Integrated health services analysis: National level

Toolkit for analysis and use of routine health facility data
Toolkit for analysis and use of routine health facility data

Integrated health services analysis: National level
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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>artemisinin-based combination therapy</td>
</tr>
<tr>
<td>ALOS</td>
<td>average length of stay</td>
</tr>
<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacille Calmette-Guérin (vaccine)</td>
</tr>
<tr>
<td>BEmONC</td>
<td>basic emergency obstetric and neonatal care</td>
</tr>
<tr>
<td>BOR</td>
<td>bed occupancy rate</td>
</tr>
<tr>
<td>CEmONC</td>
<td>comprehensive emergency obstetric and neonatal care</td>
</tr>
<tr>
<td>C-section</td>
<td>caesarean section</td>
</tr>
<tr>
<td>CFR</td>
<td>case fatality rate</td>
</tr>
<tr>
<td>CoD</td>
<td>cause of death</td>
</tr>
<tr>
<td>CPT</td>
<td>co-trimoxazole preventive therapy</td>
</tr>
<tr>
<td>CRVS</td>
<td>civil registration and vital statistics</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>DHIS2</td>
<td>district health information software, version 2</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>DR-TB</td>
<td>drug-resistant TB</td>
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<tr>
<td>DST</td>
<td>drug susceptibility test</td>
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<tr>
<td>DTP</td>
<td>diphtheria–tetanus–pertussis (vaccine)</td>
</tr>
<tr>
<td>DTPcv-3</td>
<td>third dose of the DTP containing vaccine (e.g. pentavalent vaccine)</td>
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<tr>
<td>DQA</td>
<td>data quality assurance</td>
</tr>
<tr>
<td>FMIS</td>
<td>financial management information system</td>
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<tr>
<td>FTE</td>
<td>full-time equivalent</td>
</tr>
<tr>
<td>GIS</td>
<td>geographic information system</td>
</tr>
<tr>
<td>HeRAMS</td>
<td>Health Resources Availability Monitoring System</td>
</tr>
<tr>
<td>HHFA</td>
<td>Harmonized Health Facility Assessment (WHO)</td>
</tr>
<tr>
<td>HIS</td>
<td>health information system</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information system</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>IDSR</td>
<td>Integrated Disease Surveillance Response</td>
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<tr>
<td>IHME</td>
<td>Institute for Health Metrics and Evaluation</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations</td>
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<tr>
<td>IPTp</td>
<td>intermittent preventive treatment for malaria during pregnancy</td>
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<tr>
<td>LMIS</td>
<td>logistics management information system</td>
</tr>
<tr>
<td>MCCD</td>
<td>medical certificate of cause of death</td>
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<tr>
<td>MCV</td>
<td>measles-containing vaccine</td>
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<tr>
<td>MFL</td>
<td>Master Facility List</td>
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<tr>
<td>MICS</td>
<td>Minimum Indicator Cluster Survey</td>
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<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OPD</td>
<td>outpatient department</td>
</tr>
</tbody>
</table>
Penta  pentavalent vaccine
PHC  primary health care
PLHIV  people living with human immunodeficiency virus
PMTCT  prevention of mother-to-child transmission
RDT  rapid diagnostic test
RHIS  routine health information system
RMNCAH  reproductive, maternal, newborn, child and adolescent health
SARA  Service Availability and Readiness Assessment (WHO)
SDGs  Sustainable Development Goals
SMoL  Startup Mortality List
TB  tuberculosis
UHC  universal health coverage
URTI  upper respiratory tract infection
WHO  World Health Organization
WISN  Workload Indicators of Staffing Need
Guidance overview

WHO TOOLKIT FOR ANALYSIS AND USE OF ROUTINE HEALTH FACILITY DATA

This document is part of the WHO Toolkit for analysis and use of routine health facility data – a set of capacity-building resources to optimize the analysis and use of data collected from health facilities through routine health information systems (RHIS). The toolkit is a collaborative effort by multiple WHO technical programmes and partners. It promotes an integrated, standards-based approach to facility data analysis, using a limited set of standardized core indicators with recommended analyses, visualizations and dashboards.

The toolkit consists of a series of modules that can be used individually or together:
- **General principles** introduces key concepts in RHIS data analysis that are applicable to all modules.
- **Core facility indicators** is a compendium of the indicators from the various modules.
- The **Data quality assurance (DQA) toolkit** includes guidance and tools for systematic review of the quality of routine facility data.
- **Integrated health services analysis** targets general health service managers, providing a comprehensive, integrated analysis of tracer indicators across multiple health service components and programmes.
- The **Programme-specific guidance modules** are customized according to the needs of the programme. Each module contains a guidance document, training materials and an electronic configuration package for automated dashboard production.

The materials within the Toolkit will be periodically updated and expanded.

For further details refer to the WHO website WHO Toolkit for Routine Health Information Systems Data [1].
This document provides guidance on the integrated analysis and use of data collected from health facilities through routine health information systems (RHIS).

The integrated approach provides general health service planners and managers with an overarching or “cross-cutting” view of health services, based on a limited set of tracer indicators that represent multiple health programmes and service components. This approach recognizes that the various components of a health service delivery system are interdependent and should not be viewed in isolation. Such an integrated approach is essential for the comprehensive strengthening of health services towards improving primary health care (PHC), achieving universal health coverage (UHC) and contributing to the health-related Sustainable Development Goals (SDGs). An integrated approach to analysis is facilitated by integrated or interoperable RHIS data analysis platforms.

A sample set of indicators for integrated analysis is drawn mainly from the programme-specific core indicator lists in the Toolkit for analysis and use of routine health facility data [1] and the WHO Global reference list of 100 core health indicators [2]. The list is organized into three groups, with subgroups:

- **Group 1 indicators: Health status and epidemiological profile**
  - Mortality (institutional)
  - Morbidity (inpatient and outpatient)

- **Group 2 indicators: Health service performance**
  - Utilization and access
  - Service outputs, coverage and quality

- **Group 3 indicators: Health service resources**
  - Availability, distribution and efficiency of resources required by health facilities: infrastructure, health workforce, medicines and medical products, and financial resources.¹

The data analysis approach in this guidance is based on five principles:

- Integration – of data from various health programmes and services
- Focused analysis – using a limited set of key indicators
- Standardization – of indicators, analyses and visualizations
- Data quality assessment – along with analysis
- Purpose-oriented analysis – for management and planning.

**Chapter 1: Principles**

This introductory chapter discusses the above principles and provides a basis for understanding the subsequent chapters; and provides a summary of the sample set of indicators (section 1.3).

**Chapters 2 to 4: Sample indicators**

Each of these chapters discusses one of the main indicator groups, organized into sections according to the indicator subgroups. Each section follows a similar structure:

- “Sample indicators” presents the indicators with their definitions, calculation and disaggregations.
- “About the data” describes the rationale, data collection, analysis and use specific to the subgroup.

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¹ Health service resource data are complex and often not available in RHIS; however, selected concepts and indicators are briefly discussed to highlight the importance of reviewing routine health service data in relation to the resources needed to produce the health services.
“Assessing data quality” addresses data quality issues according to four data quality dimensions.
“Analysis” discusses analysis and interpretation issues for each indicator and provides examples of recommended visualizations (charts, tables, maps).

The guidance focuses on the analysis of aggregated routine facility data, including national-level trends as well as comparisons among subnational administrative units. The Toolkit module Integrated health services analysis: district and facility levels addresses similar concepts but adapted to these levels. The Toolkit module General principles provides additional details on foundational concepts for analysis of routine facility data and should be used along with the integrated guidance. Further details are also found in the programme-specific Toolkit modules.

This document includes hyperlinked text. Click once on the hyperlinked text to go to another place in the document to review a selected figure or to find additional information. After finishing the review, in order to return to the original place in the document, hold the alt button down and click on the left arrow.

Learning objectives

This guidance will promote an understanding of:

- the concept of integrated analysis of health services, using RHIS data;
- the advantages of using a limited set of standardized indicators and visualizations;
- analysis and presentation of the data in ways that are easily understood and useful to health service planners and managers;
- the importance of and approaches to assessing data quality;
- some considerations for interpretation of RHIS data.

The guidance assumes that users will already have a basic understanding of RHIS, indicators and analytical concepts.

Audience

The guidance targets workers in ministries of health as well as other organizations, including:

- decision-makers using RHIS data for general planning, management and review of health services;
- programme staff wanting to share key programme findings with a general audience;
- staff responsible for the analysis and presentation of health data, including analysts and monitoring and evaluation officers;
- health information systems staff involved in data management and data quality improvement
- staff of national health observatories;
- research institutes and academic institutions involved in the analysis and use of RHIS data.

Suggested reading

- Toolkit for analysis and use of routine health facility data [1]
- Data quality assurance (DQA) toolkit [3]
- WHO Application of ICD-10 for low-resource settings initial cause of death collection: The start-up mortality list (ICD-10-SMoL) [4]
- Master Facility List resource package: guidance for countries wanting to strengthen their Master Facility List. Facilitator guide for the MFL Training [5]
- Routine health information systems: a curriculum on basic concepts and practice [6]
1. Introduction

1.1 Context for integrated health services analysis

1.1.1 UHC, SDGs and PHC

All countries are working toward attaining universal health coverage (UHC). UHC means that all people receive the health services they need at a level of quality that is good enough to improve their health, and without suffering financial hardship. It includes the full spectrum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. A global set of indicators for monitoring country progress toward UHC is linked to SDG 3.8.1 [7]. These are used to monitor coverage with a range of health care and related services. Most of these UHC indicators are measured through population-based surveys. However, as health facilities make a critical contribution to achieving the UHC targets and the health-related SDGs, it is essential also to specifically monitor health service performance using facility-based data across the spectrum of health services.

Primary health care (PHC) is foundational to achieving UHC. In 2018, global leaders renewed their commitment to PHC at the Global Conference on Primary Health Care in Astana, the Republic of Kazakhstan. Strong PHC systems provide comprehensive, integrated care across the spectrum of a population’s health needs over the life course. Monitoring the performance of PHC services therefore also requires a comprehensive, integrated approach.

The integrated or “cross-cutting” approach to analysis of RHIS data that is taken in this guidance can provide planners and managers of PHC and referral services with a quick but comprehensive overview, on a regular basis, of health service performance and the health status of the people using these services.

1.1.2 Country health information systems

This document provides guidance on integrated analysis of health services using data regularly reported from health facilities through routine health information systems (RHIS).¹

Routine facility data should be considered within the context of the overall country health information system (HIS). As discussed by the Framework of the Health Metrics Network [8], the HIS brings together data from multiple sources, including the RHIS, health facility assessments, household surveys, censuses, civil registration systems, surveillance systems and other administrative data sources. Other data sources are mentioned briefly in this section and are needed for calculation of some of the indicators in this guidance. Some of these other data sources may also produce data on a regular or “routine” basis (e.g. surveillance systems, logistics management information systems [LMIS]) and may use facility-generated information; however, in many health systems they tend to remain as separate data sources that are not fully integrated with the RHIS.

Routine health information systems (RHIS)

Data are continuously generated in health facilities during the processes of service delivery. Facilities routinely collect data on the diseases and other health conditions for which people seek care, as well as on facility activities (outputs such as the number of outpatient department visits, the number of vaccine doses given) and the results of these activities (outcomes such as number of tuberculosis [TB] patients cured, the number of inpatient deaths). These data are aggregated and regularly reported through the RHIS to higher levels of the health system and ultimately to the national level. While RHIS data are commonly reported each month, the frequency of reporting may vary according to the data type, information needs and system capacity, e.g. daily, weekly, monthly, quarterly, annually. Data are analysed and used at all the levels of the health system.

¹ The “RHIS” is also called the health management information system (HMIS); the terms are often used interchangeably. HMIS is also sometimes used to describe the system for routine data that are not reported through programme-specific systems. For consistency, “RHIS” is used throughout this document.
The RHIS is a primary source of data for assessing health service performance and therefore essential for improving health service delivery. RHIS have the advantage that data are collected and analysed regularly, providing updated information across a wide range of services and for health facilities throughout the country, thus enabling timely identification of problems with findings disaggregated to the level of individual health facilities.

RHIS data often focus on PHC components such as outpatient visits, maternal health, immunization, human immunodeficiency virus (HIV), TB, etc. Depending on the facility level and health system characteristics, the RHIS may also report service components such as inpatient care (e.g. number of discharges, number of inpatient days); main outpatient and inpatient diagnoses and causes of death; surgical activity (e.g. number of caesarean sections); and special investigations (e.g. number of laboratory tests by type).

RHIS data sources are individual patient/client records (e.g. individual patient files, antenatal care cards, outpatient registers). Data are typically aggregated on tally sheets or counted from registers and then consolidated in monthly hard copy report forms. In many health systems, aggregate data from the monthly reports are entered into an electronic database which keeps an electronic copy of the report of each facility and each month. This data entry may occur at various levels of the system, e.g. health centre, hospital, district office, etc.

In some RHIS, aggregate data from all programmes are entered into the same electronic system; in other cases, specific programmes have separate systems. Some programmes (e.g. immunization, TB, HIV) use tracking systems to record information on individual patients over time. Sometimes these tracking systems are electronic (e.g. electronic registers or individual electronic medical records) and may be integrated with the RHIS but are often separate systems with only selected aggregate data extracted and submitted to the RHIS.

### Surveillance systems

Surveillance systems may report daily, weekly and/or monthly on selected diseases and conditions of public health importance. Some surveillance systems are integrated into the RHIS but in many contexts they use separate reporting systems.

### Health facility assessments

Data are also collected from facilities through periodic health facility assessments/surveys that are usually conducted at intervals of several years. Such assessments provide information that usually cannot be collected through the RHIS and are conducted by trained teams of external data collectors. The surveys are also used to validate the data that are routinely reported by facilities. Health facility assessments are addressed through a separate set of WHO resources, the Harmonized Health Facility Assessment (HHFA).

### Health service resource data

Resource data may be managed in different ways. Some datasets may be recorded in electronic databases while others may remain in paper format. Data on the availability, distribution and use of resources are important for understanding health service performance.

- A Master Facility List (MFL) should contain a list of all health facilities in the country, with their location and level. The MFL should include facilities owned by all agencies: public, private-for-profit, military, police, nongovernmental organizations (NGOs), faith-based and any other providers.
- Health workforce/human resources information systems maintain updated records of all health workers, including data on their occupations and locations. (Sometimes these databases are operated by the civil service authority rather than by health authorities.)

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1. Some health systems or programmes rely on manual aggregation of paper-based data from multiple facilities before these aggregated values are entered into an electronic database (e.g. at district office level).
2. Some systems track data on malnutrition and mortality as part of an early warning system for food insecurity, e.g. Famine Early Warning System Network (FEWS NET).
Logistic management information systems (LMIS) support the management of stocks of medicines and other medical products. A well-developed LMIS records all movements of items from origin to destination as well as movements within warehouses and facilities.

Financial management information systems record all transactions related to budget execution.

Population data

Population data serve as denominators for many RHIS indicators, e.g. utilization rates, coverage. It is important that managers and analysts have estimates of the populations the system is expected to cover. However, obtaining reliable population data is often challenging. Census-based estimates may be outdated or inaccurate; in general, the smaller the geographic area, the less reliable the population data.\(^1\)

Other information sources

Other sources include community information systems, civil registration systems, population-based surveys, supervision reports, programme evaluations (e.g. qualitative assessments of the extent of implementation and other measurements of process indicators\(^2\)), and data from other sectors and informal sources. Information from these various sources can provide insights into the service context and help in interpretation of RHIS indicators.

Integrated data management systems

A country HIS often consists of many, disconnected data management systems, including multiple systems for collection and management of routine facility data. Programme-specific systems may result from partner requirements and, in some cases, the data elements and indicators in these systems may not be consistent with the national indicator list. Furthermore, RHIS managers may not have access to the programme-specific systems.

Comprehensive, integrated analysis of routine facility data requires access to data from all programmes and service components. While it is possible to extract data from different systems to conduct an integrated analysis, this requires substantial time and effort and is rarely feasible for regular analysis.

Integration of all routine facility data systems into a single, common RHIS platform enables efficient, integrated analysis and avoids duplicate data entry. It also enables efficient desk review of the quality of all data using tools such as the WHO Data quality assurance (DQA) toolkit (see section 1.2.4). Where such integration is not feasible, systems can be designed for interoperability, to allow easy transfer of data between them. Such integration and interoperability require standardization of metadata across the various systems.

Interoperability can be extended to include data from sources other than the RHIS. For example, interoperability of the RHIS with health workforce information systems and LMIS would facilitate analysis of resource distribution and use in relation to facility activities. This would also support assessment of equity and efficiency. Furthermore, a common data platform can be expanded to create a national health observatory platform or repository that stores data from various sources (e.g. health facility assessments, population-based surveys, community health information systems), to facilitate triangulation of data from various sources and comprehensive review of health sector information.

Establishment of integrated or interoperable data systems requires high-level buy-in, commitment of financial and technical resources and strong coordination from the ministry of health, as well as partner collaboration and support.

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\(^1\) Refer to the Toolkit document General principles for further discussion on population estimates [1].

\(^2\) For example, proportion of health facilities which have implemented a directly observed treatment strategy (DOTS) for tuberculosis.
1.2 Principles of this guidance

The data analysis approach of this guidance is based on five principles, listed in Box 1.

**Box 1: Principles of this guidance**

1. Integration – across programmes and services
2. Focused analysis – using a limited set of key indicators
3. Standardization – of indicators, analyses and visualizations
4. Data quality assessment – along with analysis
5. Purpose-oriented analysis – for management and planning

1.2.1 Integration – across programmes and services

In this guidance, integrated analysis refers to the presentation of indicators from multiple programmes and service components in ways that they can be reviewed together easily and assessed in relation to each other. An integrated data perspective reinforces the need for attention to the comprehensive health needs of individuals and populations, in addition to programme-specific perspectives.

An integrated approach also recognizes that the various components and processes of a service delivery system are interconnected and may influence each other. It allows assessment of indicators from various programmes in relation to each other, helping to check the consistency of the data between programmes and enabling identification of imbalances in programme performance. Indicators that use data from more than one programme (e.g. TB and HIV; reproductive, maternal, newborn, child and adolescent health [RMNCAH] and malaria; RMNCAH and HIV; etc.) provide further insights into the relationships among programmes. As discussed in the previous section, integrated analysis is greatly facilitated by integration or interoperability of data collection and analysis platforms.

1.2.2 Focused analysis – using a limited set of key indicators

General health planners and managers do not require detailed information on all aspects of health services each time they review data. A limited set of indicators serving as “tracers” can enable users to quickly identify potential problems that can be explored further through in-depth analysis if necessary. A summary list of sample indicators is provided in section 1.3. Further descriptions of each indicator are found in the indicator tables and analysis sections of the relevant chapters. All the programme-related indicators are also found in the programme-specific modules of the Toolkit.

The indicators in this guidance are intended as an example of an integrated indicator set, for countries to adapt according to their context and priorities.

The sample indicators are presented in three main groups, with subgroups:

- **Group 1: Health status and epidemiological profile**
  - Mortality (institutional)
  - Morbidity (inpatient and outpatient)

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1 The sample indicators in this guidance were selected mainly from the programme-specific modules of the Toolkit [1] and from the WHO 2018 Global reference list of 100 core health indicators [2]. A limited number of indicators from other sources was also included. The indicators were selected to provide an example of a concise overview of key facility services, to reflect the volume of activities and to provide an indication of service quality.
Group 2: Health service performance
- Utilization and access
- Service outputs, coverage and quality

Group 3: Health service resources
- Availability, distribution and efficiency of resources required by health facilities: infrastructure, health workforce, medicines and medical products, and financial resources.¹

While some indicators may not always fit neatly into a group or subgroup, the groups are helpful in organizing the analysis and providing a focus on key aspects of service delivery.

The indicator groups represent key service aspects that should be considered in management and planning processes. For sound decision-making, managers need to assess all the groups. Performance in one group may be influenced by that of other groups, e.g. measles vaccine shortage can result in low vaccination coverage which can in turn result in a measles outbreak.

The following paragraphs briefly describe how the indicators could be used by planners and managers.

Group 1 indicators: Health status and epidemiological profile
- **Institutional mortality** indicators measure the total number of inpatient deaths and the illnesses and conditions from which people die while admitted to a health facility.
- **Inpatient and outpatient morbidity** reflect the diagnoses for which people are admitted as inpatients or visit outpatient services.

While RHIS data are not representative of the entire population, facility deaths and morbidity data provide some information on the types of health problems occurring in the population. For example, an increase in the number of admissions and inpatient deaths for malaria, along with an increase in malaria cases in outpatient departments, point to a malaria outbreak that demands immediate action. This information is also important for planning the types of health service and public health interventions needed (including screening, preventive and promotive interventions) as well as the staffing, training, and medicines and supplies required. Mortality and morbidity data can also inform evaluation of the coverage and quality of disease-control programmes.

Group 2 indicators: Health service performance
- **Utilization** refers to how often the population uses health services and is measured through inpatient discharges, outpatient visits and use of surgical services. **Access** refers to whether people are able to reach the services and use them. Utilization is often used as a proxy measure for access but is also influenced by whether people choose to use the services. Thus, a perception of poor service quality may result in low utilization even where geographic access is good.
- **Service output** refers to the number of people that received an intervention or service. **Coverage** refers to the percentage of a target population that received a specific intervention or service that they need. (Where reliable population estimates are not available, service output numbers may be used as proxies to assess performance.)
- **Quality** refers to how well a service is delivered: whether it is provided according to required standards. RHIS indicators can serve as proxy quality measures that may highlight the need for in-depth quality assessments.

¹ Health service resource data are complex and often not available in RHIS; however, selected concepts are briefly discussed to highlight the importance of reviewing RHIS data in relation to the resources needed to produce the services.
The indicators in this group are important for assessing performance and for the identification of inequities. For some of the indicators there are well-defined targets. For example, administrative areas (such as provinces and districts) have defined coverage targets, based on their populations. For several indicators of service quality, the accepted target is 100%, e.g. antenatal syphilis testing or malaria diagnostic testing. Regular monitoring of such indicators shows whether services are on track to meet their targets and enables comparisons of performance among subnational areas. Such findings can help to inform decisions about supervision needs and allocation of resources.

For other indicators, a target is not well defined. For example, there are no defined targets for outpatient or inpatient service utilization, surgical volume, the number of new cases of hypertension or diabetes or the number of TB notifications. Interpretation of such indicators relies mainly on assessment of trends (both short-term and long-term) to identify improvements or disruptions of service. In addition, for indicators defined as rates per population per year (e.g. inpatient and outpatient utilization rates) it is possible to compare the performance of subnational areas.

**Group 3 indicators: Health service resources**

Health service resources are the inputs needed to deliver the services, such as infrastructure, workforce, medicines and medical products, and finances. Resource data are usually managed through specific information systems that are not linked to the RHIS. However, it is important to consider these data in relation to RHIS data, as they can help managers to assess performance and to make informed decisions about distribution and re-distribution of resources. For example, comparing the numbers of health workers per population among different districts can guide decisions about deployment of additional staff to under-served areas.

**Indicator disaggregation**

This document also provides guidance on minimum disaggregations of each indicator. Such disaggregation serves several purposes. As discussed in section 3.1.3, to determine if there is any reporting bias, it can be important to assess the completeness of data disaggregated by type of facility and by ownership of the facility. Disaggregation by geographic area permits identification of geographic inequities in access, utilization or disease risk as well as differences in service performance. Where data are disaggregated by age group or sex, it is possible to compare the data for these groups to better understand who is making use of health services and how these groups differ in their health risks.

