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Integrated Natural Resource Management (INRM)

# HEARTH Monitoring and Evaluation Toolkit:

*Health*

APRIL 2022

## **Integrated Natural Resource Management (INRM)**

Sound management of natural resources is central to long-term development and resilience. Faced with an urgent need to reduce environmental degradation while improving human well-being, solutions that effectively integrate investments in natural resource management with economic and social development are increasingly urgent. INRM promotes integrated programming across environment and non-environment sectors and across the Program Cycle. INRM supports USAID to amplify program impacts, strengthen gender equality and social inclusion, and identify best practices for integration.

For more information:

<https://land-links.org/project/integrated-natural-resource-management-inrm-activity/>

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# Acronyms

CPI	Consumer Price Index
DHS	Demographic and Health Surveys
FAO	Food and Agriculture Organization
FTF	Feed the Future
HEARTH	Health, Ecosystems, and Agriculture for Resilient Thriving Societies
INRM	Integrated Natural Resource Management
IP	Implementing Partner
LCU	Local Currency Units
MERL	Monitoring, Evaluation, Research, and Learning
MCV	Measles Containing Vaccination
MII	Method Information Index
NGO	Non-Government Organization
ORS	Oral Rehydration Solution
OFDA	Office of Foreign Disaster Assistance
PIRS	Performance Indicator Reference Sheet
PMA	Performance Monitoring for Action
PPP	Purchasing Power Parity
RAND	Research and Development
STARR II	Strengthening Tenure and Resource Rights II
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
WHO	World Health Organization



# Overview

Together, Health, Ecosystems, and Agriculture for Resilient Thriving Societies (HEARTH) and INRM have created the HEARTH Monitoring and Evaluation Toolkit, a suite of indicators and guidance that will help United States Agency for International Development (USAID) Missions and implementing partners (IPs) monitor progress and aggregate common metrics to build the evidence base around the effectiveness of integrated strategic approaches. This document is an individual module from the toolkit, presented separately to facilitate use by individual HEARTH activities. Before using this module, we recommend first accessing the full toolkit and reviewing the list of sectors covered by each module, and determining which are most relevant for your activity:

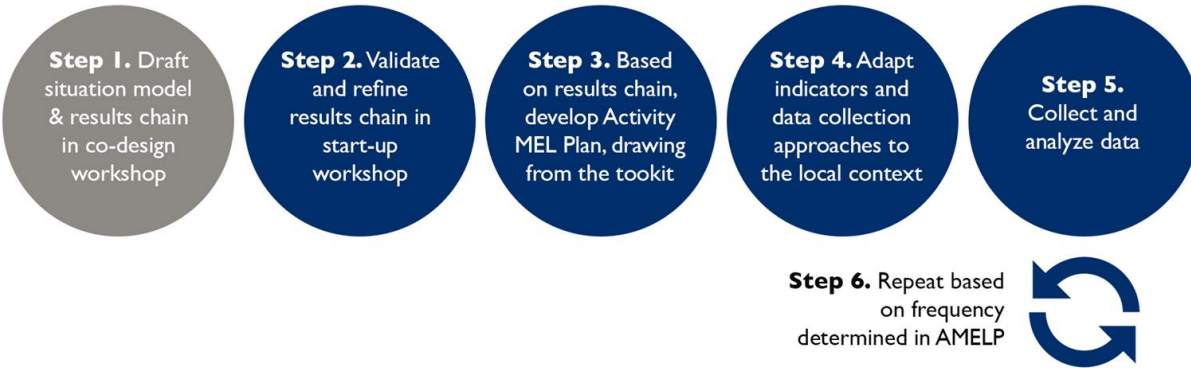
[Access Full Toolkit on Biodiversity Links Here.](#)

## How To Use This Toolkit

This toolkit presents a **menu of options** for outcomes and recommended indicators across the HEARTH activities. Before using this toolkit, activities should have developed a robust theory of change – through first drafting their situation model and results chains during the co-design workshops, many of which have been completed already, and then validating and refining those results chains during start-up workshops.

Based on the activity theory of change, HEARTHS should develop their Activity Monitoring, Evaluation, Research, and Learning (MERL) Plan, which should draw directly from the toolkit. It is not expected that all outcomes or indicators will be relevant for all activities, but that activities should select those in line with their results chains and activity theory of change. Additionally, there might be activity-specific outcomes not included in this toolkit because they were not generally applicable across the HEARTH portfolio, and Missions and IPs should therefore include additional indicators in their MERL plans, as relevant.

When developing activity MERL plans, the indicators in this toolkit are intended to be used both to **standardize reporting for monitoring data, as well as a basis for evaluation data collection**. While monitoring trends in these indicators over time may be important for some activities, USAID anticipates that Missions and IPs will also identify important questions about the causal impact of their activities during the start-up activities, best answered using evaluation approaches. Which indicators will be part of monitoring systems, and which will be used to answer evaluation questions, will affect how the toolkit is operationalized. In addition, it is expected that MERL plans will likely include **qualitative data sources**, important to further explaining monitoring and evaluation results and exploring learning questions in more depth, in addition to the quantitative data collected using the approaches from the toolkit.



## Indicator Guidance and Core Household Questionnaire

This document contains guidance for defining and collecting data for each of the recommended indicators for Missions and IPs, including Performance Indicator Reference Sheets throughout. This guidance draws heavily on established best practices, such as the Demographic and Health Surveys (DHS) and Feed the Future programs. In addition to this guidance, INRM developed a core questionnaire to provide a basis for household surveys to facilitate ease of take-up. It should be emphasized that it is important for Missions and IPs to adapt the questionnaire to their local country context – which might include adding/removing answer choice options, updating question text or translations, etc. Areas where edits for local context are typically required are identified in the tool and following guidance. The full toolkit includes additional guidance on respondent identification and inclusion of household rosters, as well as more in-depth discussions on sampling approaches, data collection administration and frequency, data management, privacy, and ethics, which should be considered.

# Outcomes and Indicators for Health

**Table 1:** Overview of Outcomes and Recommended Indicators for the Health Sector.

Outcomes	HEARTH Portfolio Indicators
<a href="#">Increased use of family planning services</a>	<ul style="list-style-type: none"> <li>• <a href="#">Percent of women/men of reproductive age who are using a contraceptive method</a></li> <li>• <a href="#">Percent of women given information on contraception methods (Method Information Index)</a></li> </ul>
<a href="#">Increased access to maternal health services</a>	<ul style="list-style-type: none"> <li>• <a href="#">Percent of pregnant women who have attended at least two comprehensive antenatal clinics</a></li> <li>• <a href="#">Percent of pregnant women who deliver assisted by a skilled attendant at birth</a></li> <li>• <a href="#">Percent of pregnant women who deliver at a health facility</a></li> </ul>
<a href="#">Increased health expenditures to seek treatment for sick family members</a>	<ul style="list-style-type: none"> <li>• <a href="#">Average amount of health expenditures per sick family member</a></li> </ul>
<a href="#">Increased access to healthcare services</a>	<ul style="list-style-type: none"> <li>• <a href="#">Average number of outpatient consultations per sick family member</a></li> </ul>
<a href="#">Increased access to treatment for common childhood illnesses</a>	<ul style="list-style-type: none"> <li>• <a href="#">Average number of visits for community-based treatment per sick child five and under</a></li> <li>• <a href="#">Percent of children 0-35 months of age who received their first dose of measles-containing vaccine by 12-months of age</a></li> </ul>
<a href="#">Improved access, reliability, and affordability of safe household drinking water</a>	<ul style="list-style-type: none"> <li>• <a href="#">Number of people gaining access to basic drinking water services</a></li> <li>• <a href="#">Number of people gaining access to safely managed drinking water services</a></li> <li>• <a href="#">Number of people receiving improved service quality from an existing basic or safely managed drinking water service</a></li> <li>• <a href="#">Percent of children under five with diarrhea in the past two weeks</a></li> <li>• <a href="#">Percent of children under five with diarrhea in the past two weeks treated with ORS</a></li> </ul>

# Health

## Pathways to Change

Access and use of healthcare services, including family planning services and maternal health services, might increase either due to direct HEARTH activities (e.g., constructing or otherwise providing financial/technical support for a health clinic, or provision of health information and services through community health workers), as a result of increased incomes, or increased knowledge/awareness of services available and their benefits. The same is true for access/use of treatment for children, which might increase due to activities directly supporting the health sector, thus increasing the availability of services, or through increased incomes. The number of children receiving treatment might also increase through greater awareness (of both availability of services, and the benefits of using them – especially vaccines). Healthier individuals and households may be more likely to engage in environmental conservation and sustainable agricultural and other income generating activities.

