

Results Framework Element	Indicator Description	Data Source
	sustained large-scale CHW programs usually have and certainly require significant support from government. They require advocacy, stewardship and direction from political leaders and ministerial officials to be considered an integral part of health sector activities. Attention to reliable and adequate resourcing is crucial. Where government does not create and sustain an enabling environment, CHW programs run the risk of withering on the geographical, organizational and political periphery. "Recognized" is a meaningful term for CHW and other cadres. It means that workers are in the establishment - they can be hired by the government and paid. It also means that they are part of a national HRH strategy. On an individual country basis this can be interpreted to meet their needs - in some cases this might mean the CHW profession is regulated. **Supporting documentation:** http://www.who.int/healthsystems/round9_7.pdf And http://www.usaid.gov/what-we-do/global-health/chw-summit	
Output	**Indicator:** *Health worker vacancy:* percent of rural districts fully staffed based on local HRH plan **Description:** Qualified and motivated human resources (HR) are essential for adequate health service provision, but HR shortages have now reached critical levels in many resource-poor settings, especially in rural areas. Strategies improving performance are essential to address shortages of the existing workforce. Performance is considered to be a combination of staff being available (retained and present) and staff being competent, productive and responsive (WHO, 2006). Health workers' willingness to practice in underserved areas, such as rural, remote or poor areas, is a recognized challenge in achieving equitable access to health services. Many countries have developed strategies to attract and retain qualified health workers in these areas. This indicator examines the rate of retention for staff identified by a rural districts HRH plan. **Supporting documentation:** http://www.who.int/bulletin/volumes/88/5/09-070920/en/ http://www.who.int/workforcealliance/media/news/2013/retentiontoolkitstory/en/index.html	Review of HRH plans and employment records

Table 12: Illustrative Indicators for Health Systems Strengthening in Information

Results Framework Element	Indicator Description	Data Source
Output	**Indicator:** National health statistics report updated and published annually **Description:** National health statistics should be compiled, reported and published on an annual basis. The report should allow a country and other stakeholders to prioritize health interventions for future planning. For the NHS to be relevant for this indicator the report must be published no more than 24 months after the end of the calendar/program year. The data in the report should be broken down by major administrative levels. The report should include : life expectancy and mortality; cause-specific mortality and morbidity; selected infectious diseases; selected non-communicable diseases; health service coverage; community outreach; health literacy; client satisfaction with services; knowledge, attitudes, and practices; risk factors; health workforce; health infrastructure; essential medicines; health expenditures and financial risk protection; health inequities; demographic and socioeconomic status; health system performance; and health information systems (including census, civil registration coverage of births, cause-of-death registration coverage, and population surveys) and data availability.	MOH, other government Ministries/authorities
Output	**Indicator:** Number, percent, and/ or type of unit(s) demonstrating use of data for planning, managing, or budgeting, supported by USG assistance **Description**: Using data for decision making for planning, managing or budgeting will enhance the usefulness of such plans. Examples of "use of data" include: funding allocation, preparing budgets for proposals, health sector planning and/or reviews, analyzing disease patterns to align services/staff/commodities to burden/needs, clinical decision making, designing health promotion activities, disease-prevention planning, results-based financing, and issuing health insurance cards. This indicator should be adapted so that the unit of measure is most appropriate for the country/program context. For example, the unit of measure could be districts, facilities, district health teams, or the M&E/planning unit within the MOH. It should also be adapted so that the timeframe is most appropriate for the country/program context. For example, the indicator could measure data use every month, on a quarterly basis, or specific to a country process such as an annual health sector planning exercise. **Supporting Documentation:** http://www.cpc.unc.edu/measure/our-work/data-demand-and-use	Program monitoring documents/reports
Output	**Indicator:** Percent of USG-supported primary health care (PHC) facilities that submitted routine reports on time, disaggregated by public sector and private sector **Description:** This indicator is a measure of the completeness and	An electronic HMIS will track and provide the number of routine reports received, by facility, or the District

Results Framework Element	Indicator Description	Data Source
	timeliness of routine reporting from PHCs. However, this indicator does not take into account the completeness of the data collection (is each form filled in completely, as appropriate), or the accuracy of the information on the reporting form (quality of the data). This indicator should allow one to examine if facilities are submitting the expected number of routine reporting forms per year, as specified in the HIS policy as well as examine the reporting patterns of public sector facilities vs. private sector facilities. This Indicator should be disaggregated by district and by public sector and private sector; can consider additional disaggregation that is most appropriate to the country/program context. **Formula:** The Numerator = the total number of USG-supported PHCs that submitted all routine reports on time over the past 12 months according to national HIS policy. The Denominator = the total number of USG-supported PHCs that had a mandate to submit routine reports over the past 12 months according to national HIS policy	MOH office will track if and when routine reports are received, by facility
Output	**Indicator:** Number and type of information technologies integrated into the MOH health information system, supported by USG assistance **Description:** This indicator specifies "MOH health information system" because the USG should be supporting country systems rather than donor systems. Reducing parallel systems is a principle all donors have committed to. By integrating information technologies into MOH health systems, data can be used for cross purposes and data collection and analysis can be reduced. Illustrative examples of information technologies include: Use of a central data warehouse, district health information system (e.g., DHIS2), human resources information system (e.g., iHRIS), logistics management information system, electronic medical record system (e.g., OpenMRS), or electronic registries/enterprise architecture (e.g., OpenHIE); and use of mobile devices for collecting and transmitting information from routine sources, surveys, or surveillance. **Supporting Documentation:** http://www.mhealthworkinggroup.org/sites/mhealthwg.org/files/usaid_mhealth_compendium_vol_2_-_final_0.pdf and http://www.who.int/healthinfo/HSS_MandE_framework_Oct_2010.pdf	MOH, other government Ministries/authorities Program monitoring documents/reports
Input	**Indicator:** Number of trainings related to data use supported by USG assistance **Description:** Training is an in-service activity. While investing in data collection is important, data use and capacity building will support that data can be used to make strategic health related decision making**.** Health data and information are valuable only if they are used to inform the decision making process. Interventions that increase local demand	Program monitoring documents/reports MOH, other government Ministries/authorities

Results Framework Element	Indicator Description	Data Source
	for information and facilitate its use enhance evidence-based decision making and help make the health system more effective. The indicator should be disaggregated by type of data related training, region (national, subnational) if possible. If attendance lists are available, the indicator can also be used to count the # of people trained and be disaggregated by sex and age. Disaggregation should be appropriate to the country/program context. Examples include: geographic area (by region or by district); target audience (MOH/government institutions vs. civil society/NGOs/CBOs); modality/type of training (in-person workshop, virtual); etc. **Supporting Documentation:** http://www.cpc.unc.edu/measure/tools/data-demand-use/data-demand-and-use-training-resources	

INTEGRATION

INTRODUCTION TO PRINCIPLE

The underlying assumption for this principle, as stated in the GHI strategy document, is that coordinating and integrating the delivery of health interventions is essential for achieving sustained improvements in health. Integration is key to the achievement of public health goals by better using the resources of the health system to meet the full range of health needs of a given population. This allows each individual contact with the health system to have the greatest possible effect on the health and wellness of the population, efficiently, and in such a way to promote sustainable gains. Through a well-integrated and interoperable health system and the effective and efficient delivery of a full range of health services, sustainable development becomes achievable.

While service delivery coordination under the GHI is desirable across the full range of health programs being implemented, true integration of health services is promoted as a targeted strategy meant to link services that "make sense" in a given epidemiological, financial, and health system context.

The literature on integration presents varied definitions and understanding of what and how integration contributes to improved health outcomes. Despite the differences in perspective, central to most concepts is the core idea around the delivery of efficient and coherent services. Different definitions elaborate the parameters of "efficient services" (as they relate to cost, inputs, outputs, use, acceptability, etc.). Others will emphasize the "coherency" in service delivery (e.g., meeting client needs, people getting the care they need when they need it, service delivery is user-friendly, etc.[3]). WHO's definition of integration focuses on management of services where clients receive a continuum of services they need over time and across levels of the health system.[4]

The goal of integration, as defined above, is to reach target populations with packages of targeted, essential services to most efficiently address a range of health needs and priorities. Monitoring and evaluation of integration, as defined through GHI, aims to measure the effectiveness and efficiency of service delivery at the community, facility, and health system level to improve population-level health outcomes and the functionality of the health system itself. The results framework and indicators detailed in this section

[3] Waddington C, Egger D. (2008). Integrated health services: What and why? Making health systems work. Technical brief no. 1 [brochure]. Geneva: World Health Organization. Available at http://www.who.int/healthsystems/service_delivery_techbrief1.pdf.

[4] Ibid.

provide approaches to support the monitoring and evaluation of GHI integration activities, with this aim in mind.

RESULTS FRAMEWORK

This integration results framework (figure 3) is a graphical and narrative representation of the theory of change (the hypothesis) of how integration as a principle contributes to improved health outcomes and supports GHI. By default, the framework will be atypical primarily because the core components do not represent specific interventions in and of themselves, but rather as approaches to programming.

The framework is a representation of the relationships of key actions along different levels (layers), that, when working synergistically, have the potential to affect results and maximize impact of health and development efforts. As with any results framework, the integration results framework makes assumptions on how these different actions relate to each other along the causal pathways from inputs, outputs, outcomes, and ultimately to impacts on health. Within this causal pathway, integration could be described broadly as an implementation strategy that supports and contributes to the effective delivery of health services.

As such, the integration results framework uses coherent service integration as central to describing how and what is required to define the integration causal pathway. At the heart of the framework is the need for actions both upstream (planning, coordination and management actions) and downstream (level of service delivery actions) to ensure clients have the services they need at the appropriate time, and services are provided in a user-friendly and acceptable manner.

The upstream part of the framework highlights the importance of key actions or inputs in several areas: (1) policy, planning, management, leadership and governance levels; (2) health system functions (drawing from the HSS building blocks), and (3) social and behavior change, and demand creation activities. These are all essential in supporting integrated service delivery.

Using the integration of family planning (FP) and HIV prevention and care services as an example, policy makers and planners need to make decisions on joint planning, budgeting, and implementing integrated services. Likewise, under the health system functions, cross training, task shifting and joint supervision are required if providers are to develop the skills and competence to deliver integrated FP and HIV services. Health behavioral campaigns that reach communities with key messages on family planning should be linked with key messages on HIV prevention and care, especially if they are serving populations with similar health needs and challenges.

Joint coordination and organization of health programs at the senior planning and management levels would translate into more efficient service delivery if provided as a package of interventions that are responsive to the population needs following a

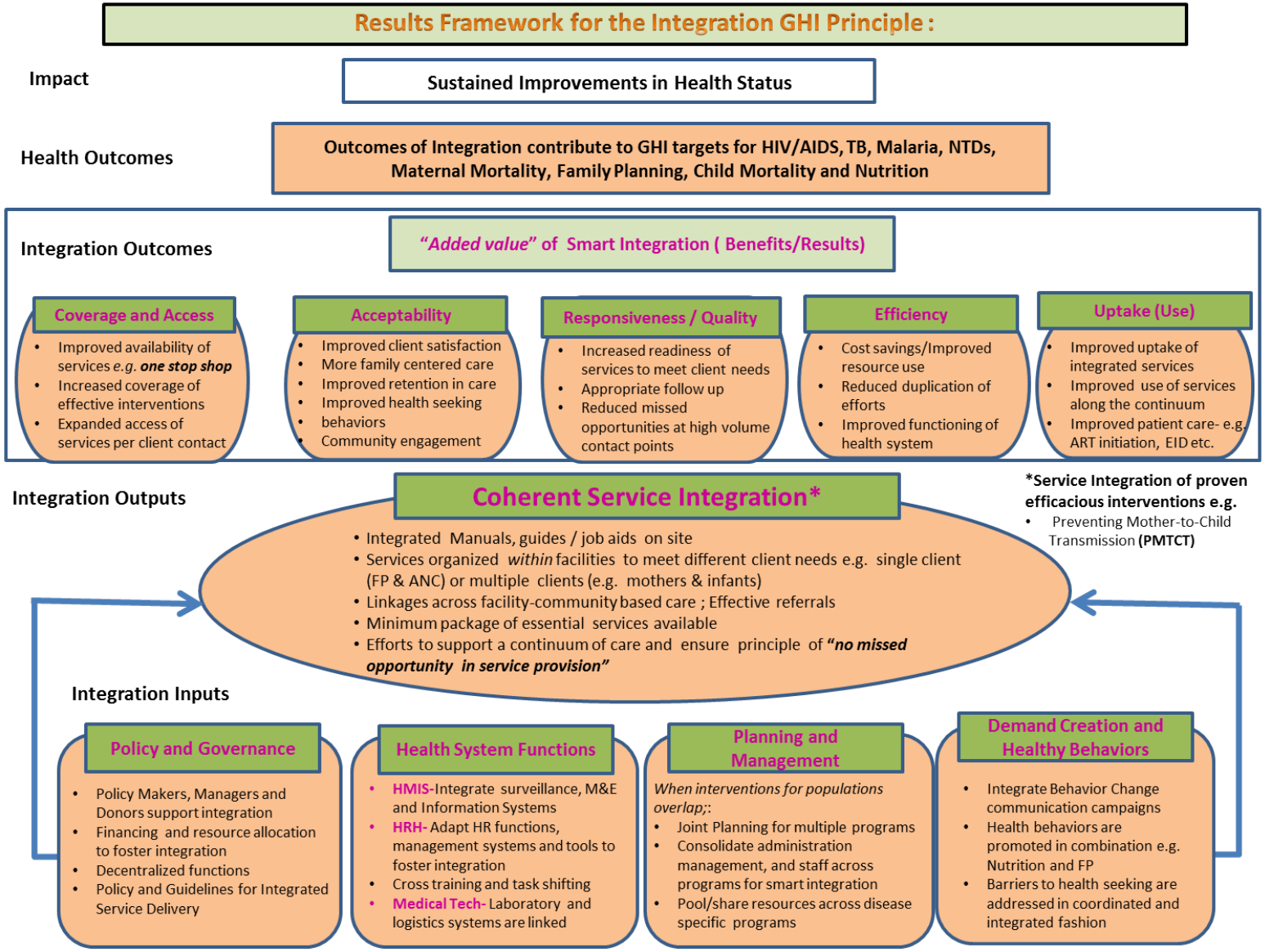
continuum of care approach to reduce missed opportunities (through linkages and coordination with others in the service delivery continuum such as linking facility and community, clinic A and clinic B, etc.), clinics coherently managed under the district health team and with districts managed under the regional or provincial health teams. The optimal model is frequently a "one-stop shop" achieving the goal of coherent services in providing care.