All indicators should be disaggregated by geographic location (e.g. province/district), facility type (e.g. referral hospital versus district hospital versus health centre, etc.) and by facility ownership (e.g. government versus private, non-profit versus private-for-profit). Many, but not all, indicators should also be disaggregated by sex and by at least a small number of age groups (under 5 years of age versus 5 years and older). Some health systems serving large refugee or displaced populations may choose to disaggregate health data by migrant versus native populations.

It is important to keep in mind when designing forms for reporting of aggregate data in paper-based systems that excessive disaggregation of data elements results in quite complex and large forms and may negatively impact the quality of data reported. It is for this reason that WHO does not recommend, for example, that data on childhood immunizations be disaggregated by sex.

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1 For further discussion of equity analysis, refer to Toolkit module: General principles, section 6.4 [1].
2 Refer to Toolkit module: Immunization [1]. In most health systems, it is best to rely on findings from population-based surveys to assess for inequities in immunization coverage by sex.
1.2.3 Standardization – of indicators, analyses and visualizations

Standardization of data elements and indicators enables a common understanding of what is being measured and allows comparison of data over time and across programmes, places and populations. Indicator standardization involves agreeing on standard definitions of indicators, data elements and metadata, including disaggregations, e.g. age groups. Standardization of data collection tools and training of staff are essential to ensure that the data are collected in the same way in all locations.

The ways in which the indicators are visualized can also be standardized. This guidance uses the following visualizations:

- line charts or column charts to show trends over time;
- column or bar charts to show comparisons, e.g. between activities or subnational areas;
- maps to show differences among subnational areas;
- “cascade” charts to show a sequence of related events;
- tables to show multiple indicators across time or across subnational areas.

A set of standard visualizations can be agreed upon and grouped in a standard dashboard to provide an easily accessible overview of key indicators. Dashboards can be presented on a computer screen (in an electronic database) or in hardcopy documents.

After a set of indicators and their visualizations have been defined, the production of standard dashboards at required intervals can be automated in the data management system, e.g. the district health information software 2 (DHIS2).

Such a standard set of indicators and their visualizations, organized into standard dashboards, can be used across administrative units (e.g. districts) and across different levels of the health system. This provides a consistent approach to data analysis, focuses the analysis on priorities and can assist in building capacity.

Health systems vary in their policies, priorities and data systems. For example, a country may currently not collect data on all the indicators presented in this guidance or may use different names for the data elements and indicators. Therefore, countries need to adapt the indicator set and analyses according to their needs. This will usually require a process for reaching consensus on a set of indicators among the various stakeholders who will analyse and use the data (e.g. health programmes, HIS staff, subnational managers, hospital authorities, partner organizations).

1.2.4 Data quality assessment – along with analysis

Data cannot be interpreted without an understanding of the data quality and should always be assessed for completeness, consistency and errors. The data quality findings should be presented in the same dashboard or report that presents the indicators, to provide the user with insights into the strengths and limitations of the data. Data quality assessment involves four main dimensions, summarized in Table 1.1.

---

1 A data element is the numerator or denominator used in the calculation of an indicator.
2 Metadata provide information about an indicator or data element, e.g. definition, calculation, disaggregation, frequency of reporting, form to be used for reporting.
3 RHIS databases sometimes contain multiple unrelated tables and charts, while lacking visualizations of key indicators. This document aims to provide guidance on the most useful and reliable analyses and visualizations. Toolkit module General principles provides further details on visualizations [1].
Table 1.1 Data quality dimensions

<table>
<thead>
<tr>
<th>Data quality dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completeness and timeliness</td>
<td>Completeness and timeliness of report submission</td>
</tr>
<tr>
<td></td>
<td>Completeness of specific data elements</td>
</tr>
<tr>
<td>2. Internal consistency</td>
<td>Presence of outliers(^1)</td>
</tr>
<tr>
<td></td>
<td>Consistency over time</td>
</tr>
<tr>
<td></td>
<td>Consistency between related data elements/indicators</td>
</tr>
<tr>
<td></td>
<td>Consistency between reported data and original records</td>
</tr>
<tr>
<td>3. External consistency with other</td>
<td>Consistency between RHIS data and sources such as population-based surveys,</td>
</tr>
<tr>
<td>data sources</td>
<td>special studies</td>
</tr>
<tr>
<td>4. External comparisons of population data</td>
<td>Consistency between population data used for calculating facility indicators</td>
</tr>
<tr>
<td></td>
<td>and other sources of population estimates</td>
</tr>
</tbody>
</table>

RHIS data quality assessment should be conducted both routinely and periodically as a part of ongoing data quality assurance.

**Routine data quality assessment** should take place regularly, e.g. monthly or quarterly, at the time that the data are submitted. Dedicated data quality dashboards can be created as part of a set of analysis dashboards. Data quality visualizations can also be included within an analysis dashboard. For example, in completeness of reporting for multiple datasets.

![Fig. 1.1 RHIS reporting rates – selected datasets, nationwide, last 12 months](image)

As another example, a chart such as Fig. 1.2 can be used to review the consistency of the data over time and can also reveal any extremely large outliers (as seen in September 2019 for BCG).

---

\(^1\) Outliers are values that differ substantially from the average reported value. Sometimes outliers are the result of true variations, but often they are the result of a data error.
Periodic data quality reviews are more extensive than routine assessments and consist of two components: a desk review and a data verification survey. The desk review involves quality checks on the data available in the electronic system. The data verification survey involves visits to health facilities and assesses a sample of districts and facilities for the extent to which the RHIS data match the source documents (e.g. facility registers and tally sheets). A data verification component may be included in general health facility assessments such as WHO’s HHFA.

Standardized methods for data quality assessment are important for understanding whether data quality improves over time and for comparing subnational areas, to enable targeting of support to where it is most needed. WHO has developed a set of resources to support standardized data quality review: the WHO Data quality assurance (DQA) toolkit [3]. This toolkit includes an Excel-based tool which, when populated with key data from health facilities and other sources, analyses the completeness, internal consistency and external consistency of the data. For countries using the DHIS2, WHO has developed an application that can be installed on the national DHIS2 system for automated generation of a data quality desk review report at national or subnational level.

1.2.5 Purpose-oriented analysis – for management and planning

Dashboard for visualizing key findings

Calculation of indicators and production of dashboards and analysis reports are essential first steps in the process toward using data for decision-making. Standard dashboards can be produced for different health system levels (e.g. national, district, facility) and for different analysis timeframes, linked to the data needed for different management processes. For example:

- **Short-term dashboards** (e.g. monthly/quarterly): for ongoing, regular monitoring of the health situation and service performance, to identify issues where immediate action may be needed.
- **Long-term dashboards** (e.g. annual): for periodic reviews of progress, equity and efficiency and to inform planning and resource allocation.

This guidance provides examples of visualizations: (charts, tables and maps) presenting mainly annual, national level statistics.  

---

1 District and facility dashboards are addressed in a separate Toolkit document Integrated health services analysis: district and facility levels [1].
The indicators and related model visualizations are organized according to the three indicator groups previously discussed.

### Interpreting the data

After the production of the dashboards and analysis reports, the next step is interpretation: looking at the data in a systematic way to uncover the underlying meaning or the “stories” that the data tell.

Box 2 presents steps to guide the interpretation process. (An integrated or interoperable data platform that enables analysis of RHIS data from all programmes will greatly facilitate these steps.)

Analysis and interpretation of RHIS data can provide insights into what is happening in health facilities and in the communities using the services. However, while these data can provide a description of a situation, they cannot explain why it is happening. The dashboards with their tracer indicators can therefore be used to identify issues that may need further investigation to find out the underlying causes.

---

**Box 2: Steps for interpreting RHIS data**

1. **Assess data quality first**
   - Review the short-term dashboards: assess completeness and internal consistency; look for errors.
   - Review the long-term dashboards: as above, plus assess external consistency with other data sources (e.g. population-based surveys) and consistency of denominators where relevant.

2. **Assess trends over time**
   - Look at the data over time (e.g. consecutive months, quarters or years).
   - Compare with data for the same period in previous years.
   - Ask:
     - Do the data remain consistent over time, or are there large or unexpected variations?
     - Are there any steady upward or downward trends?
     - Are there any seasonal variations?

3. **Assess progress against targets**
   - Ask:
     - Have targets been reached (e.g. number of children vaccinated per quarter)?

4. **Compare subnational areas**
   - Are there significant differences among geographic areas/administrative units?
   - Compare the data for one subnational area with the average for all the areas.
   - Identify areas that consistently underperform as well as those that consistently perform well.

5. **Compare different programmes**
   - Are some programmes performing better than others or showing more activity than others?

6. **Compare related data elements**
   - Do related data elements show the expected relationships (e.g. are the numbers of vaccine doses given consistent with the number of vials used)?

7. **Assess findings in relation to information from other sources**
   - Is further investigation needed to explain or expand upon the findings? (e.g. Was there an event that could explain a decrease in utilization? Was there a stockout of malaria rapid diagnostic tests [RDTs] that resulted in fewer confirmed malaria cases?)
### 1.3 Sample indicators for integrated health services analysis

<table>
<thead>
<tr>
<th>MORTALITY (institutional)</th>
<th></th>
</tr>
</thead>
</table>
| **Mortality levels**      | 1. Institutional mortality (%)  
                            | 2. Stillbirths in health facilities (%)  
                            | 3. Neonatal deaths in health facilities  
                            | 4. Maternal deaths in health facilities  |
| **Leading causes of mortality** | 5. Leading causes of inpatient deaths (percentage distribution)  |
| **Mortality due to specific causes** | 6. Case fatality rates (CFR) for major causes (%)  
                                      | 7. Population incidence of inpatient deaths  
                                      | 8. Perioperative mortality rate (%)  
                                      | 9. Emergency unit mortality rate (%)  |

<table>
<thead>
<tr>
<th>MORBIDITY (outpatient and inpatient)</th>
<th></th>
</tr>
</thead>
</table>
| **Leading causes of morbidity**    | 1. Leading inpatient discharge diagnoses (percentage distribution)  
                                      | 2. Leading outpatient diagnoses (percentage distribution)  |
| **Morbidity due to specific causes** | 3. Cases of selected diseases for surveillance  |

<table>
<thead>
<tr>
<th>UTILIZATION and ACCESS</th>
<th></th>
</tr>
</thead>
</table>
| 1. Outpatient attendance per capita  
  2. Emergency unit utilization rate  
  3. Hospital discharge rate | 4. Surgical volume  
  5. Service-specific availability  |

<table>
<thead>
<tr>
<th>SERVICE OUTPUTS and COVERAGE</th>
<th></th>
</tr>
</thead>
</table>
| 1. Antenatal care visits  
  2. Institutional deliveries  
  3. DTPcv-3 coverage (and coverage for other vaccines)  
  4. Antiretroviral therapy (ART) coverage (current) | 5. TB case notification rate  
  6. Confirmed malaria cases  
  7. Hypertension new cases  
  8. Diabetes new cases  |

<table>
<thead>
<tr>
<th>QUALITY</th>
<th></th>
</tr>
</thead>
</table>
| 1. Antenatal client 1st visit before 12 weeks (%)  
  2. PMTCT testing (ANC clients tested for HIV or known HIV+) (%)  
  3. Intermittent preventive treatment for malaria during pregnancy (IPTp3) (%)  
  4. Caesarean sections (%)  
  5. Immunization dropout rates (%)  
  6. HIV care cascade | 7. New and relapse TB cases with a documented HIV status (%)  
  8. Drug susceptibility test (DST) for TB cases (%)  
  9. TB treatment success rate (%)  
  10. Percentage of malaria suspects tested (%)  
  11. Confirmed malaria cases treated with first-line treatment courses (including ACT) (%)  |

<table>
<thead>
<tr>
<th>HEALTH SERVICE RESOURCES (availability, distribution and efficiency)</th>
<th></th>
</tr>
</thead>
</table>
| Infrastructure 1. Health facility density and distribution  
  2. Hospital bed density | 3. Bed occupancy rate (BOR)  
  4. Average length of stay (ALOS)  |
| Health workforce 5. Health worker density and distribution  
  6. Output of training institutions | 7. Vacancy rate  
  8. Health worker productivity  |
| Essential medicines 9. Availability of essential medicines and commodities: health facilities with no stockout of essential items |  |
| Finance 10. Health services expenditure per capita  
  11. Budget execution |  |

Indicator metadata including definition, calculation, recommended disaggregations and level of use are found at the beginning of the guidance sections for each indicator group.
2. Group 1 indicators: Health status and epidemiological profile

2.1 Mortality (institutional)

2.1.1 Mortality indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Calculation</th>
<th>Disaggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality levels</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Institutional mortality (%)</td>
<td>Inpatient deaths in health facilities (all causes) per 100 discharges (%)</td>
<td>N: Number of inpatient deaths x 100&lt;br&gt;D: Number of discharges (Discharges include deaths)</td>
<td>Age (minimum: 0–4 and 5+ years)&lt;br&gt;Sex&lt;br&gt;Cause of death</td>
</tr>
<tr>
<td>2. Stillbirths in health facilities (%)</td>
<td>Stillbirths* as a percentage of all births in health facilities&lt;br&gt;* Baby born with no sign of life and weighing at least 1000 g or born after 28 weeks of gestation</td>
<td>N: Number of stillbirths in health facilities x 100&lt;br&gt;D: Number of live births + still births in health facilities</td>
<td>Fresh, macerated</td>
</tr>
<tr>
<td>3. Neonatal deaths in health facilities</td>
<td>Number of newborns who die in the health facility in the first 28 days&lt;br&gt;This includes any neonatal death in a facility that occurred in the first 28 days: pre-discharge after birth or upon re-admission for an illness</td>
<td>Number of neonatal deaths in health facilities</td>
<td>Cause of death (classified by ICD-PM)</td>
</tr>
<tr>
<td>4. Maternal deaths in health facilities</td>
<td>Number of women who die in a health facility while pregnant or within the first 42 days of the end of pregnancy&lt;br&gt;Includes women who gave birth outside a facility but who die in the health facility.</td>
<td>Number of maternal deaths in health facilities</td>
<td>Age (10–14, 15–19, 20+)&lt;br&gt;Cause of death (classified by ICD-MM)</td>
</tr>
<tr>
<td><strong>Leading causes of mortality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Leading causes of inpatient deaths (percentage distribution)</td>
<td>Percentage distribution of the leading causes of inpatient deaths in health facilities (proportional mortality)</td>
<td>N: Number of inpatient deaths by cause x 100&lt;br&gt;D: Total number of inpatient deaths</td>
<td>Age (0–4, 5+)&lt;br&gt;Sex</td>
</tr>
<tr>
<td><strong>Mortality due to specific causes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Case fatality rates (CRF) for major causes (%)</td>
<td>Cause-specific inpatient deaths per 100 discharges for major causes (%)</td>
<td>N: Number of inpatient deaths due to cause “X” x 100&lt;br&gt;D: Number of discharges due to cause “X”</td>
<td>Age (0–4, 5+)&lt;br&gt;Sex</td>
</tr>
<tr>
<td>7. Population incidence of inpatient deaths (e.g. malaria)</td>
<td>Number of inpatient malaria deaths per 100 000 population at risk of malaria per year</td>
<td>N: Number of inpatient deaths due to malaria x 100 000&lt;br&gt;D: Estimated total population of areas at risk of malaria</td>
<td>Age (0–4, 5+)&lt;br&gt;</td>
</tr>
<tr>
<td>8. Perioperative mortality rate (%)</td>
<td>All-cause death rate prior to discharge among patients that had one or more procedures in an operating theatre during the relevant admission</td>
<td>N: Number of deaths prior to discharge among inpatients that had a surgical procedure x 1000&lt;br&gt;D: Number of inpatients that had a surgical procedure</td>
<td>Emergency vs elective Procedure type&lt;br&gt;Age</td>
</tr>
<tr>
<td>9. Emergency room mortality rate (%)</td>
<td>Percentage of deaths in the emergency unit (before admission as an inpatient) among all emergency unit visits</td>
<td>N: Number of deaths in emergency unit x 100&lt;br&gt;D: Number of emergency room visits</td>
<td>Age (minimum: 0–4; 5+ years)&lt;br&gt;Sex&lt;br&gt;Cause of death</td>
</tr>
</tbody>
</table>

*Note: All indicators should also be disaggregated by geographic location (e.g. district), facility type (e.g. referral hospital, district hospital, health centre) and managing authority/facility ownership (public, private, NGO, etc.).*
2.1.2 About the data

This section discusses the analysis of data on deaths that occur while patients are admitted as inpatients in hospitals and other inpatient facilities (also called facility deaths, inpatient deaths, institutional deaths or hospital deaths).

Sources of mortality data

Mortality data can come from multiple sources, including systems for civil registration and vital statistics (CRVS) [10]. Strong CRVS systems are required to provide reliable information on all deaths in a country, including those that do not occur in health facilities. However, many countries do not yet have CRVS systems that capture all deaths or provide cause of death data for a large percentage of deaths.

Hospitals and other inpatient facilities typically report routinely on inpatient diagnoses and deaths and are often the only source of available mortality data. In these facilities, doctors are likely to have the skills and diagnostic support required for reliably assigning the causes of deaths. Therefore, hospital reporting is a good starting point for the collection of data on mortality, including causes of death. In many settings, however, only a small percentage of all deaths occurs in health facilities. Inpatient deaths are therefore usually not representative of all deaths in the population. Box 3 describes some methods for comparison of inpatient mortality data with estimates of deaths in the entire population, based on modelling of data from multiple countries.

Standardized classification of cause of death (CoD)

It is essential that causes of death (CoD) are classified in a standard way – in particular, in accordance with the International Classification of Diseases (ICD) [11]. Some countries use CoD lists that do not align with the ICD classification. In some cases, the CoD list may even vary within a country or between types of facilities (e.g. referral hospitals and district hospitals). Use of non-standardized CoD lists makes it very difficult, if not impossible, to compare mortality data: from year to year; among subnational areas; between types of health facilities; or with global estimates. Furthermore, such lists may include many ill-defined categories to which a large percentage of deaths may be assigned (e.g. “other metabolic diseases”; “other gastro-intestinal”). This limits the usefulness of CoD data for decision-making. Non-standardized lists also tend to change more frequently than the ICD. These shortcomings of non-standardized CoD lists make it difficult to assure that doctors and other staff (e.g. “coders”) receive the required training to ensure that CoD are reliably assigned, and that the data are coded in a consistent manner.

WHO guidance on standardization of mortality data

WHO has developed guidance for certifying deaths with the WHO International Form of Medical Certificate of Cause of Death (MCCD) and coding of deaths according to ICD [12]. The ICD contains large numbers of codes and details that may be challenging to use in some settings. WHO has developed an ICD-based tool that is easier to use than comprehensive ICD coding: the Startup Mortality List (SMoL) [13]. The SMoL may be considered a first step toward standardized reporting of causes of death.¹

Recommendations for analysis of inpatient mortality data

For the reasons discussed above, it is a priority for countries to invest in strengthening the CRVS as well as introducing or reinforcing the certification of inpatient deaths according to international standards.

¹ A SMoL electronic module is available for capture of information on individual deaths using the DHIS2. The mortality data from the SMoL should be aggregated and incorporated into the overall RHIS, e.g. the DHIS2. The SMoL module should be interoperable with the aggregate DHIS2 database.
The indicators and visualizations presented in this chapter can be applied to any inpatient mortality data, including when only a small percentage of the inpatient deaths may be certified according to the required standards. However, any potential limitations of the data must always be acknowledged, including non-standardized CoD lists.

Even if hospitals have not reported mortality data by cause, the total numbers of deaths (disaggregated by sex and by broad age groups) should still be reported and analysed to provide the all-cause levels of institutional mortality.

Furthermore, analysis of non-standard mortality data can be used to highlight the problems of non-standard CoD lists and the need to introduce international standards for certification and coding of inpatient deaths.

### 2.1.3 Assessing data quality

The quality of inpatient mortality data can be assessed according to the data quality dimensions of completeness, internal consistency and external consistency. In addition, these data can be assessed for their representativeness of all deaths in the population and for whether standards are met in classification, coding and disaggregation of data on causes of deaths.

#### Completeness

**Percentage of hospitals reporting:** In some countries, routine reporting from hospitals is often erratic and significantly incomplete. Assessment of completeness of reporting is therefore essential. If the completeness is reasonably constant over time, mortality data can show trends based on those facilities which are reporting. If, however, there is significant variation in completeness over time or among geographic areas, the trends and any geographic comparisons should be interpreted with caution. For example, if a few large hospitals in a particular geographic area reported for a certain year, but failed to report for the following year, the total number of deaths reported for the area may be substantially reduced in the second year. This may be interpreted incorrectly as a decrease in actual inpatient deaths.

**Disaggregation by type of facility:** It is important to disaggregate the completeness of data by type of facility (e.g. referral hospitals, district hospitals). Referral facilities are often larger, admit more serious cases and have higher numbers of deaths compared with other hospitals. Consequently, incomplete reporting from such facilities can significantly influence the overall numbers of inpatient deaths. Proportional mortality is less sensitive to incomplete reporting than institutional mortality levels but may still be affected by the types of facilities reporting, e.g. referral hospitals usually have different proportional mortality profiles compared with district hospitals.

**Disaggregation by ownership:** This is also useful, as reporting by private-for-profit facilities is problematic in many settings and these facilities often provide a significant proportion of health services. In some countries, reports are expected only from a selected group of sentinel hospitals; this should be stated clearly in the analysis report.

#### Internal consistency

**Trends over time:** Consistency over time (month-to-month and year-to-year) should be assessed for deaths from all causes as well as for deaths from selected causes (e.g. malaria). Large year-to-year variations (e.g. more than 10%) in the numbers of deaths are not expected and should be investigated. Review of the trends in the numbers of deaths by month for multiple years is useful to understand whether variations represent data quality problems or expected seasonal variations.

**Outliers:** Outlier values in inpatient mortality data are especially suspicious when they are not accompanied by related outlier values in inpatient discharges.

**Consistency between inpatient mortality and morbidity data:** The trends in total inpatient deaths and in the distribution of causes of death are expected to be reasonably consistent with the trends in total inpatient discharges and the distribution of leading inpatient diagnoses. There should also be consistency over time in the distribution of total inpatient deaths by sex and by age group.
The example in Figs 2.1 and 2.2 shows trends in inpatient statistics for the United Republic of Tanzania. [14]

**Fig. 2.1** Trend in the distribution of causes of inpatient deaths, 0–4 years, United Republic of Tanzania, 2009–2012

**Fig. 2.2** Trend in the distribution of discharge diagnoses, 0–4 years, United Republic of Tanzania, 2009–2012

**Question:** For the period covered, were the trends in the distribution of deaths consistent with the trends in the distribution of inpatient discharge diagnoses? Which disease(s) declined in importance and which disease(s) increased in importance?²

- **External consistency with other data sources**

  Mortality data obtained from routine inpatient reports can be compared with mortality data from disease-specific programmes which monitor treatment outcomes (e.g. TB, HIV).

- **Quality of classification, coding and reporting of inpatient mortality data**

  The quality of inpatient mortality data can also be assessed based on whether the system meets global standards, as discussed above, for cause of death certification (i.e. use of the MCCD), coding (i.e. by trained coders using ICD) and reporting (e.g. data of good completeness; inclusion of age and sex disaggregations).

  Even when causes of death are assigned by medically qualified staff, there is often substantial use of coding categories for unknown and ill-defined causes (“garbage” codes). These refer to conditions that are vague, including where only the terminal event or mode of dying is captured (e.g. “cardiac arrest”), as there is no information on the condition that led to the terminal event. These ill-defined causes are of no value for informing public health policies and actions. The percentage of deaths with garbage codes is a key measure of the quality of mortality data.