Due to increased access to healthcare services and/or increased incomes, it is expected that health expenditures would increase as households are able to get treatment for sick family members that previously they might not have had access to or been able to afford. At the same time, health expenditures overall might decrease, as overall health improves. In particular, healthcare seeking costs will decrease as more/better health information services become more available and convenient to access.

Similar to above, improved drinking water might be a result of direct HEARTH activities (e.g., digging new or repairing existing boreholes), or increased incomes (which households can use to invest in improvements in their water supply/systems). Additionally, greater awareness of the health benefits of clean drinking water might increase demand.



# Recommended Outcomes and Indicators

Outcome	Description	Recommended Indicator & Duration
Increased use of family planning services	Contraceptive prevalence rate is the percent of women/men of reproductive age who are using a contraceptive method at a particular point in time, almost always reported for women/men married or in a sexual union. Additional questions would be asked regarding the method of contraception and who primarily chose to use contraception in the partnership. This indicator would be reported for both men and women respondents, disaggregated by sex, age, and contraception method.	<p><b>Indicator:</b> Percent of women/men of reproductive age who are using a contraceptive method</p> <p><b>Source:</b> Adapted from DHS Women’s Module<sup>1</sup></p> <p>Duration: 2 minutes</p>
	The Method Information Index <sup>2</sup> measures the extent to which women were given specific information when they received family planning services. The indicator provides a summary measure of the adequacy of information being provided to women by service providers at the time when they chose the contraception method currently being used. It is calculated by looking at the number of women who respond “yes” to a set of 3 questions, divided by the number of women of reproductive age currently using a contraceptive method.	<p><b>Indicator:</b> Percent of women given information on contraception methods (Method Information Index)</p> <p><b>Source:</b> Performance Monitoring for Action (PMA) 2020<sup>3</sup></p> <p>Duration: 2 minutes</p>
Increased access to maternal health services	This module is a set of 6 questions regarding whether the respondent sought any antenatal care, who she saw, where she received the treatment, how many weeks/months pregnant she was when she first received antenatal care, how many times she received antenatal care during the pregnancy, and type of care provided. A woman will thus be counted in the numerator of this indicator if she (1) received antenatal care 2 or more times during her pregnancy, AND (2) that care included at	<p><b>Indicator:</b> Percent of pregnant women who have attended at least two comprehensive antenatal clinics</p> <p><b>Source:</b> Adapted from USAID Office of Foreign Disaster Assistance</p>

<sup>1</sup> ibid

<sup>2</sup> Chang, Karen T., Mulenga Mukanu, Ben Bellows, Waqas Hameed, Amanda M. Kalamar, Karen A. Grépin, Xaher Gul, and Nirali M. Chakraborty. “Evaluating Quality of Contraceptive Counseling: An Analysis of the Method Information Index.” *Studies in Family Planning* 50, no. 1 (January 21, 2019): 25–42. <https://doi.org/10.1111/sifp.12081>.

<sup>3</sup> Johns Hopkins Bloomberg School of Public Health. “Data and Study Designs.” *Survey Methodology | PMA Data*. Performance Monitoring for Action, 2021. <https://www.pmadata.org/data/survey-methodology>.

Outcome	Description	Recommended Indicator & Duration
	<p>least 4 of the 7 comprehensive care components listed in the core questionnaire.</p> <p>It should be noted that it will likely be challenging to measure impacts for this indicator without a very large sample size (given that it is limited to households with women who have been pregnant in a specified time frame).</p>	<p>(OFDA) Health Performance Indicator Reference Sheet (PIRS),<sup>4</sup> measured using DHS Women’s Module<sup>5</sup></p> <p><b>Duration:</b> 6 minutes</p>
	<p>This indicator measures whether women had a delivery assisted by a skilled (not traditional) attendant at birth. Similar considerations regarding measurement and sample size as for antenatal care apply to delivery assistance.</p>	<p><b>Indicator:</b> Percent of pregnant women who deliver assisted by a skilled attendant at birth</p> <p><b>Source:</b> Adapted from USAID OFDA Health PIRS,<sup>6</sup> measured using DHS Women’s Module<sup>7</sup></p> <p><b>Duration:</b> 1 minute</p>
	<p>This indicator measures whether women had a delivery at home or at a medical facility. To reduce maternal and infant mortality, the optimal long-term objective is that all births take place in (or very near to) health facilities in which obstetric complications can be treated when they arise. This indicator is considered a key process measure for assessing country progress in reducing maternal</p>	<p><b>Indicator:</b> Percent of pregnant women who deliver at a health facility</p> <p><b>Source:</b> Adapted from USAID Standard</p> <p><b>Indicator:</b> HL.6.2-2,<sup>9</sup></p>

<sup>4</sup> “Health PIRS.” USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).

<sup>5</sup> “Demographic and Health Survey Module Woman’s Questionnaire.” Demographic and Health Survey. United States Agency for International Development, June 19, 2020. [https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8\\_Womans\\_QRE\\_EN\\_19Jun2020\\_DHSQ8.pdf](https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8_Womans_QRE_EN_19Jun2020_DHSQ8.pdf).

<sup>6</sup> “Health PIRS.” USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).

<sup>7</sup> “Demographic and Health Survey Module Woman’s Questionnaire.” Demographic and Health Survey. United States Agency for International Development, June 19, 2020. [https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8\\_Womans\\_QRE\\_EN\\_19Jun2020\\_DHSQ8.pdf](https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8_Womans_QRE_EN_19Jun2020_DHSQ8.pdf).

<sup>9</sup> “Health Indicator Reference Sheets.” IRS\_Category3. U.S. Department of State, n.d. [https://www.state.gov/wp-content/uploads/2020/09/IRS\\_Category3\\_Health\\_Public.508.xlsx](https://www.state.gov/wp-content/uploads/2020/09/IRS_Category3_Health_Public.508.xlsx).