Once rational service integration is achieved downstream, the assumption, as supported by the systematic review on integration, key outputs are: more accessible services by increasing client contact; greater acceptability through the expansion of more family-centered and client-friendly care; increased readiness to meet client needs. This will hopefully reduce missed opportunities for providing needed services; and, ultimately, increased coverage and utilization..[5]

Coherent service integration also synergistically contributes to greater efficiencies through improved resource use, reductions in duplications and a better functioning of health system. Ultimately improved functioning of the health systems combined with increased access and coverage services will result in improved uptake of core interventions thus maximizing health impact and better use of resources to meet GHI goals.

[5] Kennedy C, Lindegren ML, Brickley DB, Kennedy G, Horvath T, Azman H, Butler LM, Creanga AA, Spaulding A. (2011). *Integration of Maternal, Neonatal and Child Health and Nutrition, Family Planning and HIV: Current Evidence and Practice from a Systematic Cochrane Review.* Washington, DC: PEPFAR, CDC and USAID.
Brickley DB, Kennedy C, Lindegren ML, Kennedy G, Horvath T, Azman H, Chibber K, Spaulding A. (2011). *Integration of Maternal, Neonatal and Child Health and Nutrition and Family Planning: Current Evidence and Practice from a Systematic Cochrane Review*. Washington, DC: USAID.

Figure 3: Integration Results Framework



GLOBAL INDICATORS

Three integration global indicators (table 13) have been developed and are being field tested and proposed for global GHI reporting. The indicators address increased coverage of effective interventions and expanded access of services per client contact and improved uptake of the integrated services. The first two indicators collect information on the availability of integrated services at the service delivery point level. They are disaggregated by the type of service delivery point providing the services and the type of service that is being integrated into the base service package. See the annex 3 for more information how the indicators should be disaggregated. Note that OGAC is now requiring that PEPFAR funded countries report on HIV/FP integration, which is included as a type of disaggregation of the first indicator. Programs should be able to collect the first two indicators via routine program monitoring after some initial adjustments are made to the data collection and reporting system. The third indicator collects client level information. In most cases, the last indicator may need to be collected through a special study (see the Data Collection Method/Measurement Method sections on the indicator reference sheets, annex 3, for more information). Other details about these indicators are also provided in the global indicator reference sheets found in annex 3.

Table 13: Integration Global Indicators

Results Framework Element	Indicator	Data Source
Coverage and access	Number of HIV service delivery points that have integrated at least one non-HIV service Part 1: Number of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services. Part 2: Number of HIV service delivery points that have integrated at least one non-HIV service **other than FP.**	Routine monitoring
Coverage and access	Number of MNCH service delivery points that have integrated at least one other type of service	Routine monitoring
Uptake	Number of clients who received two or more services during a single facility visit	Special study or routine monitoring

ILLUSTRATIVE INDICATORS

In addition to the three global indicators, 19 illustrative indicators were identified for each integration input, output, and outcome domain, described in table 14. These indicators do not need to be reported by countries but rather are meant to be a resource for countries that are implementing integrated health programs and are looking for guidance on effective ways to monitor programmatic performance. The illustrative indicators are not meant to be an exhaustive list of indicators for each domain. Rather, they are meant to

provide examples of the range of results that can be used to measure program activities within each domain.

A few of these indicators have been taken from or adapted from existing sources. However, a majority of them have been newly developed by the group. This is because despite an extensive review of the grey literature and different indicator databases and compendiums, for the most part the working group was not able to find existing integration indicators and therefore had the task of filling this gap. Since most of the integration indicators, both global and illustrative, are new, they are a work in progress. As this guide was being prepared in early 2014, these indicators were being formally field tested and will be developed further as information is received from the field test and from countries regarding the validity of the indicators, as well as the feasibility and ease of collecting them.

All global and illustrative indicators were developed by the GHI integration workgroup with input from the M&E community in the United States as well as in the field at various points in the indicator development process.

Table 14: Integration Illustrative Indicators

Results Framework Element	Indicator and Description	Data Source
Policy and Governance	**Indicator:** National policies, strategies and/or guidelines that support integration developed or updated in the past year (yes/no) **Description:** This indicator tracks whether national policies, strategies and frameworks that support integration (e.g. integrated program design, integrated service delivery, system integration) have been developed or updated by the MOH in the past year in order to create an enabling environment for integration at the service delivery level.	National Policy and Program Review
Health System Functions	**Indicator:** Number of protocols, standard operating procedures, and other on-the-job tools that support integration developed in the past year **Description:** This indicator tracks the number of on-the-job tools, such as protocols, standard operating procedures (SOPs), algorithms, flowcharts, job aids, checklists etc., that help service providers translate policies and guidelines on integration into clinical practice so they can provide integrated services to clients, that have been developed in the past year. They may be developed by USG IPs, other donor funded projects or by the MOH.	National Policy and Program Review, Stakeholder Interviews
Coherent Service Integration	**Indicator:** Number and percent of service delivery points using protocols, standard operating procedures, and other on-the-job tools that support integration **Description:** This indicator tracks the extent to which on-the-job tools that support integration that were rolled out by the MOH are being used at the facility level. Specifically, the indicator tracks the number and percent of service delivery points that have on-the-job tools, such as protocols, standard operating procedures (SOPs), algorithms, flowcharts, job aids, checklists etc. that help service providers translate policies and guidelines on integration into clinical practice so they can provide integrated services to clients, in place at the facility at the time of the visit.	Facility Assessment, Special Study
Policy and Governance	**Indicator:** Changes made to financing mechanisms to support integration in the past year (yes/no) **Description:** This indicator tracks whether the financing mechanisms that finance the health sector have been designed or redesigned to support integration (e.g. integrated program design, integrated service delivery, system integration), for example, the design and use of a common procurement mechanism across multiple health program areas to procure commodities and supplies.	National Policy and Program Review

Results Framework Element	Indicator and Description	Data Source
Policy and Governance	**Indicator:** Number of new donor funded projects that support integration initiated in the past year **Description:** This indicator monitors donor commitment (both USG as well as other donors) to support integration. The indicator tracks the number of new donor funded projects initiated in the past year that aim to support integration through activities such provision of integrated services, health systems strengthening activities in support of integration (e.g. cross-training, integrated surveillance, integrated data warehousing, etc.), BCC messaging that addresses more than one health service or outcome, , etc.	Desk review of donor agreements and donor funded projects
Health System Functions	**Indicator:** Number of vertical, program-specific systems that were streamlined or interlinked to support integration in the past year **Description:** This indicator tracks the extent to which the systems that support vertical programs, such as the data collection and reporting systems, logistics and supply chain systems, lab and diagnostic systems, etc., have been streamlined or interlinked to supported integration at the service delivery level. "Vertical" programs are programs that focus on specific interventions, normally focusing on a specific disease or condition, such as HIV/AIDS, family planning, malaria, TB, malnutrition, polio, etc.	National Policy and Program Review, HMIS Review
Demand Creation	**Indicator:** Number of integrated behavior change communication campaigns launched in the last year **Description:** This indicator tracks the number of behavior change communication campaigns that address more than one health service or more than one health outcome were developed and launched in the past year (e.g. TB and HIV, SRH and HIV, etc.)	Program Records, Special Study
Health System Functions	**Indicator:** Integrated data collection and reporting tools developed (or adapted) by the MOH to support service integration in the past year (yes/no) **Description:** This indicator tracks whether integrated or interlinked facility-based data collection tools and reporting tools, such as patient files, registers and other data collection and reporting tools, have been developed by the MOH (or adapted from standardized tools developed by international agencies) to support integration at the service delivery level in the past year. An example of this type of tool is the 3 Interlinked Patient Monitoring Systems (3ILPMS).	National Policy and Program Review, HMIS Review

Results Framework Element	Indicator and Description	Data Source
Health System Functions	**Indicator:** Number and percent of service delivery points using integrated data collection tools **Description:** The indicator tracks the extent to which standardized, national data collection tools that were rolled out by the MOH are being used at the facility level. Specifically, the indicator monitors the number and percent of service delivery points that are using integrated or interlinked facility-based data collection tools, such as interlinked patient files, family folders, integrated registers, etc.	Facility Assessment, Special Study
Health System Functions	**Indicator:** Number and percent of service delivery points using integrated reporting tools **Description:** This indicator tracks the extent to which standardized, national reporting tools that were rolled out by the MOH are being used at the facility level. Specifically, the indicator tracks the number and percent of service delivery points that are using integrated facility-based reporting tools, such as integrated monthly HMIS reporting form.	Facility Assessment, Special Study
Policy and Governance	**Indicator:** Number and percent of districts with operational work plans that contain activities to support integration **Description:** National policies and guidelines addressing integration need to be operationalized and monitored at each decentralized level of the health system. This indicator tracks the number and percent of districts in the country, out of the total number of districts, which have operational work plans that contain activities to support integration in health facilities located in the catchment area. The district level (or equivalent) is the health administrative level that is closest to the service delivery level, and usually has oversight and supervisory responsibilities of facilities in the catchment area. This level is therefore also responsible for providing support to facilities to implement national policies and guidelines on integration and monitoring the extent to which they are being followed. Ensuring that these activities are explicitly included in the district work plan will hold them accountable for getting the activities done.	Program Records, National Health Sector Reports

Results Framework Element	Indicator and Description	Data Source
Health System Functions	**Indicator:** Number and percent of districts that conducted integrated supportive supervision visits to health facilities according to national guidelines (where such guidelines exist) during the last reporting period **Description:** This indicator tracks the number and percent of districts, out of the total number of districts, which conducted integrated supportive supervision visits to health facilities during the last reporting period. In an integrated supportive supervision visit, a district health team, consisting of representatives from multiple health programs, conducts a joint visit to a facility to supervise and provide feedback to facility staff on a range of services and program areas.	Program Records, National Health Sector Reports
Health System Functions	**Indicator:** Number of healthcare workers who completed an in-service cross-training or integrated training during the last reporting period **Description:** This indicator tracks the number of health care workers who successfully completed an in-service cross-training or integrated training during the reporting period. Training is a learning activity taking place in- country, a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently. Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies.	Program Records, National Health Sector Reports
Coherent Service Integration	**Indicator:** Proportion of clients referred from an initiating service (referral initiation) **Description:** This indicator captures the extent to which clients are being referred from one service to another. The numerator is the number of clients referred from the initiating service and the denominator is the number of clients seen at the initiating service. The numerator and denominators also indicate the volume of clients using various services and the potential client burden for the receiving service. Additional References: A full indicator reference sheet for this indicator is available in the Referral Systems Assessment and Monitoring Tool Kit: http://www.cpc.unc.edu/measure/publications/MS-13-60)	Routine Reporting

Results Framework Element	Indicator and Description	Data Source
Coherent Service Integration	**Indicator:** Proportion of clients referred who complete referral at receiving services (referral completion) **Description:** This indicator captures most directly the effectiveness of the referral system and is used to assess utilization of the referral system and to measure referral success. The numerator is the number of referred clients seen at the receiving service and the denominator is the number of clients referred from the initiating service. Additional References: A full indicator reference sheet for this indicator is available in the Referral Systems Assessment and Monitoring Tool Kit http://www.cpc.unc.edu/measure/publications/MS-13-60)	Routine Reporting
Coherent Service Integration	**Indicator:** Proportion of clients seen at receiving service who are seen back at the initiating service with complete counter-referral information (counter-referral completion) **Description:** This indicator assesses the completion of the referral process. Clients not only receive the referred service, but are also referred back to the original referring service for follow-up. The numerator is the number of clients with complete counter-referral information seen back at the initiating service. These are clients who were referred, received the service for which they were referred, and attended a follow-up visit at the service of origin (initiating service) with information on referral completion. The denominator is the number of referred clients seen at the receiving service. Additional References**:** A full indicator reference sheet for this indicator is available in the Referral Systems Assessment and Monitoring Tool Kit http://www.cpc.unc.edu/measure/publications/MS-13-60)	Routine Reporting
Responsiveness/Quality	**Indicator:** The average percent of public and private medicine outlets in sample areas where a selection of the 14 essential medicines are found on the day of the survey. **Description:** This indicator can be used to assess the availability of essential medicines as well as service availability and readiness. Essential medicines satisfy priority health care needs of the population and are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage, with assured quality, and at a price that individuals and the community can	Facility Assessment (i.e. Service Availability and Readiness Assessment)

Results Framework Element	Indicator and Description	Data Source
	afford. The indicator can also serve as a proxy for service quality, as represented by the presence of non-expired stock. This indicator is calculated as an average of percentages from sample areas: (The number of facilities with all 14 essential medicines in stock (present and not expired) on the day of visit / Total number of facilities surveyed in sample area) x 100 This is a core indicator in the WHO Health System Strengthening (HSS) Handbook. Additional References: WHO Model List of Essential Medicines http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf	
Responsiveness/Quality	**Indicator:** Number of facilities that have all tracer medicines and commodities in stock on the day of the visit (and the last three months) **Description:** This indicator is closely related to the indicator *Average availability of 14 selected essential medicines in public and private health facilities* but includes additional medicines plus commodities and vaccines. This indicator uses a composite index of 61 essential medicines, commodities, and vaccines. This is a core indicator in the WHO Health System Strengthening (HSS) Handbook. Additional References: WHO Model List of Essential Medicines http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf	Facility Assessment (i.e. Service Availability and Readiness Assessment)
Efficiency	**Indicator:** Number (and mean) outpatient visits per person per year **Description:** In populations with poor or suboptimal health infrastructure the service utilization rate is an indicator of access. This indicator tracks the number of visits for ambulant care, not including immunization, over the total population. The indicator must all be expressed as a percentage score compared with a target or benchmark. In	Facility Assessment (i.e. Service Availability and Readiness Assessment)

Results Framework Element	Indicator and Description	Data Source
	OECD countries, the average number of physician consultations per person per year is about 6. The proposed benchmark is 5 visits per person per year. The indicator is scored as: (Number of outpatient visits per person per year)/ 5 * 100% (max. 100). If the tracer indicator score exceeds the benchmark, it will be scored as 100% Additional References: http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/index.html	

PARTNERSHIPS

INTRODUCTION TO PRINCIPLE

The core principle around partnerships of the GHI is to "strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement." This strategy recognizes that the U.S. government will not achieve improved health outcomes and strengthened health systems based on its efforts alone, but rather that achievement of these goals will only be reached by sustained efforts with partners at all levels and from all sectors– with host countries, multilateral organizations, civil society, and the private sector.

