Module 1.1
Monitoring Primary Health Care (PHC) Program Performance

Trainer:.....

Module 1.1: Objectives

At the end of this module, participants will be able to:

1. Appreciate the importance of measuring district health system/program performance.
2. Learn about the different types of indicators that can be used to inform on system/program performance.
3. Develop a logic model for an existing district level primary health care program.

Module outline

Sr. No.	Session name	Session format	Duration
1	Introduction • Public health system in India • Primary health care (PHC) performance measurement	Facilitator led presentation and discussion	40 min
2	Logic model framework for measuring PHC performance	Facilitator led presentation and discussion	30 min
3	Developing a logic model framework for an existing PHC program	Group exercise	40 min

Pre-readings

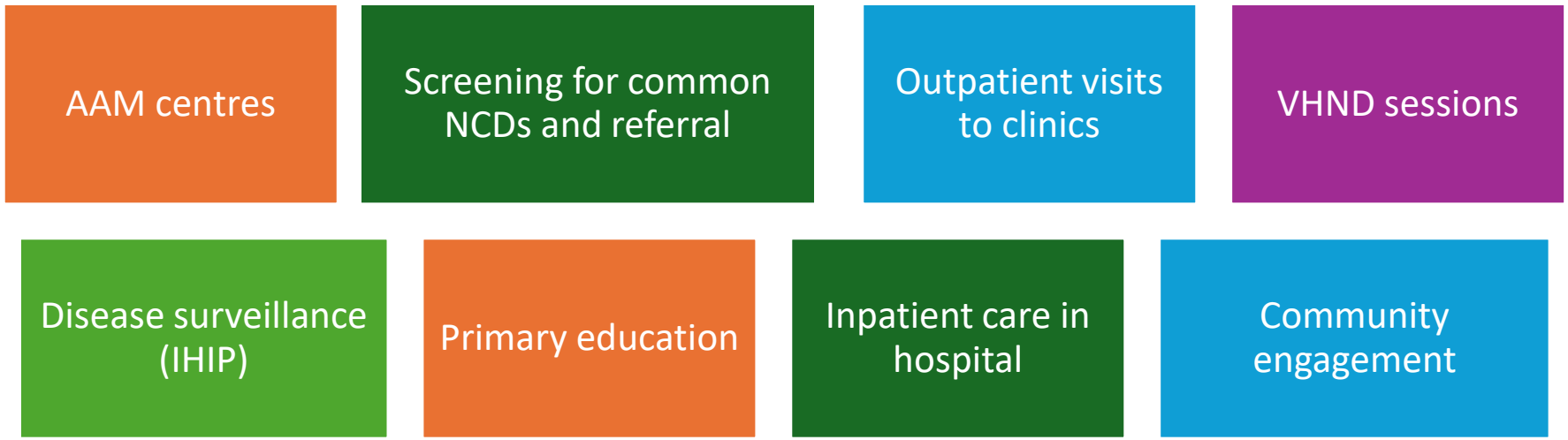
1. World Health Organization and the United Nations Children's Fund (UNICEF), 2022. Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens.

Session 1:
Introduction to primary health care (PHC) performance measurement

Duration: 40 min

Introduction to primary health care

- What do you think is included under primary health care (PHC)?



