

**Global Health
FY 2013 Supplemental Guidance
for the
Performance Plan & Report**

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Introduction

The Performance Plan & Report (PPR) is the annual data call from each Operating Unit (OU) to report on the results achieved in the past fiscal year. In an effort to streamline, headquarters has tried to utilize the PPR to gather the information needed for planning and reporting and to cut out ad hoc data calls through the year. As you are aware, the Global Health Bureau has been working to improve the PPR process over the past few years to ensure it meets those data needs. Last year we issued Supplemental Guidance specific to the Global Health Section of the PPR and followed that up with calls to the field to review the guidance to ensure a full understanding of the guidance. We also worked to improve the review process at Headquarters and better utilization of the PPR data by doing an in-depth qualitative and quantitative analysis. The specific changes made this year to address some of the remaining issues are listed below.

One of the issues affecting this year is that the Administration requested that the high level targets for GHI be revised over the summer. Due to the timing of this exercise, not all of the appropriate indicators were able to be added to the PPR. There were also some limitations with FACTSInfo. Therefore, this guidance contains some further instruction around the indicators that will not appear in FACTSInfo. The explanation is below and a summary table of all indicators is provided in Annex 3.

If you have any questions, please email: gghbmande@usaid.gov

Major Changes this Year

- **Single Key Issue Narrative for Health:** Mirroring the format of the Health Implementation Plan (HIP), the FY 13 PPR Key Issue Narratives for Health have been consolidated into one longer narrative with a limit of 40,000 characters. The Health Systems Strengthening Narrative, which used to be cross-cutting, has also been folded into the larger health narrative. This is significantly shorter in total characters than the 8 separate narratives. We have included more specific guidance for the narrative below, but the general format will be to do an overview of high level/national results, followed by a short section on each element guided by some key questions.

The Gender and Research and Innovation Key Issue Narratives are still cross-cutting and not health specific. However, this guidance does include key points which should be covered for health within those narratives.

- **Archival of Third Party Indicators:** Many of the indicators in the PPR Master Indicator List (MIL) were from the DHS, MICS or other third party data sources. When the data was analyzed last year, it was clear that these indicators were causing confusion due to the fact that there is only a new value every 5 years. Some countries included the last value in the PPR, some left it blank, some extrapolated. Therefore, this year, we have archived the majority of these indicators from the Master Indicator List for annual reported indicators. The indicators affected are listed in Annex 4, entitled Third Party Indicators. Since this data is largely available to us at Headquarters, we will pull the data for each country and post it on the F website. These are still important indicators to show long-term national level results, therefore, countries still should reference these indicators in their narrative and it will be available to reviewers as a reference document.

Since all indicators need to be “archived” for one year before being formally removed from the MIL, you will still have to report a value for the indicators that you set a target for in the FY 12 PPR. Please use the data points that we compiled and posted on the F website. The values for these indicators are the data points from the latest survey/report available. If a DHS was done in 2011, that should be the data point entered into this cell. The PPR system will not allow OUs to set out-year targets for these Archived Indicators.

- **Focus on USG Program Annual Results:** The remaining indicators in the Master Indicator List (Annex 1) are largely output and outcome indicators that can be ascertained on an annual basis, and are reflective of results of the USG programs. While the outcome/impact level data at the national level is important to demonstrate the larger picture, it will be captured in the reference table mentioned above and is already available to HQ staff. The PPR data is the only source for data specific to USG programs and is needed to report to Congress and OMB to show the results of USG programs and justify budget levels. It is also used to “tell our story” publically. Given this, each element team reviewed their list of indicators and some added new indicators to better capture USG specific results. These were posted on the USAID Learning Lab for comment. As a result the following additions and revisions were made: :
 - **Maternal and Child Health:** Given the focus on MCH, additional indicators were added in this area to ensure we have the appropriate data available. There are four below, which have officially been added to the MIL. There are also 8 additional indicators listed below under “recommended custom indicators”, as well as in Annex 3.

3.1.6-6	Number of cases of child diarrhea treated in USG-assisted programs
3.1.6-61	Number of children who received DPT3 by 12 months of age in USG-assisted programs
3.1.6-62	Number of newborn infants receiving antibiotic treatment for infection through USG-supported programs
3.1.6-63	Number of children under five years of age with suspected pneumonia receiving antibiotics by trained facility or community health workers in USG-assisted programs

- **Health System Strengthening Indicators:** Historically Health Systems Strengthening has had a Key Issue Narrative, but no associated indicators. This is because there isn’t a specific stream of funding associated with these activities. However, when looking at the list of custom indicators across countries, many OUs were adding indicators addressing this area. It also is a priority area for the GH Bureau. Therefore, to ensure consistent data across OUs, we have added indicators for HSS:

3.1-5	Development stage for an essential package of health services in the host country
3.1-6	Number of civil society organizations (CSOs) receiving USG assistance engaged in health advocacy

3.1-7	Percentage of providers complying with national guidelines/standards for labor and delivery visits at USG-supported facilities
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- **Revised Indicators:** To address some identified data quality problems, a few indicators were modified:

Number	Indicator	Change
3.1.3.4-5 (was 3.1.3.4-3)	Number of sulfadoxine-pyrimethamine (SP) tablets purchased in any fiscal year with USG funds that were distributed in this reported fiscal year.	Deleted "health facilities"
3.1.3.1-4	Number of artemisinin-based combination therapy (ACT) treatments purchased in any fiscal year with USG funds that were distributed in this reported fiscal year.	Disaggregates were dropped
3.1.3.1-8 (was 3.1.3.1-7)	Number of rapid diagnostic tests (RDTs) purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	Deleted "health facilities"
3.1.2.9-1	Number of individuals trained in any component of the WHO Stop TB Strategy with USG funding	Changed "the component" to "any component"

- **Revised Definition:** We heard from the field that there was confusion around indicator 3.1.7.1-4: Number of **additional** USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services during the year. Specifically OUs asked how to define "additional". The definition is: the increase in the number of CHWs caused by expansion or replication of USG funded projects or caused by the initiation of new USG funded projects in the reporting year.
- **Recommended Custom Indicators:** The Administration requested that the GHI Goals be revised to address various issues (budget assumptions, timeline, measurement issues, etc.). That process was happening at the same time all changes to the PPR needed to be submitted to the Office of Foreign Assistance for the FY 13 PPR. Unfortunately due to the timing, not all of the changes to the GHI Targets made it into the PPR. Since the PPR is the only source of data for some of the indicators, we have added a section called "Recommended Custom Indicators" and hope that each OU will consider adding these indicators. See Indicator Reference Sheets for these indicators in Annex 5. We recognize that you may not have data this year, but hope that at least a target can be established this year. We will continue working with F and the Streamlining Committee to formally add these indicators to the Master Indicator List for FY 14.

Element	Indicator
Health Systems Strengthening (3.1)	Percent of USG-supported primary health care (PHC) facilities that submit routine reports according to national HIS policy, disaggregated by public sector and private sector
Health Systems Strengthening (3.1)	Number of new health care workers who graduated from a USG supported pre-service training institution within the reporting period, by select cadre
Tuberculosis (TB) (3.1.2)	Number of MDR-TB cases who initiate second line treatment
Maternal & Child Health (3.1.6)	Number of women giving birth who received uterotonics in the third stage of labor through USG-supported programs

Maternal & Child Health (3.1.6)	Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC)
Maternal & Child Health (3.1.6)	Number of USG-supported communities establishing an emergency transport system for pregnant women within the reporting period
Maternal & Child Health (3.1.6)	Number of babies who received postnatal care within two days of childbirth in USG-supported programs
Maternal & Child Health (3.1.6)	Number of newborns not breathing at birth who were resuscitated in USG-supported programs
Maternal & Child Health (3.1.6)	Number of women reached with education on exclusive breastfeeding
Maternal & Child Health (3.1.6)	Number of individuals trained to implement improved sanitation methods
Maternal & Child Health (3.1.6)	Number of households with soap and water at a hand washing station commonly used by family members in USG-assisted programs
Family Planning (3.1.7)	National costed health plan developed that includes family planning (yes-no)

Note: For any indicator that is new, it is recognized that OUs need time to incorporate these measures into their M&E plans and may not have data this year. If data is available, that is great. If not, please consider adding it to the PPR and setting a target for it for FY 16 PPR.

Clarification on Reporting for the Different Health Initiatives

The reviews last year demonstrated that there is still confusion over how to report on the different health initiatives. This is understandable since each initiative is handled slightly differently. We have tried to streamline, but there are some things that cannot be changed. Here is a summary of reporting requirements:

- Global Health Initiative (GHI):** As described above, the Administration has requested that the original GHI Goals be revised to incorporate changing priorities, budget realities and updated methodologies. This was an inter-agency process guided by the NSS and OMB and included State, S/GAC, USAID, CDC, MCC, Peace Corp and DOD. Technical staff from each agency came together to revise the targets in each individual program area. The final list of targets, indicators and explanations of each is included in Annex 1. The major change for Missions is the addition of “Level 5 Targets” or targets that are specific to USG. The previous version focused largely on global change measured through third party indicators. Therefore, there were no reporting requirements for the USG Teams. However, the NSS and OMB requested that this iteration show a clearer link to USG contributions to the larger global goal. In order to do this, we need to add additional output indicators that will need to be collected through the PPR, PEPFAR’s Annual Performance Report (APR), and other agencies annual reporting process.
- President’s Emergency Plan for AIDS Relief (PEPFAR) Reporting:** The majority of OUs who receive HIV/AIDS Funding report directly to S/GAC through the Country/Regional Operational Plans and Semi/Annual Performance Reports (APR). If your OU does submit an APR to S/GAC for FY 2013, you should NOT include the indicator data in the PPR. The only requirement for those OUs is to include narrative reporting at both the Mission Objective and GH Key Issue Narrative. Include the following statement in the Mission Objective Performance Narrative related to HIV/AIDS programming: “Please refer to the <insert OU> SAPR or APR for indicator data on

HIV/AIDS programming.” The GH Key Issue Narrative should focus on how your PEPFAR funded activities link to the activities in other health element areas. If your OU receives HIV/AIDS funding and does not submit an APR for FY 13 to S/GAC, both the indicator data and the two narrative sections (Mission Objective & Health Key Issue) should discuss HIV/AIDS results.

- **President’s Malaria Initiative (PMI) Reporting:** As was the case last year, all reporting on PMI for FY 2013 should be done through the PPR. The PMI team in Washington will send out a template to each of the teams with any data from Headquarters already filled out. The OU should communicate with the appropriate contacts at Headquarters to finalize the data prior to PPR submission, but all data should still be entered and submitted through FACTSInfo.
- **Reporting on Nutrition for Feed the Future (FTF) and the Global Health Initiative (GHI):** The Nutrition Goals are shared between FTF and GHI and the M&E teams have worked together to harmonize reporting the extent possible. Therefore, the stated goals are the same, as are the indicators used to measure results. The big difference is the geographic scope of the two programs. FTF programs in the 19 FTF focus countries are concentrated in a specific geographic area called the Zone of Influence which FTF tracks results for separately via FTFMS. The data reported on the nutrition indicators in FTFMS should only reflect the results achieved in that defined geographic area. These data should be entered into FTFMS. The funding for GHI in many cases is used to fund programs that cover a much broader geographic area in the focus countries. The results reported for GHI should then reflect the larger program and this data should be entered into FACTSInfo for the PPR. The PPR results should be equal to or greater than the data reported in FTFMS. (FTF aligned countries and strategic partners do not need to report their nutrition results into FTFMS. Results data for these countries is collected directly from the PPR by BFS.)