Outcome	Description	Recommended Indicator & Duration
	mortality. <sup>8</sup> Similar considerations regarding measurement and sample size as for antenatal care apply to location of delivery.	measured using DHS Women’s Module <sup>10</sup>  <b>Duration:</b> 1 minute
Increased health expenditures to seek treatment for sick family members	<p>This indicator will be constructed as the total household expenditure on medical costs over the past three months, divided by the number of sick household members. Asking about medical costs per sick household member will provide additional information about expenditures across sex and age groups, as well as facilitate better recall. While asking by health expenditure type (e.g., outpatient costs, medication, etc.) may similarly result in more accurate recall, this would add more time to the survey, and therefore is not recommended.</p> <p>This indicator is divided by the number of sick household members, given that health may improve overall because of HEARTH activities, which would decrease average household level health expenditures (as fewer people get sick at the extensive margin). However, this does not fully account for household members experiencing less severe illness, which might reduce per household member health expenses. This indicator should be analyzed alongside other health indicators for a complete picture of health-related outcomes.</p>	<p><b>Indicator:</b> Average amount of health expenditures per sick family member</p> <p><b>Source:</b> Adapted from Research and Development (RAND) Indonesia Family Life Survey<sup>11</sup></p> <p><b>Duration:</b> 1-2 minutes (depending on the number of sick household members)</p>
Increased coverage of	This indicator will be constructed as the total number of outpatient consultations over the past three months, divided by the number of sick household members.	<b>Indicator:</b> Average number of outpatient

<sup>8</sup> See USAID Standard Health Indicator HL.6.2-2: “Health Indicator Reference Sheets.” IRS\_Category3. U.S. Department of State, n.d. [https://www.state.gov/wp-content/uploads/2020/09/IRS\\_Category3\\_Health\\_Public.508.xlsx](https://www.state.gov/wp-content/uploads/2020/09/IRS_Category3_Health_Public.508.xlsx).

<sup>10</sup> “Demographic and Health Survey Module Woman’s Questionnaire.” Demographic and Health Survey. United States Agency for International Development, June 19, 2020. [https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8\\_Womans\\_QRE\\_EN\\_19Jun2020\\_DHSQ8.pdf](https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8_Womans_QRE_EN_19Jun2020_DHSQ8.pdf).

<sup>11</sup> Strauss, John, Firman Witoelar, and Bondan Sikoki. “Household Survey Questionnaire for the Indonesia Family Life Survey, Wave 5.” RAND Corporation WR-1143/3-NIA/NICHD (2016). <https://doi.org/10.7249/wr1143.3>.

Outcome	Description	Recommended Indicator & Duration
healthcare services	<p>Outpatient consultations should be to seek curative treatment for illness and excludes preventive care visits like vaccination and antenatal care. It is recommended to disaggregate by source of consultation (e.g., community health center, traditional healer, government hospital). While this indicator is measuring the receipt of outpatient consultations, this can be used as a proxy for access.</p>	<p>consultations per sick family member</p> <p><b>Source:</b> Adapted from USAID OFDA Health PIRS<sup>12</sup></p> <p><b>Duration:</b> 2 minutes</p>
Increased coverage of treatment for common childhood illnesses	<p>This indicator will be constructed as the total number of visits by children for community-based treatment of illness over the past three months, divided by the number of sick children (5 years of age and under). It is recommended to ask this across a range of common childhood illnesses, which should be adapted for each HEARTH, rather than by specific illness to increase the potential sample size (i.e., to increase the likelihood that a household had at least one child with the illness in question over the last three months).</p>	<p><b>Indicator:</b> Average number of visits for community-based treatment per sick child 5 and under</p> <p><b>Source:</b> Adapted from USAID OFDA Health PIRS<sup>13</sup></p> <p><b>Duration:</b> 2 minutes</p>
	<p>This indicator is adapted from the USAID Standard Indicator for the number of children who received their first dose of measles-containing vaccine by 12 months of age. Measles vaccination is an important contributor to USAID's initiative to prevent child deaths. Unvaccinated children are at highest risk of measles and its complications, including death. In 2017, approximately 100,000 children died from measles, and the number of measles outbreaks have increased in recent years following anti-vaccination efforts combined with poor health systems. Measles outbreaks can be particularly</p>	<p><b>Indicator:</b> Percent of children 0-35 months of age who received their first dose of measles-containing vaccine by 12-months of age</p> <p><b>Source:</b> Adapted from USAID Standard Indicator HL.6.4-62,<sup>15</sup></p>

<sup>12</sup> "Health PIRS." USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).

<sup>13</sup> *ibid*

<sup>15</sup> "Health Indicator Reference Sheets." IRS\_Category3. U.S. Department of State, n.d. [https://www.state.gov/wp-content/uploads/2020/09/IRS\\_Category3\\_Health\\_Public.508.xlsx](https://www.state.gov/wp-content/uploads/2020/09/IRS_Category3_Health_Public.508.xlsx).

Outcome	Description	Recommended Indicator & Duration
	<p>deadly in countries experiencing or recovering from a natural disaster or conflict.<sup>14</sup></p> <p>HEARTH activities should only include this indicator if vaccination is directly relevant to program activities (i.e., if the activity is building/providing support for health facilities that might be providing vaccines, conducting vaccine awareness/information campaigns, etc.). Additionally, it should be noted that it will likely be challenging to measure impacts for this indicator without a very large sample size (given that it is limited to households with children under 3).</p>	<p>measured using DHS Women’s Module<sup>16</sup></p> <p><b>Duration:</b> 5 minutes</p>
Improved access, reliability, and affordability of safe household drinking water	<p>These indicators are the number of households gaining access to a water source categorized as limited, basic, or safely managed as a result of United States Government (USG) assistance. These water source categories reflect a combination of whether the water source is improved, its accessibility, and reliability. Improved water sources include piped water into the dwelling, piped water into the yard, a public tap or standpipe, a tube well or borehole, a protected dug well, a protected spring, and rainwater. Improved water sources may also include tanker truck, cart with small tank, or bottled water, depending on the country.<sup>17</sup> In addition to asking about the main drinking water source, recommended follow-up questions are added about perceptions of changes in availability and quality.</p>	<p><b>Indicator:</b> Number of people gaining access to basic drinking water services as a result of USG assistance</p> <p><b>Indicator:</b> Number of people gaining access to safely managed drinking water services as a result of USG assistance</p> <p><b>Source:</b> Joint Monitoring Program core questions for drinking water household survey.<sup>18</sup> Adapted from USAID Standard</p>

<sup>14</sup> ibid

<sup>16</sup> “Demographic and Health Survey Module Woman’s Questionnaire.” Demographic and Health Survey. United States Agency for International Development, June 19, 2020. [https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8\\_Womans\\_QRE\\_EN\\_19Jun2020\\_DHSQ8.pdf](https://www.dhsprogram.com/pubs/pdf/DHSQ8/DHS8_Womans_QRE_EN_19Jun2020_DHSQ8.pdf).

<sup>17</sup> Definition based on Feed the Future Guide to Statistics.

<sup>18</sup> WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. “Core questions on water, sanitation and hygiene for household surveys.” 2018. <https://washdata.org/monitoring/methods/core-questions>.



Outcome	Description	Recommended Indicator & Duration
		<p>Indicators HL.8.1-1 and HL.8.1-2.<sup>19</sup></p> <p><b>Duration:</b> 5 minutes</p>
	<p>Providing “access” does not necessarily guarantee beneficiary “use” of a basic or safely managed drinking water service, and thus potential health benefits are not certain to be realized from simply providing “access.” This indicator captures additional dimensions of a water service’s reliability or affordability--two other important factors that influence the likelihood that those defined as having access will actually use the service.</p>	<p><b>Indicator:</b> Number of people receiving improved service quality from an existing basic or safely managed drinking water service as a result of USG assistance</p> <p><b>Source:</b> Joint Monitoring Program core questions for drinking water household survey.<sup>20</sup> Adapted from USAID Standard Indicators HL.8.1-3.<sup>21</sup></p> <p><b>Duration:</b> 3 minutes</p>
	<p>Diarrheal disease is a leading cause of death in children under-five in USAID's priority Maternal &amp; Child Health countries, as well as a substantial contributor to child malnutrition. This indicator will be measured by asking the primary caregiver whether each child under 5 has had diarrhea in the last two weeks. The term(s) used for diarrhea should encompass the expressions used for all</p>	<p><b>Indicator:</b> Percent of children under five with diarrhea in the past two weeks</p> <p><b>Source:</b> Adapted from DHS Women’s Module<sup>22</sup></p>

<sup>19</sup> USAID. “Water and Development Indicator Handbook.” 2021. <https://www.globalwaters.org/resources/assets/water-and-development-indicator-handbook>.

