



# USAID/OFDA Guidance on Indicators for Programming in Response to a Public Health Emergency of International Concern (PHEIC)

Addendum to the 2012 USAID/OFDA Guidelines for Proposals  
October 27, 2016

## INTRODUCTION

As per the World Health Organization (WHO) International Health Regulations (2005), a Public Health Emergency of International Concern (PHEIC) is defined as “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response”.<sup>1</sup> In the event of a PHEIC that requires a coordinated international response, USAID/OFDA may consider support for stand-alone programs and integration of specific public health response components into larger disaster response activities. This document provides specific guidance to partners on USAID/OFDA indicators and program monitoring requirements that must be incorporated into USAID/OFDA proposals submitted to respond to a PHEIC.

Please note that this document does not provide guidance on allowable interventions in response to a PHEIC and does not replace existing USAID/OFDA health sector requirements and indicators. Further, this guidance applies specifically to an isolated disease outbreak determined to be a PHEIC and does not apply to an infectious disease outbreak that occurs in the setting of an ongoing USAID/OFDA response to a natural disaster or complex humanitarian emergency, such as large-scale flooding or displacement due to conflict.

This guidance is to be used in conjunction with the health sector requirements in the *2012 USAID/OFDA Guidelines for Proposals* and must not be used in isolation.

## 1- REQUIRED INDICATORS FOR HEALTH PROGRAMS IN RESPONSE TO A PHEIC

In addition to the standard indicators outlined in the 2012 USAID/OFDA Guidelines for Proposals, proposals for a PHEIC response must include the four indicators listed below. If any of the required reporting indicators are not appropriate or relevant for the

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<sup>1</sup> WHO. International Health Regulations (2005). <http://www.who.int/ihr/publications/9789241596664/en/> Accessed October 24, 2016.

proposed program, justification for exclusion or modification must be provided. Additional information and specific requirements for each indicator are outlined in the reference tables that follow.

#### Required Indicators

1. Percent of health workers who successfully completed training
2. Percent of persons who meet criteria for isolation and are appropriately isolated
3. Percent of supported health facilities out of stock of one or more selected PPE tracer products for more than one week
4. Percent of target population who can recall 2 or more protective measures

#### **Indicator 1: Percent of health workers who successfully completed training**

*OFDA Health Sub-Sector: Health Systems and Clinical Support*

<b>Purpose</b>	In response to a PHEIC, health workers will require training to develop specific skills and receive technical updates to provide care and respond to the health emergency. This indicator monitors the percentage of health workers (e.g. doctors, nurses, community health workers, midwives, and ambulance workers), managers and ancillary staff that are targeted for training and complete training with project assistance.
<b>Definition of Key Terms</b>	<p><b><u>Health worker</u></b> refers to a doctor, nurse, community health worker, midwife, ambulance worker, or other personnel proposed as trainees in the program.</p> <p><b><u>Training</u></b> includes courses, workshops, or training sessions that build or update skills relevant to the response, such as: disease surveillance, contact tracing, clinical case management, infection prevention and control (IPC), laboratory specimen collection, safe burial, safe patient transport, etc.</p> <p><b><u>Successfully completed</u></b> requires that each individual meets minimum requirements as defined by international or national standards.</p>
<b>Measurement</b>	<p><b>Percentage (%):</b>  <b><i>Numerator:</i></b> Number of health workers that received training in the measurement period (typically semi-annual)  <b><i>Denominator:</i></b> Total number of health workers in the workforce that</p>

	were targeted for training during the same measurement period.
<b>Disaggregation</b>	By health worker cadre, training topic, and trainee gender
<b>Data Sources</b>	Project records, training database, other human resource information system

**Indicator 2: Percent of persons presenting to each supported health facility who meet criteria for isolation (based on the case definition), and are appropriately isolated**

*OFDA Health Sub-Sector: Communicable Disease*

<b>Purpose</b>	To limit transmission of an infectious disease in healthcare settings, health care workers must follow appropriate infection prevention and control (IPC) protocols. This indicator monitors the percent of persons who are screened and isolated, based on application of a case definition and adherence to infection prevention and control (IPC) and isolation protocols.
<b>Definition of Key Terms</b>	<p><b><u>Criteria for isolation</u></b> refer to specific criteria within a case definition or triage protocol that guide clinical decision-making and indicate whether or not a patient requires isolation.</p> <p><b><u>Case definition</u></b> is a set of uniform criteria used to define a disease for public health surveillance which will include criteria for person, place, time, and clinical features. The case definition will be specific to an outbreak, agreed-upon by national health authorities and technical agencies (e.g. WHO and CDC), and may evolve during the course of the response.</p> <p><b><u>Isolation</u></b> is a single room that is segregated from other patient-care areas. When single rooms are not available, patients with the same diagnosis can be placed together. If this is not possible, patient beds should be placed at least 1 meter apart (for airborne diseases and 2 meters for Viral Hemorrhagic Fevers). For patients with suspected, probable or confirmed influenza or a coronavirus, proper airborne</p>

	precautions or Airborne Precaution rooms should be available (with negative pressure). <sup>2 3</sup>
<b>Measurement</b>	<b>Percentage (%):</b> <b>Numerator:</b> Number of persons who met the criteria for isolation and were appropriately isolated during the measurement period. <b>Denominator:</b> Total number of persons presenting to supported health facilities who meet criteria for isolation during the same measurement period.
<b>Disaggregation</b>	Per health facility, patient gender, patient age (Age groups: 0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-60 years, and 60+ years)
<b>Data Sources</b>	Health facility records