Further Considerations for Indicator Reporting

Please consider the following points when preparing the PPR:

- Indicator reporting is tied to funding. An OU is only required to report on indicators for the health elements for which they receive funding. They are not required to report on all health indicators.
 - OUs may (but are not required) report on indicators outside of these funding streams if the indicator is relevant. For example, a PMTCT program may impact maternal health indicators and an OU may report on the relevant maternal health indicator.
- Certain indicators on the standard indicator list are marked as “Required as Applicable.” These indicators feed directly into a Congressional report. Therefore, we need countries to report on these indicators if they have programming in that area. However, the remaining indicators on the master indicator list are important for monitoring progress in each of the elements, and therefore, we encourage OUs to report on them to the extent that they can.
 - For OUs with large health programs (or element areas), and who work in many of the sub-elements, we would expect that you may need to report on more than the minimal required set in order to represent the work you are doing.

- For OUs with small health programs (or elements areas), the standard indicator list may not represent the activities you are implementing. Often small programs are focused on technical assistance or capacity building and not large scale service delivery. You should still report on 1-2 indicators for each element for which you have funded activities in the previous year, but you may choose to use custom indicators that better represent your results. However, please use the master indicator list whenever possible.
- When adding custom indicators, please double check that they do not appear on the standard list. During the analysis of last year's data, this was a common problem. We used the data to the extent we could, but were not able to in all cases.
- Another common problem last year was that a different number was entered in the data table than was used in the text. Please check that both use the same data point.

Guidance for the GH Key Issue Narrative

As is mentioned above, all of the key issue narratives for health have been consolidated into one, with a character limit of 40,000. This reflects the change made as a result of the Health Implementation Plan (HIP) process. Given that the indicator results are still structured by health element, the GH Narrative will have a broader overview, but then should cover a few key questions by health element. Further guidance is provided below.

Overview Section

This section should focus on two specific issues:

- **Key results at the national level, to which USAID contributed.** This section should describe results that the host country government achieved either nationally or regionally and can be shown through survey data, routine health information systems or other third party data. Examples could include an increase in immunization rates, modern contraceptive prevalence rates, decrease in stockouts of key supplies, etc. The narrative should highlight these achievements and describe how USAID programs contributed to these results.
- **Results that are cross-cutting in nature.** This section should discuss results that focus on the GHI Principles: Research & Innovation, Integration of Programs, Key Partnerships, etc. A Mission may also use this section to focus on inter-agency work within the USG.

Each OU should then include a short section on each element for which they are funded, responding to the guidance provided below:

Health Systems Strengthening (HSS)

HSS encompasses critical health areas including policies, management, operations and implementation of one or more of the six major building block components identified by the World Health Organization (WHO) common to all health systems, both public and private, including:

- Service delivery for health promotion, disease prevention, and clinical purposes, including its quality, efficiency, accessibility, patient-centeredness, and safety
- Leadership and governance, including health policy development and implementation, regulation, strategies, and accountability
- Financing, including the mobilizing of funds, organizing risk pools for funds, allocating funds to programs, and planning for long-term sustainability
- Medical products, vaccines, and technologies, including selection, procurement, distribution, use, and monitoring
- Information systems for monitoring and evaluating health-related activities
- Human resources planning and management, including deployment, retention, and performance management

We use the WHO definition of health system strengthening: “improving [the] six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes.”

Assistance should be reported as health system strengthening if it is designed specifically to remove barriers to utilization, enhance quality, and improve affordability of services for one or more Health Elements (HIV/AIDS, maternal and child health, tuberculosis, malaria, family planning/reproductive health and other public health threats, Avian Influenza, water, and sanitation).

In reporting on your Health Systems Strengthening program, please:

- Identify the key areas the Health Systems Strengthening program is addressing and describe the progress that is being made toward achieving planned objectives, referring to the building block components listed above and how the components are designed to interact.
- Indicate whether the partner country government has a line item or other formal commitment for these cross-cutting health information systems: Disease Surveillance and Response, National Health Accounts, Human Resources Information, and Adverse Drug Reaction Information. If available, indicate how much of its own money the government is spending on them.
- Report progress on the goals of the Universal Health Coverage (UHC) agenda globally: reduced spending by households when they need services; increased coverage of

priority and underserved groups – women, children, indigenous, migrants, marginalized populations; and policies and service-availability for essential service packages that include the high impact services USAID supports

- Report progress on stimulating private sector investment in health and increased allocations to health from government budgets.
- Discuss progress in strengthening systems for services that address Health Promotion and Disease Prevention, including creation of institutional capacity in the public or private sector.

Family Planning/Reproductive Health

Family Planning/Reproductive health programs seek to expand access to high-quality voluntary family planning (FP) services and information, and reproductive health (RH) care. Programs contribute to reducing unintended pregnancy and promoting healthy reproductive behaviors of men and women, reducing abortion, and reducing maternal and child mortality and morbidity. It includes: Service Delivery, Communication (FP), Policy Analysis and System Strengthening, Health Governance and Finance (FP), and Host Country Strategic Information Capacity (FP).

In reporting on your FP program, please:

- Identify the key areas the FP program is addressing and describe progress that is being made (key elements of FP programs are service delivery, performance improvement, contraceptive supply and logistics, health communication, biomedical and social science research, policy analysis and planning, and monitoring and evaluation). Include discussion of equity.
- Indicate whether the host country government has a line item for commodities, how much of its own money the government is spending on commodities, and what share of commodities they are actually purchasing.
- Report progress on Couple Year Protection and, in a year when DHS data are available, what the DHS results indicate about the progress being made.
- Discuss progress in relevant technical priority areas (contraceptive security, voluntary access to Long Acting, Reversible Contraceptives/Permanent Methods, HTSP, FP/HIV integration, FP/MCH integration including PAC, and community-based programming) and implementation of relevant FP High Impact Practices.

HIV/AIDS

OUs that submit HIV/AIDS performance reporting to S/GAC via an Annual Performance Report (APR) must still complete the Mission Objective Narrative (if appropriate), and Key Issue Narrative in the PPR. The GH Key Issue Narrative should focus on how your PEPFAR funded activities link to the activities in other health element areas. Also, please include the following statement in the Mission Objective Performance Narrative related to HIV/AIDS programming: "Please refer to the <insert OU> APR for the indicator data on HIV/AIDS programming."

If your OU receives HIV/AIDS funding and does not submit an APR for FY 13 to S/GAC, both the key issue narrative sections for HIV/AIDS should more broadly capture results in the sub-elements for which the OU receives funding.

Maternal and Child Health (MCH)

MCH programs focus on the availability and use of proven life-saving interventions that address the major killers of mothers and children and improve their health status, including effective maternity care and management of obstetric complications; prevention services including newborn care, routine immunization, polio eradication, safe water and hygiene; and treatment of life-threatening childhood illnesses. It includes Birth Preparedness and Maternity Services, Treatment of Obstetric Complications and Disabilities (including fistula), Newborn Care and Treatment, Polio, Other Immunizations, Treatment of Child Illness, Household Level Water, Sanitation, Hygiene and Environment, Health Governance and Finance (MCH), Anti-Microbial Resistance (MCH), and Host Country Strategic Information Capacity (MCH).

In reporting on MCH please discuss:

- Any work that is being done to support newborn survival including management of sepsis, kangaroo mother care (KMC) for premature or low birth weight infants, and newborn resuscitation using “Helping Babies Breathe” (HBB) or other programs. These activities ideally should be integrated with essential newborn care. The emphasis should be not only training of health workers but activities to ensure access to life-saving commodities associated with this work such as bag-and-mask ventilation and injectable antibiotics.
- Efforts to develop, scale-up, and sustain front-line health workers, particularly those at the community level. Include specific mention of work to develop cadres engaged in integrated community-case management (iCCM) of diarrhea, pneumonia, and malaria (where appropriate). Highlights should be clear to distinguish iCCM from integrated case management of childhood illnesses (IMCI) activities, as these are typically promulgated at facility level. The emphasis should be not only on training health workers, but activities to promote access to life-saving interventions and commodities (e.g. ORS, zinc, and amoxicillin, or injectable antibiotics).
- Any work that is being done to support maternal survival including improving availability and quality of facilities providing basic and emergency obstetric services, strengthening routine delivery services to provide uterotonics during the third stage of labor, antenatal care services and integration with infectious disease programs, monitoring and tracking of outcomes, and postpartum care. The emphasis should be not only on training health workers, but activities to promote access to life-saving interventions and commodities.
- Any status update to USAID support for the introduction of pneumococcal and rotavirus vaccines.
- Efforts to improve water and sanitation, and how this work is linked with other maternal and child survival activities.
- How data is being used to sharpen country maternal and child health plans/strategies. Highlights may emphasize more timely information (possibly country health information systems) and work at subnational levels.
- How data is being used to develop scorecards, dashboards, or other profiles that benchmark progress on key MCH issues (as part of accountability framework). Highlights may include how data is being used for problem solving and performance improvement. Highlights may emphasize more timely information (possibly country health information systems) and work at subnational levels.

Malaria

This area covers the implementation of the President's Malaria Initiative (PMI), other USAID-funded malaria control activities, and malaria research activities (such as the development of effective malaria vaccines, new drugs to treat malaria, and targeted operations research). It includes diagnosis of malaria and treatment with artemisinin-based combination therapies, insecticide-treated mosquito nets (ITNs), indoor residual spraying (IRS), and intermittent preventive treatment during pregnancy (IPTp).

In reporting on Malaria, please list three to four country highlights that:

1. Are two to three sentences in length;
2. Reflect activities implemented during the 2013 Fiscal Year;
3. Describe accomplishments, successes, and challenges to implementation of key malaria interventions such as case management, ITNs, IRS, IPTp and research;
4. Dovetail well with Global Health Initiative (GHI) principles (strategic coordination and integration, country ownership, health systems strengthening, partnerships, women and girl-centered approaches, monitoring and evaluation, and research and innovation); and,
5. Are specific and quantitative in terms of the scope of activities (e.g., 125 health workers were trained on case management for malaria out of a total of 200 health workers nationwide).

An example of a country highlight is provided below:

Malaria in Pregnancy: In country Z, more than half of all antenatal clinics now offer integrated care for pregnant women including IPTp, distribution of ITNs, and HIV/AIDS-related services. During the 2013 fiscal year, PMI supported this expansion by purchasing and distributing 500,000 ITNs and providing training for 150 health workers. Many of the antenatal clinics are supported by both PMI and PEPFAR and these programs have worked closely to maximize synergies and integrate activities.