<sup>20</sup> WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. “Core questions on water, sanitation and hygiene for household surveys.” 2018. <https://washdata.org/monitoring/methods/core-questions>.

<sup>21</sup> USAID. “Water and Development Indicator Handbook.” 2021. <https://www.globalwaters.org/resources/assets/water-and-development-indicator-handbook>.

<sup>22</sup> “Demographic and Health Survey Module Woman’s Questionnaire.” Demographic and Health Survey. United States Agency for International Development, June 19, 2020.

Outcome	Description	Recommended Indicator & Duration
	forms of diarrhea, including bloody stools (consistent with dysentery), watery stools, etc.	<b>Duration:</b> 1 minute
	ORS is an effective, low-cost prevention and management intervention for diarrhea. This indicator is therefore measured as the percent of children under 5 with diarrhea in the past two weeks who were treated with ORS, divided by the total number of children under 5 with diarrhea in the past two weeks.	<p><b>Indicator:</b> Percent of children under five with diarrhea in the past two weeks treated with ORS</p> <p><b>Source:</b> Adapted from USAID Standard Indicator HL.6.6-1,<sup>23</sup> measured using DHS Women’s Module<sup>24</sup></p> <p><b>Duration:</b> 1 minute</p>

<sup>23</sup> “Health Indicator Reference Sheets.” IRS\_Category3. U.S. Department of State, n.d. [https://www.state.gov/wp-content/uploads/2020/09/IRS\\_Category3\\_Health\\_Public.508.xlsx](https://www.state.gov/wp-content/uploads/2020/09/IRS_Category3_Health_Public.508.xlsx).

<sup>24</sup> “Demographic and Health Survey Module Woman’s Questionnaire.” Demographic and Health Survey. United States Agency for International Development, June 19, 2020.

# Performance Indicator Reference Sheets

<b>INDICATOR TITLE: Percent of women/men of reproductive age who are using a contraceptive method</b>	
<p><b>DEFINITION:</b></p> <p>Contraceptive prevalence rate is the percent of women/men of reproductive age who are using a contraceptive method at a particular point in time.</p> <p>An illustrative list of contraceptive methods may include:</p> <ul style="list-style-type: none"> <li>- Female/male sterilization</li> <li>- IUD</li> <li>- Injectables</li> <li>- Implants</li> <li>- Pill</li> <li>- Female/male condom</li> <li>- Emergency contraception</li> <li>- Diaphragm</li> <li>- Foam/jelly</li> <li>- Standard days method/cycle beads</li> <li>- Lactation amenorrhea method</li> <li>- Rhythm method</li> <li>- Withdrawal</li> </ul> <p>Additional questions should be asked regarding the method of contraception and who primarily chose to use contraception in the partnership. This indicator would be reported for both men and women respondents, disaggregated by sex, age, and contraception method.</p>	
<p><b>ADAPTATION:</b></p> <p>The list of contraceptive methods and their locally understood names should be adjusted for different countries/regions.</p>	
<p><b>UNIT:</b></p> <p>Percent</p>	<p><b>DISAGGREGATE BY:</b></p> <p>Sex: Male, Female</p> <p>Age: 15-19, 20-29, 30-39</p> <p>Contraception method</p>
<p><b>TYPE:</b></p>	<p><b>DIRECTION OF CHANGE:</b></p>

<b>INDICATOR TITLE: Percent of women/men of reproductive age who are using a contraceptive method</b>	
Outcome	Higher is better
MEASUREMENT NOTES	
INTENDED RESPONDENT:	Women and men of reproductive age (15-49)
REPORTING NOTES	
<p>In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).</p>	

**INDICATOR TITLE: Percent of women given information on contraception methods (Method Information Index)**

**DEFINITION:**

The Method Information Index (MII) is a relatively new tool in the suite of indicators focused on family planning quality. The MII is a way to assess the information given to clients during family planning health visits. Assessments of counseling have traditionally relied on direct observation, exit interview, or retrospective reporting by the person seeking family planning. In the absence of direct observation, asking women about the information they received is used as a proxy indicator of the quality of the services provided.<sup>25</sup>

This indicator measures the extent to which women were given specific information when they received family planning services. The indicator provides a summary measure of the adequacy of information being provided to women by service providers at the time when they chose the contraception method currently being used.

Data for this indicator is collected by asking women a set of 3 questions: whether they were informed about other methods aside from their current method, told about possible side effects from their current method, and advised what to do if they experienced side effects. The reported index score is the percent of women who responded “yes” to all three questions.<sup>26</sup> The percentage of women given information on contraception methods is then calculated by dividing the number of women who respond “yes” to all three items by the number of women of reproductive age currently using a contraceptive method.

**ADAPTATION:**

N/A

<b>UNIT:</b> Percent	<b>DISAGGREGATE BY:</b> Age: 15-19, 20-29, 30-39
<b>TYPE:</b> Outcome	<b>DIRECTION OF CHANGE:</b> Higher is better
<b>MEASUREMENT NOTES</b>	
<b>INTENDED RESPONDENT:</b>	Women of reproductive age (15-49)

<sup>25</sup> Chang, Karen T., Mulenga Mukanu, Ben Bellows, Waqas Hameed, Amanda M. Kalamar, Karen A. Grépin, Xaher Gul, and Nirali M. Chakraborty. “Evaluating Quality of Contraceptive Counseling: An Analysis of the Method Information Index.” *Studies in Family Planning* 50, no. 1 (January 21, 2019): 25–42. <https://doi.org/10.1111/sifp.12081>.

<sup>26</sup> *ibid*



**INDICATOR TITLE: Percent of women given information on contraception methods (Method Information Index)**

**REPORTING NOTES**

In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).

**INDICATOR TITLE: Percent of pregnant women who have attended at least two comprehensive antenatal clinics**

**DEFINITION:**

Attended is defined as having presented to a health service delivery point and received services required for antenatal visits. Comprehensive antenatal clinics include the complete package of antenatal services as prescribed by Ministry of Health policy and delivered by a trained health care worker. World Health Organization (WHO) guidelines on the content of antenatal care visits include the following components: Clinical examination; Blood testing to detect syphilis and severe anemia (and HIV, malaria, etc. according to the epidemiological context); Gestational age estimation; Uterine height; Blood pressure; Maternal weight and height; Test for sexually transmitted infections (STIs); Urine test; Request blood type and Rh; Tetanus toxoid administration; Iron/folic acid supplementation; recommendations for emergencies.<sup>27</sup>

To construct this indicator, the number of pregnant women in attendance for two or more comprehensive antenatal clinics is calculated, and then divided by the total number of women who gave birth.

This module is a set of 6 questions regarding (Q1) whether the respondent sought any antenatal care, (Q2) who she saw, (Q3) where she received the treatment, (Q4) how many weeks/months pregnant she was when she first received antenatal care, (Q5) how many times she received antenatal care during the pregnancy, and (Q6) type of care provided. A woman will thus be counted in the numerator of this indicator if she (1) received antenatal care 2 or more times during her pregnancy, AND (2) that care included at least 4 of the 7 comprehensive care components listed in the core questionnaire.