- **Representativeness of inpatient mortality data**

  The **percentage of deaths occurring in health facilities** suggests the extent to which hospital deaths can be considered representative of all deaths in the population. The lower the percentage, the less representative the institutional cause of death data. The numerator is the total number of reported inpatient deaths in a given year. The denominator is the expected number of deaths in the country, which can be extracted from the United Nations population estimates [15]. The expected number of deaths can also be estimated from country data by using the projected population multiplied by a reliable estimate of the crude death rate.

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² With few exceptions, the trends in the distribution of the causes of death are matched by the trends in the distribution of discharge diagnoses. The exceptions are that “perinatal causes” and “malnutrition” are not included as leading discharge diagnoses. Children discharged after treatment for these conditions have likely been given other discharge diagnoses.
The distribution of causes of death for hospital data can also be compared with the estimates for the whole population obtained through statistical modelling, such as WHO’s Global Health Estimates [16] and the Global Burden of Disease estimates of the Institute for Health Metrics and Evaluation (IHME) [17]. An example of such a comparison is provided in Box 3.

**Box 3: Comparing causes of death distributions between health facilities and estimates for the population**

WHO uses a combination of data and modelling to compile national estimates of death by cause. These estimates are useful for driving overall health policy. In contrast, regular facility-based CoD reporting can provide more immediate insights into the most serious illnesses presenting to health facilities; these data can also potentially be analysed by small geographic areas. The following stacked bar charts compare 2016 WHO mortality estimates for the United Republic of Tanzania with mortality reported from 2006 to 2015 by a sample of 39 hospitals in the country, including district, regional and national referral facilities [18].

The comparison reveals that hospital mortality data for this period probably under-represent the percentage of deaths due to injuries, perinatal complications, diarrhoeal diseases, malignancies, TB, malnutrition and maternal causes. (Note that deaths from injuries often occur before people reach a hospital.) On the other hand, compared with the WHO estimates, hospitals reported higher percentages of deaths due to malaria, anaemia and cardiovascular diseases. If WHO’s estimates are reliable, these higher percentages may suggest that patients with certain diseases are more likely to seek care before death than those with other diseases; it could also, however, reflect excessive attribution of deaths to certain causes.

**Fig. 2.3 Distribution of causes of death, WHO estimates of deaths in the population vs reported inpatient deaths, United Republic of Tanzania, 2016**

2.1.4 Analysis

Three ways to analyse institutional mortality are considered here:

- mortality levels: inpatient deaths overall and for selected categories;
- leading causes of death: percentage distribution of leading causes of inpatient deaths;
- cause-specific mortality: inpatient deaths due to various specific causes.
Mortality levels

In this document, “mortality levels” refers to the total deaths from all causes that occur in health facilities (with disaggregation by age and sex). Four mortality level indicators are presented: institutional mortality, stillbirths, neonatal deaths and maternal deaths. The purpose of this set of indicators is to assess the trends of institutional deaths and to identify unexpected changes in the overall numbers and rates. Institutional mortality levels are the simplest measures of inpatient mortality and can provide insights into the quality of health services and offer some indication of population health issues.

These mortality levels must always be interpreted with consideration of differences in facility type and patient mix. Inpatient mortality is to a large extent a reflection of the severity of illness on admission, which may in turn reflect various delays in accessing care. Referral hospitals are likely to admit more patients with complicated or terminal conditions than other facilities and therefore often have higher mortality levels.

![Fig. 2.4 Month-to-month trend in mortality levels, Lupara district, 2019](image)

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional mortality (%)</td>
<td>7%</td>
<td>7%</td>
<td>4%</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
<td>8%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Inpatient deaths</td>
<td>31</td>
<td>29</td>
<td>5</td>
<td>28</td>
<td>44</td>
<td>62</td>
<td>61</td>
<td>49</td>
<td>38</td>
<td>35</td>
<td>36</td>
<td>53</td>
</tr>
<tr>
<td>Inpatient under five deaths</td>
<td>6</td>
<td>11</td>
<td>2</td>
<td>8</td>
<td>16</td>
<td>22</td>
<td>21</td>
<td>17</td>
<td>7</td>
<td>10</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Maternal deaths in health facilities</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal deaths in health facilities</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Stillbirths in health facilities</td>
<td>11</td>
<td>11</td>
<td>8</td>
<td>4</td>
<td>10</td>
<td>8</td>
<td>11</td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

1. Institutional mortality (%)

The numerator is the total number of deaths from all causes that occurred in health facilities during a defined period. The denominator is the number of discharges during the same period. Discharges include authorized discharges, transfers out, unauthorized discharges ("absconders") and inpatient deaths. Data should be disaggregated by sex and, at a minimum, by age groups 0–4 and 5+ years. Additional age-sex disaggregated analysis can be done if detailed age categories are available and can provide insights into age-sex related mortality patterns. Unusual variations can point to quality-of-care problems, disease outbreaks or other public health concerns, particularly when the data are disaggregated by subnational area or facility.

2. Stillbirths in health facilities (%)

Stillbirths can occur before or during delivery. Stillbirths occurring before the onset of labour (antepartum) may reflect the quality of antenatal care, whereas stillbirths occurring after the onset of labour (intrapartum) may reflect the care provided during delivery. In many settings, the physical appearance of the stillbirth (macerated versus fresh) at the time of delivery is used to determine the timing of fetal death in relation to the onset of labour. The percentage of intrapartum stillbirths in facilities is not expected to vary significantly from year to year, unless problems arise with the quality of care. Stillbirths in health facilities (%) can therefore be used as an indicator of quality of care (with consideration of the cautions related to facility type and case mix).

---

1 "Lupara district" refers to a fictitious district in a database created to produce analyses for the Toolkit module Integrated Health Services Analysis – district and facility levels [1].

2 A "macerated" stillbirth is one which shows skin discoloration or darkening, redness, peeling, and breakdown, suggesting death occurred well before delivery. A "fresh" stillbirth lacks such skin changes and is presumed to have died much more recently.
3. Neonatal deaths in health facilities

Neonatal deaths include any death in a facility that occurs in the first 28 days of life. This indicator monitors the absolute number of neonatal deaths – whether pre-discharge (i.e. after being born in the facility) or after re-admission. Given this mix of neonates, the indicator may reflect the quality of delivery care and newborn care, the quality of care for neonates admitted to the facility after birth, the severity of illness among the neonates admitted after birth, or the completeness of reporting of neonatal deaths. It is therefore difficult to interpret.

Nevertheless, it is important to monitor trends in neonatal deaths to identify unexpected changes. Comparisons among facilities should be interpreted with care as the number of neonatal deaths is very sensitive to the case mix of deliveries and neonatal admissions. Higher numbers of neonatal deaths may be expected in referral facilities that offer advanced care for high-risk newborns, e.g. pre-term and low birth weight babies.

4. Maternal deaths in health facilities

This indicator may reflect the quality of care in the facility but may also reflect delays in reaching the facility or inadequate antenatal care. In many health systems, it is the policy to conduct an audit of every maternal death. As maternal deaths are rare events, it is recommended to monitor the absolute number of maternal deaths. Maternal deaths in health facilities include antepartum deaths, deaths during delivery and postpartum deaths (according to the definition of maternal death). Women that gave birth outside of a health facility or in a different health facility, but died in the reporting facility, are included. Deaths occurring outside of the facility are not included and should be reported separately. Maternal deaths are often under-reported. Facility staff may be hesitant to report maternal deaths as they are sometimes considered to be the result of health worker failures. Furthermore, women may die in other hospital departments and these deaths are often not recorded in maternity registers; this is particularly the case for antepartum and postpartum deaths.

Leading causes of death

This analysis provides a profile of the most common causes of death among inpatients and their relative proportions. Health facility mortality data alone are rarely sufficient for estimates of causes of death in the population. They may, however, provide useful information on epidemiological trends and the relative importance of various causes of death, and may also provide insights into quality of care.

Interpretation of inpatient CoD data should consider that, in addition to the issues with data quality and representativeness previously discussed, the reliability of the data is significantly influenced by the diagnostic capacity of the health facility. This varies considerably, based on the training of the health care providers and the availability of laboratory and other diagnostic services.

5. Leading causes of inpatient deaths (percentage distribution)/proportional mortality

The analysis starts by listing and ranking the numbers of deaths by cause. Both the absolute number of deaths by cause and the percentage of deaths by cause out of the total inpatient deaths (proportional mortality) should be provided (Fig. 2.5). The 10 to 20 leading causes are then presented (Fig. 2.6).

The main analyses should, at a minimum, include:
- deaths by cause: under 5 years of age, sum of both sexes;
- deaths by cause: 5 years of age and older, disaggregated by sex; and
- comparison of deaths by cause among major geographic areas.

If data are available and numbers are sufficiently large, analyses with more detailed age-sex disaggregation should be conducted.

---

1 WHO defines a maternal death as a death from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of the termination of pregnancy.
Distribution of causes of death is presented as a ranked table or chart. Stacked bar charts are the preferred chart type (see Fig. 2.1, Fig. 2.3 and Fig. 2.6). Pie charts are sometimes used to display proportional mortality but are difficult to read when containing more than five segments.

Fig. 2.5 Distribution of causes of inpatient death, 0–4 years, country X, nationwide, 2016–2020

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>2016 Number</th>
<th>2016 %</th>
<th>2017 Number</th>
<th>2017 %</th>
<th>2018 Number</th>
<th>2018 %</th>
<th>2019 Number</th>
<th>2019 %</th>
<th>2020 Number</th>
<th>2020 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal</td>
<td>300</td>
<td>18.7%</td>
<td>441</td>
<td>25.7%</td>
<td>414</td>
<td>26.0%</td>
<td>450</td>
<td>28.9%</td>
<td>388</td>
<td>24.9%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>329</td>
<td>20.5%</td>
<td>325</td>
<td>19.0%</td>
<td>346</td>
<td>21.8%</td>
<td>288</td>
<td>18.5%</td>
<td>288</td>
<td>19.5%</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>147</td>
<td>9.1%</td>
<td>129</td>
<td>7.5%</td>
<td>130</td>
<td>8.2%</td>
<td>118</td>
<td>7.6%</td>
<td>155</td>
<td>11.2%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>152</td>
<td>9.5%</td>
<td>138</td>
<td>8.1%</td>
<td>137</td>
<td>8.6%</td>
<td>142</td>
<td>9.1%</td>
<td>159</td>
<td>10.8%</td>
</tr>
<tr>
<td>Malaria</td>
<td>277</td>
<td>17.2%</td>
<td>235</td>
<td>13.7%</td>
<td>160</td>
<td>10.1%</td>
<td>154</td>
<td>9.9%</td>
<td>149</td>
<td>10.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>125</td>
<td>7.8%</td>
<td>124</td>
<td>7.2%</td>
<td>131</td>
<td>8.2%</td>
<td>115</td>
<td>7.4%</td>
<td>106</td>
<td>7.2%</td>
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<tr>
<td>Anemia</td>
<td>90</td>
<td>5.6%</td>
<td>85</td>
<td>5.0%</td>
<td>84</td>
<td>5.3%</td>
<td>94</td>
<td>6.0%</td>
<td>99</td>
<td>6.7%</td>
</tr>
<tr>
<td>Other, unspecified</td>
<td>67</td>
<td>4.2%</td>
<td>62</td>
<td>3.8%</td>
<td>55</td>
<td>3.6%</td>
<td>41</td>
<td>2.6%</td>
<td>37</td>
<td>2.5%</td>
</tr>
<tr>
<td>Injuries</td>
<td>50</td>
<td>3.1%</td>
<td>61</td>
<td>3.6%</td>
<td>41</td>
<td>2.6%</td>
<td>48</td>
<td>3.1%</td>
<td>21</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other infectious</td>
<td>3</td>
<td>0.2%</td>
<td>21</td>
<td>1.2%</td>
<td>17</td>
<td>1.1%</td>
<td>22</td>
<td>1.4%</td>
<td>16</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other GI</td>
<td>19</td>
<td>1.2%</td>
<td>18</td>
<td>1.1%</td>
<td>17</td>
<td>1.1%</td>
<td>12</td>
<td>0.8%</td>
<td>16</td>
<td>1.1%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>15</td>
<td>0.9%</td>
<td>17</td>
<td>1.0%</td>
<td>16</td>
<td>1.1%</td>
<td>17</td>
<td>1.1%</td>
<td>15</td>
<td>1.0%</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>16</td>
<td>1.0%</td>
<td>18</td>
<td>1.1%</td>
<td>11</td>
<td>0.7%</td>
<td>16</td>
<td>1.0%</td>
<td>12</td>
<td>0.8%</td>
</tr>
<tr>
<td>Skin</td>
<td>2</td>
<td>0.1%</td>
<td>11</td>
<td>0.6%</td>
<td>4</td>
<td>0.3%</td>
<td>6</td>
<td>0.4%</td>
<td>11</td>
<td>0.7%</td>
</tr>
<tr>
<td>Cancers</td>
<td>5</td>
<td>0.3%</td>
<td>6</td>
<td>0.4%</td>
<td>2</td>
<td>0.1%</td>
<td>7</td>
<td>0.4%</td>
<td>5</td>
<td>0.3%</td>
</tr>
<tr>
<td>Mental health</td>
<td>2</td>
<td>0.1%</td>
<td>9</td>
<td>0.5%</td>
<td>4</td>
<td>0.3%</td>
<td>9</td>
<td>0.6%</td>
<td>5</td>
<td>0.3%</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>3</td>
<td>0.2%</td>
<td>2</td>
<td>0.1%</td>
<td>8</td>
<td>0.5%</td>
<td>2</td>
<td>0.1%</td>
<td>2</td>
<td>0.1%</td>
</tr>
<tr>
<td>GU</td>
<td>5</td>
<td>0.3%</td>
<td>7</td>
<td>0.4%</td>
<td>5</td>
<td>0.3%</td>
<td>4</td>
<td>0.3%</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Ear</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>0.1%</td>
<td>2</td>
<td>0.1%</td>
<td>12</td>
<td>0.8%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Eye</td>
<td>1</td>
<td>0.1%</td>
<td>3</td>
<td>0.2%</td>
<td>1</td>
<td>0.1%</td>
<td>1</td>
<td>0.1%</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The ranking is influenced by the extent to which the causes of death are grouped. For example, if all cancers are grouped together, irrespective of type, the group will represent a larger percentage of deaths than deaths from a single cancer such as lung or breast cancer.

The percentage of unknown and ill-defined causes should always be provided, as it is an important indicator of the quality of the data. In Fig. 2.6, this is represented by the category “other, unspecified”. Also, if this percentage changes over time, the percentage of deaths for known causes will also change, which has implications for interpretation of the data.
Multiple years of data should be presented, to show how the ranking of causes changes over time. (This is possible only if the same CoD categories are used over time.) For example, trend analysis can show whether the percentages of all institutional deaths that are due to malaria or noncommunicable diseases (NCDs) have changed over time.

Proportional mortality data should be assessed for causes that rank unexpectedly among the top 10 causes and for percentage distributions that differ significantly from what is expected based on the epidemiological profile of the area. This could indicate a disease outbreak or other public health concern, a quality-of-care problem, sudden changes in classification or coding practice, or a data quality problem.

The list of the top 10 or 20 causes of death can often highlight only broad groups of causes. To generate further information that can guide country policies and programmes, in-depth analyses should be conducted on key groupings. For example, an in-depth analysis of deaths from injuries would present the deaths from each specific type of injury: road traffic accidents, falls, poisonings, suicide, etc.

### Mortality due to specific causes

A limited number of diseases and conditions may be selected for further analysis, based on the local disease burden and public health priorities. These may include:

- leading causes of death;
- notifiable diseases;
- diseases under surveillance;
- diseases/conditions related to SDGs or national strategic goals;
- diseases/conditions included in the national core indicator set.

Analysis of the mortality trends for specific causes over multiple years can provide insights into epidemiological trends. Such analyses can also assist managers and policy-makers in various ways, e.g. assessing the effectiveness of specific interventions, targeting support where it is most needed, advocating for additional resources and refining policies.

**Fig. 2.7 Inpatient malaria deaths and inpatient malaria case fatality, Kenya, 2012/2013 to 2015/2016**

Data on deaths from specific causes can be analysed by examining trends and/or comparing geographic areas. The indicators to be assessed include absolute numbers of cases, incidence rates, age distribution, sex distribution and inpatient case fatality. Fig. 2.7 provides an example from an analytic review conducted in the Republic of Kenya.

Assessment of month-to-month trends in mortality from multiple years of data enables identification of seasonality for some diseases (e.g. malaria, diarrhoea, pneumonia). If the data have remained stable over several years, changes in the trend may point to changes in the epidemiological pattern as a result of, for example, an outbreak or the impact of a public health intervention. Analysis of age and sex distributions for specific causes can also provide insights into the epidemiology of some diseases (e.g. HIV, malaria).
6. **Case fatality rates (%) for major causes**

The case fatality rate (CFR) calculates the percentage of inpatient cases of a disease that end in death. The denominator is the number of discharges (including deaths) for a specific diagnosis. The quality of the data on discharge diagnoses may be more variable than the quality of the data on cause of death, which adds uncertainty to the indicator. Health systems should select the conditions that are most relevant for calculating this indicator. Case fatality rates may be influenced by quality of care but can be difficult to interpret as they can vary based on numerous factors, e.g. severity of illness on admission, age, nutritional status, other underlying illnesses, time since onset, etc. Referral facilities often have higher CFRs as they receive more severe cases than other facilities. However, unusually high CFRs or any substantial changes in CFRs warrant further investigation.

7. **Population incidence of inpatient deaths by cause (example: malaria)**

This indicator uses the estimated population at risk as the denominator. Some diseases may not be endemic throughout the country (e.g. malaria may be absent in highland areas), in which case only a subset of the national population will be at risk and thus included in the denominator. Defining the population at risk is not always easy and may result in expanding the definition to cover the whole population of an administrative unit.

This indicator represents only a minimum mortality rate because, as noted previously, a significant number of deaths are likely to occur in the community. Differences among geographic areas, particularly those with similar disease profiles, need further investigation to identify the underlying reasons. Interpretation may, however, be challenging because the percentage of deaths from the condition that occur in health facilities may vary substantially among geographic areas. There may also be variation in the completeness of reporting of inpatient deaths.

Figure 2.8 provides an example of findings for this indicator from the Republic of Ghana [20].

8. **Perioperative mortality rate (%)**

This indicator refers to all deaths prior to discharge among patients that had one or more procedures in an operating theatre during the relevant admission period. The denominator requires a register for procedures conducted in the hospital. For the numerator, the WHO MCCD form includes a question to identify whether the deceased had surgery. Perioperative mortality is an important indicator of quality and safety of care. Globally, the process of undergoing a major surgical procedure (particularly as an emergency) is associated with increased mortality [21].

Similar to other institutional mortality indicators, a high perioperative mortality rate does not necessarily reflect poor quality of care, as it is influenced by many factors including the types of procedures performed, delays in accessing care, age and underlying health conditions. However, trends over time should be assessed and unexpected changes should trigger further investigation. Substantial differences in perioperative mortality rates among facilities of similar capacity also warrant investigation.
9. Emergency unit mortality rate (%)

Deaths that occur in the emergency unit may reflect the severity of the cases presenting to the unit. Cases may present at a severe stage if there are delays in reaching the facility (e.g. due to long distances to the facility, lack of transport, cultural factors, financial barriers). However, emergency unit deaths may also result from delays in attending the patient, lack of staff capacity, lack of appropriate medications or equipment, or delays in transferring the patient to a more advanced facility. The location of the facility also affects the type and severity of cases received, e.g. facilities near major highways are likely to receive many road traffic injuries while facilities located in certain parts of a city areas may receive multiple cases of interpersonal violence or cases related to substance abuse. A sudden increase in emergency unit mortality may be the consequence of a mass casualty event, e.g. a bus accident, civil conflict. Any unexpected increase in the emergency unit mortality rate should be investigated.

2.2 Morbidity (outpatient and inpatient)

2.2.1 Morbidity indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Calculation</th>
<th>Disaggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leading causes of morbidity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Leading inpatient discharge diagnoses (percentage distribution)</td>
<td>Percentage distribution of the leading inpatient discharge diagnoses (inpatient proportional morbidity)</td>
<td>N: Number of discharges by diagnosis x 100 D: Total number of discharges</td>
<td>Age (minimum: 0–4, 5+ years) Sex</td>
</tr>
<tr>
<td>2. Leading outpatient diagnoses (percentage distribution)</td>
<td>Percentage distribution of the leading new outpatient visits (outpatient proportional morbidity)</td>
<td>N: Number of new outpatient visits by diagnosis x 100 D: Total number of new outpatient visits</td>
<td>Age (0–4, 5+ years) Sex</td>
</tr>
</tbody>
</table>

| **Morbidity due to specific conditions** | | | |
| 3. Cases of selected diseases for surveillance | Number of cases of selected diseases or conditions under surveillance | N: Number of cases of selected diseases or conditions under surveillance | Age (0–4, 5+ years) Sex | |

Note: All indicators should also be disaggregated by geographic location (e.g. district), facility type (e.g. referral hospital, district hospital, health centre, etc.) and managing authority/facility ownership (public, private, NGO, etc.).

2.2.2 About the data

This section discusses the analysis of institutional morbidity data: RHIS data on the diseases and other health conditions for which people visit outpatient services or for which they are admitted as inpatients in health facilities.

This information is important for understanding the types of diseases and conditions for which people seek care at facilities and the resulting burden on the health system. Institutional morbidity data can also, indirectly, provide an indication of epidemiological patterns in the population – including disease outbreaks.

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1 Refer also to programme-specific modules of the *Toolkit for analysis and use of routine health facility data* [1].
Regular monitoring of morbidity data is essential for timely reaction to changes and for informing service adjustments. It also provides insights into how health staff spend their time, their diagnostic and reporting practices, and the medicines, commodities and equipment that are likely to be needed in the facilities. This information contributes to policy-making, resource allocation and the planning and management of health services.

Many countries rely on population-based surveys to understand the disease burden in the population. However, as such surveys are usually conducted at intervals of several years, the findings are soon out of date and cannot be used for monitoring shorter term trends or detecting sudden changes. Furthermore, for many diseases, it is difficult to obtain population-based data, particularly for acute illnesses such as pneumonia and diarrhoea.

The RHIS is an important source of morbidity data, providing regularly updated information on a wide range of diseases and conditions at all levels and geographic locations of the health system. It is able to capture data on acute conditions that can alert managers to outbreaks and other changes in the patterns of diseases for which people seek care. Outpatient data provide information from a much larger number of health facilities than inpatient data, while inpatient data usually reflect more severe conditions and may also provide more accurate diagnoses than outpatient facilities.

Institutional morbidity data are not representative of disease occurrence in the general population, as the cases reported by health facilities usually represent only a subset of the cases in the population, depending on care-seeking behaviours and access to services. Also, in some contexts, many episodes of disease may be managed at pharmacies or by informal sellers of medicines and thus, may never be recorded or reported. Therefore, in most settings, incidence rates calculated from facility data cannot be considered population incidence rates. Nevertheless, trends in reported incidence and proportional morbidity can indirectly reflect trends in disease epidemiology.

### Capturing morbidity data

In many countries, aggregate data are reported on a monthly form containing a list of common diagnoses. Ideally, countries should use diagnostic categories which correspond to global standards for classification of diseases (i.e. the ICD). Some countries, however, use their own nationally defined lists, particularly for reporting of outpatient morbidity.

For outpatient morbidity reporting, new visits should be recorded separately from revisits for the same diagnosis. Revisits are analysed separately and are typically disaggregated by age group and sex but not by specific diagnosis.