Nutrition

Nutrition focuses on the availability and use of proven nutrition interventions to reduce mortality, morbidity, and food insecurity, including nutrition education to improve maternal diets, nutrition during pregnancy, exclusive breastfeeding, and infant and young child feeding practices; fortified or bio-fortified staple foods, specialized food products, and community gardens to improve consumption of quality food; and delivery of nutrition services including micronutrient supplementation and community management of acute malnutrition. Strengthen host country capacity by advancing supportive nutrition and food security policies and improving nutrition information systems. It includes Individual Prevention Programs, Population-based Nutrition Service Delivery (including micronutrient supplementation), Nutrition Enabling Environment and Capacity Strengthening for women and the poor.

In reporting on your Nutrition program, please discuss how:

1. Over the last year, how have you integrated approaches to improve nutrition, particularly for pregnant and preconception women and young children, across GHI, FTF and other programming?
2. How have USAID nutrition programs contributed to country-led efforts to scale up nutrition interventions?

3. If relevant, please describe country ownership of nutrition efforts, for example through Scaling Up Nutrition Movement country partnerships, coordination of multiple stakeholders in an integrated National Nutrition Plan, whether the host country invests its own resources in a specific line item for nutrition in the national budget, and how the country is supporting capacity building to design, implement, manage and evaluate effective nutrition interventions. If relevant, please comment on how USAID is contributing to country ownership of nutrition policies, plans and programs.
4. As far as relevant, describe progress towards achieving national nutrition targets for stunting, wasting, underweight and anemia or other priority targets in its national nutrition plan, and how USAID is contributing to national targets.

Tuberculosis (TB)

TB programs focus on the number of deaths caused by TB by increasing detection of cases of TB and by successfully treating detected cases, as well as addressing issues of multi-drug resistant TB, TB and HIV, and investing in new tools for TB. It includes: Expansion and enhancement of Directly Observed Therapy, Short-Course (DOTS), and Drugs for the Treatment of TB, Improvement in the Management of TB/HIV, Multi-Drug Resistant TB (MDR TB), TB Care and Support, Development of New Tools and Improved Approaches, Health Governance and Finance (TB), and Host Country Strategic Information Capacity (TB).

When reporting on TB, please consider these specific questions related to USAID priorities:

1. USAID and partners are investing in the introduction and scale up of the Xpert MTB/RIF diagnostic technology in a number of countries. This is a priority activity to be monitored continuously in the coming years, as availability of this new technology is expected to improve case detection, particularly of drug resistant and smear negative TB. Please provide a brief overview of the status of Xpert introduction in the country, including a description of USAID-funded activities to support Xpert introduction in your country.
2. Given the global momentum around addressing childhood TB and recent efforts in USG priority countries to update policies and guidelines for the diagnosis and treatment of TB among children, please provide an overview of efforts to address childhood TB, including a brief description of any USAID-funded activities related to childhood TB in your country. Please also comment on whether or not your country participated in the launch of the Stop TB Childhood TB Roadmap and any activities associated with this effort.
3. It is increasingly important for USAID to monitor domestic financing for TB programs in the countries we support and better understand what elements are fully funded by the government and where there are significant gaps. Please comment on the availability of domestic resources to support TB and note any trends in this area. Is the amount increasing over time? Is the country using the Stop TB Planning and Budgeting Tool? What areas are require significantly more resources to support implementation if key interventions?
4. Stockouts of first and second line drugs and laboratory reagents are of increasing concern in a number of USAID funded programs, as Global Fund support is reduced and countries continue to be dependent on donors to cover procurement of these commodities. Please describe the current situation with regards to drug and laboratory supply in your country, and if there has been a stock out of first line drugs or laboratory reagents in the past year, describe how the situation was resolved. What is USAID

supporting in the area of drug management in your country? Does the government cover the costs of first line drugs? Also, have there been delays in drug procurements due to GF and/or NTP operational processed? Is there any information available on when first and second line drug stocks will be depleted?

If time/data are not available to answer each question, please respond to those programmatic areas with USAID funding and omit areas for which USAID is not providing any support.

Cross-cutting Mission Narratives

Science, Technology and Innovation

In reporting on this key issue narratives please discuss these points specific to health:

1. Programs focused on the development, introduction and/or scale-up of innovative health interventions, products, technologies, and service delivery strategies and/or programs that address bottlenecks to the development, introduction, and scale-up of such interventions
2. Programs which sponsor and promote locally sourced technologies and innovations in health
3. Programs that utilize market-based or business-minded approaches to drive the uptake of health products, reduce costs, streamline distribution, or increase access to health services. For example, in the fight against malaria, pooled procurement and the establishment of manufacturing capacity in Africa for Insecticide Treated Nets (ITNs) facilitated increased coverage of ITNs from 5.6 million in 2004 to 145 million in 2010 in sub-Saharan Africa and substantial reductions in deaths due to malaria.

Gender

1. If the health team is not reporting on any of the required gender indicator, please describe why not. Most health programs should plan to address gender, so if it is not applicable, please explain. The health team should also briefly describe how they intend to address gender related health disparities through gender specific programing in the future.
2. If the health team did report, briefly describe the health program contributing to these results, how this will impact health and indicate whether OU is meeting its targets.
3. Health teams should analyze each of the health element specific data with regard to sex-disaggregation and briefly describe how they explain notable gender health disparities/disparate burden of disease between women and men.

Including Success Stories in the PPR

The Global Health Bureau has a wide range of reporting requirements, communication products and ad hoc requests throughout the year. We use the Success Stories submitted through the PPR for all of these purposes, so please consider submitting relevant stories.

Additionally, please include stories describing both successes and challenges in integration to support maternal and child mortality reduction: across MCH, FP/RH, malaria, HIV/AIDS, nutrition, water/sanitation as well as novel linkages across sectors.

Headquarters Review and Analysis Process: *December 2013 - February 2014*

As a result of ongoing discussions with F to improve the PPR review process, we have been granted a larger window to ensure that the reviews are thorough and useful. The process outlined below reflects this extended timeframe.

Step 1 – Country Team Reviews

1. F will post all PPRs on their website after an initial cleaning process.
2. The Office of Country Support and P3 will send emails to the GH Country Teams to notify them that the PPRs are ready for Review.
3. The Country Team Lead should then circulate the PPR, along with the GH review checklists and F Issues Template to the entire country team for review (lead, alternate, assistant, regional bureau point person, and technical point persons, e.g., MCH, FP, PMI, HIV/AIDS, FtF).
4. Convene a meeting to discuss comments and coordinate response (dates and times for the each country has been preset to avoid double- or over-booking of staff and can be found on the attached calendar). When reviewing the PPR, country teams should focus on issues that would assist a Mission to improve data quality or programs and not on small issues that create unnecessary work for the Mission. The hope is that PPRs report accurately on the health program and parallel the CDCS, GHI Strategy and BEST Action Plans.
5. The GH Country Team should hold a call with the Mission Health Team to discuss any issues that were raised during the review. If they are resolved on that call, they can be crossed off the list. If issues remain, they should be submitted to F.

Step 2 – Submission of Comments to Regional Bureaus

1. The Country Team Leads should synthesize comments from the meeting and fill out the F template provided. The completed templates should be emailed to the Regional Lead (Liz Kibour – Africa; Mary Vandenbroucke – LAC; Rushna Ravji – A/ME; and Mark Austin – E&E) and Regional Bureau POC on their team.
2. Once the templates are submitted to the Regional Leads and Regional Bureau point person, they will work with OCS and P3 M&E staff to review the templates and ensure any significant issues are cleared by Elise Ayers and Michael Zeilinger.
3. When templates are cleared by the regional leads and office heads (if applicable), Country Assistants can post issues to F's website directly.

Step 3 – Across Country Trend Analysis

P3 and KMS will undertake a cross-country trend analysis that uses the PPRs and other data (e.g., DHS, MICS) to compare the performance of country programs over time and with the progress of other countries within a sub-region. This will be conducted through a presentation done jointly by M&E and country leads to technical offices and GH. During this process, they will

also cull out key issues which emerge across countries or issues that inform the PPR process for the coming year.

Annex 1: New GHI Targets and Framework

The Global Health Initiative began in 2009 to strengthen the U.S. Government's existing international health programs with the goal of increasing the impact of U.S. global health investments. To ground GHI's strong focus on maximizing results, GHI set aspirational goals in eight broad health areas. As the second term begins for the Obama Administration, the leadership would like to revise our goals given the budget realities and changing priorities.

The assumptions for this exercise were:

- **Timeframe:** Targets should be set for a 10-year timeframe, funding years FY 2009 – FY 2018. FY 2008 would serve as the baseline year for indicators and final reporting on results would be in FY 2019.
- **Budget Assumptions:** Element Teams should assume a flat lined budget for the 5-years
- **Funding Streams:** The targets include all CDC, OGAC and USAID funding. For example, PEPFAR funds activities in TB, Nutrition and FP/RH, which were included in each of those target streams and not just under HIV/AIDS. All of CDC's activities are included, rather than just those that are funded out of the GHP account.
- **Global Mechanisms:** USG contributions to global mechanisms such as GAVI, GFATM, etc. were considered.

It should be noted that as we focus on Country Ownership, the USG will continue to move more towards a contribution model. The health area teams have highlighted the global goals which each of them are contributing to, but USG is just one of many players influencing that result or goal. The teams have also tried to articulate a goal that is more narrow in focus and specific to USG funding. While this is more “attributable”, it should still be recognized that we are almost never the sole player.

How to Interpret the Diagram

Level 1: Aspirational long-term goal, which all health programs contribute to globally

Level 2: The three specific priority goals that the USG has chosen to focus its resources. The goals are longer-term in nature and will not be accomplished by the USG alone or within the timeframe articulated in this framework. For this exercise, a goal shorter-term goal is noted to align with the FY 2009-FY 2018. This is based on the projections done at a global level to reach the longer-term goal. It should be noted that these goals are not “attributable” to USG, but USG will contribute to them.