**DATA COLLECTION:**

It is recommended first to include a question for all women of reproductive age (15-49 years of age, consistent with Feed the Future (FTF) and Food and Agriculture Organization (FAO) guidance) in the household roster regarding whether they have ever been pregnant, and if yes, the result of the pregnancy (live birth, still birth, abortion/miscarriage). This module should be asked to the woman in the household with the most recent live or still birth within the specified time frame (see below in [Adaptation](#) regarding the appropriate time frame). Then in this module, a question should be asked regarding whether (Q1) the respondent saw anyone for antenatal care for her most recent pregnancy (that resulted in a live or still birth).

If yes, follow-up questions will be asked regarding (Q2) whom she saw (health personnel [doctor, nurse/midwife, auxiliary midwife], other person [traditional birth attendant, community health worker/field worker], or other) and (Q3) where she received antenatal care (home [her home, other home], public sector [government hospital, government health center, government health

<sup>27</sup> Definitions taken from the OFDA Health PIRS: "Health PIRS." USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).

**INDICATOR TITLE: Percent of pregnant women who have attended at least two comprehensive antenatal clinics**

post, other public], private medical sector [private hospital, private clinic, other private medical], Non-Government Organization (NGO) medical sector [NGO hospital, NGO clinic, other NGO medical], or other).

These questions should be followed by (Q4) how many weeks or months pregnant were you when you first received antenatal care for this pregnancy, and (Q5) how many times did you receive antenatal care during this pregnancy?

Finally, a question is asked: (Q6) As part of your antenatal care during this pregnancy, did a healthcare provider do any of the following at least once: measure your blood pressure, take a urine sample, take a blood sample, listen to the baby’s heartbeat, talk with you about which foods you should eat, talk with you about breastfeeding, and/or ask if you had vaginal bleeding?

**ADAPTATION:**

The timeframe over which these questions should be asked will depend on the frequency of data collection. If activities are conducting a baseline and endline survey, it is recommended that this set of questions be asked to all women whose pregnancy resulted in a live or still birth in the last 5 years at both points in time. However, if surveys are conducted annually, activities should adapt the time frame accordingly to ask all women whose pregnancy resulted in a live or still birth in the past year.

The list of providers and location of care may be adapted for local contexts, but it is recommended that they are aggregated for reporting into the same high-level categories (see below in [Disaggregate By](#)). Additionally, it is not recommended to adapt the list of comprehensive care components for comparison across the HEARTH portfolio. However, if there are specific aspects of antenatal care which are not included in this list, HEARTH activities may add extra care components – but these should not be included in the calculation of this indicator.

Finally, while it is recommended to ask this set of questions to the woman in the household with the most recent live or still birth within the specified time frame, activities may choose to ask these questions to ALL women in the household with the most recent live or still birth within the specified time frame, especially if there is concern about smaller sample sizes. However, this is not recommended given the length of time that this would require adding to the survey, as well as additional logistical challenges due to increasing the total number of survey respondents.

**UNIT:**

Percent

**DISAGGREGATE BY:**

Type of provider: Health personnel; Other person

Location of care: Home, Public sector; Private medical sector; NGO Medical Sector

<b>INDICATOR TITLE: Percent of pregnant women who have attended at least two comprehensive antenatal clinics</b>	
TYPE:  Outcome	DIRECTION OF CHANGE:  Higher is better
MEASUREMENT NOTES	
INTENDED RESPONDENT:	This module should be asked to the woman in the household with the most recent live or still birth within the specified time frame (see above in <a href="#">Adaptation</a> regarding the appropriate time frame).
REPORTING NOTES	
In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).	

**INDICATOR TITLE: Percent of pregnant women who deliver assisted by a skilled attendant at birth**

**DEFINITION:**

Assisted by is defined as present and presiding over labor and delivery for a pregnant woman and being trained/available to perform assessment and the seven signal functions of basic emergency obstetric and newborn care, including management of complications or recommending referral, as needed. Skilled (not traditional) attendant at birth is defined as an accredited health professional who possesses the knowledge and a defined set of cognitive and practical skills that enable the individual to provide safe and effective health care during childbirth to women and their infants in the home, health center, and hospital settings. Skilled attendants include midwives, doctors, and nurses with midwifery and life-saving skills. This definition excludes traditional birth attendants whether trained or not.<sup>28</sup>

To construct this indicator, the number of pregnant women who delivered while assisted by a skilled attendant is calculated, and then divided by the total number of women who gave birth.

This information is collected by asking a single question: For your most recent birth, who assisted with the delivery? The answer choices are Health personnel (doctor, nurse/midwife, auxiliary midwife), other person (traditional birth attendant, community health worker/field worker), or other. A woman will thus be counted in the numerator of this indicator if she answers any of the three types of health personnel.

**DATA COLLECTION:**

It is recommended first to include a question for all women of reproductive age (15-49 years of age, consistent with FTF and FAO guidance) in the household roster regarding whether they have ever been pregnant, and if yes, the result of the pregnancy (live birth, still birth, abortion/miscarriage). This question should be asked to the woman in the household with the most recent live or still birth within the specified time frame (see below in [Adaptation](#) regarding the appropriate time frame).

**ADAPTATION:**

The timeframe over which these questions should be asked will depend on the frequency of data collection. If activities are conducting a baseline and end line survey, it is recommended that this set of questions be asked to all women whose pregnancy resulted in a live or still birth in the last 5 years at both points in time. However, if surveys are conducted annually, activities should adapt the time frame accordingly to ask all women whose pregnancy resulted in a live or still birth in the past year.

<sup>28</sup> Definitions taken from the OFDA Health PIRS: "Health PIRS." USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).



**INDICATOR TITLE: Percent of pregnant women who deliver assisted by a skilled attendant at birth**

The list of birth attendants may be adapted for local contexts, but it is recommended that they are aggregated for reporting into the same high-level categories (see below in [Disaggregate By](#)).

Finally, while it is recommended to ask this set of questions to the woman in the household with the most recent live or still birth within the specified time frame, activities may choose to ask these questions to ALL women in the household with the most recent live or still birth within the specified time frame, especially if there is concern about smaller sample sizes. However, this is not recommended given the length of time that this would require adding to the survey, as well as additional logistical challenges due to increasing the total number of survey respondents.

UNIT: Percent	DISAGGREGATE BY: N/A
TYPE: Outcome	DIRECTION OF CHANGE: Higher is better
MEASUREMENT NOTES	
INTENDED RESPONDENT:	This module should be asked to the woman in the household with the most recent live or still birth within the specified time frame (see above in <a href="#">Adaptation</a> regarding the appropriate time frame).
REPORTING NOTES	
In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).	

## INDICATOR TITLE: Percent of pregnant women who deliver at a health facility

### DEFINITION:

Health facility: A place that provides health care; a dispensary, health post, health center, health clinic (fixed or mobile), or hospital.

To construct this indicator, the number of pregnant women who delivered at a health facility is calculated, and then divided by the total number of women who gave birth.

This information is collected by asking a single question: For your most recent birth, where did you give birth? The answer choices are Home (her home, other home), Public sector (government hospital, government health center, government health post, other public), Private medical sector (private hospital, private clinic, other private medical), NGO medical sector (NGO hospital, NGO clinic, other NGO medical), or other. A woman will thus be counted in the numerator of this indicator if she answers any of the public, private, or NGO medical sector facilities (i.e., anything except for home or other).

**DATA COLLECTION:** It is recommended first to include a question for all women of reproductive age (15-49 years of age, consistent with FTF and FAO guidance) in the household roster regarding whether they have ever been pregnant, and if yes, the result of the pregnancy (live birth, still birth, abortion/miscarriage). This question should be asked to the woman in the household with the most recent live or still birth within the specified time frame (see below in [Adaptation](#) regarding the appropriate time frame).