Recent commitments towards aid effectiveness also highlight the centrality of effective partnerships to achieving development outcomes. The 2011 Fourth High Level Forum on Aid Effectiveness in Busan, South Korea, highlighted the importance of "inclusive development partnerships" that recognize the "different and complementary role of all actors".[6] Partnerships will take on different characteristics dependent on country context, USG investments, health challenges and partner organizations. The GHI principle paper *Promoting Partnerships to Advance GHI Objectives* is available at:

http://www.ghi.gov/principles/docs/Promoting-Partnerships-to-Advance-GHI-Objectives.pdf

This paper provides guidance to field staff in building and strengthening effective partnerships by addressing the reasons to partner, approaches for building strong partnerships, identifying partnering opportunities and monitoring and evaluating the partnership.

RESULTS FRAMEWORK

The results framework on partnership provides a common understanding for country teams on building partnerships and improving existing ones across all health programs that the U.S. government supports, as part of its public health and broader development agenda. GHI defines partnerships as collaborative relationships between two or more parties based on trust, equality, and mutual understanding and formed to achieve a specific goal. Partnerships involve risk as well as benefits, making shared responsibility and accountability critical. Partnership relationships can be an integral part of reaching objectives that no one donor, organization, or partner country is able to achieve on its own. Likewise, partnership, beyond just coordination, is a key element in improving aid

[6] Busan partnership for effective development cooperation [conference report paper]. *Fourth High Level Forum on Aid Effectiveness*, Nov. 29-Dec. 1, 2011, Busan, South Korea. Available at: http://www.oecd.org/dac/effectiveness/49650173.pdf

effectiveness. This partnership results framework (figure 4) is a graphical and narrative representation of the process and inputs necessary to achieve a successful partnership that contributes to health outcomes and impacts.

The foundation of the results framework highlights the importance of four key inputs of a partnership:

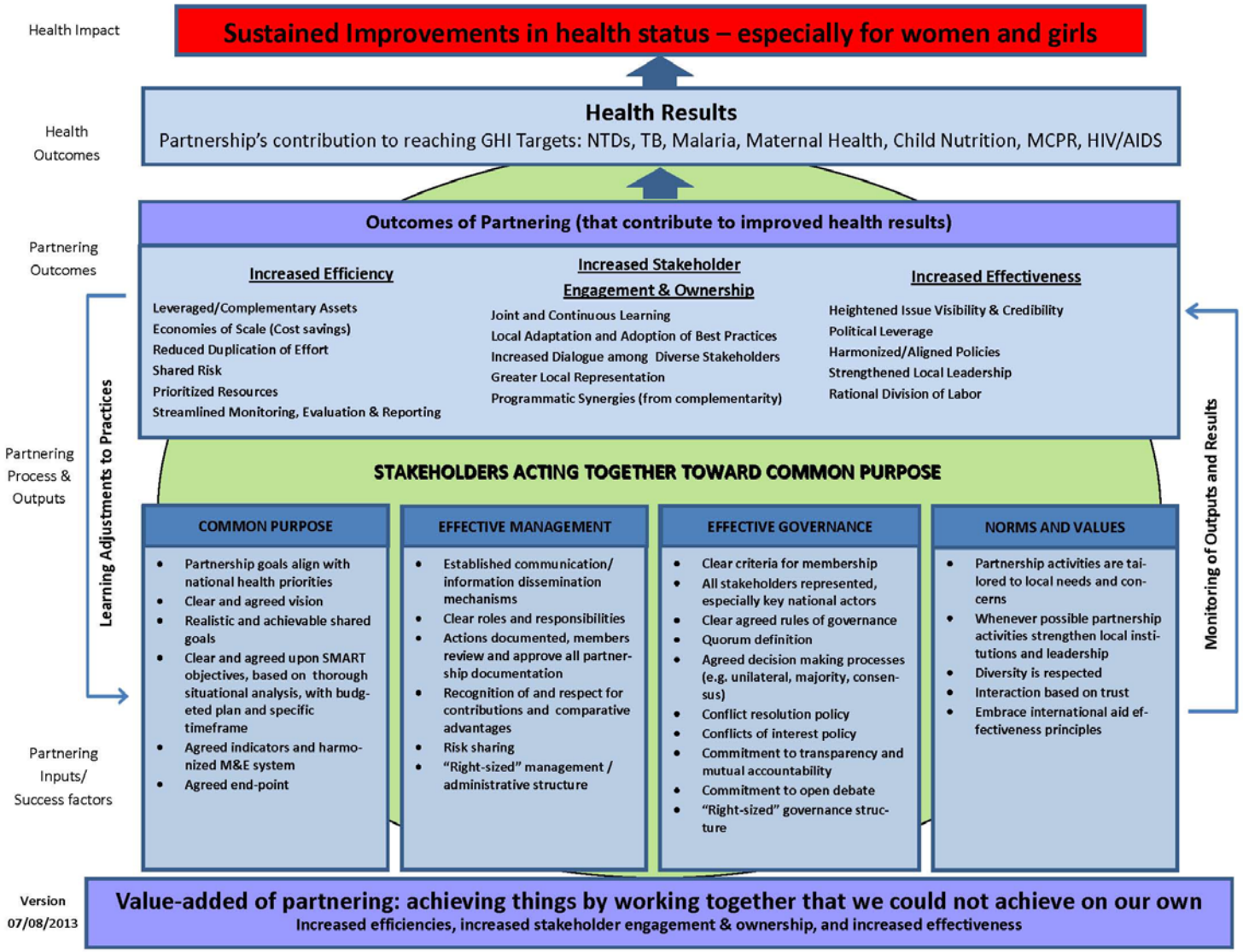
- common purpose
- effective management
- effective governance
- norms and values

Each of these is a critical best practice of an effective partnership and when brought together are able to achieve the value-added of partnering: achieving greater results by working together that could not be achieved individually. Given the global burden of disease, no single country or organization has all the necessary resources, financial or otherwise, to achieve sustained improvements in health outcomes in isolation. The GHI partnership results framework demonstrates how effective partnerships are able to contribute to health outcomes and outputs. Furthermore, it highlights that it is only when a partnership acts toward a common purpose, delivers on the necessary inputs, and achieves the outputs of increased efficiency, increased stakeholder engagement and ownership, and increased effectiveness that it is able to achieve the targeted level of health goals, outcomes, and impacts.

As shown in the results framework, this process is not simply defined by inputs and outputs but more so by systematic learning and adjusting of the partnership's values and governance. These inputs should be adjusted if monitoring suggests that the partnership is not achieving its intended outcomes.

This results framework outlines a series of components and steps to advance productive partnerships. It is intended to recognize that partnerships will inevitability work differently in different settings depending on local context, size of the partner footprint (i.e. resources) in country, strength of the partners (including the host government), disease burden and other related factors.

Figure 4: Partnerships Results Framework



GLOBAL INDICATORS

To meet GHI global reporting needs and to reduce burden on countries, the partnership group selected three partnership indicators reported in the annual PPR process. The indicators (described in table 15) address increased efficiency and increased stakeholder engagement and ownership. The required indicators address two of the three results framework elements that address the partnering outcome level. Programs should be able to collect all three indicators via routine program monitoring, USG partnership documents and other program reports. Details for these global indicators are provided in reference sheets found in annex 4.

Table 15: Partnership Global Indicators

Results Framework Element	Indicator	Data Source
I. Increased efficiency	Total number of USG-supported partnerships in the current fiscal year of reporting (that support USG planned health outcomes)	USG-supported partnership documents; program reports
I. Increased efficiency	Number of **NEW** partnerships out of the total number of USG-supported partnerships in the current fiscal year of reporting (that support USG planned health outcomes)	USG-supported partnership documents; program reports
II. Increased stakeholder engagement and ownership	Type of partner(s) (that support USG planned health outcomes): a. With Public sector (host country's governmental bodies and levels) institutions b. With Public sector Regional or International institutions c. With Private For-profit Domestic institutions d. With Private For-profit International corporations and other for-profit institutions e. With Private Not-for-profit Domestic institutions f. With Private Not-for-profit International institutions	USG-supported partnership documents; program reports

ILLUSTRATIVE INDICATORS

In addition to the three global indicators, 15 illustrative indicators were identified for each of the framework elements (efficiency, stakeholder engagement/ownership, effectiveness). These indicators, described in table 16, do not necessarily need to be reported by countries but rather are meant to be resources for countries that are implementing health programs through partnerships and are looking for guidance on effective ways to monitor programmatic performance.

Many of these indicators have been developed from studies and papers dedicated to the development of effective global health partnerships. Evaluations of these types of partnerships conducted by Buse, Rosenberg, Foege and others, identified lessons learned and successful actions taken by diverse partnerships to achieve common goals and aspirations. A few of the indicators included in the GHI Partnership paper were adapted to current USG activities. As the understanding of how successful global health partnerships expands, the indicators, both global and illustrative, should be modified, changed or replaced by more specific measurements of progress being made.

All global and illustrative indicators were developed by the GHI partnership working group with significant input from the M&E community in the USG as well as in the field at various points in the indicator development and selection process.

Table 16: Partnership Illustrative Indicators

Value-added: Increased Efficiency (Results Framework Element I)

Increased efficiencies can result when different partners bring different and (ideally) complementary **assets**—financial or in-kind— to the table in partnership arrangements, which are necessary to achieve the partnership's goal/objective.

Indicator: List and name the assets USG has leveraged through partnerships during this fiscal year

Results Framework Element	Assets Leveraged	Data Source
I	Subject area expertise that complements or supplements USG expertise Examples include core business processes, marketing	USG-supported partnership documents; program reports
I	Infrastructure Examples include buildings, equipment, roads	USG-supported partnership documents; program reports
I	Intellectual Property Examples include patented processes, protocols	USG-supported partnership documents; program reports
I	Access to populations to which USG doesn't normally have access to Examples include at-risk, marginalized and vulnerable groups; service providers; factory workers	USG-supported partnership documents; program reports
I	Products/commodities Examples include bednets, medicine, medical supplies	USG-supported partnership documents; program reports
I	Access to management/distribution networks Examples include supply chain networks, communication networks	USG-supported partnership documents; program reports
I	Access to information networks Examples include social media, mass media, or cyberspace	USG-supported partnership documents; program reports
I	Funds that do not come from USG sources, and that supplement or complement USG funds	USG-supported partnership documents; program reports
I	Other (Please specify if there are any other assets that USG has leveraged through partnerships)	USG-supported partnership documents; program reports

Value-added: Increased Stakeholder Engagement and Ownership (Results Framework Element II)

Partnering can result in increased commitment across stakeholders, stimulating greater local representation and thus ownership among stakeholders, promoting joint and continuous learning, supporting greater equity, and achieving a greater probability of sustainability over time. Below are some of the ways one can measure this value-added, but other measures may be most relevant to any specific partnership.

Indicator: List and name if USG has experienced any of the following measures of stakeholder engagement and ownership as a result of partnering during this fiscal year.

Results Framework Element	Stakeholder Engagement and Ownership	Data Source
II	Frequency of stakeholder dialogue forums conducted by partnership operations This can be measured by counting meetings between partners	USG-supported partnership documents; program reports
II	Breadth and diversity of professional profiles and/or affiliations of persons engaging in stakeholder dialogue forums conducted by partnership operations This can be collected by reviewing sign-in sheets	USG-supported partnership documents; program reports
II	Satisfaction levels This can be measured through survey; recommend that particular consideration be given to marginalized stakeholder 'voices' in partnership events	USG-supported partnership documents; program reports

Value-added: Increased Effectiveness (Results Framework Element III)

A health program may experience increased **effectiveness** as a result of partners aligning behind a common goal/objective and taking concerted, coordinated action to advance that goal/objective. Below are some of the ways one can measure this value-added, but other measures may be most relevant to any specific partnership.

Indicator: List and name if the USG has experienced any of the below measures of effectiveness a result of partnering during this fiscal year.

Results Framework Element	Effectiveness Measures	Data Source
III	Policy dialogue/political influence This can measured by the number of committee meetings, public hearings, drafting activities, press coverage, and other tangible examples that contribute to making policy change occur	USG-supported partnership documents; program reports
III	High-level visibility through a "Champion" or other prominent representation by partners This can be measured by media mentions in print, radio, or TV, of the partnership or its goal/objective or issue	USG-supported partnership documents; program reports
III	Coordinated allocation of human resource needs to reach shared goal/objective A clear example is division of labor to reach goal/objective or further address the partnerships issue	USG-supported partnership documents; program reports

RESEARCH AND INNOVATION

INTRODUCTION TO PRINCIPLE

Field-based investments in research and innovation (R&I) for global health have the potential to improve people's health in low- and middle-income countries. The inclusion of R&I as one of the seven GHI principles underscores two critical shifts in global health thinking. First, evidence must guide and underpin policy, practice, and strategy decisions in global health. Second, globalization combined with scientific advances has accelerated the rate of scientific exchange and multiplied the potential for global collaboration and local innovation while simultaneously bringing the challenges in resource-limited areas into greater focus.

Developing a reference document in support of this principle is a challenging exercise[7], given the new and complex nature of the concepts and the associated global dialog[8]. Current dialog is focused on building health research capacity while the R&I principle is more expansive to include investments in research and innovation. Consequently, a principle paper on R&I has not been produced. It is recommended that each USG field office follow the guidance of their agency-specific policies and strategic planning associated with research and innovation, and monitor such developments through the process outlined below.

RESULTS FRAMEWORK

Based on the results frameworks developed for the other GHI principles, it is possible to envision, at a high level, how R&I activities may be used to address common country challenges, improve services and accelerate progress in global health leading to positive and sustained health impact.