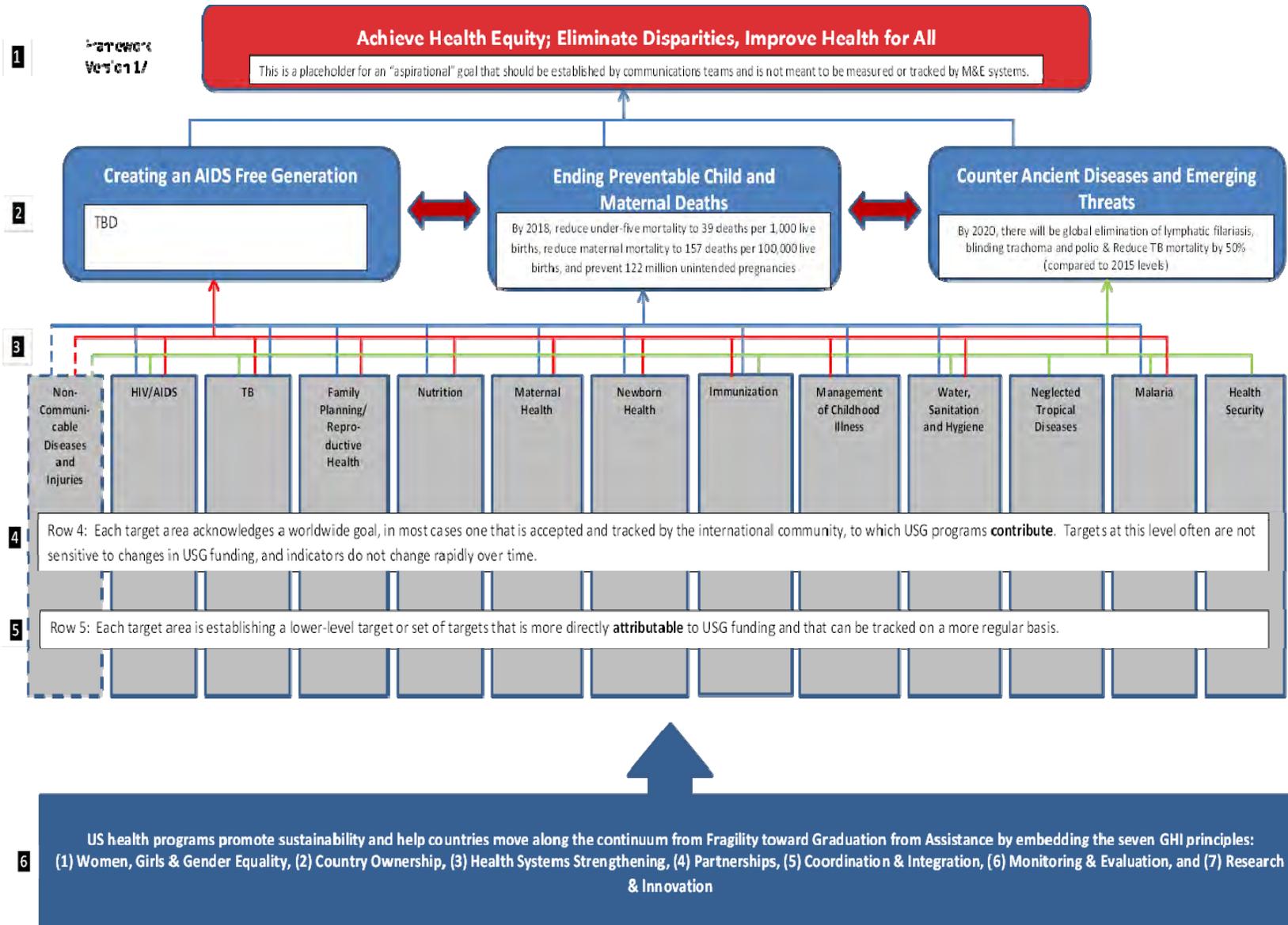
Level 3: While our funding streams are meant to be mutually exclusive, the activities in any one funding area have direct or indirect impact on other health areas. We try to demonstrate the synergies within our health programs by linking each box to the appropriate higher level goal.

Level 4: Each of the health areas works not only with each other, but also with global partners who work on that specific topic (UNAIDS, WHO, UNICEF, UNFPA, etc.) For many of these health areas, there are global targets set, to which the USG has committed to contribute. Examples include the Family Planning 2020, Rollback Malaria, Stop TB, etc. While the USG has

chosen to prioritize the goals in Level 2, we continue to contribute to goals that are noted Level 4. These are also not “attributable”, but USG’s contribution should be noted.

Level 5: Each of the health areas does have an annual budget. Level 5 articulates a target that is more “attributable” and will be accomplished through our health programs. It should be noted that the USG is still working with host country governments and other partners at this level, but the results can be more closely linked to USG dollars than national level indicators noted in Level 2 and 4. This target also does not capture all of the work being done with this funding, but tries to highlight one or two of the more significant results.

Level 6: The inter-agency continues to promote and apply the GHI Principles. They are noted on the framework to indicate that they support all the work of the USG. While they are more difficult to measure, the M&E Committee has been working with technical experts to develop indicators. It is hoped that we will have more concrete results to report in the next year.



Three Priority Goals that the USG Contributes to (Level 2 on Diagram):

Global Goal	Target for FY 09 – FY 18	Proposed Indicators
AIDS Free Generation	TBD. Will be determined in August 2013 as part of OGACs process.	
Ending Preventable Child and Maternal Deaths	Reduce U5M to 39/1000 Reduce MMR to 157/100,000 122 million unintended pregnancies prevented Source: A Promised Renewed Framework	Under 5 Mortality (IGME) Maternal Mortality (UN) Unintended Pregnancies Prevented Aspirational: Mortality by Disease Area (pneumonia, diarrhea, nutrition, malaria)
Counter Ancient Diseases and Emerging Threats	By 2020, there will be global elimination of lymphatic filariasis, blinding trachoma and polio & Reduce TB mortality by 50% (compared to 2015 levels) Source: Global NTD Strategy Stop TB Strategy	No. of countries that have eliminated lymphatic filariasis No. of countries that have eliminated blinding trachoma TB Mortality Rate Regions/Countries of the World with Polio Eradicated Aspirational: Malaria cases

Goals and Targets for Key Health Programs (Levels 4 & 5 on Diagram):

Health Program	Global Goal Health Program is Contributing To (Level 4/Blue Box)	Key Indicators	USG Specific Target (Level 5/Red Box)*	Key Indicators

NCDIs	<p>World Health Assembly:</p> <p>A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.</p> <p>A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years.</p> <p>A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure according to national circumstances.</p> <p>Halt the rise in diabetes and obesity.</p>	<p>Unconditional probability of dying between ages 30 and 70 from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.</p> <p>Prevalence of current tobacco use among adolescents.</p> <p>Age-standardized prevalence of current tobacco use among persons aged 18+ years.</p> <p>Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg).</p>	<p>There is currently limited USG funding allocated for NCDIs, but is an emerging area under discussion. Even though targets are not set under this exercise, there may be data to report as programs evolve.</p>	
HIV/AIDS	<p>TBD. Will be determined in August 2013 as part of OGACs process.</p>			