### ADAPTATION:

The timeframe over which these questions should be asked will depend on the frequency of data collection. If activities are conducting a baseline and end line survey, it is recommended that this set of questions be asked to all women whose pregnancy resulted in a live or still birth in the last 5 years at both points in time. However, if surveys are conducted annually, activities should adapt the time frame accordingly to ask all women whose pregnancy resulted in a live or still birth in the past year.

The location of delivery may be adapted for local contexts, but it is recommended that they are aggregated for reporting into the same high-level categories (see below in [Disaggregate By](#)).

Finally, while it is recommended to ask this set of questions to the woman in the household with the most recent live or still birth within the specified time frame, activities may choose to ask these questions to ALL women in the household with the most recent live or still birth within the specified time frame, especially if there is concern about smaller sample sizes. However, this is not recommended given the length of time that this would require adding to the survey, as well as additional logistical challenges due to increasing the total number of survey respondents.

<b>INDICATOR TITLE: Percent of pregnant women who deliver at a health facility</b>	
UNIT: Percent	DISAGGREGATE BY: N/A
TYPE: Outcome	DIRECTION OF CHANGE: Higher is better
MEASUREMENT NOTES	
INTENDED RESPONDENT:	This module should be asked to the woman in the household with the most recent live or still birth within the specified time frame (see above in <a href="#">Adaptation</a> regarding the appropriate time frame).
REPORTING NOTES	
In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).	

**INDICATOR TITLE: Average amount of health expenditures per sick family member**

**DEFINITION:** To measure the average amount of health expenditures per sick family member, this indicator will first identify all individuals within a household who experienced any ailment(s) over the past three months – regardless of whether they sought treatment. Then, a follow-up question will be asked for each household member who was sick regarding the total amount spent on medical costs over the past three months. Medical costs include hospitalization costs, clinic charges, physician’s fees, traditional healer’s fees, medicines, and the like.

To construct this indicator, the total amount of medical costs for all household members over the past 3 months will be calculated, and then divided by the total number of sick household members.

Expenditures should be reported by respondents in the appropriate local currency and converted into United States Dollar (USD) for comparison across the HEARTH portfolio.<sup>29</sup> To convert local currency units (LCU) for the survey year (t) into 2020 USD, HEARTH activities should first adjust for inflation from 2020 to the year and month of the survey. In all cases, the official source for the Consumer Price Index (CPI) should be used. Then, the inflation adjusted LCU should be converted into 2020 USD using the 2020 purchasing power parity (PPP) conversion factor of private consumption based on the International Comparison Program.<sup>30</sup> The PPP 2020 conversion factors can be obtained from the World Development Indicator database.<sup>31</sup> The formula for this calculation is as follows, and reporting should include the CPI and PPP used in the calculation for full transparency.

$$USD_{2020} = LCU_t \times \left(\frac{CPI_{2020}}{CPI_t}\right) \times (PPP_{2020})$$

Note that unbundling medical expenditures by individual household member leads to improvements in the accuracy and reliability of the measure by the interviewee. This method simultaneously allows for the calculation of the total household medical expenditure as well as the average per sick member.

**ADAPTATION:**

HEARTH activities should adapt the question to include local medical treatments, practices, and traditional health methodology as a part of treatment costs. Consideration for payment/expense

<sup>29</sup> For additional details on calculating interest rates and other conversions, please see the Feed the Future Survey Implementation Document: Guide to FTF Statistics section on guidelines for constructing poverty indicators.

<sup>30</sup> The International Comparison Program conducts comprehensive market surveys that are used to compute global PPP and real expenditures: “International Comparison Program (ICP).” World Bank, 2021. <https://www.worldbank.org/en/programs/icp>.

<sup>31</sup> “World Development Indicators.” Data Bank. World Bank, 2021. <https://databank.worldbank.org/source/world-development-indicators>.

**INDICATOR TITLE: Average amount of health expenditures per sick family member**

in in-kind, through bartering and trading, should also be taken if relevant. Finally, questionnaires should allow reporting in local currencies.

If health expenditure is a primary outcome for a given HEARTH activity, adaptations may be made to disaggregate reporting of medical expenses by additional categories, to further increase accuracy. Examples include separate questions for: preventative care, non-prescription medications, transportation to access health-related services, etc.<sup>32</sup>

<b>UNIT:</b> Number (USD)	<b>DISAGGREGATE BY:</b> Sex of Sick Household Member: Female, Male Age groups: <5; 5-14; 15-18; 19-49, 50+
<b>TYPE:</b> Outcome	<b>DIRECTION OF CHANGE:</b> Higher is Better

**MEASUREMENT NOTES**

<b>INTENDED RESPONDENT:</b>	Primary household decision-maker (male or female) from sample households, who is most responsible for managing household member health care. If this person is not available, another adult from the household may be used for reporting.
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**REPORTING NOTES**

In addition to calculating the average expenditures per sick household member, the total number of participant households of the health-sensitive activity must be reported, to allow a weighted average to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).

Activities should also report on the numerator (average amount of medical costs for all household members over the past 3 months) and denominator (average number of sick household members) used to calculate the indicator. Finally, activities should also report on the standard deviation.

<sup>32</sup> For more details, please see the health expenditure related questions in the Feed the Future core questionnaire.

**INDICATOR TITLE: Average number of outpatient consultations per sick family member**

**DEFINITION:** To measure the average number of outpatient consultations per sick family member, this indicator will first identify all individuals within a household who experienced any ailment(s) over the past three months. Then, a follow-up question will be asked for each household member who was sick regarding the total number of outpatient consultations used to seek curative treatment for illness, over the previous three months.

An outpatient is defined as a non-hospitalized individual. Outpatient consultations exclude preventive care visits like vaccination and antenatal care. Consultations are defined as a visit by a patient to a health care provider in which the patient presents with a problem or issue and the health care provider provides medical evaluation, diagnosis, treatment, and/or referral for that person. For the purposes of this indicator, do not include curative consultations conducted by community health workers at the household or community level.<sup>33</sup>

To construct this indicator, the total number of outpatient consultations of all household members over the past 3 months will be calculated, and then divided by the total number of sick household members.

If an individual in a household sought outpatient treatment, a follow-up question should also be asked about the type of healthcare facility that they received the consultation, which may include the following: health center, traditional healer, government hospital, private facility, or other.

**ADAPTATION:**

HEARTH activities should adapt the questionnaire to include locally relevant types of healthcare facilities, as those listed in the core questionnaire are illustrative.

<p><b>UNIT:</b></p> <p>Number</p>	<p><b>DISAGGREGATE BY:</b></p> <p>Sex of Sick Household Member: Female, Male</p> <p>Age groups: &lt;5; 5-14; 15-18; 19-49, 50+</p>
<p><b>TYPE:</b></p> <p>Outcome</p>	<p><b>DIRECTION OF CHANGE:</b></p> <p>Higher is Better</p>

**MEASUREMENT NOTES**

<sup>33</sup> Definitions taken from the OFDA Health PIRS: "Health PIRS." USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).

<b>INDICATOR TITLE: Average number of outpatient consultations per sick family member</b>	
<b>INTENDED RESPONDENT:</b>	Primary household decision-maker (male or female) from sample households, who is most responsible for managing household member health care. If this person is not available, another adult from the household may be used for reporting.
REPORTING NOTES	
<p>In addition to calculating the average number of visits per sick household member, the total number of participant households of the health-sensitive activity must be reported, to allow a weighted average to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).</p> <p>Activities should also report on the numerator (average number of outpatient consultations for all household members over the past 3 months) and denominator (average number of sick household members) used to calculate the indicator. Finally, activities should also report on the standard deviation.</p>	

**INDICATOR TITLE: Average number of visits for community based treatment per sick child 5 and under**

**DEFINITION:**

To measure the average number of visits for community-based treatment per sick child (5 years of age and under), this indicator will first identify all children within a household who experienced any ailment(s) over the past three months. Then, a follow-up question will be asked for each child who was sick regarding the total number of visits for community-based treatment over the previous three months.