For inpatient morbidity reporting, the standard is to collect the discharge diagnosis. The discharge diagnosis reflects the final diagnosis, while the admission diagnosis often requires confirmation through further investigation. Discharges include authorized and unauthorized discharges, deaths and transfers out. Hospitals should preferably use ICD coding for discharge diagnoses. Data on deliveries are not usually included in inpatient morbidity data.

In inpatient facilities, data are ideally captured in an individual patient record which may be a comprehensive electronic medical record or a register or database containing selected data. The minimum data elements required for analysis are: sex, age, facility identifier, date of admission, new or re-admission, date of discharge and discharge diagnosis. However, in many countries, databases of individual patients do not exist. In this case, the morbidity analyses are based on aggregate reports from health facilities.

Referral hospitals and sentinel site facilities may report morbidity data based on more reliable diagnoses and may also have more complete data for more years than other health facilities. Hence, data from such facilities should be analysed and presented separately from the data reported by other facilities. Caution should be exercised about generalizing the findings from sentinel sites, as the mix of patients seeking care at such facilities may not be representative of all health facilities.

Surveillance data are often captured through parallel data systems that report weekly (or daily when needed), e.g. the Integrated Disease Surveillance and Response (IDSR) system used in parts of Africa. Ideally, such systems should be integrated into or interoperable with the RHIS. Where this is not the case, the numbers of cases reported in the RHIS should be checked for consistency against those reported through the surveillance reporting system.
2.2.3 Assessing data quality

Information on data quality should be presented in the same dashboard or report as the morbidity statistics, to enable understanding of any limitations of the data and to inform interpretation. Morbidity data are assessed according to the main data quality dimensions, in ways similar to those for assessing mortality data quality.

The quality of morbidity data depends to a large extent on the consistent use of case definitions, the capacity of health workers to accurately diagnose, the availability of laboratory and other diagnostic services, and the accuracy of the coders. In some cases, information on whether the diagnosis has been confirmed by laboratory investigation is specified along with the diagnosis. For example, malaria diagnoses are often specified as either laboratory confirmed or clinical (“presumed”) diagnosis. The greater the proportion of diagnosed cases which are laboratory-confirmed, the better the quality of the data.

If aggregate monthly data are used to monitor the uptake of initiatives for management of chronic diseases (e.g. hypertension, diabetes, sickle cell anaemia, etc.), it is essential that only the initial diagnosis is reported as a new visit. If not, it is possible that large numbers of “new visits” are repeatedly reported for the same small number of patients with, for example, hypertension. This would incorrectly increase the number of new diagnoses due to the chronic disease.

■ Completeness

**Percentage of facilities reporting:** Completeness of facility reporting affects the ability to interpret trends in the numbers of people presenting with various illnesses or conditions. Where less than 90% of required facilities have reported, it is best to disaggregate completeness: by type of facility, by managing authority and by geographic area. This helps the analyst to better understand and acknowledge any potential reporting bias when interpreting the data. This can be especially important when, for example, completeness of reporting is lower for referral facilities which account for a high percentage of specialized diagnoses of chronic diseases such as cancers.

■ Internal consistency

**Trends over time:** Consistency of diagnostic patterns over time is a key indicator of data quality. Trends in the incidence of specific diseases presenting to health facilities are expected to remain reasonably constant over time, taking into account seasonal patterns. Unexpected variations may reflect data quality problems (including changes in diagnostic and reporting practices), but may also, for example, indicate an outbreak of disease. Fig. 2.9 shows how 5 years of month-to-month trends in confirmed outpatient malaria cases can be presented on a single chart. In this example, each year, a “low season” with relatively few malaria diagnoses (August to December) is followed by a “high season” with more cases (January to July). A sudden increase in reported cases in the low season is suspicious and should be investigated.

Fig. 2.9 Trend in confirmed outpatient malaria cases, nationwide, last 72 months
Outliers: The presence of extreme outliers often signals data errors.

Consistency between related data elements: For outpatient data, the number of positive tests reported in the laboratory dataset can be checked against the number of confirmed diagnoses reported in the outpatient morbidity dataset. For example, the number of confirmed malaria cases should equal the number of positive RDTs plus the number of positive microscopy examinations (assuming that there were not a significant number of patients who were tested both with RDT and microscopy).

Incorrect sex-specific diagnoses or implausible diagnoses for age: Issues to check include female diagnoses for male patients and vice versa, as well as diagnoses unlikely for age, for example:
- male diagnoses of cervical cancer or breast cancer;
- female diagnoses of prostate cancer or benign prostatic hypertrophy;
- females under 10 years of age with maternity-related diagnoses.

Percentage of ill-defined or unknown diagnoses: As for classifications of causes of death, some inpatient diagnoses and some outpatient diagnoses are poorly defined. Examples include “other”, “other intestinal” and “other metabolic disease”. When such ill-defined diagnoses are almost as frequent as more specific diagnoses (e.g. if the number of diagnoses of “other intestinal” is similar to the number of diagnoses of “diarrhoea”), this suggests that clinicians are not properly classifying the illnesses they manage. This limits the usefulness of the morbidity data for decision-making.

Use of standardized inpatient and outpatient diagnoses: It is essential that diseases/conditions are classified in a standard way – ideally, in accordance with the ICD. In some countries, the list of diagnoses varies within the country or between types of facilities (e.g. referral hospitals versus district hospitals) or from year to year. This makes it very difficult to compare morbidity data from year to year or between subnational areas. Such lack of standardization of the diagnoses also makes it difficult to train clinicians in reliable diagnosis.

- External consistency with other data sources

Comparisons with disease-specific programme data: Disease-specific data reported through routine facility morbidity reports should be compared with those from disease-specific programme reporting systems and surveillance systems.

2.2.4 Analysis

Analysis of morbidity data should provide the 10 to 20 leading diagnoses for both outpatient and inpatient services. Data from 3 to 5 years should be presented to review annual trends. This is essential for assessing data quality and may also provide insights into epidemiological changes in the population. Monthly data for several years are needed for understanding seasonal variations. At a minimum, the analyses should be done for all ages (total) and for children under 5 years of age. Further age-sex disaggregation can be included if data are available.

Two ways of analysing data on institutional morbidity are considered here:
- Leading causes of morbidity: the percentage distribution of diagnoses; and
- Morbidity due to specific conditions: the numbers of cases or the population incidence of selected diseases or conditions.

- Leading causes of morbidity

1. Leading inpatient discharge diagnoses (percentage distribution) and
2. Leading outpatient diagnoses (percentage distribution)
The analysis starts by listing and ranking the numbers of diagnoses. Both the absolute number of each diagnosis and the percentage of each diagnosis out of the total of all diagnoses (proportional morbidity) should be assessed (Fig. 2.10).

**Fig. 2.10 Top inpatient diagnoses, 0–4 years, nationwide, 2016–2020**

<table>
<thead>
<tr>
<th>Discharge diagnosis</th>
<th>2016</th>
<th>%</th>
<th>Number</th>
<th>2017</th>
<th>%</th>
<th>Number</th>
<th>2018</th>
<th>%</th>
<th>Number</th>
<th>2019</th>
<th>%</th>
<th>Number</th>
<th>2020</th>
<th>%</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>10922</td>
<td>33.7</td>
<td>9903</td>
<td>29.4</td>
<td>8814</td>
<td>29.5</td>
<td>8127</td>
<td>27.9</td>
<td>7892</td>
<td>28.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>6731</td>
<td>20.7</td>
<td>6726</td>
<td>19.9</td>
<td>6527</td>
<td>21.8</td>
<td>6336</td>
<td>21.8</td>
<td>6821</td>
<td>24.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>5503</td>
<td>17.0</td>
<td>5857</td>
<td>17.4</td>
<td>5027</td>
<td>16.8</td>
<td>4369</td>
<td>15.0</td>
<td>4804</td>
<td>17.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal</td>
<td>2899</td>
<td>8.9</td>
<td>2867</td>
<td>8.6</td>
<td>2820</td>
<td>9.4</td>
<td>3154</td>
<td>10.8</td>
<td>2683</td>
<td>9.5</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>1009</td>
<td>3.1</td>
<td>1744</td>
<td>5.2</td>
<td>1481</td>
<td>4.9</td>
<td>1192</td>
<td>4.1</td>
<td>1621</td>
<td>5.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>1322</td>
<td>4.1</td>
<td>1416</td>
<td>4.2</td>
<td>1254</td>
<td>4.2</td>
<td>1486</td>
<td>5.1</td>
<td>1258</td>
<td>4.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries</td>
<td>1078</td>
<td>3.3</td>
<td>1343</td>
<td>4.0</td>
<td>1169</td>
<td>3.9</td>
<td>1158</td>
<td>4.0</td>
<td>1064</td>
<td>3.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, unspecified</td>
<td>968</td>
<td>3.0</td>
<td>1019</td>
<td>3.0</td>
<td>844</td>
<td>2.8</td>
<td>930</td>
<td>3.2</td>
<td>543</td>
<td>1.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malnutrition</td>
<td>875</td>
<td>2.7</td>
<td>1145</td>
<td>3.4</td>
<td>708</td>
<td>2.4</td>
<td>754</td>
<td>2.8</td>
<td>407</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Gastrointestinal</td>
<td>243</td>
<td>0.7</td>
<td>488</td>
<td>1.4</td>
<td>299</td>
<td>1.0</td>
<td>388</td>
<td>1.3</td>
<td>354</td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Skin</td>
<td>161</td>
<td>0.5</td>
<td>346</td>
<td>1.0</td>
<td>266</td>
<td>0.9</td>
<td>260</td>
<td>0.9</td>
<td>135</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other infectious disease</td>
<td>167</td>
<td>0.5</td>
<td>177</td>
<td>0.5</td>
<td>126</td>
<td>0.4</td>
<td>122</td>
<td>0.4</td>
<td>127</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>123</td>
<td>0.4</td>
<td>139</td>
<td>0.4</td>
<td>108</td>
<td>0.4</td>
<td>122</td>
<td>0.4</td>
<td>122</td>
<td>0.4</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>GU</td>
<td>123</td>
<td>0.4</td>
<td>253</td>
<td>0.8</td>
<td>128</td>
<td>0.4</td>
<td>142</td>
<td>0.5</td>
<td>85</td>
<td>0.3</td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular</td>
<td>70</td>
<td>0.2</td>
<td>116</td>
<td>0.3</td>
<td>60</td>
<td>0.2</td>
<td>110</td>
<td>0.4</td>
<td>81</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>68</td>
<td>0.2</td>
<td>145</td>
<td>0.4</td>
<td>83</td>
<td>0.3</td>
<td>105</td>
<td>0.4</td>
<td>63</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>46</td>
<td>0.1</td>
<td>103</td>
<td>0.3</td>
<td>60</td>
<td>0.2</td>
<td>74</td>
<td>0.3</td>
<td>43</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye</td>
<td>68</td>
<td>0.2</td>
<td>62</td>
<td>0.2</td>
<td>67</td>
<td>0.2</td>
<td>108</td>
<td>0.4</td>
<td>38</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear</td>
<td>52</td>
<td>0.2</td>
<td>69</td>
<td>0.2</td>
<td>76</td>
<td>0.3</td>
<td>157</td>
<td>0.5</td>
<td>27</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancers</td>
<td>14</td>
<td>0.0</td>
<td>16</td>
<td>0.0</td>
<td>5</td>
<td>0.0</td>
<td>15</td>
<td>0.1</td>
<td>10</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total inpatient diagnoses</strong></td>
<td>32440</td>
<td>100.0</td>
<td>33778</td>
<td>100.0</td>
<td>29922</td>
<td>100.0</td>
<td>29119</td>
<td>100.0</td>
<td>28179</td>
<td>100.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Distribution of diagnoses can be presented as either a table or a chart. Bar charts are preferred (see Fig. 2.11). Pie charts are difficult to interpret when they contain more than five segments.

**Fig. 2.11 Top inpatient diagnoses, 0–4 years, nationwide, 2016–2020**

For both inpatient and outpatient proportional morbidity, ranking is affected by the way diagnoses are grouped. For example, if all respiratory infections are grouped together, this group will likely rank considerably higher than the diagnosis of “pneumonia”. Such grouping of diagnoses can help to simplify the chart and make interpretation easier. It is useful to define a group consisting of the main NCDs (hypertension, other cardiovascular disease, malignancies, chronic lung disease, diabetes) and a group consisting of all injuries (road traffic accidents, violence, suicide, falls, burns, animal bites, etc.). Grouping diagnoses in this way makes it easier to monitor and document the growing importance of NCDs and injuries.
Proportional morbidity is likely to vary by type of facility. This results from differences in both the reliability of diagnoses and the mix of patients. Referral hospitals are likely to report a larger number of more specialized outpatient and inpatient diagnoses than other facilities. For certain diseases that are rare and difficult to diagnose, referral facilities may be the only source of reliable diagnosis and reliable data for an entire country. This is often the case for cancers. Cancer registries may therefore obtain data from only a limited number of hospitals. The same is true for some neglected tropical diseases, for which only a small number of facilities may have the laboratory capacity and trained staff for reliable diagnosis.

Changes in diagnostic practices can influence proportional morbidity. For example, in the past, malaria was often diagnosed without laboratory confirmation. Such “presumed malaria” cases accounted for 20% or more of all outpatient diagnoses in many malaria endemic countries. With the introduction of malaria RDTs, the diagnosis of presumed malaria is declining. In some cases, health providers are now less likely to diagnose malaria and more likely to diagnose other causes of fever. Such a shift affects the reported distribution of diseases.

This is illustrated by the data presented in Fig. 2.12 for a country where malaria RDT’s were phased in over multiple years. Note that the total of confirmed malaria plus presumed malaria declined during this period, as some of the cases that were tested for malaria were found to be laboratory negative and given diagnoses other than malaria. Fig. 2.12 also provides an example of a change in diagnoses resulting from the introduction in 2018 of a new diagnostic category: upper respiratory tract infection (URTI). In 2019 and 2020 a, growing percentage of patients previously diagnosed with “other respiratory” were given the new, more specific diagnosis of “URTI”.

Fig. 2.12 Trend in outpatient diagnoses, 0–4 years, nationwide, 2016–2020

Charts presenting the month-to-month trends in diagnoses may show the seasonality of some diagnoses. Fig. 2.9 provides an example. Fig. 2.13 shows the monthly number of discharge diagnoses for three priority child diseases in one district of a country. The seasonal pattern for malaria is clear. The months of August and September also show increases in discharges for pneumonia and diarrhoea.
In addition to the leading causes of morbidity analysis, analysts and decision-makers may want to monitor selected diseases or conditions, based on local or national priorities, e.g. NCDs.

3. Selected diseases targeted for surveillance

Diseases under surveillance may include epidemic-prone diseases, diseases targeted for elimination or eradication, and, in some contexts, special events such as violence-related injuries, malnutrition and food insecurity. Trends in the absolute numbers of cases should be monitored. For some diseases such as meningitis, incidence rates (i.e. cases per 100 000 population) may be calculated, as thresholds have been defined above which an outbreak response is warranted or below which the sensitivity of surveillance is called into question [22].

WHO has developed separate guidance on surveillance in emergencies [23] as well as on the use of RHIS data for monitoring the impact of COVID-19 on essential health services [24]. Resources are also available to support counties in assessment and development of their systems for compliance with International Health Regulations (IHR)¹ [25].

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¹ The IHR provide an overarching legal framework that defines countries’ rights and obligations in managing public health events and emergencies that have the potential to cross borders.
### 3. Group 2 indicators: Health service performance

#### 3.1 Utilization and access

#### 3.1.1 Utilization and access indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Calculation</th>
<th>Disaggregation</th>
</tr>
</thead>
</table>
| 1. Outpatient attendance per capita (outpatient service utilization rate) | Number of outpatient department (OPD) visits per person per year | N: Number of new visits + re-visits to OPD  
D: Total population | Age (0–4, 5+ years)  
Sex  
New visits vs re-visits |
| Includes only visits for curative care; preventive care visits, e.g. antenatal care (ANC), immunizations, are excluded | | |
| 2. Emergency unit utilization rate | Number of visits to the emergency unit/casualty department per 1000 population per year | N: Number of emergency unit visits x 1000  
D: Total population | Age (0–4, 5+)  
Sex |
| 3. Hospital discharge rate (inpatient service utilization) | Number of inpatient discharges per 100 population per year | N: Number of inpatient discharges x 100  
D: Total population | Age (0–4, 5+)  
Sex |
| Includes authorized discharges, absconsions, transfers out and deaths; excludes discharges for delivery | | |
| 4. Surgical volume | Number of surgical procedures undertaken in an operating theatre per 100 000 population per year | N: Number of surgical procedures x 100 000  
D: Total population | Emergency vs elective  
Procedure type |
| A surgical procedure is defined as the incision, excision or manipulation of tissue that needs regional or general anaesthesia, or profound sedation to control pain | | |
| 5. Service-specific availability | a) Number of health facilities offering specific services per 10 000 population  
b) Percentage of facilities offering the specific service | N: Number of facilities offering the service x 10 000  
D: Total population  
N: Number of facilities offering the service x 100  
D: Total number of facilities | | |
| Specific services may include: general outpatient curative services; specific services, e.g. care for HIV, TB, NCDs, mental health; general maternal child health services; immunizations; basic emergency obstetric and neonatal care (BEmONC); comprehensive emergency obstetric and neonatal care (CEmONC); basic and comprehensive surgical care; laboratory; radiology, etc. | | |

*Note:* All indicators should also be disaggregated by geographic location (e.g. district), facility type (e.g. referral hospital, district hospital, health centre, etc.) and managing authority/facility ownership (public, private, NGO, etc.).

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1 The term “hospital discharge rate” is conventionally used to express the inpatient discharge rate and is preferred to the admission rate. The term “hospital discharge” includes discharges from health centres, polyclinics and other health facilities which retain patients overnight for health services other than labour and delivery.
3.1.2 About the data

This section discusses data on how often people use health services and, indirectly, their access to the services. Access to and utilization of health services are fundamental to UHC and the health of the population, and therefore also to the SDGs. Equity of access is essential for achieving UHC.

Access refers to the ability of people to reach health services and use them. It is determined by a range of factors such as availability and functionality of services and equipment, distance and travel time to facilities, availability of transport, financial barriers and cultural factors. Measurement of many of these factors requires data from sources other than the RHIS, such as population-based surveys, health facility assessments and geospatial modelling. However, some RHIS data can be used to produce indirect (proxy) measures of access.

Utilization refers to how often people seek services at health facilities. In addition to access issues, utilization is influenced by factors such as demographics, epidemiological context, perceptions of quality of care, and personal preferences.

Service utilization may be used as an indirect measure of access to health care. Utilization indicators include OPD attendance rates, hospital discharge rates, emergency unit utilization rates and rates for major surgical procedures. Higher utilization rates do not necessarily mean better access to services, as the services could be used repeatedly by a limited segment of the population. Low rates, however, usually point to poor access, availability and/or quality of services. For example, several countries have shown that OPD utilization increases when barriers to using health services are removed, such as bringing services closer to the people or reducing user fees. Conversely, utilization may decrease as a result of disruptions in supplies of medicines (see Box 4 below) or a health worker strike.

Availability of services is a prerequisite for access. The main data sources for availability of specific services are periodic health facility surveys such as the WHO HHFA [9] or the Service Availability and Readiness Assessment (SARA) [26]. Facility surveys have the advantage that data collection is standardized and conducted by external data collectors to enable an independent assessment. However, such surveys are usually conducted at intervals of several years and findings may quickly become outdated. While facility censuses (e.g. all hospitals) provide findings on all facilities, many surveys yield data on only a sample of the facilities in a country. If the sampling is well-designed and of adequate size, such samples can be used to estimate service availability at national and regional/provincial level. However, the estimates are usually not available for lower subnational (e.g. district) and facility levels, except for those types of facilities (e.g. hospitals) for which a facility census was conducted.

Periodic (e.g. annual) self-reporting by facilities can also provide information on service availability. Furthermore, in the absence of facility surveys or self-reported data, RHIS data can serve as proxy measures for service availability. For example, reported data on the number of patients receiving ART indicates the availability of ART services at a facility. However, the absence of this data does not necessarily mean that the service is not available, as the possibility of incomplete reporting should be considered.

Service availability and the capacity to provide services according to a required standard of quality (“readiness”) depend on the availability of health service resources or inputs, as discussed in Chapter 4. Some of the indicators discussed in Chapter 4 are also indicators of availability, e.g. density and distribution of health facilities, beds and health workers, and stockouts of medicines and medical products.

3.1.3 Assessing data quality

Data on utilization of health services should be reviewed for the four dimensions of data quality as presented in Table 1.1. Findings from the data quality assessment should be presented in the same dashboard or report as the utilization indicators, to enable understanding of the limitations of the data and to inform interpretation.
Completeness

Percentage of facilities reporting: Completeness of facility reporting affects the ability to interpret trends in the utilization rates of outpatient and inpatient services. Where less than 90% of required facilities have reported, it is best to disaggregate completeness by type of facility, by managing authority and by geographic area.

Internal consistency

Trends, outliers and seasonality: In areas where certain diseases are endemic, there may be significant increases in total OPD visits during certain seasons, e.g. malaria season. Utilization may also vary based on local social and economic cycles, e.g. utilization may decrease during holiday periods or harvest months. Extreme variations (“outliers”) may be due to data quality problems or they may reflect an actual sudden increase in service utilization. This complicates the process of data quality review. A way to identify possible data errors in such cases is to look for suspicious age or sex distributions of outpatient visits. This is illustrated by Fig. 3.1, which shows the trend in total outpatient attendance for the same country as is presented in Fig. 2.9. The increase in total OPD attendance during January to March might suggest a data quality issue or it might simply be due to the seasonal increase in malaria shown in Fig. 2.9. The fact that the rise in OPD attendance is seen in all three age groups suggests that this increase is more likely to represent a true increase in outpatient utilization.

Changes in reporting practices: Information on what is and is not included in the OPD data should be clearly stated in reports and dashboards, to enable informed interpretation. Large year-to-year changes in outpatient or inpatient utilization may reflect changes in reporting practices such as:

- large referral hospitals or private facilities abruptly starting or stopping submission of reports;
- whether or not repeat visits are counted as outpatient visits;
- whether or not preventive visits are counted as part of outpatient visits; or
- whether or not a utilization indicator is based on a count of total diagnoses (for which a single patient may have more than one), rather than a count of total OPD visits or total discharges.
External consistency

It is essential to estimate the percentage of all facilities (including government, military, private-non-profit and private-for-profit providers) that are included in the reporting system, to understand how representative the available RHIS data are of all health services in the country. A high percentage of the population may use private health care services that may not be included in the RHIS. Comparison of utilization rates obtained from RHIS data should therefore periodically be compared with utilization data from other sources, e.g. population-based surveys such as the DHS.

It may be difficult to assure the reliability of data that facilities periodically self-report on availability of services and resources (health workforce, medicines, beds, equipment) and their readiness to provide key services (e.g. BEmONC or CEmONC services). Moreover, reporting rates may be low for these data. Given these limitations, such self-reported data should be carefully reviewed for their consistency with data collected during health facility assessments or from other sources.

3.1.4 Analysis

Three ways to analyse data on service utilization and availability are considered here:

- overall service utilization:
  - outpatient service utilization: outpatient attendance per capita
  - emergency unit utilization: emergency unit visits per 1000 population
  - inpatient service utilization: inpatient discharges per 100 population;
- surgical service utilization: surgical volume;
- service-specific availability: e.g. laboratory services.

Analysis of utilization data should be disaggregated by sex and, at a minimum, by the age groups 0–4 years and 5+ years.