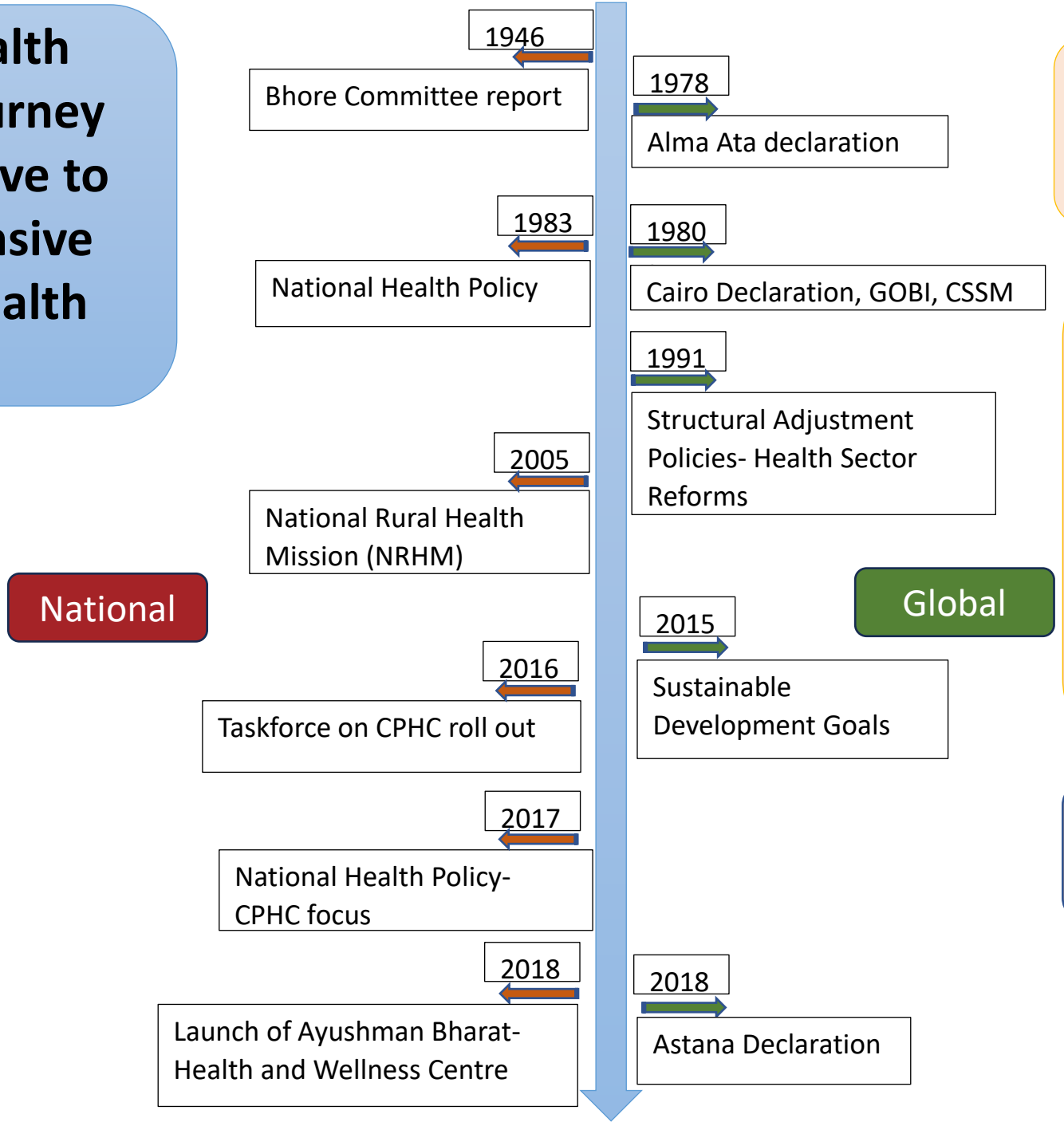
Conceptualizing Primary Health Care (PHC)



Source: A vision for primary health care in the 21st century. Geneva: WHO and UNICEF, 2018 (WHO/HIS/SDS/2018.X).

- Broader determinants of health
- Empowering individuals, families, and communities to optimize their health
- Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care services
  - ➢ Provided in communities by community-based workers
  - ➢ Provided in facilities by workers without specialized training and expensive diagnostic and laboratory support.