<p>TB</p>	<p>Reduce TB prevalence to less than 50 cases per 100,000 by 2025</p> <p>Decrease TB mortality rate by 75% reduction by 2025 (compared with 2015)</p>	<p>TB Prevalence Rate</p> <p>TB Mortality Rate</p>	<p>By 2019, USG TB programs will increase case notification rate and the absolute number of notified cases (all forms of TB) by at least 15%*</p> <p>By 2019, USG-supported countries will achieve and maintain at least 85% treatment success rate (all forms of TB) and successfully treat more than 3 million TB cases (all forms of TB) per year.</p> <p>By 2019, USG TB program will initiate on treatment more than 80,000 MDR TB cases per year.</p> <p>*This is a notional target and will need to be adjusted once 2012 data is finalized in the WHO Global TB Database.</p>	<p>Case notification rate</p> <p>Number of TB cases (all forms) notified</p> <p>Treatment success rate</p> <p>Number of TB cases (all forms) who are successfully treated</p> <p>Number of MDR-TB cases who initiate second line treatment</p>
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<p>Family Planning & Reproductive Health</p>	<p>Family Planning 2020: USG is contributing to the goal of the FP2020 initiative to reach 120 million more women and girls in the world's poorest countries with access to voluntary family planning information, contraceptives, and services by 2020.</p> <p>By 2019 the goal is to increase to 360 million the total number of family planning users in 69 low income countries thereby preventing 122 million unintended pregnancies</p>	<p>Modern contraceptive prevalence in 69 low income countries</p> <p>Total met need for family planning in 69 low income countries</p>	<p>Total family planning couple-years of protection provided in USG-supported family planning projects will increase from 30 million in 2009 to 59 million in 2019.</p>	<p>Total family planning couple-years protection provided by USG-supported projects.</p> <p>Number of new or improved contraceptive methods in the research and development, regulatory approval, and introduction process.</p> <p>Number of national costed health plans that include family planning among countries receiving at least \$2 million in USG support for family planning/reproductive health activities.</p> <p>Percent of USAID-procured contraceptive commodity shipments delivered on time to consignees. (1 month before or after desired receipt date)</p> <p>Number of individuals reached with education on modern contraceptive methods, disaggregated by age</p>
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<p>Nutrition (Goals are through 2017 since they are already established through FTF)</p>	<p>World Health Assembly Goal: Reduce stunting by 40% by the year 2025*</p> <p>* There are six high level World Health Assembly goals on nutrition. The USG has signed on and supports all six, but has chosen to make stunting a primary focus under both GHI and FTF</p>	<p>Measured by stunting in children under five years of age</p> <p>Number of children prevented from stunting</p>	<p>Feed the Future & GHI: The USG aspirational goal is to reduce child undernutrition by 20% in targeted areas of our focus countries over five years, measured by stunting in children under five years of age. The USG expects to contribute to this aspiration goal by reaching at least 60 million children over the same 5 year period with nutrition interventions</p>	<p>Number of children under five reached by USG-supported nutrition programs</p> <p>Number of people trained in child health and nutrition through USG-supported Programs</p>
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<p>Maternal Health</p>	<p>MDG (current): Reduce by three quarters the maternal mortality ratio (# of maternal deaths during pregnancy/100,000 live births)*</p> <p>*Global goals are under discussion and will be updated when final</p>	<p>Maternal Mortality Ratio</p> <p>Percentage of live births attended by skilled health personnel</p> <p>Percentage of live births delivered by cesarean section (rural, urban)</p>	<p>56% of live births attended by skilled health personnel in USG-supported countries</p> <p>5% of live births delivered by cesarean section in rural areas in USG-supported countries</p> <p>15 million of women who received uterotonics in third stage of labor through USG-supported programs</p>	<p>Percentage of live births attended by skilled health personnel in USG-supported countries (DHS/MICS)</p> <p>Percentage of live births delivered by cesarean section in USG-supported countries (rural and urban) (DHS/MICS)</p> <p>Number of women giving birth who received uterotonics in the third stage of labor through USG-supported programs (PPR)</p> <p>Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC) (Optional PPR)</p> <p>Number of USG-supported communities establishing an emergency transport system for pregnant women within the reporting period (cumulative)</p>
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<p>Newborn Health</p>	<p>Under discussion by global partners – no target at this time</p>	<p>Neonatal mortality rate</p>	<p>Neonatal mortality rate – 25 per 1000 live births in USG-supported countries</p> <p>31% of babies received postnatal care within two days of childbirth in USG-supported countries</p> <p>Congenital syphilis eliminated in 4 countries</p>	<p>Percentage of babies who received postnatal care within two days of childbirth in USG-supported countries (DHS/MICS)</p> <p>Percent of newborns that were immediately breastfed after birth (within 1 hour) (DHS/MICS)</p> <p>Number of babies who received postnatal care within two days of childbirth in USG-supported programs (Optional PPR)</p> <p>Number of newborn infants receiving antibiotic treatment for suspected sepsis through USG-supported programs (PPR)</p> <p>Number of newborns not breathing at birth who were resuscitated in USG-supported programs (Optional PPR)</p> <p>Number of countries that have eliminated congenital syphilis.</p>
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Immunizations	<p>Global Vaccine Action Plan: By 2015, all countries globally will have achieved 90% coverage with three doses of diphtheria-tetanus-pertussis (DTP3) containing vaccines nationwide</p> <p>By 2018, all WHO regions will be certified as polio-free</p> <p>By 2020, 5 of 6 WHO regions will be verified to achieve measles elimination</p> <p>By 2020, all countries globally that have introduced pneumococcal and rotavirus vaccines in national immunization programs will have achieved 90% full-dose coverage nationwide</p>	<p>Number countries achieving DTP3 coverage \geq90% nationwide</p> <p>Number of WHO regions certified as polio-free</p> <p>Number of WHO regions verified to achieve measles elimination</p> <p>Number of countries achieving 90% full-dose pneumococcal vaccine coverage nationwide</p> <p>Number of countries achieving 90% full-dose rotavirus vaccine coverage nationwide</p>	<p>By 2015, 60 million children will have received three doses of diphtheria-tetanus-pertussis (DTP3) containing vaccines in USG supported countries (as defined by GAVI eligibility in 2013)</p> <p>By 2014, all countries globally will have interrupted wild poliovirus transmission</p> <p>By 2018, 5 of 6 WHO regions will be verified to achieve measles elimination</p> <p>By 2018, 60 million children will have received full-dose pneumococcal vaccine in USG supported countries (as defined by GAVI eligibility in 2013) vaccine coverage nationwide</p> <p>By 2018, 60 million children will have received full-dose rotavirus vaccine in USG supported countries (as defined by GAVI eligibility in 2013)</p>	<p>Number of children that have received three doses of diphtheria-tetanus-pertussis (DTP3) containing vaccines (as defined by GAVI eligibility in 2013)</p> <p>Number of countries with endemic wild poliovirus transmission</p> <p>Number of WHO regions verified to achieve measles elimination</p> <p>Number of children that have received full-dose pneumococcal vaccine in USG supported countries (as defined by GAVI eligibility in 2013)</p> <p>Number of children that have received full-dose rotavirus vaccine in USG supported countries (as defined by GAVI eligibility in 2013)</p>
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Management of Pneumonia, Diarrhea and Other Child Illness Causing Significant Mortality	GAPPD: That 90% of children suspected of pneumonia or diarrhea receive care by 2020	<p>Percentage of children under 5 with diarrhea receiving oral rehydration salts</p> <p>Percent of children under 5 with suspected pneumonia taken to an appropriate health provider</p> <p>Percentage of children under five with suspected pneumonia receiving antibiotics</p>	<p>59 percent of under 5 children with diarrhea receiving oral rehydration salts in USG-supported countries</p> <p>74 percent of under 5 children with suspected pneumonia taken to an appropriate health provider in USG-supported countries</p> <p>30 million under 5 children with diarrhea treated with oral rehydration salts in USG-supported programs</p> <p>1.8 million under 5 children with suspected pneumonia seeking care in USG-supported programs</p>	<p>Percentage of under 5 children with diarrhea receiving oral rehydration salts in USG-supported countries (DHS/MICS)</p> <p>Percentage of under 5 children with suspected pneumonia take to an appropriate health provider in USG-supported countries (DHS/MICS)</p> <p>Percentage of infants aged 0–5 months who are exclusively breastfed (DHS/MICS)</p> <p>Number of cases of child diarrhea treated in USG-supported programs (PPR)</p> <p>Number of children under five years of age with suspected pneumonia seeking care in USG-supported programs (PPR optional)</p> <p>Number of women reached with education on exclusive breastfeeding</p>
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Water, Sanitation and Hygiene	<p>MDG: By 2015, halve the proportion of people without sustainable access to safe drinking water and basic sanitation</p> <p>*The most current global target for Water, Sanitation and Hygiene is the current MDG that is set to be achieved by 2015. We will update the target once new MDGs are agreed upon.</p>	<p>Percent of population using an improved sanitation facility</p> <p>Percent of population using an improved water source</p>	<p>10 million people to will gain sustainable access to an improved drinking water source as a consequence of USG assistance by 2018</p> <p>6 million people will gain sustainable access to an improved sanitation facility as a consequence of USG assistance.by 2018</p> <p>6 million households with soap and water at a hand washing station commonly used by family members by 2018</p>	<p>Number of people gaining access to an improved drinking water supply in USG-assisted programs</p> <p>Number of people gaining access to an improved sanitation facility in USG-assisted programs</p> <p>Number of households with soap and water at a hand washing station commonly used by family members in USG-assisted programs</p> <p>Number of individuals trained to implement improved sanitation methods</p>
Neglected Tropical Diseases	<p>100% of the global target population under treatment or completed treatment for LF</p> <p>100% of the global target population under treatment or completed treatment for trachoma</p>	<p>Percent of global target population receiving treatment for LF</p> <p>Percent of global target population receiving treatment for trachoma</p>	<p>60% of the population no longer requiring MDA for LF in 16 USAID supported countries</p> <p>70% of population no longer requiring district-level MDA for trachoma in 7 USAID supported countries</p> <p>1.4 billion treatments provided with USAID support</p>	<p>Percent of persons no longer requiring MDA for LF</p> <p>Percent of persons no longer requiring district level MDA for trachoma</p> <p>Number of treatments provided with USAID support</p>

Malaria	Achieve and sustain universal coverage for all populations at risk with locally appropriate interventions for prevention and case management.	Proportion of households with at least one ITN Proportion of children under five years old who slept under an ITN the previous night Proportion of pregnant who slept under an ITN the previous night	PMI will distribute 250M ITNs and 400M ACTs cumulatively (based on current annual distribution of 25M ITNs and 40M ACTs)	Number of ITNs distributed with PMI support Number of ACTs distributed with PMI support Number of people protected from malaria through a prevention measure
Health Security, including Pandemic Influenza and Emerging Threats	TBD. Will be determined through the other IPC process shortly.			

Annex 2: FY 2013 Performance Plans and Reports (PPRs) Template for Country Team Reviews

Broad overview:

1. Does the overall program direction follow the (as applicable):
 - a. Mission CDCS
 - b. Child Survival Action Plan
 - c. BEST Action Plan
 - d. GHI Strategy
2. For any of the major Presidential Initiatives (FTF, GHI, and PMI) supported by the mission's programs, are there any notable highlights that demonstrate success or might suggest best practice for others to replicate? If so, please describe.

Indicators:

1. The PPR should include Indicators that align with funding streams and the focus areas of their GHI Strategy.
 - a. Are there at least 1-2 indicators per element funded in FY 13 and/or key priority to communicate the Missions progress?
 - b. Do the indicators the Mission selected accurately reflect their work?
 - c. Do the custom indicators the country selected make sense, if they are proposed or are there key indicators/topic areas that are missing? FY 13 Data and FY 14 Targets
 - d. Does FY 13 data align with past year's trends and other reported data (DHS type indicators)?
 - e. Does the data align with the targets laid out in last year's PPR, BEST Strategy, GHI Strategy, etc.?
 - f. Are there any serious performance issues (e.g. deviations of X percent) with inadequate explanation?
 - g. Do the targets make sense? Are deviations explained?

Narrative:

Element specific questions should only be assessed if the Mission receives funding for that element. These are criteria to assess the key issue narrative specifically:

2. Did the Mission include an overview which describes the host country government and/or cross-cutting results?
3. Did the Mission's GH Key Issue Narrative discuss results for all elements which they receive funding?
4. Did they answer each of the key questions outlined in the guidance for each element?
5. Did the data quoted in the narrative match the data entered in the indicator data table?

Annex 3: New List of Health Indicators for FY 2013 and Future Reporting

As mentioned in the guidance, the PPR process and the GHI Target Revision process did not align, therefore, some of the indicators needed to report on GHI did not get included in the PPR. The list below reflects all of the health indicators needed for Congressional, OMB and GHI reporting over the next 5 years. The indicators marked in red are those that don't appear in the PPR and we are requesting countries add as custom indicators.

Note: To make this list more user-friendly, we have removed the third party indicators that will be archived in future years. However, if you set a target in FY 12 PPR, you will need to report on this for one final year. Please enter the most recent data point for any of these indicators. If a DHS was done in FY 11, that should be the value filled in for this year's PPR.

Num	Title	Required As Applicable (RAA)	Category	Type
3	Investing In People		category	
3.1	Health		category	
3.1-5	Development stage for an essential package of health services in the host country		New 2013	Outcome
3.1-6	Number of civil society organizations (CSOs) receiving USG assistance engaged in health advocacy		New 2013	Output
3.1-7	Percentage of providers complying with national guidelines/standards for labor and delivery visits at USG-supported facilities		New 2013	Output
	Percent of USG-supported primary health care (PHC) facilities that submitted routine reports on time, disaggregated by public sector and private sector, and disaggregated by numerator and denominator		Recommended Custom	Output
	Number of new health care workers who graduated from a USG supported pre-service training institution within the reporting period, by select cadre		Recommended Custom	Output
3.1.1	HIV/AIDS		category	
3.1.1-6	Number of adults and children with advanced HIV infection newly enrolled on ART (PEPFAR Output - #T1.1.D)	**	Active	Output

3.1.1-10	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (PEPFAR output - #T1.2.D)	**	Active	Direct
3.1.1-24	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (PEPFAR Output - #P11.1.D)	**	Active	Output
3.1.1-59	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) (PEPFAR output - #P1.1D)		Active	Output
3.1.1-60	Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results) (National outcome - #P1.1N))		Restore 2012	Output
3.1.1-61	Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (National outcome - #P1.2N))		Restore 2012	blank
3.1.1-62	Number of injecting drug users (IDUs) on opioid substitution therapy (PEPFAR Output - #P4.1.D)		Active	Output
3.1.1-63	Number of males circumcised as part of the minimum package of MC for HIV prevention services (PEPFAR Output - #P5.1.D)		Active	Output
3.1.1-64	Number of persons provided with post-exposure prophylaxis (PEP) (PEPFAR Output - #P6.1.D)		Active	Output
3.1.1-65	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions (PEPFAR Output - #P7.1.D)		Active	Output
3.1.1-66	Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (PEPFAR Output - #P8.1D)		Active	Output
3.1.1-67	Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required (PEPFAR Output - #P8.2D - Subset of indicator #P8.1.D)		Active	Output
3.1.1-68	Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (PEPFAR Output - #P8.3.D)		Active	Output