**Indicator 3: Percent of supported health facilities out of stock of one or more selected PPE tracer products for more than one week**

*OFDA Health Sub-Sector: Medical Commodities including Pharmaceuticals*

<b>Purpose</b>	Medical commodities, such as personal protective equipment (PPE) and other items required to perform standard IPC practices, are critical to control an infectious disease outbreak. The procurement, distribution, and use of these items should meet specifications and standard IPC protocols as developed by WHO and national health authorities. This indicator monitors the frequency of stock outs of selected PPE tracer products at the facility level. It may provide an indication of the availability and management of the specific PPE commodities required to provide care and safeguard health workers.
<b>Definition of Key Terms</b>	<b>Personal Protective Equipment (PPE)</b> is equipment worn to minimize exposure to hazards that may cause serious injury and illness. PPE is a set of items that together provide a physical barrier between microorganisms and health care workers who provide direct care to patients or other responders who may have contact with patient blood

<sup>2</sup> WHO. Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care (2014). [http://apps.who.int/iris/bitstream/10665/112656/1/9789241507134\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/112656/1/9789241507134_eng.pdf). Accessed October 27, 2016

<sup>3</sup> CDC and WHO. Infection Control for Viral Haemorrhagic Fevers in the African Health Care Setting. Atlanta, Centers for Disease Control and Prevention, 1998: 1-198. <http://www.who.int/csr/resources/publications/ebola/whoemcesr982sec1-4.pdf>. Accessed October 25, 2016.

	<p>and body fluids. PPE may include but is not limited to: gloves, masks, face shields, boots, shoe covers, protective eye-wear (such as goggles), and gowns.</p> <p>A <b><u>pre-determined list of tracer products</u></b> must be relevant to the proposed program and specified by the partner. In some instances, national health authorities, technical agencies including WHO and CDC, and/or USAID/OFDA may specify tracer products to be monitored; in this case, this response-level guidance should be used.</p>
<b>Measurement</b>	<p><b>Percentage (%):</b>  <b>Numerator:</b> Total number of health facilities out of stock of 1 or more pre-defined PPE tracer product for more than one week during the measurement period.  <b>Denominator:</b> Total number of health facilities supported/targeted during the same measurement period.</p>
<b>Disaggregation</b>	By facility
<b>Data Sources</b>	Health facility records (inventory, pharmacy/warehouse), delivery records, inventory management records, logistics information systems

**Indicator 4: Percent of target population who can recall 2 or more protective measures**

*OFDA Health Sub-Sector: Community Health Education/Behavior Change*

<b>Purpose</b>	In response to a PHEIC, USAID/OFDA will support health education, social mobilization, and community engagement activities that promote behavior change to prevent disease transmission and encourage health seeking-behavior. This indicator is related to community-level acceptance and understanding of disease preventions. The indicator monitors the percentage of the target population that can recall 2 or more protective measures to prevent or protect against disease transmission.
<b>Definition of Key Terms</b>	<b><u>Protective measures</u></b> are defined as a set of specific measures that prevent transmission of a disease or encourage health-seeking behaviors, as relevant to the outbreak and the proposed program, and aligned with response-level messages and awareness campaigns.

	Examples of protective measures include but are not limited to: handwashing with soap, seeking care at a health facility as soon as symptoms appear, and not touching dead bodies.
<b>Measurement</b>	<p><b>Percentage (%):</b>  <b>Numerator:</b> Number of persons in the target population who correctly identify 2 or more protective measures at the time of the survey.  <b>Denominator:</b> Total number of persons in the target population at the time the survey was conducted.</p> <p><b>Sampling:</b> Collecting data to inform this indicator may require a community-level survey among a representative sample of the target population.</p>
<b>Disaggregation</b>	Per respondent gender, age (Age groups: 0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-60 years, and 60+ years)
<b>Data Sources</b>	Survey data

## 2- CUSTOM INDICATORS

In response to disease outbreaks in which new or tailored approaches may be required, custom indicators will need to be established in order to best assess performance. In addition to the required indicators above, USAID/OFDA encourages applicants submitting proposals to develop, use and report on additional output and outcome indicators suited to the proposed program. Custom indicators must meet the following requirements:

### Output indicator requirements

An output indicator measures the direct result of an activity. For example, if the activity is a training program, an output indicator would be the number of people trained.