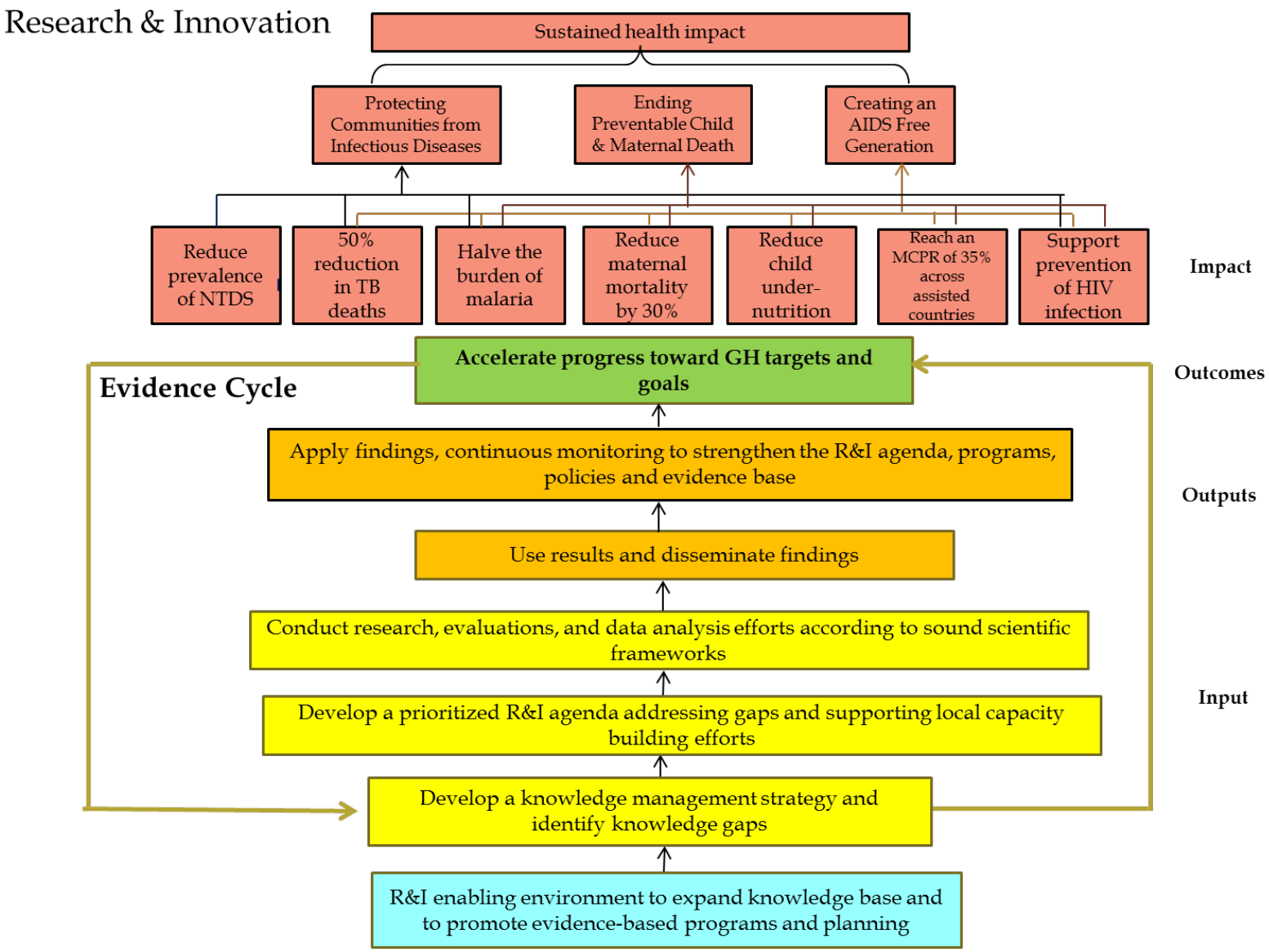
A potential R&I results framework is illustrated below (figure 5) to facilitate the development and use of country-led research and innovation activities for accelerated progress in global health. This framework outlines potential causal pathways for how research and innovation activities associated with developing and applying novel findings/evidence generated by research may contribute toward the eventual goal of sustained health impact. Similarly, this conceptual framework may also serve as a model of

[7] Cole et al "Indicators for tracking programmes to strengthen health research capacity in lower- and middle-income countries: a qualitative synthesis" *Health Research Policy and Research* 2014, 12:17 http://www.health-policy-systems.com/content/12/1/17.

[8] WHO *ESSENCE (Enhancing Support for Strengthening the Effectiveness of National Capacity Efforts) Geneva* http://www.who.int/tdr/partnerships/initiatives/essence/en/

how the synergies among key research and innovation activities have the potential to maximize the impact of health and development efforts and improve programmatic results. Additionally, this framework makes assumptions along the causal pathway on how these activities relate to each other from inputs to outputs to outcomes and finally to sustained health impacts. The information provided here for measuring research and innovation progress is presented for consideration, and possible adaptation, by USG Country Health Teams.

Figure 5: Research and Innovation Results Framework



GLOBAL INDICATORS

Metrics associated with the formulation and implementation of research and innovation strategies are nascent in form, consistent with the status of the general concept and global dialogue. Considerable work needs to be accomplished in the definition of the general concept as a precursor to development of indicators, and these latter measures will need to be applied and tested in appropriate contexts. Global and illustrative indicators are presented here as potential examples for use in the country setting. Recognizing that these measures have not been fully vetted, nor have they been validated in a systematic manner, use of these indicators should be managed carefully and results shared broadly to inform ongoing work in this area.

Two global indicators are proposed (table 17). These are standard indicators and were adapted from previous research and innovation indicators developed for other purposes.

Annex 5 provides reference sheets with additional information.

Table 17: Research and Innovation Global Indicators

Results Framework Element	Indicator	Data Source
R&I enabling environment R&I prioritized agenda Disseminate results Apply findings	Publically available country-specific research and innovation priorities and/or agenda.	Collaborative research and innovation priorities and/or agenda documentation
R&I enabling environment R&I prioritized agenda Disseminate results Apply findings	Is there a publically available inventory of all USG-supported research in country, updated annually, no later than the end of the fiscal year?	Mission records, implementing partner records

ILLUSTRATIVE INDICATORS

A set of five illustrative indicators for adaptation by country programs is also proposed. These indicators, described in table 18, are intended to align to the proposed results framework. For further information and discussion on possible R&I indicators, please consult Cole et al. Article presents an excellent analysis and assessment of health research capacity (HRC) evaluation, diversity of indicators to measure progress and the need for a tried and true framework.

Table 18: Research and Innovation Illustrative Indicators

Results Framework Objectives	Illustrative Indicators	Data Source
R&I enabling environment R&I prioritized agenda Disseminate results Apply findings	Existence of a national and/or sub-national database(s) that enable stakeholders to access relevant health data and evidence for policy formulation and program management and improvement. (Y/N)	Various
	Existence of functional knowledge management system available to countries as a resource for guidance on health practice, policy, and programs. (Y/N)	Various sources: e.g. WHO, USG Agencies
R&I enabling environment R&I prioritized agenda Disseminate results Apply findings	Number of health innovations developed locally with USG support	Implementing partner records/ documents; US agency records
R&I enabling environment R&I prioritized agenda Disseminate results Apply findings	Number and list of health innovations being scaled in host country with USG funding.	Implementing partner records/documents
R&I enabling environment R&I prioritized agenda Disseminate results Apply findings	Number of instances when the findings from research supported by USG funds were used to inform policy decisions or program planning/allocation.	Implementing partner records/documents

SUSTAINABILITY

INTRODUCTION TO PRINCIPLE

The concept of sustainable country-owned programs is not new; USG agencies in partnership with host country partners have been working to accomplish sustainable, country-led and country-owned responses for many years. However, under the GHI there is an opportunity to accelerate and realize these efforts across all health areas. Approximately 24 percent[9] of the foreign assistance budgets for the U.S. Department of State and USAID are in the health sector; it is a critical component of the USG's diplomatic engagement.[10] In the current development arena, this investment constitutes the largest contribution to a single sector from any one country and is critical to understanding the USG approach to promoting country ownership. In fulfilling its responsibilities, the U.S. Congress sets high expectations on the use of taxpayer dollars; a responsibility ultimately borne by the programs and people tasked with delivering and reporting on the use of USG assistance for health. Ideally, country ownership results in sustainable health systems and outcomes.

Sustainable country-owned programs are characterized by government, communities, civil society and private sector-able to lead, prioritize, implement and be accountable for a country's health response.

Countries that effectively manage their public health response demonstrate leadership over their health budgets, manage development of policies and strategies, and coordinate public health actions, including the contributions of the private sector, donors, and civil society. Sustaining country-owned programs involves shared responsibility and mutual accountability with donors and other partners, particularly when outside financial and technical resources are necessary to respond fully to the health sector needs of host countries. The USG fosters sustainable country-owned programs by investing in high impact and evidence-based country-led priorities, plans, and systems. The USG also encourages sustainable country-owned programs when it promotes direct financing by recipient countries for priority interventions such as malaria and family planning commodities. Ultimately, a well-coordinated, country-led health response enhances efficient use of resources and contributes to long-term sustainability of heath programming.

Developing countries operate along a spectrum of capacities for addressing the burden of morbidity and mortality and these capacities includes managing, owning, and financing their health sector, as well as the systems that deliver care. Any measurement of sustainable country-owned programs must therefore recognize this spectrum. There is no

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9 In FY2012, the United States government provided about 27% in global health assistance to the health sector of partner countries. Approximately 24% was in the foreign assistance budget for the Department of State and USAID; about 3 percent through both the Department of Health and Human Services and the Department of Defense. – Source, U.S. Department of State, Office of Foreign Assistance. www.foreignassistance.gov.

10 Tarnoof C, Lawson ML. *Foreign Aid: An Introduction to U.S. Programs and Policy*. Washington, DC: Congressional Research Service; 2011. Available at: http://www.fas.org/sgp/crs/row/R40213.pdf.

one-size-fits-all; the goal of USG efforts at fostering sustainable country-owned programs is to assist host countries transition to higher levels of sustainable country-owned programs while continuing to improve health outcomes.

FOUR DIMENSIONS OF SUSTAINABLE COUNTRY-OWNED PROGRAMS

For the USG, sustainable country-owned programs in health are conceptualized along the four dimensions:

- political ownership and stewardship;
- institutional and community ownership;
- capabilities, and
- mutual accountability, including finance.

These reflect the actions taken by political and institutional stakeholders in host countries to plan, finance, and manage their own health sector activities, responsive to the needs of host nationals. They are supported by capacity strengthening actions for individuals, institutions, and systems, which ensure sustainability.

Sustainable country-owned programs are best advanced in a country when progress is made towards all four dimensions. The four dimensions operate independently, but there is a complex interplay between them (table 19). Since there is a non-linear relationship among the dimensions, there is no single sequencing or formula for how to improve the various elements. This, therefore, does not fit into a traditional left-to-right, linear cause-and-effect framework.

Table 19. Four Dimensions of Sustainable Country-Owned Programs

Sustainability Dimension	Characteristics
Political ownership and stewardship	• Host government has a clear aspiration for what should be accomplished in each stage of program development, implementation and monitoring, generated with input from their own cities and rural areas, civil society, NGOs, and private sector, as well as their own citizens • National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated • Host country (public and private sectors) is the architect that fully implements and provides oversight of national plan to achieve results and applies and scales-up evidence-based best practices; this includes specific activities conducted by stakeholders in each stage from design to delivery of programs
Institutional and community ownership	• Host country institutions (inclusive of government, NGOs, civil society, and the private sector) constitute the primary vehicles through which health programs are delivered and take responsibility for each program • Host country institutions adopt and implement transparent, evidence-based policies/regulations for priority areas that align with national plans • Host country institutions manage funds
Capabilities	• Host country has effective workforce, organizations, and systems at all levels able to perform activities and carry out responsibilities that achieve priority health outcomes • National coordinating bodies and local institutions have the ability to gather and analyze epidemiological and program data to plan and measure program progress and results • Host country institutions have the capabilities required to perform or oversee activities for programs • Host country institutions have the ability to dynamically modify programs based on evidence and feedback from monitoring processes
Mutual accountability, including finance	• Host country is responsible to country citizens and international stakeholders for achieving planned results • Host government is responsible for financing and financial stewardship over health • Explicit roles and responsibilities are described with appropriate management of performance in place • Measures are robust • Information and processes are transparent and there are mechanisms for input and feedback from civil society, the private sector and donors

GLOBAL INDICATORS

Each of the working groups were asked to draw from existing required indicators when recommending global indicators. The three global indicators for sustainable, country-owned programs were recently rolled out as part of the new Monitoring, Evaluation and Research Guidance for PEPFAR (table 20). These indicators are collected in country and reporting through the PEPFAR Annual Progress Report (APR). Similar indicators are also captured through the USAID Performance Plan & Report to capture efforts of USAID Forward. The indicators are key measures of local leadership and management, capacity to implement health programs, and the sustainability of health programs. The first indicator measures the participation of civil society, through funding, in the country's health program planning and implementation. The second indicator assesses which partners are funding key components of the various health program supply chain. The third indicator documents the degrees to which the host country government, specific donors, and other groups are responsible for financing health programs. It measures how funds are spent at the national level and identifies the source of the funds. Details about these indicators are provided in the global indicator reference sheets found in annex 6.

Table 20: Sustainability Global Indicators

Dimensions	Indicator	Data Source
Institutional and community ownership	Percentage of civil society organizations receiving HIV program funding	Collected from the host country government, other entities monitoring civil society organizations, National AIDS Spending Assessment (NASA), and/or National Health Accounts (NHA)
Capacities	Estimated percentage of key HIV program supply chain components funded by each partner type	This is collected from the national AIDS Authority, PEPFAR country teams, non-government partners, and/or other supply chain authorities working in the selected program areas. .
Mutual accountability	Domestic and international HIV/AIDS spending by financing sources	Host country government financial tracking systems, National AIDS Spending Assessment, National Health Accounts, and/or other relevant data sources

In addition to the global indicators, there are five indicators that are auto-calculated from USG finance and reporting systems (table 21).

Table 21: Indicators Calculated from USG Finance and Reporting Systems

Dimensions	Indicator
Institutional and community ownership	• Number of local, prime partners with active mechanisms in the given Fiscal Year Country Operations Plan • PEPFAR planned funding, in U.S. dollars, allocated to local, prime partners. • Percent of USG PEPFAR planned funding allocated to local, prime partners • Percentage of PEPFAR targets reported by local, prime partners per indicator. • Percentage of PEPFAR results reported by local, prime partners per indicator.

The ultimate goal of the USG is to support host country partners (including local stakeholders) in planning, overseeing, managing, delivering, and eventually financing a health program responsive to the needs of people to achieve and sustain health goals. These indicators assess the participation of local stakeholders in health programs.

ILLUSTRATIVE INDICATORS

In addition to the three global indicators and five auto-calculated indicators, there are eight illustrative indicators. These illustrative indicators are provided for countries to consider as they select their own indicators to monitor country-specific sustainable country-owned programs that are not required to report to headquarters. The illustrative indicators are not meant to be an exhaustive list of indicators. Rather, they are meant to provide examples of the range of results that can be used to measure program activities (table 22).