3.1.1-69	Number of eligible adults and children provided with a minimum of one care service (PEPFAR output - #C.1.1D)	**	Active	Output
3.1.1-70	Number of eligible adults and children provided with a minimum of one care service (National output - #C1.1N)		Restore 2012	blank
3.1.1-71	Number of HIV-positive adults and children receiving a minimum of one clinical service (PEPFAR output - #C2.1D)		Active	Output
3.1.1-72	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis (PEPFAR Output - #C2.2.D - Subset of indicator #C2.1.D)		Active	Output
3.1.1-73	Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food (PEPFAR Output - #C2.3.D)		Active	Output
3.1.1-74	Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting (PEPFAR Output - #C2.4.D)		Active	Output
3.1.1-75	Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment (PEPFAR Output - #C2.5D)		Active	Output
3.1.1-76	Number of eligible clients who received food and/or other nutrition services (PEPFAR Output - #C5.1.D)		Active	Output
3.1.1-77	Percent of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (National outcome - #T1.2.N)		Restore 2012	Output
3.1.1-78	Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy (PEPFAR Output - #T1.3.D)		Active	blank
3.1.1-79	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests (PEPFAR Output - #H1.1.D)		Active	blank
3.1.1-80	Percent of testing facilities (laboratories) that are accredited according to national or international standards (PEPFAR Outcome - #H1.2.D)		Active	Output
3.1.1-81	Number of new health care workers who graduated from a pre-service training institution within the reporting period (National Outcome - #H2.1.N)		Restore 2012	Output
3.1.1-82	Number of new health care workers who graduated from a pre-service training institution within the reporting period (PEPFAR Output - #H2.1.D)		Active	Output

3.1.1-83	Number of community health and para-social workers who successfully completed a pre-service training program (PEPFAR Output - #H2.2.D)		Restore 2012	Output
3.1.1-84	Number of health care workers who successfully completed an in-service training program within the reporting period (PEPFAR Output - #H2.3.D)		Active	Output
3.1.1-85	Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth		Active	output
3.1.1-86	Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (PEPFAR output -#P1.2.D)		Active	blank
3.1.2	Tuberculosis		category	
3.1.2.1	DOTS Expansion and Enhancement		category	
	Number of MDR-TB cases who initiate second line treatment		Recommended Custom	Output
3.1.2.9	Capacity Building (Proposed new sub element)		category	
3.1.2.9-1	Number of individuals trained in any component of the WHO Stop TB Strategy with USG funding	**	Active	Output
3.1.3	Malaria		category	
3.1.3.1	Treatment with Artemisinin-Based Combination Therapies		category	
3.1.3.1-1	Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	**	Active	Output
3.1.3.1-2	Number of artemisinin-based combination therapy (ACT) treatments purchased by other partners that were distributed with USG funds	**	Active	Output
3.1.3.1-3	Number of artemisinin-based combination therapy (ACT) treatments purchased with USG funds	**	Active	Output
3.1.3.1-4	Number of artemisinin-based combination therapy (ACT) treatments purchased in any fiscal year with USG funds that were distributed in this reported fiscal year.	**	Active	Output
3.1.3.1-5	Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy) with USG funds	**	Active	Output
3.1.3.1-6	Number of malaria rapid diagnostic tests (RDTs) purchased with USG funds	**	Active	Output

3.1.3.1-8	Number of rapid diagnostic tests (RDTs) purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	**	New 2013	Output
3.1.3.2	Insecticide-Treated Nets (ITNs) to Prevent Malaria		category	
3.1.3.2-1	Number of insecticide treated nets (ITNs) purchased by other partners that were distributed with USG funds	**	Active	Output
3.1.3.2-2	Number of insecticide treated nets (ITNs) purchased with USG funds (3.1.3-10)	**	Active	Output
3.1.3.2-3	Number of insecticide treated nets (ITNs) purchased in any fiscal year with USG funds that were distributed in this reported fiscal year.	**	Active	Output
3.1.3.3	Indoor Residual Spraying (IRS) to Prevent Malaria		category	
3.1.3.3-1	Number of people trained with USG funds to deliver indoor residual spraying (IRS) (3.1.2-23)	**	Active	Output
3.1.3.3-2	Number of houses targeted for spraying with USG funds	**	Active	Output
3.1.3.3-3	Number of houses sprayed with IRS with USG funds (3.1.3-6)	**	Active	Output
3.1.3.3-4	Total number of residents of sprayed houses	**	Active	Output
3.1.3.4	Intermittent Preventive Treatment of Pregnant Women		category	
3.1.3.4-1	Number of health workers trained in intermittent preventive treatment in pregnancy(IPTp) with USG funds	**	Active	Output
3.1.3.4-2	Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds	**	Active	Output
3.1.3.4-5	Number of sulfadoxine-pyrimethamine (SP) tablets purchased in any fiscal year with USG funds that were distributed in this reported fiscal year.	**	New 2013	Output
3.1.5	Other Public Health Threats		category	
3.1.5-32	Number of Neglected Tropical Disease (NTD) Treatments delivered through USG-funded programs	**	Active	Output
3.1.5-34	Number of people trained with USG funds in non-Neglected Tropical Diseases, other infectious diseases, and issues of public health importance.		Active	Output
3.1.5.2	Non-Communicable Public Health Threats Including Injuries		category	

3.1.5.2-1	Number of consolidated national Non-Communicable Diseases and Injury action plans finalized which were developed with USG assistance.		Active	Output
3.1.5.2-2	Percent of pregnant women who received counseling on the effects of tobacco and smoking in USG-assisted health facilities.		Active	Output
3.1.5.2-3	Number of USG assisted service delivery points offering a basic package of Non Communicable Disease and Injury (NCDI) prevention and control services.		Active	Output
3.1.6	Maternal and Child Health		category	
3.1.6-6	Number of cases of child diarrhea treated in USG-assisted programs		Restore 2013	Output
3.1.6-61	Number of children who received DPT3 by 12 months of age in USG-assisted programs		New 2013	Output
3.1.6-62	Number of newborn infants receiving antibiotic treatment for infection through USG-supported programs		New 2013	Output
3.1.6-63	Number of children under five years of age with suspected pneumonia receiving antibiotics by trained facility or community health workers in USG-assisted programs		New 2013	Output
3.1.6-64	Number of women giving birth who received uterotonics in the third stage of labor through USG-supported programs		New 2013	Output
	Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC)		Recommended Custom	Output
	Number of USG-supported communities establishing an emergency transport system for pregnant women within the reporting period		Recommended Custom	Output
	Number of babies who received postnatal care within two days of childbirth in USG-supported programs		Recommended Custom	Output
	Number of newborns not breathing at birth who were resuscitated in USG-supported programs		Recommended Custom	Output
	Number of women reached with education on exclusive breastfeeding		Recommended Custom	Output

3.1.6.8	Household Level Water, Sanitation, Hygiene and Environment		category	
3.1.6.8-2	Percent of households in target areas practicing correct use of recommended household water treatment technologies		Active	Outcome
3.1.6.8-3	Percent of population in target areas practicing open defecation		Active	Outcome
3.1.6.8-4	Number of liters of drinking water disinfected with point-of-use treatment products as a result of USG assistance		Active	Output
3.1.6.8-5	Number of communities certified as "open defecation free" (ODF) as a result of USG assistance		Active	Output
	Number of households with soap and water at a hand washing station commonly used by family members in USG-assisted programs		Recommended Custom	Output
	Number of individuals trained to implement improved sanitation methods		Recommended Custom	Output
3.1.7	Family Planning and Reproductive Health		category	
3.1.7.1	Service Delivery		category	
3.1.7.1-1	Couple Years protection in USG supported programs	**	Active	Output
3.1.7.1-2	Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide	**	Active	Output
3.1.7.1-3	Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services.		Active	Output
3.1.7.1-4	Number of additional USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services during the year		Active	Output
	National costed health plan developed that includes family planning (yes-no)		Recommended Custom	Output
3.1.7.2	Communication (FP)		category	
3.1.7.2-1	Percent of audience who recall hearing or seeing a specific USG-supported FP/RH message		Active	output
3.1.8	Water Supply and Sanitation		category	
3.1.8-31	Percent of population using an improved drinking water source		Active	Outcome

3.1.8-32	Percent of population using an improved sanitation facility		Active	Outcome
3.1.8-33	Percentage of children under age five who had diarrhea in the prior two weeks		Active	Outcome
3.1.8.1	Safe Water Access		category	
3.1.8.1-1	Percent of households using an improved drinking water source	**	Active	Outcome
3.1.8.1-2	Number of people gaining access to an improved drinking water source		Active	Output
3.1.8.1-3	Number of people receiving improved service quality from existing improved drinking water sources		Active	Output
3.1.8.2	Basic Sanitation		category	
3.1.8.2-1	Percent of households using an improved sanitation facility	**	Active	Outcome
3.1.8.2-2	Number of people gaining access to an improved sanitation facility		Active	Output
3.1.8.2-3	Number of improved toilets provided in institutional settings		Active	Output
3.1.8.3	Water and Sanitation Policy and Governance		category	
3.1.8.3-1	Number of policies, laws, agreements, regulations, or investment agreements (public or private) that promote access to improved water supply and sanitation		Active	Output
3.1.8.4	Sustainable Financing for Water and Sanitation Services		category	
3.1.8.4-1	Public sector expenditures on drinking water and sanitation as a percentage of national budget		Active	Outcome
3.1.8.5	Water Resources Productivity		category	
3.1.8.5-1	Percent of a drinking water utility's supply that is non-revenue		Active	Outcome
3.1.9	Nutrition		category	
3.1.9-1	Number of people trained in child health and nutrition through USG-supported programs	**	Active	Output
3.1.9-15	Number of children under five reached by USG-supported nutrition programs	**	Active	Output
3.1.9.1	Individual Prevention Programs		category	
3.1.9.1-1	Prevalence of children 6-23 months receiving a minimum		Active	Outcome

	acceptable diet			
3.1.9.1-2	Women's Dietary Diversity: Mean number of food groups consumed by women of reproductive age		Active	Outcome
3.1.9.1-3	Prevalence of households with moderate or severe hunger		Active	Outcome
3.1.9.2	Population-based Nutrition Service Delivery		category	
3.1.9.2-2	Number of health facilities with established capacity to manage acute under-nutrition	**	Active	Outcome
3.1.9.2-3	Number of children under five who received Vitamin A from USG-supported programs	**	Active	Output
3.1.9.3	Nutrition Enabling Environment and Capacity		category	
3.1.9.3-1	Percentage of national budget invested in nutrition			Outcome

Annex 4: List of Third Party Indicators (Archived)

These indicators have been identified as third party indicators. While they are key to track for programs, we have removed them from the PPR due to the fact that they are either not annual or they are available through a public data source that we can access at Headquarters. We have pulled all data for the countries receiving funding in Health in FY 13 and will make them available to both countries and HQ country teams