India's health system: Journey from Selective to Comprehensive Primary Health Care



1950 to 1980- Focus on Family planning, maternal and child survival and few communicable diseases- malaria

1990s

- Government health care systems focus on narrow range of services, leaving the rest to private sector
- User fees- barrier
- Referral for most cases especially NCDs to secondary care facilities-> weakening of PHC systems

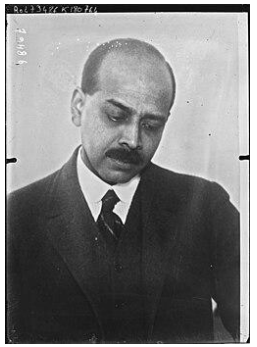
2005-2015- NHM; focus on CPHC, but low funding for PHC over the decade

2018- Launch of Ayushman Bharat- Health and Wellness Centre for provision of CPHC

Public Sector Health System: Bhore Committee

- The Bhore Committee Report (1946) is the foundational document of India's health system.

- The Bhore Committee (headed by Sir Joseph Bhore) was set up in 1943 by the Viceroy of British India to come up with a blueprint for health service development in India
  - ➢ rooted in the concept of 'social medicine' i.e. focus on social determinants of health, community engagement
  - ➢ proposed a three-tier structure consisting of primary, secondary and tertiary levels of care to delivery
  - ➢ national health service publicly financed and managed so all can afford health care



