IASC
Inter-Agency Standing Committee

Global Health Cluster

GLOBAL HEALTH CLUSTER SUGGESTED SET OF CORE INDICATORS AND BENCHMARKS BY CATEGORY

Category	#	Name of indicator	Type	Data collection method	Benchmarks	Comments
Health resources availability	A.1	Average population per functioning health facility (HF), by type of HF and by administrative unit	Input, proxy	HeRAMS	SPHERE standards: 10 000 for1 Health Unit, 50 000 for 1 Health Centre, 250 000 for 1 Rural/District Hospital	Proxy indicator of geographical accessibility, and of equity in availability of health facilities across different administrative units within the crisis areas.
	A.2	Number of HF with Basic Emergency Obstetric Care/ 500 000 population, by administrative unit	Input, proxy	HeRAMS	>= 4 BEmOC/500 000	Proxy indicators for the physical availability and geographical accessibility of emergency obstetric services and their distribution across districts in the affected areas. An unbalance between the availability of BEmOC and CEmOC (with too few BEmOC) is often observed.
	A.3	Number of HF with Comprehensive Emergency Obstetric Care/500 000 population, by administrative unit	Input	HeRAMS	>= 1 CEmOC/500 000	
	A.4	Percentage of HF without stock out of a selected essential drug in 4 groups of drugs, by administrative unit	Input	IRA	100%	Indicator for the effectiveness of the procurement and distribution of essential drugs, and proxy indicator of the quality of care. Its comparison across the crisis areas and its monitoring over time is very important.
	A.5	Number of hospital beds per 10 000 population (inpatients & maternity), by administrative unit	Input	HeRAMS	> 10	Indicator for the availability of hospital beds across crisis areas and proxy indicator of equity in the allocation of resources.
	A.6	Percentage of HF with clinical management of rape survivors + emergency contraception + PEP available	Input	HeRAMS	100%	Key indicator to measure the allocation of resources and the availability of services to address consequences of sexual violence.
	A.7	Number of health workers (medical doctor + nurse + midwife) per 10 000 population, by administrative unit (% m/f)	Input	HeRAMS	> 22	Key indicator to monitor the availability of health workers. It can serve as a proxy to monitor equity in the allocation of resources by humanitarian actors across different groups within the humanitarian case load and/or crisis affected population versus local populations. No consensus about optimal level of health workers for a population. It can be broken down according to the type of health worker to present the workforce mix.
	A.8	Number of CHWs per 10 000 population, by administrative unit	Input	HeRAMS	>= 10	Indicator monitoring the availability of human resources key to delivering community-based intervention.
Health services coverage	C.1	Number of outpatient consultations per person, per year, by administrative unit	Output, proxy	HIS / EWARS	> = 1 new visit/person per year	Proxy indicator for accessibility and utilization that may reflect the quality of services. It does not measure the coverage of this service, but the average number of visits in a defined population.
	C.2	Number of consultations per clinician, per day, by administrative unit	Output	HIS	Less than 50/day per clinician	Measure for the workload and proxy indicator of the quality of care.
	C.3	Coverage of measles vaccination (6 months–15 years)	Output	HIS, survey	> 95% in camps or urban areas > 90% in rural areas	These indicators are used for estimating the vaccine coverage of the total EPI strategy. To avoid overestimation, measles vaccination coverage is often used as a proxy since it is usually lower than DPT3 coverage. Both indicators should be calculated on a yearly basis. Good indicators of health system performance.
	C.4	Coverage of DTC3 in < 1 year old, by administrative unit	Output	HIS, survey	> 95%	

Category	#	Name of indicator	Type	Data collection method	Benchmarks	Comments
Health services coverage	C.5	Percentage of births assisted by a skilled attendant	Output	HIS, survey	> 90%	Measure for the utilization rate of obstetrics services in health facilities and in communities where Village-Trained Midwives are operating. It can serve as a proxy for monitoring progress.
	C.6	Percentage of deliveries by Caesarean section, by administrative unit	Output	Prospective HF based surveillance	>= 5% and <= 15%	Number of deliveries by C section for a given period over the expected number of births during the same period. Denominator should be calculated by using the fertility rate by age class and region (e.g. obtained via demographic and health surveys). In Sub-Saharan Africa, for instance, the expected proportion of births is between 4 and 5 % of the total population. It can serve as a proxy for monitoring progress.
Risks factors	R.1	Number of cases or incidence rates for selected diseases relevant to the local context (cholera, measles, acute meningitis, others)	Outcome	EWARS, IRA, prospective HF based surveillance, surveys	Measure trends	Useful measure of the burden of diseases. The list of diseases is context-specific. Health facility surveillance may have low sensitivity for conditions that do not commonly go to clinic. Access to health services is another factor.
	R.2	Number of cases or incidence of sexual violence	Outcome	Prospective HF based surveillance, surveys	Measure trends	Health facility surveillance may have low sensitivity for conditions that do not commonly go to clinic, also depends on access to health services. Can be very sensitive and difficult to measure, requires highly trained staff to collect data.
	R.3	CFR for most common diseases	Outcome, proxy	Prospective HF based surveillance	Measure trends	Mixture of disease severity and of quality of health care. Most likely will be biased upwards because only more severe cases normally go to clinic.
	R.4	Proportional mortality	Outcome, proxy	Prospective HF based surveillance	Measure trends	Non-violent versus violent causes of death.
	R.5	Number of admissions to SFT and TFC	Outcome, proxy	Prospective HF based surveillance	Measure trends	Proxy for measuring trends. Pre-requirements such as stability of quality of care and access are needed (validity not demonstrated).
	R.6	Proportion/number of U5 GAM and SAM cases detected at OPD/IPD	Outcome, proxy	Prospective HF, SFC and TFC based surveillance	Measure trends	Proxy for measuring trends, preferably through MUAC I must be seen in light of the context (national policy, existence of nutrition programmes) (validity not demonstrated).
	R.7	Proportion of people with <15L of water/day			Measure trends	L/person per day is more informative because it is continuous. Since the L/p/day must be measured, presenting the actual figure, rather than a yes/no variable, is more informative.
Health outcomes	O.1	CMR	Outcome	HH survey	>=2 x base rate OR >1/10 000 per day*	
	O.2	U5MR	Outcome	HH survey	>=2 x base rate OR >2/10 000 per day*	Difficult to measure in surveys with sufficient precision. A very large sample size is needed.
	O.3	Prevalence of GAM	Outcome	HH survey	< 10 %, measure trends	
	O.4	Prevalence of SAM	Outcome	HH survey	Measure trends	Difficult to measure in surveys with sufficient precision. A very large sample size is needed.
	O.5	Percentage of the population in worst quintile of functioning, including those with severe or extreme difficulties in functioning	Outcome	WHODAS 2.0*, population survey	Thresholds have to be defined according to the local context and the nature of the crisis. Measure trends	WHODAS 2.0* is a tool that can be used to assess and monitor the overall health status of crisis-affected populations, measuring the level of functioning/disability. The instrument is applicable across cultures, it captures the level of functioning in six domains of life (i.e. cognition, mobility, self-care, getting along, life activities, participation), and allows to compute domain-specific and a summary score of disability.

* *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule* WHODAS 2.0, WHO 2010 (in press).