Output indicators must be quantitative.

Output indicators must be direct, objective, useful, practical, and attributable.

1. Direct: The indicator must be directly linked to the result it is intended to measure.
2. Objective: It must be unambiguous and uni-dimensional. It must be a measure of change and not the target of change.
3. Useful: It must serve a specific programmatic purpose and must be useful to the management of the program.

4. Practical: Data related to the indicator must be collected with reasonable effort, time, and cost.
5. Attributable: The indicator must be directly related to the action, good, or service in the activity it is measuring.

Output indicators must be checked for validity, reliability, timeliness, precision, and integrity:

1. Validity: Is the measurement consistently applied?
2. Reliability: If the same indicator is used from project to project, is the same thing being observed and reported?
3. Timeliness: Can the information be collected and made available when needed?
4. Precision: Is what it measures clear, with sufficient specificity, detail, and statistical value, such that the data they feed into can be confidently used for decision-making?
5. Integrity: Have personal, political, or professional interests that could potentially bias the data been minimized? Have mechanisms be put in place to prevent corruption of the data for personal, political, or professional interests?

#### Outcome indicator requirements

Proposals must contain one custom outcome indicator. An outcome indicator measures the short term change that occurs as a result of an activity among the direct beneficiary population. For example, if the activity is a training program, an outcome indicator would be the percent change in specific knowledge in one of the training topic areas among the trainees.

Outcome indicators may be quantitative or qualitative.

#### Impact indicators

An impact indicator measures the change in the health or socioeconomic status of the population of interest, including direct and indirect beneficiaries that can be directly attributable to an activity. USAID/OFDA does not support the collection of impact indicators at the individual program level given multiple factors, in addition to the proposed activity itself, will contribute to overall impact.

### 3- MONITORING PLAN

The Monitoring Plan must include two components: the monitoring table and the monitoring narrative.

#### *Monitoring table requirements*

The monitoring table must include the following information for every indicator in the proposal: indicator type, definition, data collection method(s), data source, data collection frequency, data collection location, person(s) responsible, baseline value, and target.

Indicator	Indicator Type	Definition	Data collection method(s)	Data source	Data collection frequency	Data collection location	Person(s) responsible	Baseline value	Target

#### *Definition of monitoring table terms*

1. Indicator: Name of the indicator.
2. Indicator type: Output or outcome indicator.
3. Definition: Description of what the indicator measures. Are there any terms in the name of the indicator that need more explanation? For indicators that measure percentages or proportions, numerators and denominators must be clearly explained. For indicators that measure ratios or rates, clearly explain and define calculations. The definition should explain disaggregation category or categories used for that specific indicator.
4. Data collection method(s): Description of how the data will be collected, and sample size. One indicator may have several activities that contribute towards progress against that indicator, and several corresponding data collection methods may need to be included in the plan. In general, utilizing a variety of data collection and verification methods will strengthen the monitoring plan.
5. Data source: The person, object, or group from which the information comes.
6. Data collection frequency: How often the data is collected.
7. Data collection location: The location where the data is collected. Identifying a data collection location in the monitoring plan will not limit the partner's ability to be flexible and adjust the location of their programming as new needs arise, because the monitoring plan will change as the program changes.
8. Person(s) responsible: The primary or lead person undertaking the task of data collection. The persons(s) responsible for data collection should be independent

and non-biased. Project implementation staff should not be responsible for monitoring their own projects. Rather, separate monitoring and evaluation (M&E) staff should be responsible for data collection.

9. Baseline value: The pre-project value of a given indicator.
10. Target: The protected value for each indicator at a given time during the period of performance of the award.

### *Monitoring narrative requirements*

The monitoring narrative must include the following elements:

1. Limitations: Factors that present challenges to the implementation of the M&E plan.
2. Data use: Identify management decisions, processes, or external stakeholders that will use this information. This might include presentations; donor reporting; sector information sharing, such as reporting to clusters; internal organizational analysis; and program adaptation and future program planning.
3. Verification: How will the data be verified? What methods will the partner use to check that the data collected has not been falsified or manipulated during data collection, data entry, or data analysis? Staff other than those who collected the data should undertake verification.
4. Access and weather considerations: Which access or weather considerations, if any, will affect partners' ability to collect monitoring data? How will the partner overcome barriers to data collection? Factors influencing data collection should be clearly described and the data interpreted accordingly.
5. Protection and "Do-No-Harm" considerations: Specific protection concerns apply to certain beneficiary populations. What protection concerns are relevant to monitoring this activity? How does the partner plan to address these considerations? Monitoring projects must do no harm to the respondent, the enumerator, and the beneficiary population. How will the partner ensure that data collection will not increase threats or risk to these parties?