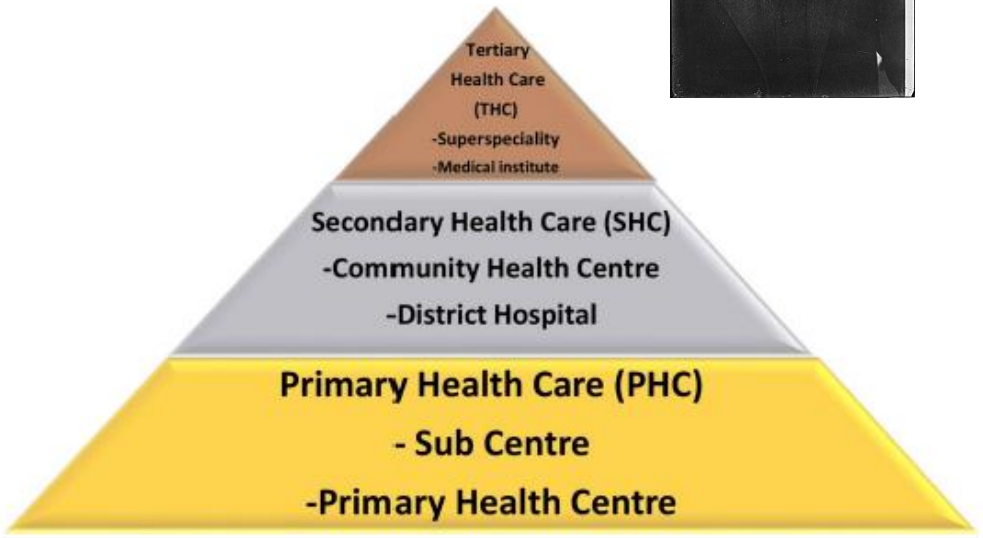


FIGURE 2: The three-tier health care system given by the Bhore Committee

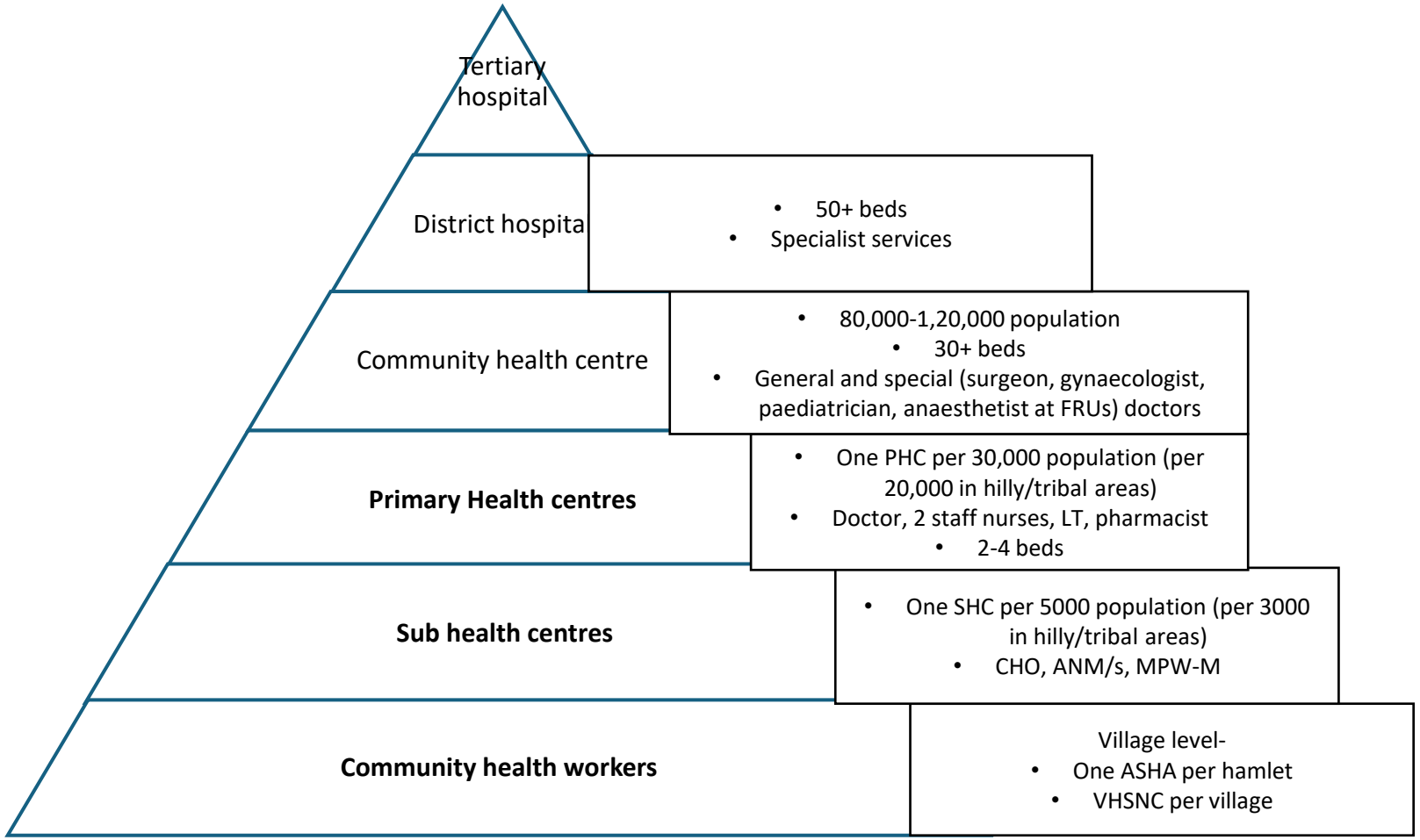
Sources: Baru, Rama V. **The Bhore Committee and recent debates.** https://www.india-seminar.com/2019/714/714_rama_v_baru.htm**;** Handa A, Choudhari SG, Gaidhane A. Joseph William Bhore (1878-1960): The Architect Behind the Bhore Committee Legacy. Cureus. 2024 Aug 21;16(8):e67405.

Public Sector Health System









Reforms: National Health Mission (2005)

- Two components - The National Rural Health Mission (NRHM) and The National Urban Health Mission (NUHM)

- Focus on system strengthening, reproductive-maternal- neonatal-child and adolescent health (RMNCH+A), and communicable diseases.