1. Outpatient service utilization/outpatient attendance per capita per year

Outpatient attendance data should include all types of visits for curative care (general OPD as well as programme-specific and specialist consultations) but exclude visits for preventive care, e.g. ANC, immunization. However, in practice, there may be variations among countries and facilities in what is included. For example, visits of specific programmes (e.g. TB, HIV) may be excluded or there may be variation concerning inclusion of specialist consultations. To assist interpretation and make comparison possible, details of what is included and excluded should be provided when presenting the indicator.

New OPD visits should be reported separately from re-visits. OPD utilization is calculated using the sum of new visits and re-visits (unlike the analysis of outpatient morbidity which includes only the diagnoses for new visits). It is useful to also disaggregate the analysis by new visits versus re-visits (see Fig. 3.2a). A high re-visit proportion (e.g. 20% or more), along with a low overall OPD utilization rate, may suggest that a large proportion of the population has very poor access to services, but that some people have good access, i.e. some individuals visit multiple times while others do not use the facilities at all.

Benchmarking OPD utilization is difficult because utilization is influenced by many factors, including access to services, supply of medicines and medical products, availability of laboratory and other diagnostic services, and perceptions of quality of care. In most European Union Member States, the number of physician consultations per person per year ranges from 4.3 to 10.0. The WHO SARA Reference Manual suggests a target of five outpatient visits per person per year [26]; however, in many settings, this may be unrealistically high.

Box 4 provides an example from the Republic of Angola of variation in OPD utilization as a result of differences in the availability of medicines [28].

---

1 This indicator may be expressed in various ways, e.g. outpatient or OPD consultations per person per year, outpatient or OPD visits per person in the population per year.
Box 4: Differences in OPD utilization may result from changes in availability of medicines

As part of the decentralization policy of the Republic of Angola, municipalities were given the responsibility to procure essential medicines, but were given only a small and insufficient budget for this purpose. Most provinces (including Huambo) allowed municipal health managers to set up a revolving drug fund, where people were charged for medicines and these funds were then used to replenish medicine stocks. In other provinces, such as Huíla, medicines were dispensed free of charge, even though the available budget did not enable adequate replenishment of the stocks. The effect on OPD consultations per capita is shown in Fig. 3.3, with utilization in Huíla province significantly lower than that in Huambo province.

Fig. 3.3 Outpatient visits per capita, by municipality of Huíla and Huambo provinces of Angola, 2005

2. Emergency unit utilization rate

Many countries are experiencing an increasing burden from conditions that warrant emergency treatment: injuries and life-threatening acute illnesses whether communicable, perinatal or NCD. Emergency unit utilization per 1000 persons per year is monitored to track access to/use of officially designated emergency unit services. There is no benchmark for this indicator. Very low values (or lack of reporting on the indicator) may suggest inadequate access to or focus on emergency services. An abrupt increase in utilization of emergency units may reflect a major disaster, epidemic or civil conflict. However, consistently high values may be the result of overuse of emergency units for conditions that could be treated in outpatient departments or PHC facilities.

3. Inpatient service utilization/hospital discharge rate

The hospital discharge rate is the sum of inpatient discharges (including deaths) per 100 population per year.\(^1\) An inpatient discharge is defined by having at least one overnight stay in the hospital. The rate includes all discharges except those for delivery. It is difficult to benchmark discharge rates. Organisation for Economic Co-operation and Development (OECD) countries with ageing populations may have about 17 discharges per 100 population per year [29]. The WHO SARA Reference Manual suggests 10 discharges per 100 population per year [26].

In low- and middle-income countries with high disease burdens, low hospital discharge rates suggest limited access to inpatient services. In hospital-oriented health systems (e.g. some Eastern European countries), discharge rates are often high. High rates may also indicate poor quality of care in PHC, especially for conditions that can be treated through outpatient care or where early intervention can prevent complications, e.g. diabetes, hypertension, asthma and congestive heart failure. The percentage of discharges related to re-admissions, if available by diagnosis, may also provide information on quality of care.

4. Surgical volume

The numerator requires standardized recording and reporting to avoid inclusion of minor surgical procedures. A surgical procedure is defined here as the incision, excision or manipulation of tissue that needs regional or general anaesthesia, or profound sedation to control pain. It usually involves an overnight stay in hospital. This is sometimes referred to as a “major surgery”. The most common surgical interventions in secondary (e.g. district) hospitals are generally caesarean section, hernia repair and surgery related to fractures.

If the number of surgical procedures for a defined population is relatively low, surgical services may not be accessible to all groups within this population. When availability of surgical care is low, conditions that could easily be treated may progress to lasting disability or high fatality. Surgical interventions also require the availability of appropriate anaesthetic capacity. The Lancet Global Commission on Surgery [30] has set a target for 5 000 procedures per 100 000 population per year by 2030 for surgical and anaesthesia care.

---

\(^1\) Hospital discharge rate may also be expressed as discharges per 10 000 or per 100 000 population per year.
5. Service-specific availability

Service-specific availability indicates the presence of defined services, and measures whether the service delivery system meets the range of needs of the target population. Measures of service availability can be expressed as:

- the percentage of health facilities that offer a specific service (e.g. 70% of all facilities offer ART); or
- the number of health facilities that offer a specific service per 10 000 population.

As noted previously, the main sources of data on the availability of specific services are periodic health facility surveys or, if available, an updated national MFL. RHIS data can, however, be used to obtain indirect information on the availability of selected services, based on the assumption that reporting of an activity implies that the required service is provided. For example, facilities reporting “full blood counts”\(^1\) can be assumed to have a laboratory. Fig. 3.5 provides an example of service-specific availability data from the Islamic Republic of Afghanistan [31].

**Fig. 3.5 Percentage of facilities offering specific services, Afghanistan, 2014**

<table>
<thead>
<tr>
<th>Service/Type of HF</th>
<th>HSC</th>
<th>BHC</th>
<th>CHC</th>
<th>DH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>2%</td>
<td>6%</td>
<td>50%</td>
<td>86%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>5%</td>
<td>35%</td>
<td>90%</td>
<td>93%</td>
</tr>
<tr>
<td>BEmOC</td>
<td>68%</td>
<td>74%</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>CEmOC</td>
<td>7%</td>
<td>87%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOTS service</td>
<td>47%</td>
<td>66%</td>
<td>87%</td>
<td>92%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>4%</td>
<td>63%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>TB diagnosis and treatment</td>
<td>28%</td>
<td>47%</td>
<td>55%</td>
<td>69%</td>
</tr>
<tr>
<td>Approp. Waste Disposal</td>
<td>32%</td>
<td>97%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>EPI (Penta)</td>
<td>85%</td>
<td>88%</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>ANC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliveries</td>
<td>62%</td>
<td>71%</td>
<td>87%</td>
<td>96%</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
<td>28%</td>
<td>95%</td>
</tr>
<tr>
<td>Surgical Operations</td>
<td>6%</td>
<td></td>
<td>84%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Afghanistan Joint Health Sector Review 2015. Afghanistan Ministry of Public Health [31].

Distribution of maternal and child health services, general OPD curative services and services for NCDs such as hypertension and mental health conditions, should be reasonably uniform across the country as all areas require these services. In some contexts, service-specific availability is adapted to the disease profile of the area. For example, availability of malaria services for an area with endemic malaria will differ from the availability for an area that is free of malaria.

Targets for the number of facilities offering a specific service per population exist only for selected services. For example, there are targets for emergency obstetric care of four basic (BEmONC) facilities and one comprehensive (CEmONC) facility per 500 000 people [27].

When assessing service-specific availability, the distances and travel time required to reach a facility offering a specific service should also be considered. A map showing the locations of various services in relation to population distribution and road networks is useful.

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\(^1\) Not all laboratory tests are suitable for this purpose. For example, RDT for malaria and blood sugar measurements using a glucometer do not require a laboratory.
Figs 3.6 illustrates the substantial variation in availability of PHC and emergency surgery services among four provinces of the Republic of Angola [32]. Based on the population per service (see Fig. 3.6), residents of Bie and Huíla provinces appear to have good access to emergency surgery services. However, a map of the area shows that access to such services is limited in the eastern third of Huíla province and the southern third of Bie province.

**Fig. 3.6 Population served by PHC and emergency surgery services in four provinces of Angola, 2007**

<table>
<thead>
<tr>
<th>Province</th>
<th>Population</th>
<th>Health facilities</th>
<th>Population per service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>PHC</td>
</tr>
<tr>
<td>Benguela</td>
<td>2 723 136</td>
<td>152</td>
<td>17 915</td>
</tr>
<tr>
<td>Bie</td>
<td>1 165 836</td>
<td>80</td>
<td>14 573</td>
</tr>
<tr>
<td>Huambo</td>
<td>1 299 835</td>
<td>135</td>
<td>9628</td>
</tr>
<tr>
<td>Huíla</td>
<td>1 491 998</td>
<td>183</td>
<td>8153</td>
</tr>
</tbody>
</table>

*Source: Health maps of Benguela, Bie, Huambo and Huíla provinces, Angola, 2007 [32].*
3.2 Service outputs and coverage

3.2.1 Service output and coverage indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Calculation</th>
<th>Disaggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care (ANC) visits</td>
<td>Number of antenatal care clients who had a 1st, 4th or 8th visit</td>
<td>Number of ANC visits (1st, 4th or 8th)</td>
<td>Age (10–14, 15–19, 20+ years) Visit (1st, 4th, 8th)</td>
</tr>
<tr>
<td>Institutional delivery</td>
<td>Number of women who gave birth in a health facility</td>
<td>Number of deliveries in facilities</td>
<td>Age (10–14, 15–19, 20+)</td>
</tr>
<tr>
<td>DTPcv-3 coverage</td>
<td>Percentage of the target population that received the third dose of diphtheria–tetanus–pertussis containing vaccine (DTPcv-3)</td>
<td>N: Number of children receiving DTPcv-3 × 100 D: Estimated number of surviving infants</td>
<td>By vaccine/dose of vaccine Age (0–11 months, 12–23 months for infant immunization; 1–2 years, 2+ years for toddler immunizations) Status for tetanus toxoid (pregnant women, other)</td>
</tr>
<tr>
<td>ART coverage (current)</td>
<td>Percentage of the estimated number of people living with HIV that are currently receiving antiretroviral therapy (ART)</td>
<td>N: Number persons living with HIV currently receiving ART × 100 D: Estimated number of persons living with HIV</td>
<td>Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–49, 50–59, 60+) Sex (M, F, TG) Special populations (key populations)</td>
</tr>
<tr>
<td>TB case notification rate</td>
<td>TB cases notified per 100 000 population</td>
<td>N: Number of TB cases notified × 100 000 D: Estimated population</td>
<td>By case type: pulmonary bacteriologically confirmed vs pulmonary clinically diagnosed; By treatment history: new and relapse (incident cases) vs previously treated, excluding relapse</td>
</tr>
<tr>
<td>Confirmed malaria cases</td>
<td>Number of laboratory-confirmed malaria cases</td>
<td>N: Number of confirmed malaria cases</td>
<td>Age Type of test (microscopy, RDT)</td>
</tr>
<tr>
<td>Hypertension new cases</td>
<td>Number of people newly diagnosed with hypertension</td>
<td>N: Number of hypertension new cases</td>
<td>Age Sex</td>
</tr>
<tr>
<td>Diabetes new cases</td>
<td>Number of people newly diagnosed with diabetes</td>
<td>N: Number of diabetes new cases</td>
<td>Age Sex</td>
</tr>
</tbody>
</table>

Note: All indicators should also be disaggregated by geographic location (e.g. district), facility type (e.g. referral hospital, district hospital, health centre, etc.) and managing authority/facility ownership (public, private, NGO, etc.).

3.2.2 About the data

This section discusses data on the coverage of essential health services or, where reliable denominators are not available, the outputs of these services. Coverage refers to the percentage of a target population that received a specific health intervention or service. In this guidance, service output refers to the absolute number of people that received the intervention or service or diagnosis. The reported number of service outputs is used as a proxy for service coverage or, in the cases of diagnoses, the percentage of cases detected out of all cases in the community.

In most resource-limited settings, the main source for national-level coverage estimates is population-based surveys. Such surveys are, however, conducted only at intervals of several years and survey findings may therefore be out of date. Furthermore, they rarely produce estimates that are reliable at the level of relatively small subnational areas such as districts.

For some indicators, the RHIS can provide data for subnational coverage estimates (e.g. district level) to determine whether services are on track to meet local targets and to assess equity among geographic/administrative...
areas. Countries may use coverage estimates based on RHIS data to assess progress during the periods between population-based surveys. **However, when using RHIS data to estimate coverage, the limitations of RHIS data must always be considered, including: the extent to which reported RHIS data represent all service providers (including private), the completeness and quality of reporting and the reliability of target population estimates. Where estimates of target populations are considered unreliable, service outputs can be used as an alternative measure for tracking progress. An example of this is given in Box 6.**

The advantage of using indicators calculated with a reliable denominator is that they enable comparisons between geographic areas with different target populations and can be used to inform equity assessments. This is illustrated in Figs 3.7 and 3.8.

**Fig. 3.7 Coverage with DTPcv-1 and DTPcv-3, by district, 2019**  

![Coverage with DTPcv-1 and DTPcv-3, by district, 2019](image)

**Fig. 3.8 DTPcv-3 coverage, by district, 2019**  

![DTPcv-3 coverage, by district, 2019](image)

It is important to keep in mind that, in the absence of an estimated denominator, the count of services or diagnoses in different geographic areas or different demographic groups (e.g. children under 5 years versus persons 5 years and older) cannot be compared, as the populations of some areas or demographic groups may be much greater than those of others.

**Coverage, quality and UHC**

Quality of health service delivery is discussed in the next section but is mentioned here as there are relationships between coverage and quality. Quality refers to the extent to which the services are delivered according to required standards. Coverage may be considered a dimension of overall health system quality. Perceptions of service quality affect utilization and coverage.

Health service coverage and quality are central to UHC (SDG 3.8). Without quality, coverage will not be effective. The global UHC indicators require nationally representative data and have definitions developed for population-based surveys or data sources other than the RHIS. Only two UHC indicators specifically require RHIS data. Therefore, national level progress in the UHC indicators cannot be measured using only RHIS data. However, regular monitoring of health service performance using RHIS data is needed for management and improvement of the services which are essential to achieving UHC.

The indicators discussed in this section include “RHIS versions” of selected UHC indicators. However, strengthening of facility services for UHC requires attention to a wider range of service aspects than those reflected by the UHC indicators and, therefore, measurement of a wider range of indicators. Selection of such indicators should be guided by country priorities. This section provides some examples.

---

1 UHC indicators specifically requiring RHIS data: percentage of incident TB cases that are detected and successfully treated in a given year, and percentage of people living with HIV currently receiving antiretroviral therapy.
3.2.3 Assessing data quality

As is the case for all RHIS data, the quality of coverage data should be assessed according to the four main data quality dimensions (refer to Table 1.1). Evidence of poor data quality includes erratic year-to-year fluctuations, coverage estimates far in excess of 100%, implausibly low coverage and disease outbreaks in areas with high estimated coverage.

■ Completeness

**Percentage of facilities reporting:** Incomplete reporting can significantly reduce coverage calculated using facility data as the numerator.

**Trends and outliers:** Service output or coverage estimates are expected to remain relatively stable or show gradual improvement over time. Unusual increases or decreases require investigation. A few “extreme outlier” values can significantly distort coverage estimates.

■ Internal consistency

**Consistency between related indicators/data elements:** Related service outputs or coverage indicators should follow a similar trend, for example, DTPcv-1 and DTPcv-3 doses. This is easily visualized by plotting the data element trends on the same chart.

■ External consistency

Coverage estimates based on RHIS data should periodically be compared with coverage estimates derived from a high-quality, nationwide household survey such as a DHS or a Minimum Indicator Cluster Survey (MICS). An example of such a comparison is presented in Box 5 [33]. Estimates from household surveys are often considered the gold standard for coverage estimation. However, while surveys are very useful, they also have inherent limitations including their infrequency (several years may elapse between surveys); limited geographic disaggregation (estimates at district level and below are often not available); and quality (not all surveys adhere to strict sampling and interview protocols, and data based upon the recall of persons interviewed may not be reliable).

### Box 5: Comparing administrative and survey coverage indicators in Afghanistan

In this example, comparison of coverage indicators calculated using RHIS (“HMIS”) data with those obtained from population-based surveys, reveals systematic differences: RHIS-based coverage is consistently higher than survey-based coverage estimates.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Afghanistan Health Survey 2018</th>
<th>HMIS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional deliveries</td>
<td>59%</td>
<td>67%</td>
</tr>
<tr>
<td>Antenatal care 1st visit</td>
<td>65%</td>
<td>98%</td>
</tr>
<tr>
<td>DTPcv-3 vaccine</td>
<td>61%</td>
<td>92%</td>
</tr>
</tbody>
</table>

In the case of the Islamic Republic of Afghanistan Afghanistan, the discrepancies could reflect poor quality HMIS data. (There was an incentive to over-report, as these indicators were used in a pay-for-performance scheme.) However, the discrepancies were most likely the result of unreliable population data. Population estimates were projected from the last census, conducted in 1979, and are likely to differ significantly from reality.

External comparisons of population data

Target populations: A major challenge in coverage calculation involves obtaining the correct denominator – the target population. Various methods have been proposed to improve denominator estimations and coverage calculations. Refer to the Toolkit module General principles (especially Annex 1) for detailed discussion on denominator issues.

Estimating the population at risk: Where certain diseases (e.g. malaria) are endemic only in some parts of the country, care must be taken to include only the populations of these areas “at risk” as the denominator when calculating nationwide coverage of, for example, IPTp.

Other data quality issues

Patients needing long-term follow-up: Patients with chronic diseases (e.g. hypertension, diabetes, sickle cell anaemia, HIV, TB, etc.) and clients on contraceptives are expected to make multiple follow-up visits. In the absence of a system of longitudinal individual patient records, it is difficult to assess programme coverage using RHIS data. Reliable monitoring of care over time is challenging even with a longitudinal tracking system such as is usually available for ART or TB treatment. Patients who initiate care at one clinic but seek follow-up at a different clinic should be reported as having “transferred in” rather than as having initiated treatment at the second clinic. Reliable monitoring of treatment outcomes (e.g. TB treatment success, ART retention) requires reliable recording of the number of persons who began treatment (“the treatment cohort”), transfers-in and -out and those who died or were lost to follow-up. Compiling all the required data takes time and often results in delays in reporting of reliable statistics on treatment outcomes.

The coverage indicators in this document represent multiple programmes and several indicators have specific data quality issues that are addressed in the programme-specific guidance documents of the Toolkit.

3.2.4 Analysis

This section describes basic coverage calculations using RHIS data and available target population estimates. High levels of coverage reflect good access to and utilization of services. Low coverage levels may reflect access problems and/or perceptions of poor service quality.

When target population estimates are unavailable or unreliable, trends in the absolute numbers of service outputs (i.e. numerators) can be monitored over time, including comparisons with the same month or quarter in previous years. Refer to Box 6 for an example.

Sometimes “coverage” is used to refer to the percentage of individuals receiving a specific intervention among those that accessed the service, e.g. “PMTCT testing coverage”. The denominator in such indicators is based on facility data rather than on population estimates. However, in this guidance, “coverage” is used exclusively to refer to population coverage. Hence, in this guidance, this indicator is named “PMTCT testing (%)” and is included among the indicators of quality rather than those of coverage.

1. Antenatal care visits

WHO recommends that pregnant women should have eight ANC visits, starting in the first trimester. As discussed in the quality section following, the reported number of ANC first visits can serve as a denominator for calculating indicators of ANC service quality. In systems where reliable individual patient-based data are available, the numbers of fourth and eighth ANC visits can also be monitored, as well as the percentages of women with a fourth and eighth visit among those who had a first ANC visit. The RMNCAH module of the Toolkit does not recommended the use of RHIS indicators with population estimates as denominators, unless certain conditions are met. As illustrated in Box 6, where reliable estimates of the denominator (i.e. the estimated number of pregnant women in the population during the period) are not available, trends in the numbers of ANC visits (i.e. “numerator trends”) can be monitored.
Box 6: Trends in numerator data correspond closely to trends in coverage estimates

Charts showing trends in numerator data (e.g. numbers of ANC 1st visits) can often be interpreted without reference to an estimated target/denominator. This is especially useful where a survey has shown that coverage of a service is quite high (> 90%) in almost all geographic areas. Comparison of the two charts of Fig. 3.9 shows that the lines in both charts display the same trends and the same relative levels. For example, in both cases the line for ANC 1st visits is highest (almost equal to the target of 100%), but it dropped somewhat in 2019. Even if the chart on the right did not include a line showing the estimated target (estimated live births), the line for ANC 1st visits could be used as a reference for showing the lower coverage achieved with ANC 4th visits and deliveries in a health facility. The close correspondence between the two charts shows that when good estimates of the denominator are not available (e.g. at facility level), it is useful to track the trends in the numerators.

Fig. 3.9 Trends in maternal health coverage (left) and service outputs (right), nationwide, 2016–2019

This close correspondence means that numerator data can also be used as proxy measures to monitor short-term trends in coverage. This is illustrated in Fig. 3.10, which shows a modest drop in service outputs (and thus coverage) in June and a major drop in December. A chart such as this showing the month-to-month trend in services can also sometimes help to identify very large outliers suggesting errors in data entry.

Fig. 3.10 Trend in antenatal and delivery service outputs, nationwide, last 12 months
2. Institutional delivery

WHO recommends that all births take place in health facilities so that obstetric complications can be identified and managed as soon as they occur. Increasing the percentage of institutional deliveries is a key strategy for reducing maternal and newborn mortality and stillbirths. Institutional delivery is presented as a service output (absolute number) in the sample indicator set of this manual. Where conditions permit, the indicator “institutional delivery coverage” may be calculated. The denominator is the estimated number of live births\(^1\) in the population.

Fig. 3.11 shows trends over a period of 5 years in various maternal health service outputs for Lupara district. Also shown is an estimate of the number of live births in the district. ANC 1st visits remained relatively stable and there has been an increase in deliveries in facilities. However, the persistent gap between ANC 1st visits and deliveries in facilities suggests that a significant proportion (10% to 20%) of pregnant women did not deliver in a health facility. Skilled birth attendance is also a commonly used indicator but is less objectively measurable than institutional deliveries. Furthermore, although delivery in a health facility does not guarantee skilled attendance, and some community deliveries have skilled attendance, the institutional delivery and skilled attendance indicators are highly correlated\(^{[34]}\).

3. DTPcv-3 coverage (and coverage with other vaccines)

DTPcv-3\(^2\) coverage by the age of 1 year is used to measure overall performance of the immunization programme. Comparing the coverage of several tracer vaccine doses provides insights into factors affecting coverage at different points in the immunization schedule. Early doses, such as BCG or DTPcv-1, are indicative of access to immunization services. High DTPcv-1 coverage indicates that health services are easily available to a high proportion of the population and that people value vaccination. High coverage of later doses, e.g. DTPcv-3, indicates that people also understand the importance of completing the schedule. Low DTPcv-3 coverage may reflect perceptions of poor quality of care at the time of an early dose.

The numerator for calculating immunization coverage should include doses administered during both fixed and outreach sessions, but doses delivered during vaccination campaigns should be excluded.\(^3\) The denominator is the estimated number of surviving infants. (Refer to General principles for details on calculation of the denominator.) Coverage that is significantly over 100% (or significantly higher than that found in a coverage survey) can indicate either under-estimation of the denominator or over-reporting of vaccine doses administered.

---

\(^1\) Sometimes deliveries or total births is used as the denominator for this indicator. However, the difference in the values of the indicator when using the various denominators is likely to be less than 1%. As a result of stillbirths, the number of deliveries may be 1–2% more than the number of live births. However, this effect is balanced by the fact that, because of twin and triplet deliveries, the number of deliveries may be 1–2% less than the number of live births.