3 Investing In People
3.1 Health Systems Strengthening
Ratio of household out-of-pocket payments for health to total expenditure on health
Average (or median) availability of a set of selected essential medicines in public and private health facilities
Responsiveness as measured by client satisfaction
Percent of population enrolled in a health insurance scheme
3.1.2 Tuberculosis
TB Mortality Rate
TB Prevalence Rate
Percent of registered new smear positive pulmonary TB cases registered for treatment that were cured and completed treatment (Treatment Success Rate)
Number of TB cases (all forms) notified
Number of TB cases (all forms) who are successfully treated
TB case notification rate (all forms) per 100,000 population nationally
Percent of TB patients tested for HIV
Number of multi-drug resistant TB (MDR-TB) patients initiated on treatment
Treatment success rate among multi-drug resistant TB (MDR TB) cases
3.1.3 Malaria
Under-Five Mortality Rate
Proportion of households with at least one insecticide-treated net (ITN)
Proportion of children under 5 years old who slept under an insecticide-treated net (ITN) the previous night
Proportion of pregnant women who slept under an insecticide-treated net (ITN) the previous night
Proportion of Women who Received Intermittent Preventive Treatment (IPT) During Antenatal Care (ANC) Visits during Their Last Pregnancy
3.1.6 Maternal and Child Health
Under Five Mortality Rate (U5MR)
Maternal Mortality Ratio (MMR)
Newborn Mortality Rate (NMR)
Percent of Births Attended by a Skilled Doctor, Nurse or Midwife
Percent of Births receiving at least 4 antenatal care (ANC) visits during pregnancy
Percent of births delivered by caesarean section (rural and urban)
Percent of newborns receiving postnatal health check within two days of birth
Percent of newborns that were immediately breastfed after birth (within 1 hour)

Percent of children who received DPT3 vaccine by 12 months of age
Percent of children who have received the third dose of Pneumococcal conjugate vaccine by 12 months of age
Percent of children 12-23 months of age who have received measles vaccine by 12 months of age
Percent of children who received full-dose of rotavirus vaccine
Rate of non-polio acute flaccid paralysis (AFP) cases occurring per 100,000 children less than 15 years of age (non-polio AFP rate)
Regions/Countries of the world with Polio eradicated
Percent of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT)
Percent of children under five with suspected pneumonia taken to appropriate health provider
Percent of children under five with suspected pneumonia taken receiving antibiotics
Percent of infants aged 0-5mos who are exclusively breastfed
Percent of households with soap and water at a hand washing station commonly used by family members
Percent of population using an improved sanitation facility
Percent of population using an improved water source
3.1.7 Family Planning and Reproductive Health
MCPR: Modern method contraceptive prevalence rate
Total met need for family planning
Percent of women aged 18-24 who have their first birth before age 18.
Total Fertility Rate
Proportion of all closed birth intervals 36 - 59 months.
3.1.9 Nutrition
Prevalence of anemia among women of reproductive age
Prevalence of stunted children under five years of age
Prevalence of wasted children under five years of age
Prevalence of underweight women
Prevalence of anemia among children 6-59 months
Prevalence of underweight children under five years of age
Prevalence of exclusive breast feeding of children under six months of age
Neglected and Tropical Diseases
Number of countries that have eliminated lymphatic filariasis
Number of countries that have eliminated blinding trachoma
Percent of global target population receiving treatment for lymphatic filariasis
Percent of global target population receiving treatment for trachoma

Annex 5: Indicator Reference Sheets for Custom Recommended Indicators

Indicator	Percent of USG-supported primary health care (PHC) facilities that submitted routine reports on time, disaggregated by public sector and private sector, and disaggregated by numerator and denominator
Type of Indicator	Output
Disaggregates	Public and Private Sector Numerator and Denominator
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
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
Purpose:	<ul style="list-style-type: none"> To examine if facilities are submitting expected routine reporting forms, and if they are submitting them on time, per year, as specified in the HIS policy; To examine the reporting patterns of public sector facilities vs. private sector facilities
Applicability:	All countries where USAID is supporting PHC facility-level data collection and reporting. The system of PHC facility-level data collection and reporting is often referred to as the health management information system (HMIS).
Data Collection Frequency:	Annual
Measurement Tool:	An electronic HMIS will track if and when routine reports are received, by facility, or the District MOH office will track if and when routine reports are received, by facility.
Method of Measurement:	<p>The national HIS policy specifies for PHCs the routine reports that must be submitted and the required timeframe for submitting them over a 12 month period.</p> <p>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.</p> <p>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.</p>
Interpretation:	This indicator is a measure of the completeness and 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).

Indicator	Number of new health care workers who graduated from a USG supported pre-service training institution within the reporting period, by select cadre
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Type of Indicator:	Output
Numerator:	The number of new health workers who graduated from a pre-service training institution or program as a result of full or partial USG support.
Denominator:	N/A
Disaggregation:	<p>Disaggregation of doctors, nurses, and midwives is required.</p> <p>Countries are encouraged, but not required, to disaggregate also by other cadres and clinical/non-clinical (as defined below), and can consider disaggregation by geographical location, training duration, urban/rural, public/private, gender, etc.</p>
Purpose:	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. The data will tell us the number of new health workers who are available to enter the health work force each year as a result of full or partial USG support.
Applicability:	<p>All USG countries programming in this area.</p> <p>Countries may need to consider multiple smaller activities and how they fit together to determine if the support to the graduates of a particular institution is sufficient to count them in your program summary result.</p> <p>Applicability for partner level performance tracking: All partners working in USG-funded activities with a focus on workforce expansion through support to pre-service training institutions, tuition support, or education system strengthening and expansion should report on this indicator.</p>
Data Collection Frequency:	Annually for PPR
Measurement Tool:	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.
Method of Measurement:	<p>The number is the sum of new health workers from the host country who graduated from a pre-service training institution within the reporting period with full or partial USG support. Individuals may be in pre-service training over a number of years, but can be counted as graduated when they have completed the program. Graduates do not need to attend a formal ceremony – completing the program and being eligible to enter into service is sufficient. Local pre-service institutions may support other host country nationals under their program but those graduates should not be included in a country’s report on this indicator.</p> <p>Explanation: Training under this indicator is defined as “pre-service” training – the training of “new” health workers (see definition below). All training must occur prior to the individual entering the health workforce in his or her new position. A health worker who advances to a higher cadre (e.g., nurse completes medical school to become a doctor, clinical assistant completes training to become a clinical officer) shall be counted as a “new” health worker for the purposes of this indicator. The intent of</p>

the legislative goal is to expand the number of workers in the workforce and increase access to care this could occur through advancing current workers to higher level cadres through additional training and education. Pre-service training institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre's entry into the workforce.

"In-service" and "continuing education" training should **not** be included in the count for this indicator, but continue to be encouraged. These types of training are captured by other indicators. In order to count the duration of training must meet or exceed a minimum of 6 months. For example, community health workers who receive a 3-month training course cannot be counted here.

A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above.

Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted. Successful completion of training may be documented by diploma, certificate or other evidence of completion of the program and subsequent eligibility to enter service. Individuals not meeting these documented requirements should not be counted in this indicator.

"Health workers" refers to individuals involved in safeguarding and contributing to the prevention, promotion and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. This is not an exhaustive list of all health workers and position titles may vary from country to country.

For the purposes of this indicator, health workers include the following:

- 1) Clinical health workers – Clinical health workers play clinical roles in direct service delivery and patient care:
 - a) Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, social workers, medical technologists, and psychologists; They usually have a tertiary education and most countries have a formal method of certifying their qualifications.
 - b) Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counselors. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.
- 2) Non-clinical health workers - Non-clinical workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support.

Only disaggregation of doctors, nurses, and midwives is required. However, if the data were available by the other disaggregation areas mentioned above, and

	reviewed along with survey or other human resources data, country teams could assess if the numbers and mix of health workers trained adequately match the human resource demands of the health system, according to each country's HRH strategy or plan. Based on this assessment, countries can determine how to prioritize investments in the education, recruitment, deployment, and retention and training of health workers to maximize workforce expansion within the varieties of professionals that are most needed in line with national priorities around HRH.
Interpretation:	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.
Additional information:	http://www.who.int/healthinfo/systems/monitoring/en/index.html

Indicator	Number of women giving birth who received uterotonics in the third stage of labor through USG-supported programs
Type of Indicator:	Output
Numerator:	Number of women who gave birth in the last year who received uterotonics in the third stage of labor through USG-supported programs Uterotonic could include oxytocin or misoprostol. Uterotonics represent one element of active management of third stage of labor (AMTSL)
Denominator:	N/A
Disaggregation:	None
Purpose:	This indicator is used to measure the number of women receiving uterotonics in the third stage of labor through USG-supported programs
Applicability:	Globally, post-partum hemorrhage (PPH) is the main cause of maternal death. AMTSL is the recommended standard practice for all births to prevent PPH; administration of a uterotonic is one element of AMTSL
Data Collection Frequency:	Data collection by USG partners, reported annually
Measurement Tool	Registers/ databases, program monitoring tools
Method of Measurement:	Number of women giving birth who receive uterotonics in the third stage of labor through USG-supported programs

Indicator	Number of USG-supported facilities that provide appropriate life-saving maternity care (disaggregated by the level of facility)
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Type of Indicator:	Output
Numerator:	<p>Number of USG-supported facilities that provide appropriate life-saving maternity care</p> <p>For BEmONC facilities: All seven signal functions must be provided:</p> <ol style="list-style-type: none"> (1) Administer parenteral antibiotics (2) Administer uterotonic drugs (3) Administer parenteral anticonvulsants for preeclampsia and eclampsia (i.e., magnesium sulfate). (4) Manually remove the placenta (5) Remove retained products (e.g. manual vacuum extraction, dilation and curettage) (6) Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery) (7) Perform basic neonatal resuscitation (e.g., with bag and mask) <p>For CEmONC facilities: All nine signal functions must be provided:</p> <ol style="list-style-type: none"> (1) Administer parenteral antibiotics (2) Administer uterotonic drugs (3) Administer parenteral anticonvulsants for preeclampsia and eclampsia (i.e., magnesium sulfate). (4) Manually remove the placenta (5) Remove retained products (e.g. manual vacuum extraction, dilation and curettage) (6) Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery) (7) Perform basic neonatal resuscitation (e.g., with bag and mask) (8) Perform surgery (e.g. caesarean delivery) (9) Perform blood transfusion
Denominator:	N/A
Disaggregation:	Level of facility (BEmONC and CEmONC)
Purpose:	This indicator is used to measure number of USG-supported facilities that that provide appropriate life-saving maternity care. This is an indication of availability of services to address obstetric complications and improve maternal mortality.
Applicability:	The signal functions identify interventions needed to manage emergencies and life-threatening complications.
Data Collection Frequency:	Data collection by USG partners, reported annually
Measurement Tool	Registers/ databases, program monitoring tools
Method of Measurement:	Number of USG-supported facilities that provide appropriate life-saving maternity care

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Indicator	Number of USG-supported communities establishing an emergency transport system for pregnant women within the reporting period
Definition	<p>To be counted for this indicator the following criteria must be met:</p> <ul style="list-style-type: none"> • The community must have a written plan clearly outlining where, how and by whom the emergency transport will be provided • There must be a formal MOU established with the local health center and/or hospital and the USG implementing partner for referrals • The transportation system must be accessible to all pregnant women • There must be a registry for documenting requests for service and use of services • The system must have been used at least once since the last reporting period • The USG implementing partner must have assisted the community to develop and establish the emergency transportation system <p>Community: As defined by the local/district government</p> <p>Emergency transportation: is defined as a vehicle (simple as a bike or motor bike with an attached stretcher, taxi or ambulance service) able to quickly and efficiently carry women to an appropriate health facility for obstetric emergencies and deliveries.</p>
Type of Indicator:	Output
Disaggregation:	None
Primary Program Element	Health/Maternal Health
Data Source, Data Collection Plan, Reporting Frequency:	This indicator would be reported on a regular basis from implementing partners to the USAID Mission based on documented registration logs/program document.
Known Data Limitations	This indicator established the existence of an emergency transportation system, but not use or access.
Linkage to Long-Term Outcome or Impact	Pregnancy complications can be unpredictable and many women in developing countries cannot access health facilities where life-saving care is available. The three delays that have been shown to contribute to preventable perinatal deaths and maternal mortality are: a delay in recognizing danger signs of pregnancy and/or labor; a delay to seek care or a delay related to transportation to an adequate facility. Thus, timely availability of emergency transport services and prompt decision-making contribute to better maternal and neonatal outcomes.