- System strengthening reforms
  - Increased funding for health
  - improved infrastructure, human resources, coverage.
  - Introduction and expansion of community health workers (ASHA)
  - Consolidate vertical programs (except HIV/AIDS)
  - Conditional cash transfers for institutional deliveries (JSY)
  - Community engagement: ASHAs, RKS/HMS
  - Decentralized financing: untied funds



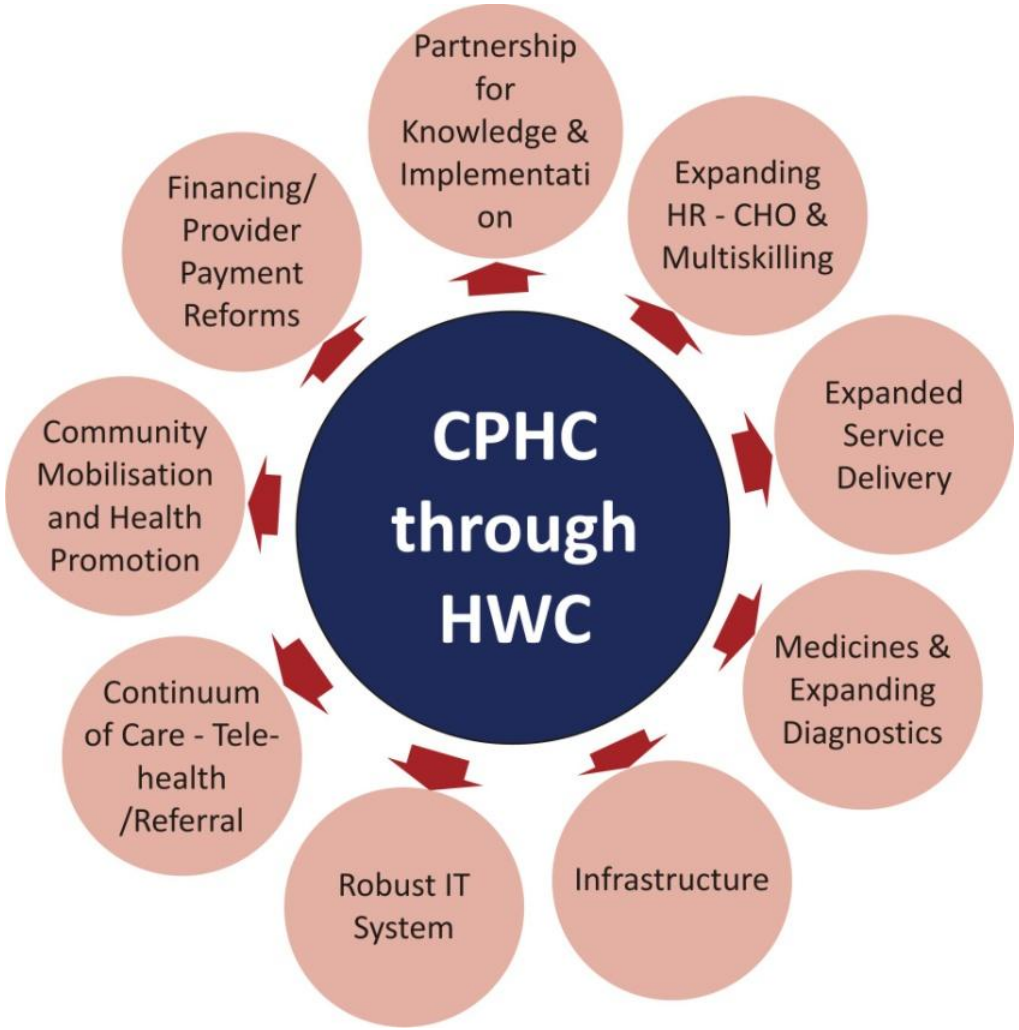
Reforms: Ayushman Bharat – Health & Wellness Center