Table 22: Illustrative Indicators

Dimensions	Indicator	Data Source
Political ownership	• There is an active donor coordination body • The USG actively participates in national donor coordinating bodies (CCM, Donor Coordination Group, Other)Civil society actively engaged in planning and monitoring the implementation of health programs • The national health strategy is evidence-based, costed and being implemented(at least partially) by the national government	• Generated from an assessment by donor coordinating bodies of USG's active involvement during a given year • International Health Partnership (IHP+) Country Assessments • Generated by the assessment of the critical features of the strategy at a joint USG/host government meeting
Institutional and Community Ownership	• Percent of reported results delivered by a local prime partner/institution • The HCGs commitment to promoting gender equality by providing women and men with the same legal ability to interact with the private and public sector • Local governments effectively provide oversight and implement the national strategy	• Country/USG HMIS • World Bank/Millennium Challenge Corporation Scorecard
Capacities	• Percent of USG supported staff transferred to host country government per year • Donor awards with specific country capacity outcomes stated • Vacancy rate within the ministry of health • Availability of basic services and qualified staff to meet client need • World Bank rating on public sector management and institutions • There is existing local capacity to collect and use health data • Median availability of select generic medicines	• Ministry of health • USG or other donors • Service Provision Assessment • World Bank • Health Metrics Network, M&E System Strengthening Tool, World Bank or other local M&E assessments • WHO
Mutual accountability	• Percent of national budget spent on health • Percent of GDP spent on health • Health information is public and available • Percent of USG required indicators that are aligned with global reporting requirements (WHO, UNAIDS, etc.) and national health monitoring system • Percent of USG health funding disbursed within a timely manner • There is an agreed upon plan for transition in place between USG and HCG for health	• WHO • Open government partnership • Host country government • IHP+ scorecard

CONCLUSION

The seven GHI principles provide a common foundation for interagency health teams as they work to achieve sustainable health outcomes and build lasting country capacity. In order to meet the ambitious global health targets for GHI, country teams are encouraged to consider and apply these principles across their health programs, and monitor and evaluate their contribution to the success of the USG global health efforts.

Application or adoption of these principles will need to be reflective of local country context, and the M&E for these principles will need to be similarly adaptive. The resource guide should prompt teams to think and better conceptualize how local programs and projects link to the global health goals and targets by suggesting a set of illustrative indicators for five of the principles. It is anticipated that these indicators will be reviewed, debated, and revised in keeping with the needs of country programs and their priorities. In selecting indicators, the M&E working groups considered a number of factors including technical soundness, utility for program management, cost/availability of data collection, and harmonization with other frameworks and models. They considered the trade-offs between development of new indicators which might more accurately measure the key results and the use of indicators already collected through M&E or other systems. In principle areas where standardized indicators did not exist, the groups developed new indicators in consultation with technical experts.

The Foreword described this resource document as part of an "evolving conversation". Through piloting and ongoing feedback, these GHI principle indicator sets will continue to be refined to achieve the best balance of these different factors. In this spirit, the country teams and other relevant stakeholders are invited to continue the dialogue by engaging with the GHI Principles M&E Working Groups and participating in the online community located on the Learning Lab (http://usaidlearninglab.org/) to inform and strengthen our understanding of these principles in action.

ANNEX 1: GLOBAL INDICATOR REFERENCE SHEETS FOR GENDER

GLOBAL Indicators
Indicator Name: Proportion of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment)
Indicator Source: ___ New _X__ Existing (Source: Standard Foreign Assistance Indicator)
Definition/Description: *Productive economic resources* include: assets - land, housing, businesses, livestock or financial assets such as savings; credit; wage or self-employment; and income. Programs include micro, small, and medium enterprise programs; workforce development programs that have job placement activities; programs that build assets (such as land redistribution or titling; housing titling; agricultural programs that provide assets such as livestock; programs designed to help adolescent females and young women set up savings accounts). This indicator does NOT track access to services – such as business development services or stand-alone employment training (e.g., that does not also include job placement following the training). Indicator narratives should specify type of assets. The unit of measure will be a proportion, expressed in the format of X/Y. The numerator (X) is the number of program participants that are female. The denominator (Y) is the total number of program participants (both male and female). In cases where all program participants are female and/or where the numerator and denominator are the same, please provide a brief explanation in the narrative.
Linkage to Long Term Outcome or Impact: The lack of access to resources is frequently cited as a major impediment to gender equality and women's empowerment. Tracking the proportion of females among participants in USG funded interventions designed to increase access to economic resources can provide information on the scope of USG efforts to life women out of poverty.
Indicator Type: Output
Use of Indicator: This indicator would be used to measure women's participation in USG-supported programs that provide access to economic opportunity.
Data Source and Reporting Frequency: Data will be collected by USAID implementing partners.
Known Data Limitations: The limitation of this indicator is that it does not track the quality of the program or actual increases or improvements in assets, income, or returns to an enterprise.
Baseline Timeframe: N/A
Disaggregate (s): By age: 10-29; and 30 and over Numerator, Denominator

GLOBAL Indicators

Indicator Name: Number of people reached by a USG funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)

Indicator Source: ___ New _X__ Existing (Source: Standard Foreign Assistance Indicator)

Definition/Description:

This indicator is a count of the individuals served by GBV services.

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Forms of gender-based violence include, but are not limited to, domestic or intimate partner violence; rape as a weapon of war; sexual violence and abuse; female infanticide; psychological or emotional abuse; sexual harassment or violence in the workplace or in educational institutions; and harmful traditional practices including female genital mutilation/cutting, honor crimes, early marriage, forced marriage, bride kidnapping, and dowry-related violence.

Examples of type of service include:

- Legal: Legal advice or accompaniment for survivors of GBV seeking protection or redress through the justice system; advice and assistance regarding divorce laws, restraining orders, remediation for property disputes, among others.
- Health: Includes GBV screening, GBV referral programs that connect GBV survivors with appropriate psychosocial services, legal services, or economic support, and examination and treatment services for rape survivors.
- Psycho-social counseling
- Economic: Skills training or income-generation activities to help establish/re-establish livelihoods for survivors and their families.
- Shelters: Activities to establish or rehabilitate centers where survivors of GBV can seek shelter, information, or services.
- Hotlines

Note: Individuals reached by mass media interventions are not counted in this indicator.

Linkage to Long-Term Outcome or Impact:

Gender-based violence impacts both development and humanitarian assistance objectives and cuts across most technical sectors (e.g., health, education, democracy and governance, economic growth, and disaster response). This indicator indicates the types of services that are being delivered to male and female victims of abuse within and across countries.

Indicator Type: Output

Number of individuals who are provided with the intended intervention as defined in the program description and as prescribed in the intervention or service.

Use of Indicator:

This indicator will enable headquarters to:

- Gain a basic, but essential, understanding of the reach and scale of programs to address various types of services that are provided to male and female victims of abuse within and across countries.
- Provide important, and possibly required, information to Congress and answer inquiries about GBV programming by Congress, external partners, the public, and international organizations.

At the country level, this indicator will enable USG country teams, governments, implementing partners, and other in-country counterparts to:

- Help assess whether interventions are adequately addressing identified needs within the country

based on the country's baseline data on GBV, national strategy, and other information.
- Identify programmatic gaps by analyzing the number and types of people (m/f, age group) being reached by services/interventions.

Data Source and Reporting Frequency:
Data to be collected and reported by implementing partners with programs in any sector (health, humanitarian, education, etc.) that are designed to raise awareness about or prevent gender-based violence.

Known Data Limitations:
The indicator cannot provide information about the quality or intensity of GBV interventions or services. Because the indicator is a basic count without a denominator, and because distinctions between individual-, small group-, and community-level interventions are not being made: program coverage is difficult to estimate and comparisons across programs or countries will be difficult to interpret. Modifying the indicator to be percentage-based (i.e., adding a denominator to count the intended target population) would overcome this limitation. However, the denominator will differ according to the social and cultural contexts in which each program operates and therefore would be difficult to standardize across programs. Additionally, the indicator could be subject to double-counting (e.g., a beneficiary could be reached by both individual- and community-level interventions and counted twice) which could inflate estimates of the number of people reached.

Baseline Timeframe: To be established

Disaggregate (s):
By sex: Male, Female
By age: 10-29; 30 and over

GLOBAL Indicators

Indicator Name: Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities

Indicator Source: ___ New _X_ Existing (Source: Standard Foreign Assistance Indicator)

Definition/Description:

This indicator will be used to gauge the effectiveness of USG efforts to promote gender equality by measuring changes in target population attitudes about whether men and women should have equal opportunities in social, political, and economic spheres. Any program in any sector that has gender equality or women's empowerment as an objective should report against this indicator. This indicator will be particularly relevant to programs that seek to address or change social norms, especially those around gender. Illustrative programs include those designed to raise broad awareness of human rights, programs that train journalists to report more responsibly on gender issues, education programs designed to change social norms and gender roles, programs designed to increase the political participation of women, youth development and empowerment, or behavior change in the health sector, among others.

The unit of measure is a proportion, expressed in the form of X/Y, where the numerator is the number of persons in the target group whose scores on the equal opportunity survey have increased over time and the denominator is the total number of persons who participated in the relevant training/programming.

Indicator Type: Outcome

Linkage to Long-Term Outcome or Impact:

This indicator measures changes in societal attitudes and norms about gender equality that may proxy for deeper structural changes in the social, political, and economic spheres.

Use of indicator:

The indicator will be used to measure the extent that USG supported gender equality and women's empowerment programs are changing attitudes. The information will be used for planning and reporting purposes by bureau-level and in-country program managers, and will support reporting to external stakeholders such as Congress, NGOs, and international organizations.

Data Collection Method/Measurement Method

Data for this indicator will be collected by survey, once at the start of relevant USG-funded training/programming and a second time at the end of the training/programming by implementing partners. The survey may be read to program beneficiaries who are illiterate. Each COTR or AOTR would be responsible for ensuring that implementers collect these data.

Respondents will be asked: To what extent do you agree or disagree with the following three statements (based on a 5 pt scale: strongly disagree, disagree, neither agree nor disagree, agree and strongly agree):

- Women should have equal rights with men and receive the same treatment as men do.
- On the whole, men make better political leaders than women and should be elected rather than women. (r)
- When jobs are scarce, men should have more right to a job than women. (r)

To score the opportunity measure, responses are coded as follows:
-2 = Strongly Disagree
-1 = Disagree
0 = Neither Agree nor Disagree
+1 = Agree

+2 = Strongly Agree

The items with an (r) should be reverse-scored. In other words, those items followed by an "*r*" that have a score of -2 should be recoded as a score of +2, -1 should be recoded as +1, +1 as -1 and +2 as -2. For example, for item 2 ("On the whole, men make better political leaders than women and should be elected rather than women"), a response of 'strongly agree' would be re-coded as "- 2" and a response of 'strongly disagree' would be re-coded as "+2." Responses on each item should be added to yield a score between -3 and 3. A higher score indicates greater agreement that men and women should have equal opportunities.

The proportion of participants whose score increased across time should be reported as a fraction, where the numerator is the number of persons in the target group whose scores have increased across time and the denominator is the total number of participants in the relevant training/programming.

Known Data Limitations
These questions have been validated in the World Values Survey, and AfroBarometer in Africa and Ibero-American surveys in Latin America.

Baseline Timeframe:
The baseline should be set at the beginning of the program.

Disaggregates (s):
Proportions to be disaggregated by sex; numerator, denominator

ANNEX 2: GLOBAL INDICATOR REFERENCE SHEETS FOR HEALTH SYSTEMS STRENGTHENING

GLOBAL Indicators
Indicator Name: Development stage for an essential package of health services in the host country
Indicator Source: _ X__ New ___ Existing (Source: also put forth for USAID HSS bureau mandatory indicator)
Disaggregation: none
Definition/Description: This indicator will provide information on development stage of an essential package of health services at the national level.
Purpose of the indicator: Essential package of health services (EPHS) aim to concentrate scarce resources on interventions which provide the best value for the money spent on health. By doing this EPHSs are expected to achieve multiple goals: improve efficiency; equity; political empowerment, accountability, and more effective care. EPHSs are designed to be a guaranteed minimum of care for the population.[11] The movement for universal health coverage also requires measurement of a service package. While the essential services for UHC have yet to be defined, efforts to measure the existence of a country-specific essential package of health services can provide the groundwork for measurement of other dimensions of UHC, such as population coverage.
Data Collection Method/Measurement Method National policy records and documents pertaining to an essential package of health services The services that are included in the EPHS should depend on the epidemiological profile of the country and where USAID has invested in specific interventions. Review of national policy records and documents to determine the stage of an essential package of health services using the options below. Select the number that best represents the country development stage for an essential package of health services: 1. It is not indicated at national policy level 2. It is indicated at national policy level; package is defined 3. Includes all high impact cost effective interventions USAID supports [includes 2] 4. It includes guidance on how to implement package [also includes 2 and 3] 5. It is operationalized [also includes 2, 3, and 4] 6. It has dedicated funding, included in national health insurance schemes [also includes 2, 3, 4 and 5]
Limitations, Challenges, Caveats This is a newly developed and not yet piloted indicator and therefore the full extent of its limitations, challenges and caveats will be fleshed out upon field testing. ESPH will vary by country context More money for health, and more health for the money 2009 *http://www.who.int/tobacco/economics/en_tfi_economics_final_task_force_report.pdf* Constraints to Scaling Up Health Related MDGs *http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf* Indicators for Measuring Universal Health Coverage: A Five-Country Analysis, Health Systems 20/20, September 2012. *http://www.healthsystems2020.org/userfiles/Indicators%20for%20UHC%20Draft%20Report_Sept27.pdf*

[11] WHO Service Delivery Seminar Series, Essential Health Packages: What are they for? What do they change?, Technical Brief No. 2, 3 July 2008.

GLOBAL Indicators

Indicator Name: Service-Specific Readiness

Indicator Source: __X_ New ___ Existing (Source: Source: Service Provision Assessment (SPA) health facility survey or Service Availability and Readiness Assessment (SARA) health facility survey)

Definition/Description: Service-specific Readiness refers to the ability of health facilities to offer a specific service and the capacity to provide that service measured through selected tracer items that include trained staff, guidelines, equipment, diagnostic capacity, and medicines and commodities.