Indicator	Number of babies who received postnatal care within two days of childbirth in USG-supported programs.
Type of Indicator:	Output
Numerator:	Number of babies who received postnatal care within two days of

	<p>childbirth in USG-support programs.</p> <p>Postnatal care includes a check on the newborn to assess health and well-being and refer or treat complications. It also includes counseling on essential newborn care (clean cord care, thermal care, and breastfeeding) as well as danger signs that may indicate potentially life-threatening complications. Postnatal care can be conducted at a health facility or at home, by a skilled health worker, an outreach worker, or a trained community health worker depending on the local context.</p>
Denominator:	N/A
Disaggregation:	None
Purpose:	This indicator is used to assess the number of babies who received postnatal care within two days of childbirth.
Applicability:	Postnatal care (especially home visits after birth) have demonstrated significant reductions in neonatal mortality.
Data Collection Frequency:	Data collection by USG partners, reported annually
Measurement Tool	Registers/ databases, program monitoring tools
Method of Measurement:	Number of babies who received postnatal care within two days of childbirth in USG-supported programs.

Indicator	Number of newborns not breathing at birth who were resuscitated in USG-supported programs
Type of Indicator:	Output
Numerator:	<p>Number of newborns not breathing at birth who were resuscitated in USG-supported programs</p> <p>Resuscitation includes drying, wrapping, stimulation, and bag/mask.</p>
Denominator:	N/A
Disaggregation:	Type of resuscitation (drying/wrapping, stimulation, bag/mask)
Purpose:	This indicator is used to assess the number of newborns not breathing at birth who were resuscitated in USG-supported programs.
Applicability:	Birth asphyxia is one of the leading causes of neonatal mortality. Appropriate resuscitation is an evidence-based intervention to decrease asphyxia-related mortality.

Data Collection Frequency:	Data collection by USG partners, reported annually
Measurement Tool	Registers/ databases, program monitoring tools
Method of Measurement:	Number of newborns not breathing at birth who were resuscitated in USG-supported programs

Indicator	Number of women reached with individual or small group level education on the benefits of exclusive breastfeeding.
Definition	<p>Exclusive breastfeeding is defined as an infant feeding practice where the infant receives breast milk (including expressed breast milk or breast milk from a wet nurse) but nothing else during the first six months of life, with the exception of vitamin or mineral supplements, medicine or ORS (under recommendation of a medical professional). An infant receiving plain boiled water, soups, porridge, semi-solid foods before six months of age cannot be counted as exclusively breast fed.</p> <p>Immediate initiation of breastfeeding is defined as putting the infant to breast within one hour of delivery.</p> <p>Individual session: is defined as an intervention that is provided to one individual at a time.</p>
Type of Indicator:	Output
Disaggregation:	None
Primary Program Element	Health, Maternal and Child Health
Data Source, Data Collection Plan, Reporting Frequency:	This indicator would be reported on a regular basis from implementing partners to the USAID Mission based on documented registration logs/program document.
Known Data Limitations	The number of women reached with education does not always translate into adaption of breast feeding practice.
Linkage to Long-Term Outcome or Impact	Exclusive breastfeeding is the single most effective intervention to improve the survival of children and directly affects the nutritional status of children. An estimated 1 million child deaths could be averted every year if all children were optimally breastfed.

Indicator	Number of individuals trained to implement improved sanitation methods
Definition	<p>To be counted for this indicator, all of the following criteria must be met:</p> <ul style="list-style-type: none"> • The individual must have attended a training on how to implement an improved sanitation method • The training must have been provided by the USG or an implementing partner in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger.

	<ul style="list-style-type: none"> Attendance at educational session/s must be documented by the partner <p>Examples of Improved sanitation facilities include:</p> <ul style="list-style-type: none"> Flush toilet uses a cistern or holding tank for flushing water, and a water seal (which is a U-shaped pipe below the seat or squatting pan) that prevents the passage of flies and odors. A pour flush toilet uses a water seal, but unlike a flush toilet, a pour flush toilet uses water poured by hand for flushing (no cistern is used). Piped sewer system is a system of sewer pipes, also called sewerage, that is designed to collect human excreta (feces and urine) and wastewater and remove them from the household environment. Sewerage systems consist of facilities for collection, pumping, treating and disposing of human excreta and wastewater. Septic tank is an excreta collection device consisting of a water-tight settling tank, which is normally located underground, away from the house or toilet. The treated effluent of a septic tank usually seeps into the ground through a leaching pit. It can also be discharged into a sewerage system. Flush/pour flush to pit latrine refers to a system that flushes excreta to a hole in the ground or leaching pit (protected, covered). Ventilated improved pit latrine (VIP) is a dry pit latrine ventilated by a pipe that extends above the latrine roof. The open end of the vent pipe is covered with gauze mesh or fly-proof netting and the inside of the superstructure is kept dark.
Type of Indicator:	Output
Disaggregation:	None
Primary Program Element	Health/WASH
Data Source, Data Collection Plan, Reporting Frequency:	This indicator would be reported on a regular basis from implementing partners to the USAID Mission based on documented registration logs/program document.
Known Data Limitations	This indicator captures whether an individual was trained, but doesn't capture if knowledge was gained or applied.
Linkage to Long-Term Outcome or Impact	<p>According to the World Health Organization and UNICEF, in 2010, only 63% of the world's population used improved sanitation facilities, with Sub-Saharan Africa and Southern Asia having only 30% and 41%, respectively¹. An estimated 2.5 billion people are still without improved sanitation. About 15% of the world's population lives without any form of sanitation and practice open defecation.</p> <p>Latrines provide a barrier to diseases carried in fecal matter thereby reducing sanitation related diseases, especially diarrhea, incidence of worms and other parasites and improving sanitation, hygiene and the water supply. Use of latrines improves safety, especially for women who do not need to go out in the fields alone to defecate. Lack of adequate sanitation facilities at schools prevents girls from attending. Latrines produce compost and biogas that can be used to fertilize fields or for energy.</p>

Indicator	Number of households with soap and water at a hand washing station commonly used by family members in USG-assisted programs
Definition	<p>A hand washing station is a location where family members go to wash their hands. In some instances, these are fixed locations where hand washing devices are built in and are permanently placed. But they may also be movable devices that may be placed in a convenient spot for family members to use. The measurement takes place via observation by an enumerator during the household visit. The enumerator must see the soap and water at this station. The soap may be in bar, powder, or liquid form. Shampoo will be considered liquid soap. The cleansing product must be at the hand washing station or reachable by hand when standing in front of it.</p> <p>A “commonly used” hand washing station, including water and soap, is one that can be readily observed by the enumerator during the household visit, and where study participants indicate that family members generally wash their hands.</p>
Type of Indicator:	Output
Disaggregation:	None
Primary Program Element	Health/Maternal and Child Health/WASH
Data Source, Data Collection Plan, Reporting Frequency:	This indicator would be reported on a regular basis from implementing partners to the USAID Mission based on documented registration logs/program document.
Known Data Limitations	<p>The measurement of hand washing is difficult and should preferably be conducted by objective measures that do not rely on self-reports. Spot checks required to obtain information are an objective proxy for measuring hand washing. A study conducted in India tested the validity of different hand washing indicators. The reference for this study is: Biran, A., T. Rabie, W. Schmidt, S. Juvekar, S. Hirve, V. Curtis. (2008). See also, “Comparing the performance of indicators of hand-washing practices in rural Indian households.” <i>Tropical Medicine and International Health</i>. Vol. 13, No. 2, pp. 278-285. In this study, 27 measures were compared to what is believed to be the gold standard for hand washing measurement: structured observations. Using the 27 measures, the study attempted to predict whether individuals were washers or non-washers as defined via structured observation. The results indicated an ability to predict the non-washers but were inconclusive about predicting the washers. The indicator associated with prediction of non-washers was the lack of soap in different locations in the household, including the yard. If there is no soap at a hand washing station, then no hand washing with soap will ever occur. Consequently, checking to see if soap is present at hand washing stations is a simple and important indicator. Water is obviously needed to wash hands and the quality of water is not important and may not be detected through the survey.</p>

	<p>In some contexts soap may be an expensive commodity and family members may carry the soap to the hand washing station when they want to wash their hands, in order to prevent theft of the soap or misuse. However, it is assumed that the visible presence of soap at a hand washing station acts as a cue and thus as a reminder that it needs to be used at critical junctures. When conducting the analysis, program managers and evaluators may decide to cross the information about the presence of water at hand washing stations with the presence of soap anywhere in the house (in households with no observable soap at a hand washing station). In such instances: 1) the presence of water plus soap at the most commonly used hand washing station and 2) the presence of water at the same location plus the presence of soap elsewhere in the house may be reported separately.</p>
Linkage to Long-Term Outcome or Impact	<p>A clear link can be made between hand washing with soap among child caretakers at critical junctures and the reduction of diarrheal disease among children under 5, one of the two major causes of child morbidity and mortality in developing countries. The critical junctures in question include hand washing with soap after the risk of fecal contact (after defecation and after cleaning a child's bottom) and before handling food (before preparing food, eating, or feeding a child).</p>

Indicator	National costed health plan developed that includes family planning
Definition	<p>This indicator measures the presence of an in country health plan, that includes Family Planning activities, developed on the national level, with cost components.</p> <p>Costed: The national plan should have cost elements associated with the planned activities or projects. However, it does not require the presence of actual budget allocations.</p>
Type of Indicator	Output. This is a Yes/No measure indicating the presence of a costed national health plan.
Disaggregation	None
Primary Program Element	Health/Family Planning
Data Source, Data Collection Plan, Reporting Frequency:	Host country Government Ministry of Health. Annual reporting.
Known Data Limitations	None
Linkage to Long-Term Outcome or Impact	Ensuring that Host Country is committed to implementing Family Planning activities to reach the goals of the FP2020 initiative.