Community-based treatment is defined as diagnosis and treatment of common childhood illnesses (malaria, diarrhea and/or acute respiratory infections) by trained community health workers (CHWs) at the household or community-level. The strategies for diagnosis and level of treatment provided by CHWs should be dictated by Ministry of Health policy and/or receive approval from health authorities. Common childhood illnesses include, for the purposes of this indicator, malaria, diarrhea, and acute respiratory infections. CHWs are members of a community who are chosen by community members or organizations to provide basic preventive health care through health information, messaging, and health facility referrals. In some countries CHWs are also able to provide curative care for members of their community, depending on Ministry of Health protocols. CHWs may be formally or informally trained, depending on Ministry of Health requirements. CHWs can be referred to by different names depending on the context: Lay health workers; Volunteer health workers; Community health promoters; Village health workers; Village health volunteers; Community health agents; Health surveillance assistants.<sup>34</sup>

To construct this indicator, the total number of visits for community-based treatment for all children over the past 3 months will be calculated, and then divided by the total number of sick children.

It is recommended to ask this across a range of common childhood illnesses, which should be adapted for each HEARTH, rather than by specific illness to increase the potential sample size (i.e., to increase the likelihood that a household had at least one child with the illness in question over the last three months).

**ADAPTATION:**

HEARTH activities should adapt the questionnaire to include locally relevant/important types of common childhood illnesses, as relevant. For the purposes of this indicator, illnesses should include at minimum malaria, diarrhea, and acute respiratory infections for comparison across the HEARTH portfolio.

<sup>34</sup> Definitions taken from the OFDA Health PIRS: "Health PIRS." USAID/OFDA Proposal Guidelines. United States Agency for International Development, February 2018. [https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA\\_Health\\_PIRS\\_Feb\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1866/USAID-OFDA_Health_PIRS_Feb_2018.pdf).



<b>INDICATOR TITLE: Average number of visits for community based treatment per sick child 5 and under</b>	
<b>UNIT:</b> Number	<b>DISAGGREGATE BY:</b> Sex of Child: Male, Female Type of Childhood Illness
<b>TYPE:</b> Outcome	<b>DIRECTION OF CHANGE:</b> Higher is Better
<b>MEASUREMENT NOTES</b>	
<b>INTENDED RESPONDENT:</b>	Primary household decision-maker (male or female) from sample households, who is most responsible for managing household member health care. If this person is not available, another adult from the household may be used for reporting.
<b>REPORTING NOTES</b>	
<p>In addition to calculating the average number of visits per child, the total number of participant households of the health-sensitive activity must be reported, in order to allow a weighted average to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).</p> <p>Activities should also report on the numerator (average number of visits for community-based treatment for all children over the past 3 months) and denominator (average number of sick children) used to calculate the indicator. Finally, activities should also report on the standard deviation.</p>	

**INDICATOR TITLE: Percent of children 0-35 months of age who received their first dose of measles containing vaccine by 12 months of age**

**DEFINITION:** This indicator is adapted from the USAID Standard Indicator for the number of children who received their first dose of measles-containing vaccine by 12 months of age (HL 6.4-62), measured using questions adapted from the DHS Women’s module. These questions would be asked for all surviving children born 0-35 months before the survey being conducted.

To construct this indicator, the number of children 0-35 months of age who received their first dose of measles-containing vaccine by 12-months of age will be calculated, and then divided by the total number of surviving children aged 0-35 months.

This module is a set of 3 questions regarding (Q1) whether the child ever received a measles-containing vaccine, (Q2) if the first dose was received before 12 months of age, and (Q3) how many times the child received the measles vaccine (if relevant). A child will thus be counted in the numerator of this indicator if they received their first dose before 12 months of age.

**DATA COLLECTION:**

The age of each household member, including children, should be collected during the household roster module. Then, a set of up to 3 questions will be asked regarding vaccinations received by children born in the last 3 years. First, respondents will be asked (Q1) if the child ever received a measles vaccination, that is, an injection in the arm to prevent measles. If yes, follow-up questions will be asked regarding (Q2) if the first dose of the measles-containing vaccine was received by 12 months of age, and (Q3) how many times the child received the measles vaccine (if relevant).

**ADAPTATION:**

The questionnaire should be adapted to use the name of the measles containing vaccination (MCV) used in the country locally: measles, measles mumps & rubella, or measles & rubella, if relevant.

Q3 regarding how many times the child received the measles vaccine should only be asked in countries where the vaccination schedule includes more than one dose of the measles-containing vaccine, to determine the percent of children who completed the full vaccine schedule (if relevant).

If of interest for a given activity, follow-up questions regarding where the child received the vaccine (public, private, or NGO) health facility, or other source, such as a vaccination campaign) may be included, but it is not necessary for the measurement/reporting of this indicator.

**UNIT:**

Percent

**DISAGGREGATE BY:**

Sex of Child: Male, Female

<b>INDICATOR TITLE: Percent of children 0 35 months of age who received their first dose of measles containing vaccine by 12 months of age</b>	
TYPE:  Outcome	DIRECTION OF CHANGE:  Higher is Better
MEASUREMENT NOTES	
INTENDED RESPONDENT:	Primary household decision-maker (male or female) from sample households, who is most responsible for managing household member health care. If this person is not available, another adult from the household may be used for reporting.
REPORTING NOTES	
In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).	

**INDICATOR TITLE: Number of people gaining access to basic drinking water services as a result of USG assistance**

**DEFINITION:**

Basic drinking water services, according to the Joint Monitoring Programme (JMP), are defined as improved sources or delivery points that by nature of their construction or through active intervention are protected from outside contamination, in particular from outside contamination with fecal matter, and where collection time is no more than 30 minutes for a roundtrip including queuing. Access must be measured from the beneficiary's place of residence, and does not include access at a day school, health facility or place of work.

Drinking water sources meeting this criteria include:

- piped drinking water supply on premises;
- public tap/standpost; tube well/borehole;
- protected dug well; protected spring;
- rainwater; and/or
- bottled water (when another basic service is used for hand washing, cooking or other basic personal hygiene purposes).

All other services are considered to be “unimproved”, including: unprotected dug well, unprotected spring, cart with small tank/drum, tanker truck, surface water (river, dam, lake, pond, stream, canal, irrigation channel), and bottled water (unless basic services are being used for hand washing, cooking and other basic personal hygiene purposes).

The following criteria must be met for persons counted as gaining access to basic drinking water services as a result of USG assistance:

1. The total collection time must be 30 minutes or less for a round trip (including wait time). Given this definition, the number of people considered to have “gained access” to a basic service will be limited by the physical distance to the service from beneficiaries’ dwellings, the amount of time typically spent queuing at the service, and the production capacity of the service.
2. The service must be able to consistently (i.e. year-round) produce 20 liters per day for each person counted as “gaining access.” This amount is considered the daily minimum required to effectively meet a person’s drinking, sanitation, and hygiene needs.
3. The service is either newly established or was rehabilitated from a non-functional state within the reporting fiscal year as a result of USG assistance.
4. Persons counting toward the indicator must not have previously had similar “access” to basic drinking water services, prior to the establishment or rehabilitation of the USG-supported basic service.