Potential specific intervention areas (note that the below are potential this would be tailored to country context:

- Routine child immunization
- PMTCT
- Labor and Delivery/obstetrics care
- Malaria prevention and treatment
- Family planning
- Antenatal care
- Child health (preventative and curative)
- Tuberculosis
- HIV (counseling and testing, care and support)

Purpose of the indicator:

Both the Service Provision Assessment (SPA) and the Service Availability and Readiness Assessment (SARA) are health facility assessment tools designed to assess and monitor the service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system. The SARA and the Inventory Questionnaire component of the SPA are harmonized and designed to generate a set of tracer indicators of service availability and readiness. The objective is to generate reliable and regular information on service delivery (such as the availability of key human and infrastructure resources), on the availability of basic equipment, basic amenities, essential medicines, and diagnostic capacities, and on the readiness of health facilities to provide basic health-care interventions relating to family planning, child health services, basic and comprehensive emergency obstetric care, HIV, TB, malaria, and non-communicable diseases.

Data Collection Method/Measurement Method

For SARA and SPA surveys (and health facility surveys in general) it is important to have a master facility list. A census of facilities may be required to establish this list. The recommended design methodology for collecting information on service readiness is a sample survey. Sampling from the master list is done in a systematic way to ensure that the findings are representative of the country and region/district in which the survey is being conducted. Health facility assessments use a standardized questionnaire to assess the availability and functioning of the tracer items in each domain of general service readiness (e.g. WHO core tool for Service Availability and Readiness Assessment). Service readiness should be monitored annually at the subnational level as a management tool. National statistics should be updated every 2-3 years, through regular reporting by districts, sample surveys and a census once every 3-5 years to validate all information.

Limitations, Challenges, Caveats

Time-consuming and costly; information most useful at national level; long intervals between surveys Drawing a random sample of health facilities will be much more complicated if the country does not have a comprehensive and up-to-date master facility list. Therefore, it is highly recommended to invest in establishing a master facility list that includes all public and private facilities.

http://www.who.int/healthinfo/systems/WHO_CreatingMFL_draft.pdf
http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/service-delivery-ii.h.1/service-availability-and-readiness-assessment-sara
http://www.who.int/healthinfo/systems/SARA_Reference_Manual_Chapter4.pdf?ua=1
http://measuredhs.com/publications/publication-spaq5-spa-questionnaires.cfm

GLOBAL Indicators
Indicator Name: Ratio of household out-of-pocket payments for health to total expenditure on health
Indicator Source: ___ New _X__ Existing (Source: http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/hss/the-ratio-of-household-out-of-pocket-payments-for -health
Disaggregation: none
Definition/Description: Out-of-pocket expenditure measures households' direct payments for health expenditure. Measured as a proportion of total health expenditure, out-of-pocket expenditure is an indicator of financial protection.
Purpose of the indicator: When people make direct payments for health care, through fees or co-payments, the amount can be so high in relation to income that it results in catastrophic health expenditure for the individual or the household. Catastrophic expenditure is defined by WHO as out-of-pocket health expenditures in excess of 40 percent of income, and can require households to reallocate expenditures from basic needs such as food, clothing, or children's education. Catastrophic health expenditure also can lead to impoverishment. When out-of-pocket expenditure is high, many people may decide not to use services, simply because they cannot afford either the direct costs, such as for consultations, medicines and laboratory tests, or the indirect costs, such as for transport and special food. Poor households are likely to sink even further into poverty because of the adverse effects of illness on their earnings and general welfare.
Data Collection Method/Measurement Method Total health expenditure can be collected from NHAs. However, not all countries conduct or update national health accounts regularly and in these instances, estimates from WHO's Global Health Expenditures Database are most reliable. Data on households' direct payments for health care are collected in household surveys conducted as part of an NHA exercise or in a related survey. This indicator is calculated as: The direct payments by households for health care / Total household expenditure on health x 100
Limitations, Challenges, Caveats Data collection for household income and expenditures is subject to sampling error, non-sampling error, and reporting error. This indicator does not disaggregate household out-of-pocket spending by income quintile and masks disparities in household out-of-pocket spending across income quintiles. In many countries the quintile with the lowest income (or total expenditures) also has a lower incidence of catastrophic payments than richer quintiles. People who are very poor often do not use services for which they have to pay, and thus do not experience a financial catastrophe (although they may suffer health consequences if they have inadequate care). As people have slightly more income, they may begin to use services and experience adverse financial consequences linked to paying for care.

GLOBAL Indicators

Indicator Name: Responsiveness as measured by client satisfaction

Indicator Source: _X__ New ___ Existing

Disaggregation: Disaggregation is required by the type of service received: ANC, FP, Sick Child, STI Optional areas of disaggregation countries may want to include:
Facility Type -- Hospital, health center/maternity, Clinic/dispensary
Managing Authority -- Government, Private not-for-profit (includes NGO and faith-based), Private for-profit
Region/Province -- by country regions/provinces
Urban, peri-urban, rural

Definition/Description:
Clients who received health care service(s) are interviewed as they exit the health facility in which they received the service(s). During the interview, clients are asked their opinion of the service they received and rank the service on three levels:
(1) I am very satisfied with the services I received;
(2) I am satisfied with the services I received; or
(3) I am not satisfied with the services I received

This indicator produces three measures:
1) Percentage of clients who ranked their satisfaction with the service(s) they received as "very satisfied";
2) Percentage of clients who ranked their satisfaction with the service(s) they received as "satisfied"; and
3) Percentage of clients who ranked their satisfaction with the service(s) they received as "not satisfied".

Numerator:
1) The number of clients who ranked their satisfaction with the service(s) they received as "very satisfied";
2) The number of clients who ranked their satisfaction with the service(s) they received as "satisfied"; and
3) The number of clients who ranked their satisfaction with the service(s) they received as "not satisfied".

Denominator:
Total number of clients who were interviewed.

The indicator is calculated as = (numerator/denominator) x 100

Purpose of the indicator:
One of the goals of a health system is to improve the responsiveness of the system to people's needs and expectations. This particular indicator will be used as a proxy for system responsiveness. This indicator is designed to monitor whether or not clients are satisfied with the service delivery environment.

Data Collection Method/Measurement Method
The measurement tool is a standardized questionnaire administered to clients as they exit the health facility. The standardized questionnaire can be adapted to the service delivery area(s) of interest; for example, antenatal care (ANC); family planning (FP); care of a sick child; or delivery services; etc.

An example is the Exit Interview questionnaire that is part of the Service Provision Assessment (SPA) healthy facility survey. The SPA Exit Interview is three separate questionnaires to measure client satisfaction for three different groups of clients: clients who received ANC services, clients who received FP services, and clients who received services for a sick child. http://measuredhs.com/publications/publication-spaq3-spa-questionnaires.cfm

Client exit interviews are administered to a sample of clients that are present in a health facility on the day of the survey, and the survey is administered in a sample of health facilities within the geographic or administrative area of interest. Depending on data needs, the sample of health facilities can be designed to represent a smaller administrative or intervention area or a larger area such as the regional or national level.

For example, SPA surveys are nationally representative sample surveys of formal sector health facilities. Typically, SPA surveys collect data from 400-700 facilities, selected from a comprehensive list of health facilities in a country

(sampling frame), categorized by facility type, managing authority (public and non-public), and by region. Usually, hospitals are oversampled as they exist in small numbers in a country. Subsequently, the data are weighted during analysis in order to ensure that the data are proportionally representative when presented. To do this, a multiplier (weight) is applied to the data to ensure that the contribution of facilities to the total is proportionate to their existence in the country.

Limitations, Challenges, Caveats

This can be a complex indicator to measure to do the various contextual factors that influence satisfaction of clients. Client satisfaction does not always directly relate to quality of care. Note that this measure does not cover issues related to overall organization of services such as patient appointment systems, waiting times, quality of service provision and courtesy.

Patients often do not have the time to complete an exit interview thoughtfully or may experience fatigue post clinic visit or have privacy concerns related to being completely honest. Clients may overstate their level of satisfaction (courtesy bias) and this affect validity of the measure.

ANNEX 3: GLOBAL INDICATOR REFERENCE SHEETS FOR INTEGRATION

GLOBAL Indicators

Indicator Name: Indicator Name: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services

Indicator Source: _X_ New ___ Existing (Source:)

Definition/Description:

Explanation of Numerator:

Definition: PEPFAR-supported HIV service delivery point

A PEPFAR-supported service delivery point uses PEPFAR funds to directly provide HIV-related services. It offers one or more HIV-related service including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV; anti-retroviral treatment (ART); screening and prophylaxis for opportunistic infections (OI); and other health services for people living with HIV (e.g. positive health, dignity and prevention (PHDP), nutrition support, etc.). It can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include clinics, hospitals, health facilities and community-based organizations (government, private or NGO). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point.

Definition: Voluntary Family Planning Service Provision

In order to be considered as a PEPFAR-supported service delivery point that directly provides integrated voluntary family planning services, **all 3 criteria below must be met**. If a service delivery point provides fewer than 3 of the services noted below, it should not be counted under this indicator.

The PEPFAR-supported HIV service delivery point must provide for all relevant clients, including partners in HIV discordant couples (as documented by standard operating procedures, guidelines, protocols, manuals and/or intake documents, etc.):

1. Assessment of voluntary family planning needs through routine screening;
2. Provision of voluntary family planning counseling (including safe pregnancy counseling for those wishing to become pregnant, or those who are pregnant);
3. Provision of a broad range of modern contraceptive methods, in accordance with the National FP policy guidelines, for clients who voluntarily wish to delay or prevent pregnancy either directly or through referral that includes detailed information (e.g. facility location, hours of operation, etc.) about where methods not available at the site can be accessed.

Definition: Assess Voluntary Family Planning Needs

In assessing family planning needs, all clients as part of their routine care visit should be asked about topics that can include (depending upon the individual client and his or her needs): reproductive goals; prior pregnancies; living and family situation; family planning knowledge; previously used family planning methods and satisfaction with use; and any family planning-related concerns.

Definition: Provide Voluntary Family Planning Counseling (including Safe Pregnancy Counseling)

Quality voluntary FP counseling should cover a wide range of topics that are client and context specific, and that

include both safe pregnancy counseling for individuals who wish to become pregnant as well as contraception for individuals who wish to avoid, space or delay pregnancy. Voluntary FP counseling should follow highest standards and best practices outlined in the "Additional References" section below.

Definition: Provide Modern Contraceptive Methods

Per U.S. Government legislation, and in line with national FP policies, a broad range of methods should be provided to clients, allowing them to choose the method most appropriate for them, either directly or through referral. All referrals should include detailed information about where methods not available at the site can be accessed (e.g. facility location, operating hours, etc.).

Definition: Clinical and community service delivery points

A **clinical service delivery point** can be a public or private: tertiary level hospital, second level referral hospital (provincial or regional hospital), first level hospital (district level hospital), hospital affiliated health center/satellite clinic, health center (urban/rural), clinic, or health post/dispensary.

A **community service delivery point** can be any public or private non-clinical site where an HIV-related service is offered (e.g. HIV testing and counseling, HIV care and support, treatment, PHDP, etc.). This can include (but is not limited to) PEPFAR-supported community-based NGOs and FBOs (e.g. community support groups, women's groups, collectives, community health workers, etc.). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point.

Special Considerations:

1. **HIV/FP Integration Principles**

As articulated in the FY14 COP guidance, USG-supported family planning and HIV/AIDS programs must adhere to the following principles:

- People living with HIV (PLHIV) and their partners should be provided with information on, and be able to exercise voluntary choices about their health, including their reproductive health.
- The USG, including PEPFAR, supports a person's right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as use of family planning methods, regardless of HIV/AIDS status.
- Family planning use should always be a choice, made freely and voluntarily, independent of the person's HIV status.
- The decision to use or not to use family planning should be free of any discrimination, judgment, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
- Access to and provision of health services, including antiretroviral treatment, for PLHIV should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of antiretroviral treatment and other drug interactions).
- PLHIV who wish to have children should have access to safe and non-judgmental pregnancy counseling services.

2. **Compliance with U.S. Government Legislative Requirements**

All USG personnel and PEPFAR implementing partners should be aware of legal restrictions and program requirements relating to family planning, and should consult with relevant Agency legal counsel with any questions in this area. Implementing Agencies must ensure that staff are trained as needed on compliance with relevant provisions, and that implementing partners are made aware of the provisions. (see http://www.usaid.gov/what-we-do/global-health/family-planning/usaids-family-planning-guiding-principles-and-us-0.)

Documentation

The PEPFAR-supported HIV service delivery point must be able to document (through information that can include standard operating procedure, guidelines, protocols, manuals and/or intake documents, etc.) **that it does all of the following:**

1. Assessment of voluntary family planning needs.
2. Provision of voluntary family planning counseling (including safe pregnancy counseling for those wishing to become pregnant, or those who are pregnant).
3. Provision of a broad range of contraceptive methods for clients who voluntarily wish to delay or prevent pregnancy either directly or through referral that includes detailed information about where methods not available at the site can be accessed.

Training

The PEPFAR-supported HIV service delivery point must be able to demonstrate through information that can include training manuals, training records, curricula, certification, etc. that it provides adequate training to ensure staff competency in family planning counseling and service provision and compliance with any national guidelines, protocols, etc., concerning the provision of related services., and that such staff competencies are updated on a routine basis.

Explanation of Denominator:

The denominator is the number of PEPFAR-supported HIV service delivery points. This should be aggregated by the USG team as part of the reporting process, not by the implementing partner. With the denominator, this indicator can be used to determine an overall percentage of integrated voluntary family planning services as a measure of coverage.

Disaggregated by :

1. **By Service Delivery Type:**
    a. ***Clinical*** (as defined under Method of Measurement)
    b. ***Community*** (as defined under Method of Measurement)
2. **Type of PEPFAR support:** Direct Service Delivery, Technical Assistance-only *(disaggregation required for both numerator and denominator)*

Purpose of the indicator:

This output indicator provides basic information on the coverage of voluntary family planning (FP) services within PEPFAR-supported service delivery points.

The indicator aims to measure progress towards integrating voluntary family planning within the PEPFAR platform at the service delivery level. It thus captures information about service components that are available, rather than service uptake among individual patients in order to avoid setting targets and support voluntarism in family planning.

This indicator will enable headquarters, PEPFAR country teams, national governments, and other implementing partners to:

- Gain a basic, but essential, understanding of trends in coverage of family planning services among PEPFAR-supported service delivery points.
- Provide information on the integration of HIV and family planning services that can be reported to key stakeholders.
- Identify programmatic HIV/FP gaps, including countries or regions with low levels of HIV/FP integration.
- Assess the need for strategically focused technical assistance concerning the integration of HIV/FP services.
- Advocate for greater resources and technical assistance for the integration of family planning within the PEPFAR platform.

This indicator will be used to monitor coverage of HIV/FP integration at a global level. Therefore, detailed information on completion of referrals, FP service uptake, types of contraceptive methods offered on site, and other critical components of integrated programs will not be captured.