\(^2\) DTP vaccine is included in the pentavalent vaccine, also called “Penta”, “DTP-Hep-Hib” or “DTP-containing vaccine” (DTPcv).

\(^3\) While it is essential that campaign data are reported separately (i.e. not merged with RHIS data), such merging is unfortunately quite common. During campaigns, children that were already immunized during a routine facility visit are frequently re-immunized. Merging these two types of data makes it very difficult to interpret RHIS immunization data.
Figs 3.12 and 3.13 illustrate some recommended ways of visualizing immunization data. Both the charts in Fig. 3.12 show similar findings:

- high levels of coverage with BCG and DTPcv-1 and DTPcv-3;
- some dropout from DTPcv-1 to DTPcv-3 and the first dose of measles-containing vaccine (MCV1);
- a gradual rise in coverage with the new rotavirus vaccine; and
- limited progress with introduction of MCV2 and yellow fever vaccines.

The trends in vaccine doses (“numerator only” data) mirror the trends in vaccination coverage (numerators divided by population-based denominators). As discussed further in Box 6, this principle can be useful where reliable estimates of the target population are not available.

**Fig. 3.12 Trends in tracer vaccine coverage (left) and doses (right), nationwide, 2016–2019**

Note in Fig. 3.13, the modest decrease in service outputs (and thus coverage) in June. A drop is also seen for the same country in antenatal services in Fig. 3.10 in Box 6. A drop in the values for multiple services suggests a general disruption of health services and/or of reporting. Note also the rises in yellow fever doses in May 2019 and of BCG doses in September 2019. As the values for the other vaccines do not change much during these months, these isolated outliers are quite suspicious and should be investigated.  

**Fig. 3.13 Month-to-month trends in tracer vaccine doses, nationwide, Dec 2018–November 2019**

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1 A possible explanation for the abrupt increase in the value for yellow fever is that this vaccine was first introduced in May 2019, when there was a backlog of many children 9 months or older who had not previously been vaccinated. The abrupt increase in the value of BCG in September 2019 is probably due to a data entry error.
4. Antiretroviral therapy (ART) coverage

This indicator assesses how well health services are performing in linking persons living with HIV to ART services.

The numerator, the number of people living with HIV currently on ART, refers to the cumulative number of patients on ART at the end of the reporting period.

The numbers should not be summed over different periods of time, such as a quarter, a year or multiple years as this will result in double-counting. The indicator must take into account people living with HIV that were on ART at the end of the previous reporting period, those newly started on ART in the current reporting period, as well as those that transferred in or out, were lost to follow-up or died.

The denominator is based on estimates of the total number of people living with HIV. The extent to which ART coverage estimates can be produced for lower subnational levels (e.g. district) depends on the levels for which estimates of the number of people living with HIV are available. Estimates of people living with HIV for national and, increasingly, also for subnational levels, are provided annually by UNAIDS, using a software product called Spectrum. Such estimates may, however, not always be updated every year.

It is important to disaggregate this indicator by sex and age groups as there can be significant differences both in the prevalence of HIV and in access to ART services. For example, in the case shown in Fig. 3.15, the ART coverage was higher among females living with HIV due to ART being initiated during antenatal care and delivery.
5. **Tuberculosis (TB) case notification rate**

TB data are usually reported quarterly from health facilities using a paper-based system or as frequently as real-time in digital surveillance systems. When comparing geographic areas, case notification rates should be examined alongside the number of TB notifications. Notification numbers are important for resource planning and budgeting, while rates per population help to interpret trends in TB burden, identify populations at high risk of TB and assess the effectiveness of case finding. Low notification rates may result from poor access to care or reporting problems, rather than actual low numbers of cases.

In Figs 3.16 (from the Tuberculosis module of the WHO Toolkit), the blue circles indicate a province with a high number of TB cases (numerator), but a lower TB case notification rate, due to a high population (denominator). The red circles show a province with a lower number of TB notifications but a higher TB notification rate due to a low population. Planners must decide whether to target additional interventions to areas with higher risk (e.g. the province circled in red) or to areas with the highest number of notifications (e.g. the province circled in blue). As a third option, planners may suspect that TB is under-diagnosed in one of the other provinces with a low notification rate (e.g. one of the provinces shaded pale yellow) and work to improve detection of TB in that province.

![Fig. 3.16 New and relapse TB cases (left), case notification rate per 100 000 population per year (centre), and population (right), by province (map of Benin, fictitious data) [1]](image)

Trends in the epidemiology of TB are expected to change relatively slowly. Large changes (> 10% increase or decrease) in reported numbers of cases are likely to reflect data quality issues or factors beyond the control of the TB programme, such as changes in the number of treatment sites, changes in case definition, security issues or disasters. Rapid changes, however, could also be directly related to changes in TB programme activities, such as new screening or diagnostic practices or active case finding or, sometimes, to ongoing transmission in the community. Figs 3.17 and 3.18 show that in the Republic of Benin, while the numbers of notifications increased, the notification rate decreased over the preceding two decades.
6. **Confirmed malaria cases**

As for other priority diseases, trends in the numbers of confirmed malaria cases should be monitored. To highlight seasonal increases in malaria incidence, it is helpful to compare multiple years of data, as shown in Fig. 3.19 – an example of a “year-on-year” chart. Malaria testing practices have an impact on the reported number of confirmed malaria cases. This is assessed using the indicator “percentage of suspected malaria tested”, as discussed in the next section. The reported number of confirmed malaria cases also depends on the percentage of people sick with malaria that seek care at reporting health facilities as opposed to non-reporting private facilities, pharmacies, informal drug sellers, traditional healers and home care providers. A policy to routinely test all pregnant women is another determinant of the number of confirmed malaria cases detected and reported – unless ANC diagnoses are reported separately.
7. Hypertension new cases and 8. Diabetes new cases

The ongoing global increase in NCDs such as hypertension and diabetes means that increasing numbers of people will require treatment. Early detection is essential for prevention of long-term consequences such as heart attack, stroke and kidney failure. Most patients with hypertension and diabetes can be managed in PHC facilities. It is therefore important that the RHIS addresses the need for NCD data. The purpose of the proposed indicators is to track the extent to which health services are detecting people with hypertension and diabetes. The counts of absolute numbers of new cases represent a starting point for contexts where little or no NCD data are reported from PHC and other outpatient services.

Many countries capture the total numbers of OPD visits for hypertension and/or diabetes. However, beyond showing the workload associated with NCD cases, the total number of visits is of limited use. The number of visits does not represent the number of patients receiving treatment, as visit frequency may vary among patients and often depends on the frequency of medication refills. However, if the numbers of new hypertension or diabetes cases are captured separately from repeat visits (as is recommended for OPD morbidity reporting), it is possible to obtain the numbers of new cases detected each month.

A limitation of these indicators is that people with NCDs may visit more than one health facility to obtain treatment and would therefore be counted more than once as new cases. It is also important to track the cumulative number of people that are currently on hypertension/diabetes treatment, whether the diseases are controlled and whether there are complications. This requires a well-developed facility information system with longitudinal individual patient records based on a system of unique patient identifiers. In some countries, many people with hypertension and other cardiovascular diseases may seek care in the private sector, whereas those with diabetes (particularly insulin-dependent diabetes) tend to seek care in public facilities where they receive medication free of charge.

Additional facility-based indicators for NCD management are available in WHO’s HEARTS Technical package for management of cardiovascular disease in primary health care: systems for monitoring [35].
## 3.3 Quality

### 3.3.1 Quality indicators

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<th>Calculation</th>
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<tr>
<td>1. Antenatal client 1st visit before 12 weeks’ gestation (%)</td>
<td>Percentage of antenatal care clients with 1st visit before 12 weeks’ gestation</td>
<td>N: Number of ANC 1st visits before 12 weeks ( \times ) 100</td>
<td>Age (10–14, 15–19, 20+ years)</td>
</tr>
<tr>
<td>2. Prevention of mother-to-child transmission (PMTCT) testing (%) (ANC clients tested for HIV or known HIV+)</td>
<td>Percentage of antenatal clients and/or women delivering in a facility who were tested for HIV (or who already know they are HIV positive), for prevention of mother-to-child transmission</td>
<td>N: Number of pregnant women attending ANC and/or who had a facility-based delivery, who were tested for HIV during pregnancy or already knew they were HIV positive ( \times ) 100</td>
<td>HIV status/test results: 1) Known HIV infection at ANC entry 2) Tested HIV positive at ANC during current pregnancy 3) Tested HIV negative at ANC during current pregnancy Total identified HIV positive women = 1 + 2</td>
</tr>
<tr>
<td>3. Intermittent preventive treatment for malaria during pregnancy (IPTp) (%)</td>
<td>Percentage of pregnant women attending antenatal clinics who received three or more doses of intermittent preventive treatment for malaria</td>
<td>N: Number of pregnant women given 3 doses of IPTp ( \times ) 100</td>
<td></td>
</tr>
<tr>
<td>4. Caesarean sections (%)</td>
<td>Percentage of deliveries in health facilities by caesarean section</td>
<td>N: Number of caesarean sections ( \times ) 100</td>
<td>Age (10–14;15–19; 20+)</td>
</tr>
<tr>
<td>5. Immunization dropout rates (%): DTPcv-1 to DTPcv-3</td>
<td>Percentage of infants who received a 1st dose of DTPcv but did not receive a 3rd dose</td>
<td>N: (DTPcv-1 doses - DTPcv-3 doses) ( \times ) 100</td>
<td>Age: 0–4; 5–9; 10–14; 15–19; 20–24; 25–49; 50–59; 60+ Special populations (key populations) Specified duration: (current/ever, 12 m, 24 m, 36 m, 48 m, 60 m)</td>
</tr>
<tr>
<td>BCG to MCV1</td>
<td>Percentage of infants who received BCG but did not receive a 1st dose MCV</td>
<td>N: (BCG doses - MCV1 doses) ( \times ) 100</td>
<td></td>
</tr>
<tr>
<td>MCV1 to MCV2</td>
<td>Percentage of children who received a 1st dose of MCV but did not receive a 2nd dose</td>
<td>N: (MCV1 doses - MCV2 doses) ( \times ) 100</td>
<td></td>
</tr>
</tbody>
</table>
| 6. HIV care cascade                                                      | Number of persons newly diagnosed with HIV  
Number of persons newly diagnosed with HIV that initiated ART  
Number of persons retained on ART after a specified time period among those that initiated ART |                                                                                                   | Age: 0–4; 5–9; 10–14; 15–19; 20–24; 25–49; 50–59; 60+ Sex (M, F, TG) Special populations (key populations) Specified duration: (current/ever, 12 m, 24 m, 36 m, 48 m, 60 m) |
<p>| 7. New and relapse TB cases with a documented HIV status (%)             | Percentage of new and relapse TB cases who had a HIV test result recorded in the TB register among all TB cases notified during a specified time period, usually 1 year | N: Number of new and relapse TB cases notified in a specified time period who had a HIV test result recorded in the TB register ( \times ) 100 |                                                                                                   |</p>
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Calculation</th>
<th>Disaggregation</th>
</tr>
</thead>
</table>
| 8. Drug susceptibility test (DST) for TB cases (%) | Percentage of TB cases with DST results for at least rifampicin resistance, during a specified time period, usually 1 year | N: Number of TB cases notified with DST results for at least rifampicin resistance in a specified time period x 100  
D: Number of TB cases notified in the same time period | By treatment history: new, previously treated, unknown history |
| 9. TB treatment success rate (%)              | Percentage of TB cases (all types) successfully treated (cured or treatment completed) among TB cases notified to national health authorities during a specified time period, usually 1 year | N: Number of TB cases notified in a specified period time period that were successfully treated x 100  
D: Number of TB cases notified in same period | Treatment outcome  
Case type  
Treatment history  
HIV status  
Drug sensitivity (refer to Toolkit TB module for details) |
| 10. Percentage of malaria suspects tested     | Percentage of patients with suspected malaria who received a parasitological test (microscopy or RDT) | N: Number of suspected malaria cases who received a parasitological test (microscopy or RDT) x 100  
D: Number of suspected malaria cases | Microscopy, RDT  
Age (0–4, 5–14, 15+) |
|                                               |                                                                           | If suspected malaria cases are not collected directly from the OPD register, then:  
Suspected cases = Number tested + Number of presumed cases of malaria reported  
Presumed cases are reported cases of malaria which were not confirmed by a diagnostic test | |
| 11. Confirmed malaria cases treated with first-line treatment courses (including ACT) (%) | Percentage of confirmed cases of malaria that receive first-line antimalarial treatment according to national policy*  
* For example, artemisinin-based combination therapy (ACT), where it is national policy | N: Number of confirmed cases of malaria treated with first-line antimalarial treatment according to national policy x 100  
D: Number of confirmed malaria cases  
Confirmed cases = RDT positive + microscopy positive | Age (0–4, 5–14, 15+) |

Notes:

1. All indicators should also be disaggregated by geographic location (e.g. district), facility type (e.g. referral hospital, district hospital, health centre, etc.) and managing authority/facility ownership (public, private, NGO, etc.).

2. Quality-related indicators are also found in other indicator groups (some may require special data collection methods):
   a. Mortality: selected mortality indicators, e.g. CFRs, may reflect quality of care in facilities.
   b. Morbidity: admissions for certain diagnoses (e.g. hypertension, diabetes, chronic lung disease) may reflect inadequate care in PHC facilities. Re-admissions for certain diagnoses (e.g. postoperative infections) may reflect inadequate inpatient care.
   c. Health service resources: availability of appropriate inputs are a prerequisite for quality services.

3.3.2 About the data

The indicators presented in this section are proxy or indirect measures for quality of care. They are intended to highlight issues that may require further investigation. Some of the indicators use data from more than one programme and can help to assess collaboration and integration.

The quality of a health service or a specific intervention determines its effectiveness. Service quality has multiple dimensions. It is dependent on the availability and functionality (“readiness”) of key health service resources (e.g. finance, workforce, medicines, infrastructure) and their appropriate management. Quality is also influenced by health worker training, working conditions, competence and behaviour, as well as by appropriate health worker support, supervision and accountability mechanisms.

Quality of care can be measured both directly and indirectly. Adequate quality assessment requires data sources other than RHIS, such as facility surveys, clinical record audits and patient interviews. Some aspects of quality can, however, be assessed through proxy indicators using RHIS data and can highlight a need for further, in-depth quality assessments.
This document features a limited set of tracer indicators for quality that can be obtained from RHIS data. The analysis sections of this chapter provide brief notes on each indicator. Further details are available in the programme-specific guidance documents of the Toolkit.

### 3.3.3 Assessing data quality

The quality-of-care indicators in this document should be assessed for the data quality dimensions of completeness, internal consistency and external consistency. Some examples of data quality issues that are specific to certain indicators are discussed below.

### 3.3.4 Analysis

1. **Antenatal client 1st visit before 12 weeks’ gestation (%)**
   
   This indicator assesses awareness of the importance of an early start to ANC care. WHO recommends that ANC starts in the first trimester (before reaching 12 weeks of pregnancy), to allow early detection of problems and to promote the best possible outcomes for both mother and baby. Health education and support starting early in pregnancy also help to promote a positive pregnancy experience for the woman.

2. **PMTCT testing (%) (ANC clients tested for HIV or known HIV+) and**

3. **Intermittent preventive treatment for malaria during pregnancy (IPTp) (%)**

   These two indicators reflect standard ANC interventions in many settings. Poor performance may highlight failure to implement protocols and/or lack of commodities. Screening for HIV during early pregnancy enables treatment of the mother, protection of the baby and minimizes the risks of complications. To determine the total number of pregnant women for whom test results are available, the number tested for HIV during the period is added to the number of pregnant women who began antenatal care during the period who were not tested because they were previously known to be HIV positive. In malaria-endemic areas, intermittent preventive treatment for malaria with sulfadoxine-pyrimethamine (IPTp-SP) is recommended for all pregnant women.\(^1\) Doses are given at least 1 month apart, ensuring at least three doses [36]. If mothers present for their first ANC visit during late pregnancy or if they do not attend follow-up appointments, it may not be possible to receive three doses before delivery.

---

\(^1\) IPTp-SP should not be given before week 13 of pregnancy due to limited evidence of an increased risk of fetal malformation. IPTp-SP should start in the second trimester.

---

Fig. 3.20 Antenatal care quality indicators (% of ANC 1), nationwide, 2016–2019 (left); and by region (right), 2019
4. Caesarean sections (%)

WHO does not provide benchmarks for facility C-section rates but emphasizes that the intervention should be provided to women in need. However, in recent years, governments and clinicians have expressed concern about the rise in C-sections and the potential negative consequences for maternal and infant health [37].

C-section rates may vary widely among facilities, depending on differences in infrastructure and staff capacities, in clinical management protocols and, particularly, in the types of cases received. High-level referral facilities are more likely to receive complicated cases requiring C-sections. Therefore, caution is needed when comparing C-section rates among facilities. However, review of facility C-section trends may highlight significant changes over time or unusually high rates that may require further investigation.

5. Immunization dropout rates (%)

Dropout rates measure the percentage of children that received the early dose(s) of a series of vaccinations but failed to receive the later dose(s). A dropout rate of greater than 10% is considered too high. (The upper black lines in Figs 3.22 and 3.23 represent 10%.)

A high dropout rate may reflect dissatisfaction with immunization services, or it may be due to barriers such as distance, fees or irregular sessions, e.g. where immunizations are delivered to a community only through irregular outreach. The MCV1 to MCV2 dropout rate assesses the ability of the programme to reach children after the first year of life.

If the number of later doses (e.g. DTPcv-3) exceeds the number of early doses (e.g. DTPcv-1), the result is a negative dropout rate, as shown for Districts 8 and 9 in Fig. 3.23. A negative dropout rate for an entire district over a full year usually points to data quality problems. Negative BCG to MCV dropout is sometimes the result of inappropriate reporting of campaign doses of MCV along with routine doses.
6. HIV care cascade

The cascade monitors achievement of the 95-95-95 targets of HIV care: 95% of all people living with HIV will know their HIV status, 95% of all people with diagnosed HIV infection will receive ART, and 95% of all people receiving ART will have viral suppression at the end of a given period (e.g. 1 year). The ideal 95-95-95 cascade is based on longitudinal review of individual data for people living with HIV within a group (cohort) that were newly diagnosed within the same time period. In a mature, well-functioning “treat all” ART programme, the number of “newly on ART” is expected to be 95% or more of “PLHIV newly diagnosed”. The number of “PLHIV retained on ART at 12 months” should be 95% or more of the number “newly on ART”.

The bar chart demonstrates the ideal 95-95-95 HIV care cascade by showing cascade indicators as absolute numbers, using data available from the RHIS. Ideally, the data in the columns of the cascade for each period should refer to the same group (cohort) of people that were diagnosed within the same time period. However, some individuals “newly on ART” (second bar) in 2019 may have been newly diagnosed more than a year earlier but waiting to enrol in treatment. Individuals included in “retained on ART at 12 months” (third bar) would have been diagnosed and started on ART in the year prior to those people included in the second bar. Despite these limitations, the chart is useful in providing an idea of the functioning of the HIV care programme.
If the number of people living with HIV newly on ART is greater than the number of people living with HIV newly diagnosed, this may reflect a data quality issue, but could also be explained by other factors. For example, Fig. 3.25 presents data from a country that adopted a universal ART treatment policy at the beginning of 2019. When the new treatment policy was adopted, there was a surge in people living with HIV new on ART as a result of a backlog of patients that had previously had to wait before they were eligible to start ART.

The trend in the first bar of the cascade (“PLHIV newly diagnosed”) provides insights into progress towards the first target, although the cascade based upon routine data does not indicate the denominator (total PLHIV). Note, however, that an increase in people living with HIV newly diagnosed may not necessarily mean progress towards the first target as such an increase may reflect a recent increase in the denominator (i.e. an increase in the prevalence of HIV).

7. **New and relapse TB cases with a documented HIV status (%)**

This indicator assesses the percentage of TB cases for which HIV status was assessed. Assessing the HIV status among TB cases is critical for appropriate clinical management of both TB and HIV. TB accounts for almost one third of the AIDS-related deaths worldwide. The percentage of TB patients who are HIV positive provides useful data to forecast treatment and support needs for management of co-infected patients.

Tracking of these indicators helps TB programme managers to identify weaknesses in collaborative activities between HIV and TB service providers, which may result in TB patients not being tested for HIV and co-infected patients not being treated with ART or co-trimoxazole preventive therapy (CPT).

Data on HIV status are collected both during notification and during treatment outcome reporting. This is necessary because some TB patients are not tested for HIV at the start of treatment but are tested later during the treatment period. Incorrect data collection and reporting processes result in either under-reporting or double counting, with data showing more than 100% of TB cases being tested for HIV.
8. **Drug susceptibility test (DST) for TB cases (%)**

This indicator reflects the percentage of TB cases with DST results for at least rifampicin resistance. Drug-resistant TB (DR-TB) can develop through inadequate treatment or can be acquired through transmission between individuals. Rapid drug susceptibility testing should be provided for all TB cases to ensure that DR-TB cases are rapidly detected and treated with the correct treatment regimen, to improve patient outcomes and prevent onward transmission of DR-TB.

WHO requires that, by 2025, 100% of all TB cases notified in a national system will have documented DST results at least for rifampicin. Fig. 3.27 presents an example of a country that has increased DST testing of previously treated TB but has yet to introduce testing of new cases. Since total notifications are largely comprised of new cases, less than 5% of total cases were tested for rifampicin susceptibility as of 2017.

**Fig. 3.27 Rifampicin susceptibility testing (%), nationwide, 2011–2017**

9. **TB treatment success rate (%)**

TB treatment success rate is the percentage of notified TB cases (all forms) started on treatment that were cured (based on laboratory confirmation) or that completed treatment. It is an important marker of disease control and service quality. Low treatment success rates may indicate problems with treatment regimens, poor treatment management, adverse side-effects of TB medicines, death from any cause or loss to follow-up. Cases without a documented outcome are considered not evaluated, this can also contribute to low treatment success due to poor recording and reporting practices. It is important to investigate why treatment success rate is low, in order to be able to implement solutions for improving patient care.

Treatment success should be disaggregated to monitor outcomes for cases where treatment success may be more difficult to achieve, such as those which were previously treated and cases which are HIV positive (see Fig. 3.28). Monitoring the proportion of TB notifications in each treatment outcome category is used to highlight the extent to which loss to follow-up, death and treatment failure each contribute to the inability to achieve treatment success (see Fig. 3.29).

**Fig. 3.28 Treatment success rate, various forms, nationwide, 2011–2017**
10. Percentage of suspected malaria cases tested

This indicator tracks the percentage of suspected malaria cases that receive a laboratory test (RDT or microscopy). The numerator is the total number of malaria tests performed (RDT + microscopy). The denominator is the total number of “suspected cases”, i.e. people presenting with fever or other symptoms and signs of malaria. It is important to note that in some countries there is double counting of microscopy and RDT (one patient receives both tests). This should be corrected prior to analysis of this indicator.

If the number of suspected cases is not specifically reported, then:

\[
\text{Suspected cases} = \text{persons tested} + \text{presumed cases of malaria}; \text{ or } \\
\text{Suspected cases} = \text{total malaria diagnoses (confirmed + presumed)} + \text{negative malaria tests}
\]

Confirmed malaria cases are those diagnosed through a laboratory test. Presumed malaria cases are those that did not receive a laboratory test but were diagnosed based on clinical assessment only.

The target for the percentage of suspected malaria cases tested is 100%. Health systems are working to reduce the number of “presumed malaria” diagnoses in order to improve diagnostic accuracy and effective management of febrile illness (especially in areas where malaria is not a common cause of fever) and to reduce unnecessary prescription of antimalarials.