- 2017 National Health Policy – Strengthen comprehensive PHC by establishing Health and Wellness Centers (HWC or AAM)
- 2018- Ayushman Bharat was launched to achieve the vision of Universal Health Coverage (UHC)
  - ➢ Creation of 150,000 AAMs by transforming existing sub-centers and primary health centers.
- Key innovations
  - ➢ Moves beyond traditional maternal-child health focus
  - ➢ Mid-Level Healthcare Provider (MLHP)
  - ➢ Brings facility based PHC services closer to communities



Figure 1: CPHC 12 service packages

PHC through AAM Centres



Key reforms:

1. Expanded package of services
2. Health promotion and wellness
3. Reaching the last mile
4. Ensuring continuum of care from community to facility
5. Team based approach

Source: NHSRC (2018), Operational guidelines for comprehensive primary health care through health and wellness centres

District health programs and PHC

- Reproductive and child health
- Non-communicable diseases
- TB
- Leprosy
- Vector-borne diseases
- Sickle-cell
- RBSK
- Quality of care programs e.g. NQAS
- Community processes
- IEC/BCC

Which of the following PHC components do these district program services belong to:

1. Primary care
2. Empowered people and communities
3. Intersectoral policy and action

Which of the following PHC components does the vector borne disease services belong to?

Primary care

0%

Empowered people and communities

0%

Intersectoral policy and action

0%

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Which of the following PHC components does the RCH services belong to?

Primary care

0%

Empowered people and communities

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Intersectoral policy and action

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Why measure health systems performance

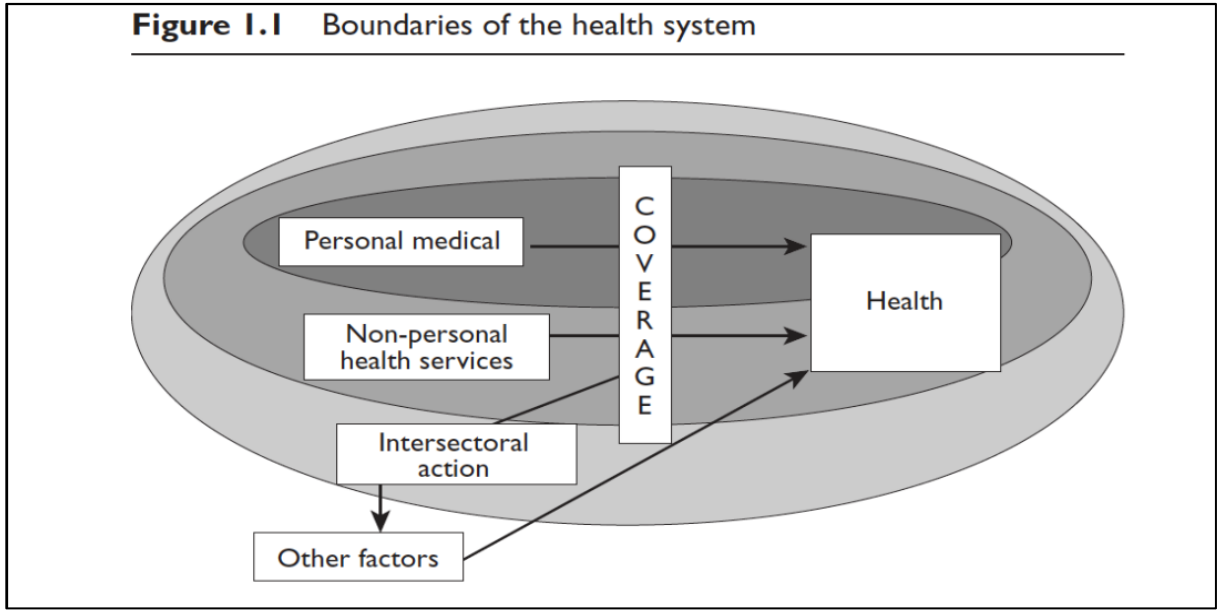
Health system performance assessments are conducted for various reasons:

- diagnosis of health system problems to motivate health system reforms
- monitoring and evaluation of systems performance
- enable comparisons in performance across facilities/blocks/districts.
- relate what happens within the health system to the health of the population.