Data Collection Method/Measurement Method

Monitoring tools, such as forms, check lists, log books, spreadsheets, etc. developed by Ministries of Health and/or implementing partners (adapted as necessary).

Limitations, Challenges, Caveats

GLOBAL Indicators

Indicator Name: Indicator Name: Number of HIV service delivery points that have integrated at least one non-HIV service other than family planning

Indicator Source: _X_ New ___ Existing (Source:)

Definition/Description:
Number of USG supported HIV service delivery points providing HIV prevention, care and treatment services that are directly providing at least one non-HIV service. The different categories of non-HIV services are listed and described below under Disaggregation.

Disaggregated by :

A) The type of service delivery point that is providing HIV services:

1. **Hospital:** including tertiary/third level hospital, second level referral hospital (e.g. provincial hospital), first level hospital (e.g. district level hospital)
2. **Health center:** including hospital affiliated health center, health center (urban/rural)
3. Clinic
4. Health post/dispensary
5. **Community service delivery point:** A community service delivery point can be any non-clinical site where health services are offered. This can include (but is not limited to) USG-supported community-based NGOs and FBOs (e.g. community support groups, women's groups, collectives, etc.).

B) The type of non-HIV service that is being integrated:

3. **Family Planning and Reproductive Health**: availability of contraceptives and supplies, counseling and client assessment, diagnosis and treatment of STIs
4. **Tuberculosis**: availability of TB diagnostic services, availability of first line medicines for treating TB
5. **Child Health**: availability of vaccines, medicines, and Vitamin A, availability of curative care services and the availability of equipment and supplies for outpatient care, adherence to guidelines for sick child care
6. **Maternal and Newborn Health**: availability and appropriate assessment of clients for antenatal care, delivery services, newborn care, emergency obstetric care
7. **Malaria**: availability of malaria diagnostic and treatment services, guidelines, antimalarial, laboratory diagnostic capacity
8. **Non-communicable diseases**: diabetes, cardiovascular diseases and chronic respiratory diseases
9. Other services

Purpose of the indicator:
This indicator maps to the Coverage and Access outcome of the GHI Integration Principle Results Framework. The indicator aims to measure progress towards integrating non-HIV services into the HIV platform at the service delivery level.

This indicator will enable USG, national governments and other implementing partners to:

- Gain a basic, but essential, understanding of whether over time the number of USG supported HIV service delivery points providing non-HIV services is increasing;

- Provide information on the integration of HIV with non-HIV related services to Congress and other key stakeholders;
- Identify programmatic gaps in HIV integration; and
- Assess the need for strategically focused technical assistance concerning the integration of HIV and non-HIV services

Data Collection Method/Measurement Method

Monitoring tools such as forms, checklists, log books, spreadsheets, etc. that partners develop or already use in support of the national system.

Limitations, Challenges, Caveats

The indicator does not provide information on the model of integration (e.g. one-stop shop, co-location of services, linking services across sites etc.) which may vary from country to country and even context to context within a country. While it monitors the availability of non-HIV services in primarily HIV service delivery points, it does not assure that all needed services are being adequately provided to clients, nor does it provide information on the quality of services provided (whether HIV or non-HIV services). The indicator also does not monitor linkages and referrals to non-HIV services.

GLOBAL Indicators

Indicator Name: Number of MNCH service delivery points that have integrated at least one other type of service

Indicator Source: _X__ New ___ Existing (Source:)

Definition/Description:

The number of USG supported service delivery points primarily providing MNCH services that are directly providing at least one other type of service, in addition to the services included in the MNCH platform.

Other service refers to additional services that the MNCH service delivery point is integrating into its package of services, as defined by the MOH. The different categories of other services are listed and described below under Disaggregation.

Disaggregated by:

A) The type of service delivery point that is providing MNCH services:

1. Antenatal care clinic
2. Labor and delivery ward
3. Post-natal care clinic
4. Immunization clinic
5. Well-child clinic

B) The type of other service that is being integrated:

1. **Family Planning and Reproductive Health:** availability of contraceptives and supplies, counseling and client assessment, diagnosis and treatment of STIs
2. **HIV/AIDS:** availability HIV testing services, HIV/AIDS care and support services, antiretroviral treatment, prevention of mother-to-child-transmission, post-exposure prophylaxis
3. **Malaria:** availability of malaria diagnostic and treatment services, guidelines, antimalarial, laboratory diagnostic capacity
4. **Tuberculosis:** availability of TB diagnostic services, availability of first line medicines for treating TB
5. **Non-communicable diseases:** diabetes, cardiovascular diseases and chronic respiratory diseases
6. Other services

Purpose of the indicator:

This indicator maps to the **Coverage and Access** outcome of the GHI Integration Principle Results Framework. The indicator aims to measure progress towards integrating other types of services to MNCH services at the service delivery level.

This indicator will enable USG, national governments and other implementing partners to:

- Gain a basic, but essential, understanding of whether over time the number of USG supported service delivery points primarily providing MNCH services are integrating other types of services into the MNCH platform;
- Provide information on the integration of MNCH services with other services to Congress and other key

stakeholders;

- Identify programmatic gaps in MNCH integration; and
- Assess the need for strategically focused technical assistance concerning the integration.

Data Collection Method/Measurement Method

Monitoring tools such as forms, checklists, log books, spreadsheets, etc. that partners develop or already use in support of the national system.

Limitations, Challenges, Caveats

The indicator does not provide information on the model of integration (e.g. one-stop shop, co-location of services i.e. multiple services on site provided by different service providers, linking services across sites etc.) which may vary from country to country and even context to context within a country. While it monitors the availability of other types of services being provided at MNCH service delivery points, it does not assure that all needed services are being adequately provided to clients nor does it provide information on the quality of services (MNCH or other). The indicator also does not monitor linkages and referrals to other service delivery points.

GLOBAL Indicators

Indicator Name: Number of clients who received two or more services during a single service delivery point visit.

Indicator Source: _X_ New ___ Existing (Source:)

Definition/Description:

Number of clients visiting a USG supported service delivery point who reported having received two or more services during a single visit. At least two of the services received should be from two different service areas. The different types of service areas are:

Child Health: availability of vaccines, medicines, and Vitamin A, availability of curative care services and the availability of equipment and supplies for outpatient care, adherence to guidelines for sick child care

Maternal and Newborn Health: availability and appropriate assessment of clients for antenatal care, delivery services, newborn care, emergency obstetric care

Family Planning and Reproductive Health: availability of contraceptives and supplies, counseling and client assessment, diagnosis and treatment of STIs

HIV/AIDS: availability HIV testing services, HIV/AIDS care and support services, antiretroviral treatment, prevention of mother-to-child-transmission, post-exposure prophylaxis

Malaria: availability of malaria diagnostic and treatment services, guidelines, antimalarial, laboratory diagnostic capacity

Tuberculosis: availability of TB diagnostic services, availability of first line medicines for treating TB

Non-communicable diseases: diabetes, cardiovascular diseases and chronic respiratory diseases

Disaggregated by:

A) The type of service delivery point:

1. **Hospital:** including tertiary/third level hospital, second level referral hospital (provincial hospital), first level hospital (district level hospital)
2. **Health center:** including hospital affiliated health center, health center (urban/rural)
3. Clinic
4. Health post/dispensary
5. **Community service delivery point:** A community service delivery point can be any non-clinical site where health services are offered. This can include (but is not limited to) PEPFAR-supported community-based NGOs and FBOs (e.g. community support groups, women's groups, collectives, etc.).

Purpose of the indicator:

This indicator maps to the **Uptake and Responsiveness/Quality** outcomes of the GHI Integration Principle Results Framework.

The indicator is used to monitor if there have been improvements in the accessibility/readiness of services to meet the holistic needs of clients when they visit a service delivery point.

Data Collection Method/Measurement Method

In most cases this indicator will need to be collected through a special study involving a client exit interview or similar data collection method. If that is the case and the indicator is based on a self-report, the indicator would be more appropriately worded as, "number of clients who reported receiving two or more services during a single facility visit".

In countries that have health systems where every client is assigned a unique patient identifier that is linked to the client's patient records and files, it may be possible to extract this indicator directly from facility records, either during a regular supervision visit or during a dedicated data collection visit, instead of conducting client interviews.

Limitations, Challenges, Caveats

The indicator monitors if clients receive at least two services during a facility visit but doesn't track what type of services they received, whether the services they received were needed or the quality of the services.

ANNEX 4: GLOBAL INDICATOR REFERENCE SHEETS FOR PARTNERSHIPS

GLOBAL Indicators

Indicator Name: Total number of USG-supported partnerships in the current fiscal year of reporting (that support USG planned health outcomes)

Indicator Source: USG-supported partnership documents; program reports (these should be kept available for verification purposes)

___ New partnership in this fiscal year ___ Existing partnership in this fiscal year

Disaggregation: by **new** and **previously** existing per fiscal year

Definition/Description:

The total number of partnerships active within a fiscal year (that support GHI health targets)

Partnership is an arrangement involving two or more parties acting together to achieve a common goal and/or objective by bringing to bear a set of complementary assets. Ideally, each partner offers assets that draw on its core institutional capabilities. Moreover, the process of partnering produces a concrete value-added that benefits all partners, helping each to achieve something that no single partner could have achieved on its own. Similarly, each partner is better able to achieve its own objectives than it could have operating solo. Stakeholders acting together toward common purpose is the heart of a partnership endeavor.

A **USG-supported partnership** is one in which the USG is a partner per the definition above and works through a partnership to achieve USG health targets.

Purpose of the indicator:

- This indicator maps to the Partnership Outcomes of the Partnership Result Framework (07/08/13)
- The indicator is used to monitor the total number of partnerships active in a fiscal year.

Data Collection Method/Measurement Method

Reporting/Program Unit self-reporting on the number of currently existing partnerships with other institutions with which USG engages to achieve the GHI health targets (NTDs, TB, Malaria, Maternal health, Child Nutrition, MCPR, HIV/AIDS).

The Reporting/Program Unit will fill out a form sent to them by USG to report on this indicator.

Limitations, Challenges, Caveats

This indicator collects the number of USG-supported partnerships in a fiscal year but does not track the longevity of such partnerships, measure the quality of partnership, or prove causality of their intended health outcome.

Note: Partnerships are framed per the nature of engagement not the acquisition or assistance mechanism by which a USG agency enters into the relationship.

This indicator and the indicator titled*: total number of **NEW** USG-supported partnerships in the current fiscal year of reporting (that support USG planned health outcomes)* should NOT be combined to avoid double counting.

GLOBAL Indicators

Indicator Name: Number of **NEW** partnerships out of the total number of USG-supported partnerships in the current fiscal year of reporting (that support USG planned health outcomes)

Indicator Source: USG-supported partnership documents; program reports (these should be kept available for verification purposes)

___ New partnership in this fiscal year

Disaggregation: none

Definition/Description:

The number of **NEW** partnerships entered within a fiscal year (that support GHI health targets)
Partnership is an arrangement involving two or more parties acting together to achieve a common goal and/or objective by bringing to bear a set of complementary assets. Ideally, each partner offers assets that draw on its core institutional capabilities. Moreover, the process of partnering produces a concrete value-added that benefits all partners, helping each to achieve something that no single partner could have achieved on its own. Similarly, each partner is better able to achieve its own objectives than it could have operating solo. Stakeholders acting together toward common purpose is the heart of partnership endeavor.

A **USG-supported partnership** is one in which the USG is a partner per the definition above and works through a partnership to achieve USG health targets.

Purpose of the indicator:

- This indicator maps to the Partnership Outcomes of the Partnership Result Framework (version 07/08/13).
- The indicator is used to monitor the number of **NEW** partnerships created in a fiscal year to track change/growth in the volume of partnership activity contributing to GHI health targets.

Data Collection Method/Measurement Method

Reporting/Program Unit self-reporting on the number of **NEW** partnerships with other institutions with which USG engages to achieve the GHI health targets (NTDs, TB, Malaria, Maternal health, Child Nutrition, MCPR, HIV/AIDS). The Reporting/Program Unit will fill out a form to report on this indicator.

Limitations, Challenges, Caveats

This indicator collects the number of **NEW** USG-supported partnerships in a fiscal year but does not track the longevity of such partnerships, measure the quality of partnership, or prove causality of their intended health outcome.

Note: Partnerships are framed per the nature of engagement not the acquisition or assistance mechanism by which a USG agency enters into the relationship.

This indicator and the indicator titled: *Total number of USG-supported partnerships in the current fiscal year of reporting (that support USG planned health outcomes)* should NOT be combined to avoid double counting.

GLOBAL Indicators

Indicator Name: Total number of partnerships (that support USG planned USG health outcomes) disaggregated by type of partner

a. With Public sector (host country's governmental bodies and levels) institutions
b. With Public sector Regional or International institutions
c. With Private For-profit Domestic institutions
d. With **Private For-profit International** corporations and other for-profit institutions
e. With Private Not-for-profit Domestic institutions
f. With Private Not-for-profit International institutions

Indicator Source: USG-supported partnership documents; program reports (these should be kept available for verification purposes)

___ New partnership in this fiscal year ___ Existing partnership in this fiscal year

Disaggregation: See a-f below; please disaggregate also between new partnerships and existing partnerships as stated in the line above.

Definition/Description:
The total number of partners by type engaged within a fiscal year that support GHI health targets.

a. ***Public sector (host country's governmental bodies and levels)*** *institutions* including but not limited to: Ministries, regulatory agencies, legislative bodies, leading politicians and public officials, and political parties and committees at the national, provincial, district, local, etc. levels.

b. ***Public sector Regional or International*** *institutions* advancing public goods including bilateral donor agencies, regional cooperative institutions such as the African Union, financial institutions such as the World Bank, and bilateral and regional trade platforms.

c. ***Private For-profit Domestic*** *institutions* including local indigenous businesses, private health facilities and laboratories, consulting firms, banks, investors, and investment funds. This definition excludes local branches of multinational companies (see d.) and local not-for-profit institutions (see e.).

d. ***Private For-profit International*** *corporations and other for-profit institutions* that work in or with in-country partners including but not limited to multinational corporations, consulting firms, and investment banks.

e. ***Private Not-for-profit Domestic*** *institutions* including indigenous NGOs, PVOs, CBOs, faith-based organizations, labor unions, industry trade groups, associations, think tanks, universities, and similar organizations.

f. ***Private Not-for-profit International*** *institutions* that work in or with in-country partners, including but not limited to philanthropic foundations (i.e., the Bill and Melinda Gates Foundation), international NGOs, and international social investment funds (i.e., Acumen).