Fig. 3.30 provides an example of a country that increased the use of RDTs beginning in 2014. As a result, the percentage of suspected malaria cases tested increased steadily and has been close to 100% since 2017.
It is important, however, to avoid potential under-reporting of actual presumed diagnoses or over-reporting of confirmed diagnoses, as this will make the percentage of suspected malaria cases tested no longer reliable for monitoring diagnostic practice. To assess this, it is useful to compare the percentage of suspected malaria cases tested obtained from RHIS data with findings from a population-based survey measuring the percentage of fever cases attending health facilities that received a malaria diagnostic test. It is also important to investigate whether a low percentage of suspected malaria cases tested may reflect a lack of diagnostic testing supplies. Where laboratory data on malaria testing are reported separately from clinical data on malaria testing, the data should be compared for consistency.

11. **Confirmed malaria cases treated with first-line treatment courses (including ACT) (%)**

ACT is the first-line treatment for uncomplicated *Plasmodium falciparum* malaria. Low or decreasing percentages of confirmed cases treated with ACT could point to problems with ACT availability or to poor quality of care. Some health information systems are unable to generate reliable data on this indicator. As the indicator assesses the percentage of confirmed malaria cases treated with ACT, it is incorrect to use the total ACT treatments given as the numerator, since it is possible that some patients who were given ACT did not have their diagnosis confirmed by RDT or microscopy (presumed cases of malaria).

Reporting on this indicator is possible if the register and the form for reporting aggregate data disaggregate the data for ACT treatment by confirmed and presumed malaria cases. Some countries have designed a general outpatient register and general outpatient report to capture such data. Others have introduced a separate register and a separate form for this purpose.
4. Group 3 indicators: Health service resources

4.1 Availability, distribution and efficiency

4.1.1 Health service resource indicators

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<td></td>
<td></td>
</tr>
<tr>
<td>1. Health facility density and distribution</td>
<td>Total number of health facilities per 10 000 population or Population per facility</td>
<td>N: Number of health facilities x 10 000 Plan population = Total population</td>
<td>Specific services offered</td>
</tr>
<tr>
<td></td>
<td>(Total number of hospitals per 100 000 population)</td>
<td>D: Total population</td>
<td></td>
</tr>
<tr>
<td>2. Hospital bed density</td>
<td>Number of hospital beds per 10 000 population</td>
<td>N: Number of hospital beds reported as available x 10 000 D: Total population</td>
<td>Type of bed</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Bed occupancy rate (BOR)</td>
<td>Percentage of available beds that were occupied over a specified period</td>
<td>N: Number of occupied bed-days x 100 D: Number of available bed-days</td>
<td>Hospital department (medical, surgical, etc.) Acute vs long-term care</td>
</tr>
<tr>
<td>4. Average length of stay (ALOS)</td>
<td>Average number of days that an inpatient spends in hospital over a specified period</td>
<td>N: Number of occupied bed-days D: Number of discharges</td>
<td></td>
</tr>
<tr>
<td><strong>Health workforce</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Health worker density and distribution</td>
<td>Number of health workers per 10 000 population</td>
<td>N: Number of skilled* health workers x 10 000 D: Total population</td>
<td>Occupation Distribution: place of employment: (urban/rural; PHC/specialist clinic/hospital)</td>
</tr>
<tr>
<td></td>
<td>* Should include only health workers with proof (degree, diploma, certificate) of professional training</td>
<td>* *</td>
<td></td>
</tr>
<tr>
<td>6. Output of training institutions</td>
<td>Graduates from health education and training programmes in the past academic year per 100 000 population</td>
<td>N: Number of graduates from health education and training programmes x 100 000 D: Total population</td>
<td>Occupation</td>
</tr>
<tr>
<td>7. Vacancy rate</td>
<td>Percentage of funded full-time posts not filled for at least 6 months and which employers are actively trying to fill</td>
<td>N: Number of full-time posts not filled for at least 6 months x 100 D: Number of full-time posts.</td>
<td>Occupation PHC vs hospital</td>
</tr>
<tr>
<td><strong>Efficiency productivity</strong> [38]</td>
<td>Average number of service units provided by a given health worker in a specified period (e.g. working day, year)</td>
<td>N: Number of service units provided in a specified period D: Number of workers providing the service x number of available working days in same period</td>
<td>Service type Occupation³</td>
</tr>
</tbody>
</table>

1 Efficiency is proxied by hospital bed-capacity utilization measures.

2 Newborns are usually excluded from both the numerator and the denominator for calculation of both BOR and ALOS.

3 For example, physician, nurse, clinical assistant, etc.
### Integrated health services analysis | National level

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<td>9. Health facilities with no stockout</td>
<td>Percentage of health facilities with no stockout of selected tracer medicines and medical products</td>
<td>N: Number of health facilities reporting no stockout in a specified period x 100</td>
<td>Type of medicine or commodity (e.g. vaccines, antibiotics, syringes)</td>
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<tr>
<td></td>
<td></td>
<td>D: Number of health facilities reporting through the RHIS in the same period</td>
<td></td>
</tr>
<tr>
<td><strong>Financial resources</strong></td>
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<td></td>
<td></td>
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<tr>
<td>10. Health services expenditure per capita</td>
<td>Public health system expenditure per capita on health facility services</td>
<td>N: Expenditure</td>
<td>Funding source</td>
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<td></td>
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<td>11. Budget execution (financial implementation)</td>
<td>Percentage of allocated health service budget that was spent over a specified period</td>
<td>N: Expenditure x 100</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: Allocated budget</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All indicators should also be disaggregated by geographic location (e.g. district), facility type (e.g. referral hospital, district hospital, health centre, etc.) and managing authority/facility ownership (public, private, NGO, etc.).

### 4.1.2 About the data

Health service resources are the inputs (production factors) needed to provide the health services that are the sources of the data analysed in the previous chapters. The resources discussed in this chapter include infrastructure (health facilities), health workforce, medicines and medical products, and health service financing.

The availability and use of these resources are important determinants of health system performance. Therefore, managers need to assess resource data in relation to RHIS data.

Health service resource systems and their data are extensive and complex. This section provides a limited number of indicators that highlight selected aspects of resource availability and the efficiency of resource use.

**Availability indicators** compare the amount of a given resource (e.g. facilities, nurses) to the population served. Availability is assessed through **density** (resources per population)\(^1\) and **distribution** (the locations of the resources).\(^2\) These indicators are used as proxy measures for **access** and can also be used as **equity** measures when comparing subnational administrative units.

**Efficiency indicators** broadly assess value-for-money by comparing the amount of a given resource (or its cost) used, with the amount of services/outputs produced using the resource, e.g. number of consultations per medical doctor per day or percentage of hospital beds that are occupied.

---

1. Density may be expressed as the amount of the resource per person (“per capita”) or per population (e.g. per 1000 or per 10 000).
2. Locations may include geographic location, facility type/level and provider (e.g. public, private, NGO, etc.).
Producing health resource indicators may require specific efforts. Health resource data are often not available through the RHIS and need to be obtained from various information systems maintained by or for various agencies within or external to the ministry of health (e.g. central medical stores, health workforce department, finance department, national immunization programme, the national AIDS control programme, etc.). As discussed in the next section, there may be variations among these systems in definitions, classifications and reporting periods of resource data. Some preliminary steps are therefore usually needed to extract these data before indicators can be produced.

**Health infrastructure** data can be obtained from the national MFL\(^1\) which should specify facility location, type/level, ownership/managing authority (public, private-for-profit, NGO, military, etc.) and operational status. It may also specify types of services offered and numbers of beds. However, the MFL may not be up-to-date and often includes only public sector facilities. The RHIS can also serve as a data source, although it usually only lists facilities reporting into the RHIS and private sector facilities may not be included.

Data on the availability and functional status of **equipment** are usually obtained from facility surveys, e.g. WHO SARA or HHFA. However, such surveys are usually conducted only every few years and the available information may therefore be outdated. Alternatively, proxy information on equipment availability can often be obtained from the RHIS, e.g. reports on the number of X-ray examinations or computed tomography (CT) scans performed each month implies the presence and functional status of the relevant equipment.

National-level **health workforce** data are obtained from four main sources: administrative systems, health facility surveys, labour force surveys and some population censuses. Examples of administrative systems include country databases that contain individual records of their health workforce members. As a further example of an administrative system — in some health systems facilities are required to report their numbers of staff, by occupation, through the RHIS at regular intervals, e.g. quarterly or bi-annually. Workforce statistics should ideally include workers of all managing authorities. Health workforce databases may, however, vary substantially in comprehensiveness (e.g. inclusion or not of private sector workers).

Data on **medicines and medical products** present specific challenges. A specialized logistics management information system (LMIS) is often used for stock management. Where there is a well-developed but separate LMIS, data on stockouts as well as data on consumption of items can be exported from the LMIS to the RHIS and used in the analysis and interpretation of other health facility data. However, the LMIS may not be designed to enable such extraction of data. Alternatively, the RHIS may provide some information on availability by reporting on stockouts of individual items or groups of “tracer” items. A further option is to monitor expenditures. This approach has the advantage that consumption of multiple items can be summarized in a single common monetary unit. Central supply chain managers usually have estimates of the prices of items they purchase or distribute. Documents (e.g. waybills) that accompany medicines to their final destinations often also include the assigned price and this information is often included in the LMIS.

**Financial** data also pose challenges. These data are typically managed using specific financial management information systems (FMIS). Even when analysts can access the FMIS data, it may be difficult to attribute expenditures to specific activities, geographic areas and periods (e.g. expenditures for activities in one period may be attributed to an earlier or later period). In this guidance, analysis is limited to only two broad indicators of financing: total health services expenditure per capita and budget execution by major budget line. Further analyses are possible where more detailed financial data can be obtained and reliably interpreted. Such analyses are beyond the scope of this guidance.

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\(^1\) The MFL may also be called the national facility register.
Health resources are not distributed evenly across administrative units, but according to the structure of the health system. The health network consists of facilities of increasing levels of complexity, e.g. from health posts to referral hospitals. Higher level referral facilities require additional resources and may serve several administrative units. Most resources (health workers, medicines, funds) tend to “follow” the network of facilities and their level (e.g. medical doctors may be present only at hospital level and specialists only at facilities above district hospital level). These two issues (referral facilities serving multiple administrative units and resource concentration at higher level facilities) must be considered when calculating and interpreting availability indicators. If possible, comparisons should be made only among administrative units that have the same level of resources (e.g. between districts with a district hospital, or between provinces with provincial and district hospitals). This avoids comparison between administrative units which include a referral facility and other administrative units which can only refer to a referral facility.

Some resources (e.g. staff, medicines, budget) may be assigned to central or provincial levels but not to districts or facilities. In this case, the data can be used to calculate only national- and provincial-level indicators, unless ways exist to estimate their distribution and use by lower levels of the health system.

4.1.3 Assessing data quality

Health service resource data face the same quality issues as RHIS data, as well as some additional challenges resulting from their generation by or for various agencies that have varying definitions, classifications and reporting periods.

Definitions and terms

Resources may be defined in different ways in different health systems and may even vary among different agencies within the same health system. Adjustments may therefore be necessary when data from diverse reporting systems are compared or merged/aggregated. Clear definitions of the terms used in each context must be presented along with the indicators.

Health facility types/levels are named according to the tradition of each health system. For example, basic health units, health posts and health subcentres may all represent the same general facility type in different contexts. Each facility type is usually defined by the services it provides, the team staffing the facility and the range of medicines that can be dispensed at this level. However, boundaries between levels may be blurred. In some systems, levels are defined by the provision of a service (e.g. all district hospitals must provide emergency surgery). In others, the level is defined by the location (e.g. all referral facilities located at the capital of a district are considered district hospitals, regardless of the range of services provided). Therefore, when assessing facility densities, it is important to consider that the indicators could represent access to different service types in different contexts.

The definition of “hospital bed” may also vary. Some health systems report only acute care beds, while others may include beds for chronic care (e.g. mental health) or beds used for periods shorter than 1 day (e.g. emergency room, post-surgery recovery, day surgery, etc.). These differences may substantially affect estimations of bed density, as well as the calculation of bed occupancy rates.

Health workforce classification is complex. Different countries may have adopted various training strategies and qualifications over the years. While “doctor” usually represents the same general definition, the term “nurse” may group together workers of different training levels (e.g. from nurses with certificates for training of up to 18 months, to nurses with 4-year bachelor’s degrees). Depending on the health system context, it may be necessary to calculate workforce indicators that disaggregate such training levels.

The definition of medicine availability also varies. Many systems define it as the presence (in any quantity) of a defined list of selected tracer items. Some RHIS report it as percentage of facilities with no stockout of individual tracer medicines during a specified period. Stockouts ranging from 1 day to 30 days in a month are often recorded in the same way.
Budgets and expenditures are grouped according to budget lines which may also vary among agencies. Such variations in classifications and definitions must be considered and documented when extracting, cleaning, combining and interpreting the data from diverse reporting systems.

**Completeness and timeliness**
The primary sources of resource data are forms and databases beyond the control of RHIS analysts. It may therefore be very difficult to ascertain the completeness of the data. Moreover, different departments/agencies may have different reporting periods and timing. For example, budgets typically refer to the financial year rather than the calendar year; infrastructure data and some health workforce data may be updated only once a year; some procurement expenditures (e.g. medicines) may consist of one or two large purchases rather than being spread throughout the year, etc. Funds in the budget of one year may not be spent until a subsequent year. These factors make it challenging to ascertain the period to which the data correspond.

**Internal consistency**
Data that show large discrepancies between geographic areas in the population density of resources may reflect a real disparity resulting from, for example, the inclusion of referral facilities in some administrative units but not in others. On the other hand, such inconsistencies may reflect data quality issues or inconsistencies in definitions and terms, as discussed previously. RHIS analysts may have less experience in cleaning and interpreting resource data than RHIS data. Therefore, identifying outliers or unusual patterns may be more difficult than for RHIS data. Nevertheless, some quality problems can be identified easily, e.g. budget execution above 100%, or large variability in bed occupancy rates (BOR) across facilities of the same level.

**External consistency with other data sources**
As resource data are usually produced by multiple sources outside the RHIS, it is important to compare the extracted or summarized data with the primary data from these other sources. Much of the resource data are obtained from summaries (e.g. reports of facility surveys, accounting reports) that may be of variable reliability. The data used to calculate resource indicators should therefore be checked against the detailed reports and, if possible, against the databases that are the sources of the reports (e.g. accounting database, health workforce database).

### 4.1.4 Analysis
Resource data are used to calculate indicators of availability and of efficiency when combined with population figures and service outputs respectively.

Availability indicators can be used for comparisons among countries or with international standards. They can be used to motivate or plan for additional resources to reach required standards. They can also be used to assess equity among subnational administrative units and to inform resource allocation.

Efficiency indicators are usually more context-specific than availability indicators and do not have defined standards. They can be used to assess technical or allocative efficiency,\(^1\) as well as to identify values that differ significantly from the average and which should trigger further investigations, e.g. a situation where medicines expenditure per capita in one province is double the average for the country.

**Health infrastructure**
The physical availability of health infrastructure is a component of access to health services and can be used to assess equity and to inform decision-making on investments in additional infrastructure and services.

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\(^1\) Technical efficiency is concerned with achieving the maximum outputs at least cost. Allocative efficiency looks at the ways in which different inputs are combined to produce a mix of different outputs.
Health facility density is a crude indicator of overall geographic access to health services. It can be expressed as the number of facilities per 10 000 population or as the number of hospitals per 100 000 population. Alternatively, health facility density may also be expressed as population per facility.

Density of selected medical devices and essential technologies assesses the availability of diagnostic and treatment technologies, which may reflect the level of development of the health system. Availability of selected equipment can also serve as proxy indicators of access to specific services. For example, the availability of radiotherapy equipment is required for access to treatment of certain cancers.

1. **Health facility density**

   Overall health facility density data should include facilities of all managing authorities. If the facility density data do not include all facilities or managing authorities, this should be clearly stated when presenting the indicator. There are no global norms for health facility density. Targets should be defined according to the local context.

   Interpretation of facility density is not straightforward and additional information is needed to provide a meaningful picture of the situation. Lower facility density does not necessarily mean poorer access, or vice versa. Other aspects should be considered. For example, facility density may be lower in urban areas than rural areas. However, urban facilities tend to be larger than those in remote areas, with better staffing and more services; urban areas also imply high population density and short distances. Geographically large, sparsely populated areas might require relatively high facility densities to ensure equity of access. Facilities do not all provide the same selection of services. In many countries, outpatient services for diseases such as TB, HIV or NCDs are available only in hospitals or higher level PHC facilities. Therefore, facility density should also be assessed in relation to facility type/level and the services available.

   The following section provides examples of various uses, limitations and interpretation issues related to facility density indicators.

   Inter-country comparisons have shown little consistent relationship between facility density and UHC service coverage. As country health systems and contexts vary widely, comparisons of facility densities among countries may be of limited use. However, it may be useful to use facility density to assess network growth at country level over time. Fig. 4.1 shows trends in facility density over 4 years in the Republic of Kenya [19]. The initial increase from 1.9 to 2.3 may reflect implementation of a national infrastructure development plan. The subsequent decrease may reflect that the increase in infrastructure has not matched population growth.

   ![Fig. 4.1 Trends in health facility density 2013–2016 (all facility types)](image)

   **Source:** Statistical Review of Progress Towards the Mid-term Targets of the Kenya Health Sector Strategic Plan 2014–2018 [19].

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1 Note that "density", as used here, refers to facilities (or other resources) per population rather than facilities per geographic area. Hence, urban areas tend to have both a low facility density and yet a high geographic concentration of facilities.
Facility density can be compared among subnational administrative units to help identify underserved areas. Fig. 4.2 shows higher facility density in some peripheral regions of the United Republic of Tanzania [14] than in the region of the main city (Dar es Salaam). As previously discussed, urban areas usually have fewer but larger and better equipped facilities than rural areas. The figure also shows that more than half of the facilities in Dar es Salaam are managed by private providers and these may not correspond to the facility types/levels of the public sector, making comparison with other regions difficult.

Geographic information systems (GIS) are often integrated within the RHIS and can map the locations of health facilities as well as showing geographic differences in indicators. Geographic access can also be crudely assessed using an indicator such as the radius of the average catchment, which rather simplistically assumes that all health facilities in an area have an equivalent catchment area. GIS can map the locations of facilities in relation to the population and calculate more robust indicators, e.g. percentage of the population living within a certain distance of a facility. As shown in Fig. 4.3, approximately half of the population of the Sahel health region of Burkina live more than 10 km from a facility [39].

2. Hospital bed density

Hospital beds are assumed to be present only in facilities offering inpatient care. Hospital bed density, expressed as the number of beds per 10,000 population, is an indicator of access to inpatient care and, indirectly, to referral services.

The indicator includes all hospital beds (acute and long term) but excludes “non-ward” beds (labour and delivery beds, emergency room beds, etc.). However, some countries may include only acute care beds. The definition of the indicator should therefore be presented along with the data. The indicator can be calculated for all beds as well as for beds with specialized use, such as maternity, intensive care or paediatric beds.
A hospital bed density below a threshold of 18 per 10,000 can be considered indicative of serious constraints in access to secondary and tertiary inpatient care. Many countries in Africa, South-East Asia and the Americas had a hospital bed density lower than the threshold in 2020, whereas the hospital bed density was at least four times higher than the threshold in a majority of countries in the European and Western Pacific regions [40]. Data for international comparisons are available from the website of the Global Health Observatory [41].

There can be considerable variation in numbers of beds per hospital and beds per specialty, making comparisons difficult. In addition to development and affordability issues, bed density depends to a large extent on the health care delivery model. Hospital-centred systems usually have higher bed densities than PHC-focused systems. Fig. 4.5 shows higher bed densities in some former Soviet countries than in countries with strong PHC-based systems, e.g. India and Pakistan.

When assessing smaller administrative units such as districts, it is important to note that the population living in the district may not be using the hospitals in the district for various reasons, including logistics, sociocultural preferences and perceptions of quality. Also, large, more sophisticated hospitals may serve more than one administrative unit.

![Fig. 4.4 Inpatient beds per 10 000 population, nationwide, by type of facility of an East African country, 2011–2020](image)

**Fig. 4.5 Comparison of hospital bed density, selected countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Beds/10,000 pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>2015</td>
<td>5</td>
</tr>
<tr>
<td>China</td>
<td>2012</td>
<td>42</td>
</tr>
<tr>
<td>India</td>
<td>2011</td>
<td>7</td>
</tr>
<tr>
<td>Iran</td>
<td>2014</td>
<td>15</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>2013</td>
<td>67</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>2013</td>
<td>45</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2014</td>
<td>6</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>2013</td>
<td>48</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>2013</td>
<td>74</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>2013</td>
<td>40</td>
</tr>
</tbody>
</table>

*Source: Global Health Observatory [41]*

Fig. 4.6 ranks the districts of a country by their inpatient bed densities. The districts with the two highest populations per km² (average = 6.116) are shown in green while the districts with the two lowest populations per km² (average = 8) are shown in red. Bed density is thus clearly influenced by population density, as referral facilities are typically located in the most densely populated cities and it is expensive to provide a high number of beds per person if the population is widely dispersed.

On the other hand, the rankings of the district with the third highest number of people per km² (1 145; striped green) and the district with the third lowest number of people per km² (11; striped red) show that bed density may be determined by factors other than population density.
The following two indicators are measures of hospital bed-capacity utilization that may serve as proxies for efficiency.

3. **Bed occupancy rate (BOR) (%)**

   BOR is a proxy measure of the efficiency of hospital bed utilization. It is defined as the percentage of available beds that were occupied by patients over a defined time period. For example:

   \[
   \text{BOR} \text{ } (\%) \text{ for 1 year} = \frac{\text{sum of occupied bed-days}^1 \text{ during the year}}{\text{Number of available beds} \times 365} \times 100
   \]

   or

   \[
   \text{BOR} \text{ } (\%) \text{ for 1 year} = \frac{\text{sum of inpatient days during the year}}{\text{Number of available beds} \times 365} \times 100
   \]

   Maternity, delivery and emergency room beds are usually excluded from BOR calculations, as well as beds reserved for day cases, e.g. day surgeries or diagnostic procedures. (BOR for these and other specific bed categories may be analysed separately.) Traditionally, a BOR of around 85% has been considered adequate [42], as it means that most beds are occupied on an ongoing basis, but that the facility has room to respond to unexpected emergencies, e.g. outbreaks, mass casualties. BORs of above 90% have been associated with quality-of-care problems.

4. **Average length of stay (ALOS)**

   ALOS is also a proxy measure of efficiency. It is the average number of days that a patient occupies an inpatient bed over a specified period. There is no standard for ALOS as it depends on the hospitalization policies of each health system. When calculated for individual facilities, it also depends on the types of cases and types of care provided. For example, elective surgeries usually have short ALOS (e.g. 2–3 days), while mental health admissions may generate ALOS of over 30 days [43]. ALOS does not usually include hospitalization for uncomplicated deliveries. These may be analysed separately.

   Fig. 4.7 presents findings from a study of utilization of 40 hospitals in the Republic of Malawi [44] where the ALOS of both public and mission hospitals was within the range of 3 to 5, which is typical for acute care hospitals. Note that the BOR (%), while considerably below the recommended threshold of 85%, was somewhat higher for public than for mission hospitals.