Key considerations while measuring PHC performance

1. What are the system/program boundaries i.e. activities/services that constitute the program?
2. What are the system/program goals?
3. What factors influence system/program performance?
4. How do system/program performance factors link to system/program goals?

Measuring PHC Performance

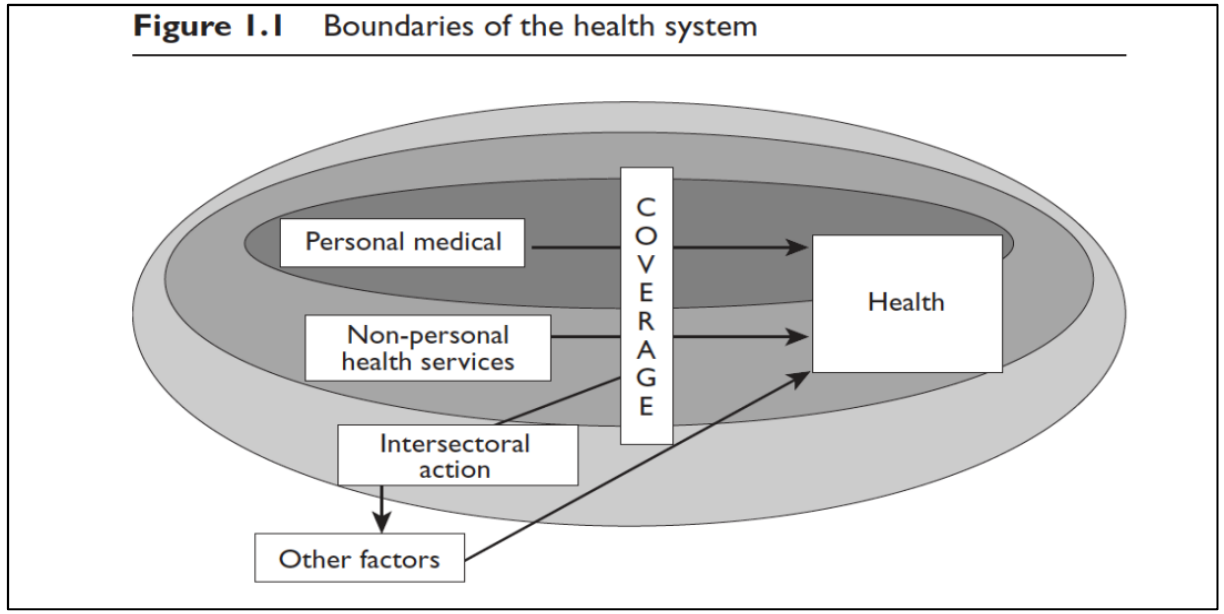


1. **What are the system/program boundaries?**
2. What are the system/program goals?
3. What factors influence system/program performance?
4. How do performance factors link to system/program goals?

- Health system/program boundaries can be set ‘narrowly’ (e.g. personal medical services) or ‘broadly’ (e.g. personal, non-personal and inter-sectoral action)
- A broad boundary provides a comprehensive picture of the factors that influence system/program performance; however, activities withing a narrower boundary are typically better attributable to the actions of health workers.

Source: Murray and Evans, Health Systems Performance Assessment, 2003.