Purpose of the indicator:

- This indicator maps to the Partnership Outcomes of the Partnership Result Framework (version 07/08/13)
- This indicator monitors the types of organizations with which the USG engages in partnership to achieve the GHI health targets.

Data Collection Method/Measurement Method

Reporting/Program Unit reporting on the types of organizations with which the USG engages in partnership to achieve the GHI health targets (NTDs, TB, Malaria, Maternal health, Child Nutrition, MCPR, HIV/AIDS).

Notes on measurement:

a. With Public sector (host country's governmental bodies and levels) institutions (Data Entry Codes: Yes= 1, No=0)
b. With **Public sector Regional or International** institutions (Data Entry Codes: Yes= 1, No=0)
c. With **Private For-profit Domestic** institutions (Data Entry Codes: Yes= 1, No=0)
d. With **Private For-profit International** corporations and other for-profit institutions (Data Entry Codes: Yes= 1, No=0)
e. With **Private Not-for-profit Domestic** institutions (Data Entry Codes: Yes=1, No=0)
f. With **Private Not-for-profit International** institutions (Data Entry Codes: Yes= 1, No=0)

The Reporting/Program Unit will fill out a form to report on this indicator.

Limitations, Challenges, Caveats

This indicator tracks over time the types of organizations with which the USG partners to achieve the GHI health targets. It does not count the number of partnerships of each type but provides a general picture of the range of stakeholders with which the USG engages.

Note: Partnerships are framed per the nature of engagement not the acquisition or assistance mechanism by which a USG agency enters into the relationship.

ANNEX 5: GLOBAL INDICATOR REFERENCE SHEETS FOR RESEARCH AND INNOVATION

GLOBAL Indicators
Indicator Name: Publically Available Collaborative Research & Innovation Priorities/Agenda
Indicator Source: NEW (Y/N)
Definitions: National (host country) R&I priorities/agenda should clearly articulate specific problems to be addressed; evidence needed, and anticipated impact on public health targets, and goals.
Purpose of the indicator: This is a Yes/No indicator which is designed to indicate the presence of a document which outlines multi-year, country specific, public, research and innovation priorities. Publically available R&I priorities help to identify, clarify, and communicate the locally relevant research and innovation priorities that when addressed will result in accelerated progress toward global health goals and targets. R&I priorities must reflect host country public health priorities and challenges. The development of a publically available R&I agenda is often a mechanism for attracting significant stakeholders to challenge areas and promoting R&I and may help USG teams identify relevant evidence, knowledge gaps, and the local technical assistance needed around country health research priorities, and ultimately close the gap between evidence and policy
Data Collection Method/Measurement Method Data will be collected from the host country government and USG records. Data will be submitted on an annual basis by the Embassy
Limitations, Challenges, Caveats The indicator is static and therefore will not demonstrate progress over time.

GLOBAL Indicators
Indicator Name: Is there a publically available inventory of all USG-supported research in country, updated annually, no later than the end of the fiscal year?
Indicator Source: NEW (Y/N)
Definitions: The inventory of USG-supported research (as defined by the funding agency) should include a list of all research, even partially funded, by any of the USG agencies working in that specific country. This list should be published at least annually, no later than the fiscal year, but could be updated more regularly if applicable.
Purpose of the indicator: This is a Yes/No indicator which is designed to indicate the presence of a document that has been updated within the last fiscal year. Making this list publically available should facilitate better coordination around research priorities in the country and funding of those priorities. It should also facilitate linkages between related research topics to maximize results and the utility of the findings. Finally, it should serve as a tool to avoid duplication of effort within the research field in order to maximize the funding in this area.
Data Collection Method/Measurement Method Data will be collected from records from the different USG agencies working in country. Data will be submitted on an annual basis.
Limitations, Challenges, Caveats The indicator is static and therefore will not demonstrate progress over time.

ANNEX 6: GLOBAL INDICATOR REFERENCE SHEETS FOR SUSTAINABILITY

Country Ownership.

Mutual Accountability Dimension		
Indicator code: **CO_FIN_NAT**	**1**	Domestic and international HIV/AIDS Spending by financing sources
Purpose: This indicator documents the degrees to which the host country government, specific donors and other groups are responsible for financing the HIV program. It measures how funds are spent at the national level and identifies the source of the funds.		
NGI Mapping:	H3.1.N continuing – same indicator	
PEPFAR Support Target/Result Type:	N/A	
Numerator:	**1**	Total domestic and international HIV/AIDS spending
Denominator:	N/A	
Disaggregation(s):	**1**	**Funding source:** • Domestic public • Domestic private out-of-pocket expenditures • Global fund • Non- Global Fund multilateral • PEPFAR • Non- PEPFAR bilateral • Other international
Data Source:	Host country government financial tracking systems, National AIDS Spending Assessment, National Health Accounts, and/or other relevant data sources	
Data Collection Frequency:	Annually	
Method of Measurement: The data for this indicator may come from the HCG and/or National AIDS Council financial tracking systems, from National AIDS Spending Assessment (NASA) data, from National Health Accounts (NHA) data, and/or from other relevant data sources available. Details on NASAs and NHAs are given below. Because availability and/or quality of these expenditure data are expected to vary, it is very important to include in the accompanying narrative for this indicator when submitting targets and results both the source of the data and quality of the data. **NASA** The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix. Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources:		

1. Prevention
2. Care and treatment
3. Orphans and vulnerable children
4. Program management and administration strengthening
5. Incentives for human resources
6. Social protection and social services (excluding orphans and vulnerable children)
7. Enabling environment and community development
8. Research (excluding operations research included under program management)

Three main groups of financing sources:

1. Domestic public
2. International
3. Domestic private (optional for global AIDS progress report reporting)

See Global AIDS Response Progress Reporting 2013: Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS for details on the application of the NASA.

National Health Accounts

National Health Accounts is a systematic, comprehensive and consistent monitoring of resource flows in a country's health system for a given periods and reflect the main functions of health care financing: resource mobilization & allocation, pooling and insurance, purchasing of care and the distribution of benefits. They address a basic set of questions: where do the resources come from; where do the resources go; what kinds of services and goods do they purchase; who provides what services; what inputs are used for providing services; and whom do they benefit.

Explanation of Numerator:

The results for this numerator and its disaggregates submitted at the APR are the actual expenditures only (not planned funding). Planned funding levels should instead be submitted for the targets for this indicator during the COP.

This numerator and its disaggregates should be based on the country's program year, not the USG FY.

Explanation of Denominator: N/A

Interpretation:

This indicator documents the level and the sources of expended funding for the HIV response. This is critical information both for planning and evaluating HIV programs, and also serves as one indication of the sustainability of national HIV programs.

Because availability and/or quality of these expenditure data are expected to vary, it is very important to include in the accompanying narrative for this indicator when submitting targets and results both the source of the data and quality of the data.

PEPFAR Direct Support: N/A

Additional References:

- GARPR Indicator #6.1: Domestic and international AIDS spending by categories and financing sources. Pg. 82 of Global AIDS Response Progress Reporting 2013 Guidelines. (http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf)
- Avila, C. (2007) National AIDS Spending Assessment: Conceptual Framework Overview. Resource Tracking and Projections Unit, UNAIDS. Geneva Switzerland (http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/presentation/2007/20080116_5_nasa_framework_en.pdf)
- UNAIDS NASA Country Reports. (http://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports/)
- World Health Organization: What are National Health Accounts? (http://www.who.int/nha/what/en/index.html)

Country Ownership.

Capabilities Dimension		
Indicator code: CO_SC_NAT	**1**	Estimated percentage of key HIV program supply chain components funded by each partner type
Purpose: This indicator is intended to assess which partners are funding key components of the HIV program supply chain. This indicator is differentiated and disaggregated by definition components and partner groups.		
NGI Mapping:	N/A – this is a new indicator	
PEPFAR Support Target/Result Type:	N/A	
Numerator:	**1**	Estimated obligated funding for key components of the HIV program supply chain defined in the disaggregation section, for each partner type defined in the disaggregation section
Denominator:	**1**	Total estimated obligated funding from all sources for the key components of the HIV program supply chain defined in the disaggregation sections
Disaggregation(s):	**1**	The key parts of the HIV supply chain for which this indicator should be estimated are: • ARV procurement • ARV supply chain distribution system • Rapid Test Kit supply chain purchasing system • Rapid Test Kit supply chain distribution system • Optional disaggregate for other key aspects of the HIV supply chain determined by the PEPFAR country team as necessary to monitor • For each of these key components of the HIV supply chain above, the percentage of the obligated funding paid by each of the following partner types should be estimated as follows: • Estimated percentage obligated by the Host country government • Estimated percentage obligated by the PEPFAR • Estimated percentage obligated by the Global Fund • Estimated percentage obligated by other sources
Data Source:	N/A	
Data Collection Frequency:	Annually	
Method of Measurement: This is collected from the national AIDS Authority, PEPFAR country teams, non-government partners, and/or other supply chain authorities working in the selected program areas. It is very important to describe in the accompanying narrative for results the source and the data quality of the data submitted.		
Explanation of Numerator: The numerator is the amount obligated by different partners (Host country government, PEPFAR, Global Fund, and Other sources) to support each key component of the HIV supply chain during the country's program year. The disaggregation is as follows: • Host country government		

- PEPFAR
- Global Fund
- Other sources

This amount does not consider the amount spent, only the amount obligated to the program.

In many countries, the numerator and denominator may have to be estimated, and the resulting percentage estimations are expected to be broad (e.g. 60-80%), rather than exact (e.g. 81%).

Explanation of Denominator:

The denominator is the total amount obligated by all partners to support each key component of the HIV supply chain during the country's program year.

In many countries, the numerator and denominator may have to be estimated, and the resulting percentage estimations are expected to be broad (e.g. 60-80%), rather than exact (e.g. 81%).

Interpretation:

The purpose of this indicator is to assess the partner proportion of financial support for key components of the HIV supply chain. In many countries, increases over time in the host country government's funding of key aspects of the HIV supply chain may be an important goal in the country's plan to increase sustainability of the HIV response.

It should also be noted that improvements in the ability to measure this indicator more exactly over time may also indicate improvements in the key components of the country's HIV supply chain. This is one reason why it is very important to describe in the accompanying narrative for results both the source and the data quality of the data submitted.

PEPFAR Direct Support:
N/A

Additional References:
N/A

Country Ownership.

Institutional and Community Ownership Dimension		
Indicator code: CO_CSO_NAT	**1**	Percentage of civil society organizations receiving HIV program funding
Purpose: This indicator measures the participation of civil society, through funding, in the country's HIV program planning and implementation.		
NGI Mapping:	N/A – this is a new indicator	
PEPFAR Support Target/Result Type:	N/A	
Numerator:	**1**	Number of civil society organizations receiving HIV program funding
Denominator:	**1**	Total number of HIV-related civil society organizations
Disaggregation(s):	**1**	**Funding source:** • Host country government (including MOH, NAC, and other ministries) • Global Fund • PEPFAR • Other sources
Data Source:	Collected from the host country government, other entities monitoring civil society organizations, National AIDS Spending Assessment (NASA), and/or National Health Accounts (NHA)	
Data Collection Frequency:	Annually	
Method of Measurement: The data sources for this indicator will differ by country depending on the level of coordination of registering and monitoring civil society organizations. If there is a process within the MOH and/or national AIDS council for registering and/or monitoring civil society organizations, this will likely be the prime source of data for this indicator. Or these data may come from another national body that registers and/or monitors civil society organizations. If none of these resources exist, then some information about the HIV funding of civil society organizations can be found in National AIDS Spending Assessments (NASA) and/or National Health Accounts (NHA), described below. Because the possible data sources and data quality for this indicator may vary, it is very important to describe the data source and the data quality for this indicator in the accompanying narrative when results are submitted. Note that this indicator does not seek to measure the <u>amount</u> of civil society funding, only the <u>number</u> of civil society organizations that receive HIV program funding. The **National AIDS Spending Assessment (NASA)** describes the flow of resources spent in the HIV response from their origin to the beneficiary populations. It therefore describes the source of funds, who manages the funds, who provides the services, what is provided, what the components are and who benefits. **National Health Accounts** is a systematic, comprehensive, and consistent monitoring of resource flows in a country's health system for a given period and reflects the main functions of health care financing: resource mobilization & allocation, pooling and insurance, purchasing of care, and the distribution of benefits. They address a basic set of questions: where do the resources come from; where do the resources go; what kinds of services and goods do they purchase; who provides what services; what inputs are used for providing services; and whom do they benefit.		
Explanation of Numerator:		

The numerator is the number of civil society organizations receiving HIV program funding. This number is then disaggregated by those organizations receiving funding from the host country government (including national AIDS councils, MOH, and/or other ministries), those receiving funding through the Global Fund, those receiving funding from PEPFAR, and those receiving funding from other sources. Since a single civil society organization may receive funding from more than one of the sources above, the sum of the disaggregates is expected to exceed the numerator in many countries. The numerator, however, should be the number of unique civil society organizations receiving HIV program funding.

A **civil society organization** is defined as international and/or national non-government organizations (NGOs), faith-based organizations, and community-based organizations, as well as other nonstate actors such as the media, youth, and women's organizations, and organizations of people living with HIV/AIDS.

A **civil society organization receiving HIV program funding** has some portion of its funding that is specific to HIV/AIDS. The organization does not need to have its entire focus be on HIV/AIDS, and may in fact have only a small portion of its activities focused on HIV/AIDS.

Explanation of Denominator:

The denominator is the total number of HIV-related civil society organizations. This includes civil society organizations that have activities or part of their mission focused on HIV/AIDS, but do not receive HIV/AIDS funding.

Interpretation:

The participation of civil society organizations is considered critical to the HIV response. From their initial roles of advocating for those infected and affected with HIV/AIDS, to the more contemporary role of providing services and ensuring continuity of care, civil society participation is a cornerstone of the national HIV response.

Although funding serves as a proxy for involvement of civil society organizations in the national HIV program planning and implementation, it is expected that the greater the number of civil society organizations receiving HIV program funding, the greater the multi-sectoral nature of the HIV response and the greater the involvement of civil society organizations in planning and implementing the HIV response.

PEPFAR Direct Support:
N/A

Additional References:

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- Coutinho, A., Roxo, U., Epino, H., Muganzi, A., Dorward, E., & Pick, B. (2012). The expanding role of civil society in the global HIV/AIDS response: what has the President's Emergency Program For AIDS Relief's role been? *J Acquir Immune Defic Syndr, 60 Suppl 3*, S152-157. doi: 10.1097/QAI.0b013e31825d0383