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1 An "occupied bed-day" is counted for each day that a single bed is occupied. For example, two occupied bed-days would be counted either for two beds each occupied for one day or for one bed occupied for two days.
Integrated health services analysis | National level

Fig. 4.7 ALOS, bed turnover ratio (patients per bed per year) and BOR (%), 40 hospitals in Malawi, 2005/2006

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Average length of stay (days)</th>
<th>Bed turnover ratio</th>
<th>Bed occupancy rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard deviation</td>
<td>Mean</td>
</tr>
<tr>
<td>Mission</td>
<td>4.3</td>
<td>1.7</td>
<td>34</td>
</tr>
<tr>
<td>Public</td>
<td>3.8</td>
<td>4.4</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>4.0</td>
<td>3.6</td>
<td>51</td>
</tr>
</tbody>
</table>

Source: Assessing the efficiency of hospitals in Malawi: an application of the Pabón Lasso technique. African Health Monitor. Special Issue September 2014 [44]

A further useful measure of hospital bed-capacity utilization is the **bed turnover ratio** (BTR). BTR is a measure of hospital bed productivity and represents the number of patients treated per bed in a defined period of time.

BTR = Total admissions (or discharges) / number of available beds

The usefulness of bed-capacity utilization indicators can be enhanced if they are used simultaneously. A single indicator may not give a reliable indication and may sometimes be misleading. For example, a high BOR (e.g. 80%) may or may not indicate optimal bed-capacity utilization. Increasing the ALOS unnecessarily (such as in insurance systems where fee-for-service, per diem, or other methods excluding diagnosis-related groups are used for provider payment) could result in a high BOR. A high BOR could also be the consequence of hospital-acquired conditions/infections resulting from poor medical and nursing care. These examples illustrate poor performance despite an optimal BOR.

Fig. 4.8 shows the Pabón Lasso diagram [45] which provides scenarios using BTR and BOR simultaneously to better understand bed-capacity utilization.

Fig. 4.8 Pabón Lasso diagram illustrating simultaneous use of BTR and BOR

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**Equipment availability**

Service availability is often determined by the presence of specialized equipment, e.g. laboratory and radiology equipment. Availability of such items may provide an indication of the stage of health system development. These data are usually not reported through the RHIS but are obtained from facility assessments (e.g. the WHO SARA or HHFA or, in emergency contexts, the Health Resources Availability Monitoring System [HeRAMS]). The Global Health Observatory provides data on national-level availability of selected specialized equipment. Subnational comparisons for such items may be relevant only in higher income countries.

RHIS data can be used to obtain indirect information on the availability of selected equipment, based on the assumption that reporting of an activity implies that the required equipment is present. For example, reporting of selected laboratory tests in the RHIS means that the facility has a functioning laboratory with the necessary equipment. Refer to the coverage and quality chapter for further discussion on service-specific availability.
Health workforce

Effective health systems require a strong health workforce, i.e. adequate numbers of health workers with knowledge, skills and motivation that are equitably distributed by occupation to deliver services across the country. When assessing geographic equity and comparing health worker density among subnational units, it is best practice to exclude from the analysis health professionals that are engaged in administrative tasks rather than provision of clinical services. Some analyses may also exclude staff of tertiary referral hospitals. Without such exclusions, the analysis will exaggerate the access to health services in national and provincial capitals and other large cities.

5. Health worker density

WHO has defined minimum thresholds for health worker density that include medical doctors, nurses and midwives and, in some countries, other occupations that perform similar clinical work after formal training, e.g. medical assistant, clinical officer. The 2006 World health report proposed a minimum 22.8 clinical workers per 10,000 population. In the Global strategy on human resources for health: workforce 2030 [46], this figure increased to 44.5 per 10,000 as a requirement for achieving UHC.

Selected indicators of workforce density are accessible from the website of the Global Health Observatory and in WHO’s annual world health statistics reports. These data enable international comparisons and can be used to advocate for additional resources for the health sector. Fig. 4.9 compares health worker density among Southern African countries [47]. Almost half of the countries fail to reach the 2006 threshold of 22.8 workers per 10,000 population and only the countries with the smallest populations have so far achieved the UHC threshold.

Fig. 4.9 Density of selected health workers per 10,000 population, Southern Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Density of medical doctors (per 10,000 population)</th>
<th>Density of nursing and midwifery personnel (per 10,000 population)</th>
<th>Health worker Density (per 10,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>2.10</td>
<td>4.10</td>
<td>6.20</td>
</tr>
<tr>
<td>Botswana</td>
<td>5.30</td>
<td>54.00</td>
<td>59.30</td>
</tr>
<tr>
<td>Eswatini</td>
<td>3.30</td>
<td>41.40</td>
<td>44.70</td>
</tr>
<tr>
<td>Lesotho</td>
<td>0.70</td>
<td>32.60</td>
<td>33.30</td>
</tr>
<tr>
<td>Madagascar</td>
<td>1.80</td>
<td>1.50</td>
<td>3.30</td>
</tr>
<tr>
<td>Malawi</td>
<td>0.40</td>
<td>4.40</td>
<td>4.80</td>
</tr>
<tr>
<td>Mauritius</td>
<td>25.30</td>
<td>35.20</td>
<td>60.50</td>
</tr>
<tr>
<td>Mozambique</td>
<td>0.80</td>
<td>6.80</td>
<td>7.60</td>
</tr>
<tr>
<td>Namibia</td>
<td>4.20</td>
<td>19.50</td>
<td>23.70</td>
</tr>
<tr>
<td>Seychelles</td>
<td>21.20</td>
<td>80.80</td>
<td>102.00</td>
</tr>
<tr>
<td>South Africa</td>
<td>9.10</td>
<td>13.10</td>
<td>22.20</td>
</tr>
<tr>
<td>Zambia</td>
<td>11.90</td>
<td>13.40</td>
<td>25.30</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>2.10</td>
<td>19.30</td>
<td>21.40</td>
</tr>
</tbody>
</table>

Source: World Health Statistics 2020

At country level, comparisons of health worker densities across subnational administrative units can be used to inform decisions on staff deployment. However, health worker distribution also depends on other criteria. Staff tend to “follow” the facility network, often in the form of standard teams. Low health worker density in a subnational unit may therefore be the result of an insufficient number of facilities rather than inequitable staff deployment.
Fig. 4.10 Health worker density per 10,000 population by cadre and by region, mainland United Republic of Tanzania, 2013

Fig. 4.10 shows health worker density in the United Republic of Tanzania [14], with substantial differences across regions. In this example, some of the differences may result from the presence of large hospitals in some of the regions, e.g. Dar es Salaam.


Some contexts may require analysis of health worker characteristics in additional detail. For example, Iraq [48] has made efforts to reduce underqualified nursing personnel and to increase deployment of qualified nurses. Fig. 4.11 shows the comparative density of both groups by governorate; note the differences between the three governorates that compose the autonomous Kurdistan Region (Erbil, Duhouk and Al-Sulaimaniya of the Republic of Iraq) and the remaining administrative areas.

Fig. 4.11 Health worker densities per 10,000 population, by province, Iraq, 2015

Source: Annual Report 2015, Ministry of Health, Republic of Iraq [47]
In many contexts, access to female health care providers is an important determinant of women’s health service utilization patterns. Sex disaggregation of workforce data therefore represents an important additional analysis. Information on an appropriate ethnic mix of health workers may also be important in some contexts, to encourage utilization of services among marginalized communities.

6. Output of training institutions

WHO estimates a projected shortfall of 15 million health workers by 2030, mostly in low- and lower-middle income countries. Chronic underinvestment in health worker education in some countries and a mismatch between education and employment strategies in relation to health systems and population needs contribute to continuous shortages. These are compounded by difficulties in deploying health workers to rural, remote and underserved areas, as well as increasing international migration of health workers. However, in some countries, the public sector may lack the capacity to absorb the supply of health workers due to budgetary constraints [49]. As part of the efforts to address these challenges, countries need reliable information on the annual numbers of health workers, by occupation, graduating from certified training institutions.

7. Vacancy rate

Many health systems have defined standard staffing requirements (or “teams”) by facility type and level, based on the range of services that should be provided. Actual staffing (i.e. positions filled) can be compared with the standard, to identify which facility levels are furthest from the defined standards, and which occupations are in shortest supply.

Fig. 4.12 presents vacancy rates for selected health worker occupations within a district. In this example, positions remained vacant for medical officers and clinical officers, but the numbers of enrolled and registered nurses exceeded the staffing standards, resulting in negative vacancy rates for these groups.

Fig. 4.12 Vacancy rates, Lupara district

However, such staffing standards may not correspond to the actual amounts of activities performed in all facilities. In facilities receiving low numbers of patients, allocated health workers may be under-utilized, while in facilities with high numbers of patients, there may not be enough workers to meet patient needs. In the Republic of Uganda, the WHO Workload Indicators of Staffing Need (WISN) [52] methodology was used to define staffing norms for a sample of health facilities based upon the actual workloads of facilities [50]. Fig. 4.13 shows how actual staffing compared with workload-based staffing norms. The report stated “all three types of health centres had fewer nurses and midwives than required and consequently exhibited high workload pressure for those cadres. Health centres IV and hospitals lacked doctors but were adequately staffed with clinical officers. All facilities displayed overstaffing of nursing assistants.”
Fig. 4.13 Current staffing as a percentage of WISN requirements, selected health facilities of Uganda, by facility type, 2011

<table>
<thead>
<tr>
<th>Type of health facility (N = 136)</th>
<th>Doctors (%)</th>
<th>Clinical officers (%)</th>
<th>Midwives (%)</th>
<th>Nurses (%)</th>
<th>Nursing assistants (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre II</td>
<td>-</td>
<td>-</td>
<td>67</td>
<td>70</td>
<td>167</td>
</tr>
<tr>
<td>Health centre III</td>
<td>-</td>
<td>56</td>
<td>62</td>
<td>42</td>
<td>145</td>
</tr>
<tr>
<td>Health centre IV</td>
<td>39</td>
<td>140</td>
<td>53</td>
<td>52</td>
<td>191</td>
</tr>
<tr>
<td>General hospital</td>
<td>42</td>
<td>113</td>
<td>126</td>
<td>134</td>
<td>119</td>
</tr>
</tbody>
</table>

Fig. 4.14 shows that for health centre II facilities, the WISN for nurses exceeded the official staffing standards (“LG norms”). In fact, this was the case for all types of health centres and all health worker occupations other than nursing assistants.

Fig. 4.14 Current staffing versus staffing norms (“LG norms”) versus WISN in selected level II health centres of Uganda, 2011

<table>
<thead>
<tr>
<th>Facility/cadre</th>
<th>Current</th>
<th>LG norms</th>
<th>WISN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre II (n = 59)</td>
<td>92</td>
<td>118</td>
<td>55</td>
</tr>
<tr>
<td>Nursing assistants</td>
<td>48</td>
<td>59</td>
<td>69</td>
</tr>
<tr>
<td>Nurses</td>
<td>45</td>
<td>59</td>
<td>67</td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Health worker productivity

This indicator assesses the relationship between health workforce inputs and health service outputs. Measurement of productivity can help in assessing workloads and making decisions about where additional staff should be allocated. Note, however, that this indicator may be useful in making comparisons between facilities or subnational areas such as districts. It is less useful as an aggregate national level indicator.

The simplest way to calculate a productivity indicator is:

Productivity = Number of service units (e.g. consultations) reported / Number of health workers providing the service

Fig. 4.15 provides an example of a simple productivity estimation comparing districts based on the average number of outpatient consultations per nurse working in a dispensary.

Fig. 4.15 Average number of outpatient consultations per nurse per year in dispensaries, by district, country X
These estimations can also be converted into daily productivity, by dividing the annual number of consultations by the estimated number of working days per year.

Estimated working days per year:
(52 weeks x 5 days/week) – (20 days annual leave + 10 days sick leave + 10 days other activities) = 220

In the above example, district 19 (on the far left of the chart) had approximately 6200 outpatient consultations per nurse per year or 6200 / 220 = 28 outpatient consultations per nurse per day.

The analysis above focuses only on a single service output and a single group of health workers. Many health workers are, however, involved in more than one activity (e.g. doctors may provide consultations, assist in complicated deliveries and perform surgical procedures). Also, the average time needed to provide different service units varies substantially, from a few minutes to give a vaccine to several hours to attend a complicated delivery. Comparing the productivity of different activities and workers may therefore be difficult.

A solution to these challenges is to convert reported activities into a single unit of measure (usually minutes of staff time). This enables comparison of productivity for different activities. Box 7 presents findings from the Republic of Namibia [51], using the WISN methodology.

---

**Box 7: Assessing staff productivity using the WISN methodology**

To calculate staff productivity where more than one type of service is provided, it is necessary to estimate the optimal time required to provide each service. For example, the optimal time for an ANC consultation may be 15 minutes, while 2 hours (120 minutes) may be needed to attend a normal delivery. 100 ANC consultations would need 1500 minutes of staff time, while 10 deliveries would need 1200 minutes.

The WHO WISN methodology requires agreement among local experts on the adequate length of time needed for the most common activities (e.g. OPD consultation, caesarian section, delivery, immunization, etc.). Using the agreed time durations, a survey is conducted to assess current productivity, and overall staffing needs can be projected. Fig. 4.16 shows a partial summary of standard contact time by activity for nurses in the Republic of Namibia, produced as part of a WISN exercise.

**Fig. 4.16 Standard length of contact time for selected activities by nursing staff in Namibia, 2015**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Activity Standard EN</th>
<th>Workload EN</th>
<th>Activity Standard RN</th>
<th>Workload RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit a patient</td>
<td>20 minutes / admission</td>
<td>40% of Total admissions</td>
<td>20 minutes / admission</td>
<td>60% of Total admissions</td>
</tr>
<tr>
<td>ANC 1st visit</td>
<td>30 minutes / ANC 1st visit</td>
<td>80% of Total ANC 1st visits</td>
<td>30 minutes / ANC 1st visit</td>
<td>20% of Total ANC 1st visits</td>
</tr>
<tr>
<td>ANC revisit</td>
<td>20 minutes / ANC revisit</td>
<td>80% of Total ANC revisits</td>
<td>20 minutes / ANC revisit</td>
<td>20% of Total ANC revisits</td>
</tr>
<tr>
<td>Conduct a daily ward round</td>
<td>10 minutes / examination</td>
<td>40% of Total examinations</td>
<td>20 minutes / examination</td>
<td>80% of Total examinations</td>
</tr>
<tr>
<td>Death Lost office</td>
<td>60 minutes / death</td>
<td>40% of Total deaths</td>
<td>60 minutes / death</td>
<td>60% of Total deaths</td>
</tr>
<tr>
<td>Discharge a patient</td>
<td>10 minutes / discharge</td>
<td>40% of Total discharges</td>
<td>10 minutes / discharge</td>
<td>60% of Total discharges</td>
</tr>
<tr>
<td>Do a DBS blood test</td>
<td>15 minutes / DBS test</td>
<td>40% of Total DBS tests</td>
<td>15 minutes / DBS test</td>
<td>60% of Total DBS tests</td>
</tr>
<tr>
<td>Dressing wounds</td>
<td>20 minutes / dressing</td>
<td>40% of Total dressings</td>
<td>20 minutes / dressing</td>
<td>60% of Total dressings</td>
</tr>
<tr>
<td>Family Planning 1st visit</td>
<td>20 minutes / FP 1st visit</td>
<td>40% of Total FP 1st visits</td>
<td>20 minutes / FP 1st visit</td>
<td>60% of Total FP 1st visits</td>
</tr>
<tr>
<td>Family Planning revisit</td>
<td>10 minutes / FP revisit</td>
<td>40% of Total FP revisits</td>
<td>10 minutes / FP revisit</td>
<td>60% of Total FP revisits</td>
</tr>
</tbody>
</table>

EN – enrolled nurse; RN – registered nurse.
Medicines and medical products

A well-functioning health system ensures equitable access to essential medicines and medical products. Indicators of medicine availability enable decision-makers to re-distribute existing items according to explicit criteria, or to advocate for additional funding. Indirectly, they also provide information about the performance of the supply chain.

9. Health facilities with no stockout (of defined items)

Many health information systems use “no stockout” to define availability. Given the large variety of items, a limited number of essential medicines are used as tracers for this indicator. In the RHIS, “no stockout” usually means that the item has been present in the facility on every day of the reporting period. The indicator does not distinguish between stockouts of 1 day and those of several days. Some systems may however define a “stockout” as an amount below a defined minimum level; in other systems, the item must be unavailable for a defined number of days to consider it out of stock. For example, the WHO malaria programme defines a stockout as an absence of the item for at least 7 days in 3-month period [1]. The definition of “stockout” or “no stockout” should therefore be made explicit when presenting the indicators.

Fig. 4.17 shows the percentage of facilities reporting no stockout of a basket of 10 tracer medicines, by region in the United Republic of Tanzania [14]. The chart highlights two issues that require investigation: less than 20% of facilities nationwide had no stockouts during the period, and there are large differences across the regions.

Fig. 4.17 Percentage of facilities reporting “no stockout” of 10 tracer medicines during March 2013, United Republic of Tanzania

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1 The stockout indicator is different from other availability indicators in that it reflects stock control, rather than resource availability per population or in relation to service outputs.

2 As another example, in some health systems, vaccines are expected to be available only on select days each period. In such cases, the indicator “full availability of vaccines and supplies” assesses whether the health facility had stocks at those times when these commodities are expected to be available.
At district level, health facility stockouts of individual medical products can also be monitored as shown in Fig. 4.18.

**Fig. 4.18 Stockouts of medicines for NCDs, by clinic of district X, over a 6-month period in 2013**

<table>
<thead>
<tr>
<th>Clinic name</th>
<th>Thiazide diuretics</th>
<th>Calcium channel blockers</th>
<th>Beta-blockers</th>
<th>ACE inhibitors</th>
<th>Statins</th>
<th>Metformin</th>
<th>Glipizide</th>
<th>Glibenclamide</th>
<th>Fenofibrate</th>
<th>Sildenafil</th>
<th>Ipratropium</th>
<th>Prednisone</th>
<th>Aspirin (ASA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>C</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td>D</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
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<td>1</td>
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<tr>
<td>M</td>
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<tr>
<td>N</td>
<td>0</td>
<td>1</td>
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<td>0</td>
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<td>1</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Total no stockout</td>
<td>5</td>
<td>12</td>
<td>12</td>
<td>8</td>
<td>10</td>
<td>4</td>
<td>12</td>
<td>13</td>
<td>12</td>
<td>9</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Maximum</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>% clinics with no stockout per medicine in 6 m period</td>
<td>36%</td>
<td>86%</td>
<td>86%</td>
<td>57%</td>
<td>71%</td>
<td>29%</td>
<td>86%</td>
<td>93%</td>
<td>86%</td>
<td>64%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Financial resources**

Funds are resources in themselves, but they are also a common unit of measure of resource availability, as all other resources (e.g. health workers, medicines) can be converted into monetary values. Financial resource availability is therefore a measure of general resource availability.

However, many health systems are financed by funds from several sources including government, external donors and private payments (e.g. pre-payments, out-of-pocket expenditure). A complete analysis of this resource would require updated information on all the sources and is beyond the scope of this document. This section proposes two relatively simple indicators reflecting availability (and equity) and efficiency of financial resource use for health services delivery.

10. Health services expenditure per capita

This indicator combines financial resource data (either budget or expenditure) with population numbers. This enables decision-makers to compare administrative units and identify units with relatively less funding and therefore to correct the imbalances in subsequent budget exercises. The indicator may, however, be influenced by the presence of large referral facilities in some but not all administrative units. Such facilities disproportionately consume financial resources through highly specialized staff, sophisticated equipment and expensive medicines. These facilities may require a separate calculation and their assigned funds should reflect the combined populations of all the administrative units they serve.

Most countries conduct periodic health accounts exercises to produce health financing indicators such as the proportions of government funding or out-of-pocket expenditure relative to the total health expenditure of the country⁴.

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⁴ Data for these indicators are based upon final consumption of goods and services.
Health expenditure reviews or public expenditure tracking surveys may also be conducted, where public funding is analysed in detail. All these products are useful for informing policy, but less so for shorter term management decision-making. Furthermore, none of this information is reported through the RHIS, but is obtained through complex exercises. However, the collection of information through RHIS can be a valuable addition to the production of health accounts.

Producing financial indicators that are useful for allocation and management (and that are available from close-to-routine sources) has some challenges. Sources of information are limited to the public sector. Depending on the administrative structure of a country, annual health budgets and expenditure may either be centralized and obtainable from the ministry of health or decentralized and in the possession of local health authorities or district/provincial governments. In some cases, where budgets and their execution (e.g. payment of salaries) are significantly centralized, this information may simply not be available for lower administrative levels.

Expenditure per capita is useful for comparisons across subnational administrative units. Fig. 4.19 shows significant variation among the counties of the Republic of Kenya [19] in the amounts budgeted for health. Although per capita health budget allocations should in general be similar across subnational units within a country, there may be reasons to justify some differences, such as the presence of large referral facilities as previously noted, or the need to provide services to scattered or vulnerable populations, which is inherently more expensive.
11. Budget execution

This indicator measures the percentage of a budget that has been spent. It may be calculated for the total budget or by budget line/item.

Budgets usually are allocated for a fiscal year and their execution is reported continuously, monthly or quarterly, according to the system enforced by the ministry of finance. At the end of the fiscal year, execution should be close to 100%. If it is substantially lower (or higher) than this, the reasons should be investigated, e.g. cash flow problems in the ministry of finance resulting in failure to disburse allocated budgets, cumbersome execution procedures, poor performance of health system managers or budgeting for funds in excess of needs.
Fig. 4.20 shows that the Ministry of Health of Ghana selected this as one of 53 core indicators for monitoring their programme of work [53].

Fig. 4.20 Trend in Ministry of Health budget execution, Ghana, up to 2014

<table>
<thead>
<tr>
<th>2014 Performance: 61%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 Target: &gt; 80%</td>
</tr>
<tr>
<td>Source: MOH</td>
</tr>
<tr>
<td>Trend: Improving (9%)</td>
</tr>
<tr>
<td>Target: Not achieved</td>
</tr>
</tbody>
</table>

Note that budget execution does not truly assess the efficiency of expenditures as funding may have been used wastefully. This indicator does, however, help to identify problems with the disbursement of funds or problems with realistic budgeting.

Calculation of the indicator for different budget lines is useful as a quarterly exercise. The pattern of execution for the various lines may be very different (e.g. salaries are systematically paid each month, while medicines may be purchased in one or two annual procurement exercises). A quarterly exercise can therefore identify issues in individual budget lines and so enable timely corrective actions.

Fig. 4.21 presents a simple table used to monitor cumulative quarterly expenditures against the major lines of an annual district budget. The most revealing information is seen in the two columns at the far right of the table: the expected balance at the start of Quarter 4 is equal to 25% of annual budget; the actual balance is the actual amount of the annual budget that is remaining.

The example shows that Lupara district has spent more than was originally budgeted on line 1 and line 2 during Quarter 3. This resulted from unanticipated field expenses in Quarter 3 related to a vaccination campaign in response to a measles outbreak. Consequently, the actual balance is less than the expected balance for lines 1 and 2 and for the budget overall.

Fig. 4.21 Summary of 2019 budget execution, Lupara district, as of the end of Q3 2019

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1 The 2014 Holistic Assessment of the Health Sector Programme of Work [52] notes that “One possible contributing factor to low execution rate is difficulties in accessing the funds through the GIFMIS [Ghana Integrated Financial Management Information System of the Ghana Ministry of Finance]. Procedures are cumbersome and funds get locked up in the system inaccessible to the recipient.”
References


2. 2018 Global reference list of 100 core health indicators (plus health-related SDGs). World Health Organization (https://apps.who.int/iris/handle/10665/259951).


25 International Health Regulations [Website]. World Health Organization (https://www.who.int/health-topics/international-health-regulations#tab=tab_1, accessed 15 November 2022).