Note: Although USAID expects that all drinking water services supported by USG assistance be tested for fecal coliform and arsenic during the program cycle, compliance with water quality

**INDICATOR TITLE: Number of people gaining access to basic drinking water services as a result of USG assistance**

standards is not required for attribution to this indicator. For guidance on water testing requirements during the program cycle, contact USAID/E3/Water Office.

Limitations: Providing “access” does not necessarily guarantee beneficiary “use” of a basic drinking water service and thus potential health benefits are not certain to be realized from simply providing “access.” This indicator does not capture the full dimensions of a water service’s reliability or affordability--two other important factors that influence the likelihood that those defined as having “access” will actually use the service. For more information on these factors please refer to indicator HL.8.1-3.

**ADAPTATION:**

N/A

**UNIT:**

Number

**DISAGGREGATE BY:**

Sex (Female, Male)  
Residence (Rural, Urban)  
Wealth Quintile

**TYPE:**

Outcome

**DIRECTION OF CHANGE:**

Higher is better

**MEASUREMENT NOTES**

**INTENDED RESPONDENT:**

Primary adult decision-maker who is most knowledgeable about the household’s water source.

**REPORTING NOTES**

In addition to reporting the number of households gaining access to basic drinking water services, the total number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).

**INDICATOR TITLE: Number of people gaining access to safely managed drinking water services as a result of USG assistance**

**DEFINITION:**

A safely managed drinking service is defined as one that meets the definition of a basic drinking water service (see indicator HL.8.1-1), and is also:

- Located on premises: water is provided directly to the household or on premises;
- Available when needed: consistently produces 20 liters per day for each person counted as “gaining access.” This amount is considered the daily minimum required to effectively meet a person’s drinking, sanitation, and hygiene needs;
- Compliant with faecal (and priority chemical) standards: meets a fecal coliform standard of 0 CFU/100 mL, arsenic standard of 10 parts per billion, and (at a minimum) host country standards for other chemicals that have been identified to pose a site-specific risk to human health.

Persons are counted as “gaining access” to a safely managed drinking water service if the service is either newly established, rehabilitated from a non-functional state, or upgraded from a basic water service within the reporting fiscal year as a result of USG assistance, and these persons did not previously have similar “access” to a safely managed drinking water service prior to the establishment or rehabilitation of the USG-supported safely managed service.

Limitations: Providing “access” does not necessarily guarantee beneficiary “use” of an safely managed drinking water service and thus potential health benefits are not certain to be realized from simply providing “access.” Although, the chosen definition of “access” does attempt to define standard ease of use/accessibility and minimum volume of water to meet potential user needs, this definition does not capture the water service’s affordability. For more information on this factor please refer to indicator HL.8.1-3.

**ADAPTATION:**

N/A

**UNIT:**

Number

**DISAGGREGATE BY:**

Sex (Female, Male)  
Residence (Rural, Urban)  
Wealth Quintile

**TYPE:**

Outcome

**DIRECTION OF CHANGE:**

Higher is better

**MEASUREMENT NOTES**

**INDICATOR TITLE: Number of people gaining access to safely managed drinking water services as a result of USG assistance**

INTENDED RESPONDENT:	Primary adult decision-maker who is most knowledgeable about the household's water source.
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**REPORTING NOTES**

In addition to reporting the number of households gaining access to safely managed drinking water services, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).

**INDICATOR TITLE: Number of people receiving improved service quality from an existing basic or safely managed drinking water service as a result of USG assistance**

**DEFINITION:**

A person is counted for this indicator when their current primary drinking water service qualifies as a “basic,” or “safely managed” (see indicators HL.8.1-1 and HL.8.1-2) but, the quality of “service” they receive is further “improved” as a result of USG assistance in terms of its ease of accessibility, reliability, water quality and/or affordability. Access must be measured from the beneficiary’s place of residence, and does not include access at a day school, health facility or place of work.

Specifically, “improved service quality” is defined as being achieved if:

- The accessibility measure, time taken to collect water from a basic or safely managed service, is further reduced to less than the minimum requirements for a basic water service (see indicator HL.8.1-1) or safely managed water service (see indicator HL.8.1-2); and/or
- Reliability of supply improves such that the person’s main service is available regularly or more frequently, i.e. there is no regular rationing of supply or regular seasonal failure of their improved service; and/or,
- Water quality improvements are made that would be reasonably expected to result in long term improvements to the fecal, biological or chemical contamination of a drinking water sources (e.g., construction of water treatment systems, support to service provider to consistently chlorinate water, implementation of a water safety plan); and/or,
- - Affordability of their basic or safely managed drinking water services improves such that the average price they pay for water is no higher than two times the average water tariff for piped water into the dwelling in their country (where applicable).

**ADAPTATION:**

N/A

**UNIT:**

Number

**DISAGGREGATE BY:**

Sex (Female, Male)  
Residence (Rural, Urban)  
Wealth Quintile

**TYPE:**

Outcome

**DIRECTION OF CHANGE:**

Higher is better

**MEASUREMENT NOTES**



**INDICATOR TITLE: Number of people receiving improved service quality from an existing basic or safely managed drinking water service as a result of USG assistance**

INTENDED RESPONDENT:	Primary adult decision-maker who is most knowledgeable about the household's water source.
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**REPORTING NOTES**

In addition to reporting the number of households receiving improved service quality, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).

**INDICATOR TITLE: Percent of children under five with diarrhea in the past two weeks****DEFINITION:**

Diarrhea accounts for approximately 8 percent of all deaths among children under age 5 worldwide in 2017, despite the availability of a simple treatment solution. Most deaths from diarrhea occur among children under two living in South Asia and sub-Saharan Africa.<sup>35</sup>

This indicator measures the percentage of children under five (0-59 months) experiencing an episode of diarrhea (as defined by a survey respondent, usually the child's mother or other primary caregiver) at any time during the two weeks preceding data collection.

**ADAPTATION:**

The term(s) used for diarrhea in each country should be adapted to encompass the expressions used for all forms of diarrhea, including bloody stools (consistent with dysentery), watery stools, etc.

**UNIT:**

Percent

**DISAGGREGATE BY:**

Sex: Male, Female

**TYPE:**

Outcome

**DIRECTION OF CHANGE:**

Lower is better

**MEASUREMENT NOTES****INTENDED RESPONDENT:**

Children under five (0-59 months)

**REPORTING NOTES**

In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).

<sup>35</sup> Food for Peace Indicators Handbook Part I: Indicators for Baseline and Endline Surveys for Development Food Security Activities. Revised: May 2020.

<b>INDICATOR TITLE: Percent of children under five with diarrhea in the past two weeks treated with ORS</b>	
<b>DEFINITION:</b>	
<p>Oral rehydration solution (ORS) is an effective, low-cost prevention and management intervention for diarrhea.</p> <p>This indicator measures the percent of children under 5 (0-59 months) with diarrhea in the past two weeks who were treated with ORS, divided by the total number of children under 5 with diarrhea in the past two weeks.</p>	
<b>ADAPTATION:</b>	
Similar considerations for the definition of diarrhea (outlined above) are applicable to this indicator.	
<b>UNIT:</b>	<b>DISAGGREGATE BY:</b>
Percent	Sex: Male, Female
<b>TYPE:</b>	<b>DIRECTION OF CHANGE:</b>
Outcome	Higher is better
<b>MEASUREMENT NOTES</b>	
<b>INTENDED RESPONDENT:</b>	Children under five (0-59 months)
<b>REPORTING NOTES</b>	
In addition to reporting the percent value, the number of participant households of the health-sensitive activity must be reported, to allow a weighted average percent to be calculated across HEARTH activities for reporting. Additionally, activities should report on the total sample size (including any disaggregation for participant households vs. comparison/control households if an evaluation is being conducted).	