Measuring PHC performance

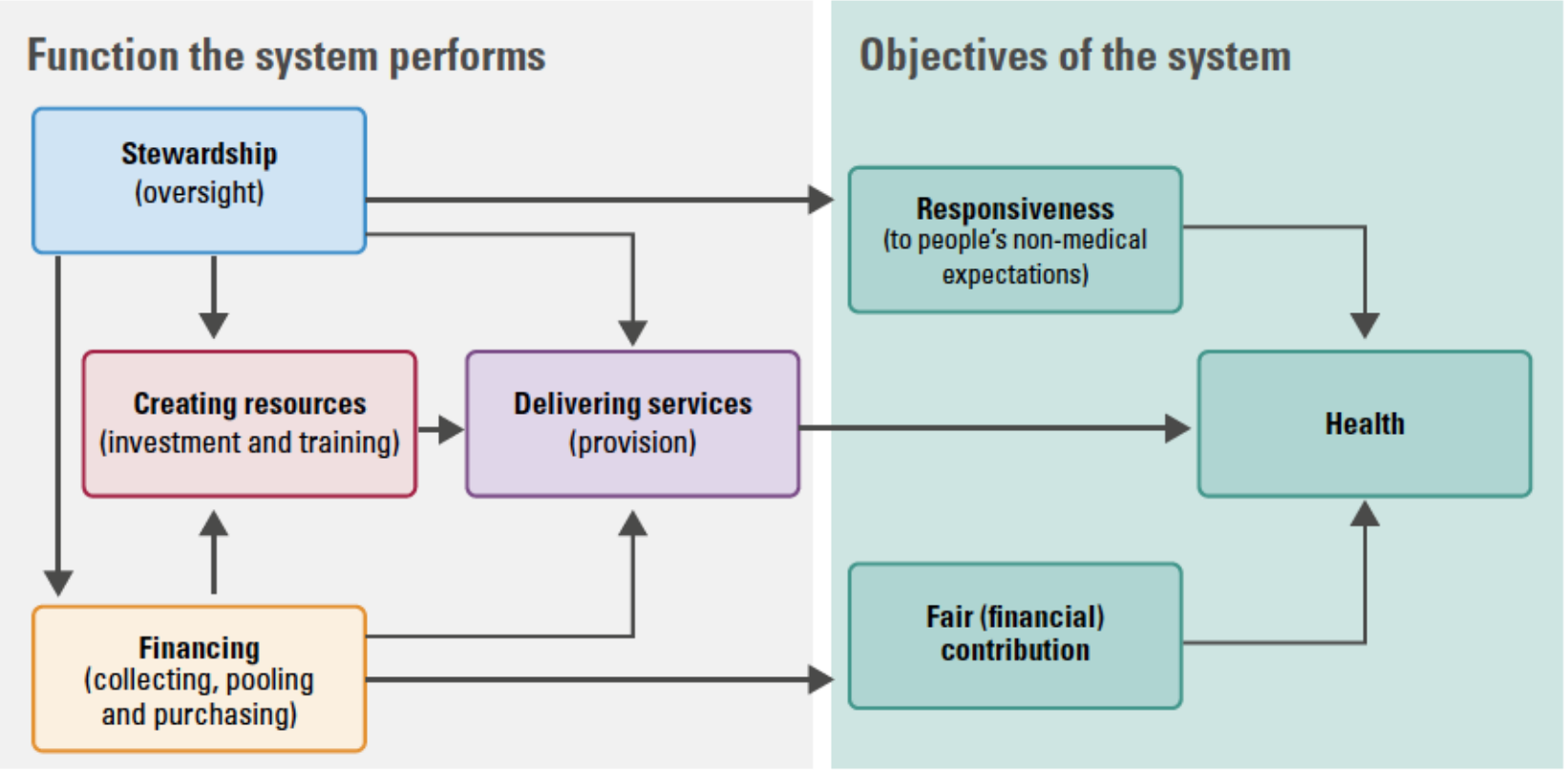


In your district, PHC services are delivered through various health facilities. Which of the following services/activities will you classify as “personal medical”, “non-personal health service”, or “intersectoral action”:

- Outpatient visits to Primary Health Centers
- Hypertension screening by CHOs
- Tobacco control messaging on the radio
- Health education in schools
- Village level meetings/VHSNC
- Taxes on sugary drinks

Source: Murray and Evans, Health Systems Performance Assessment, 2003.

Measuring PHC performance

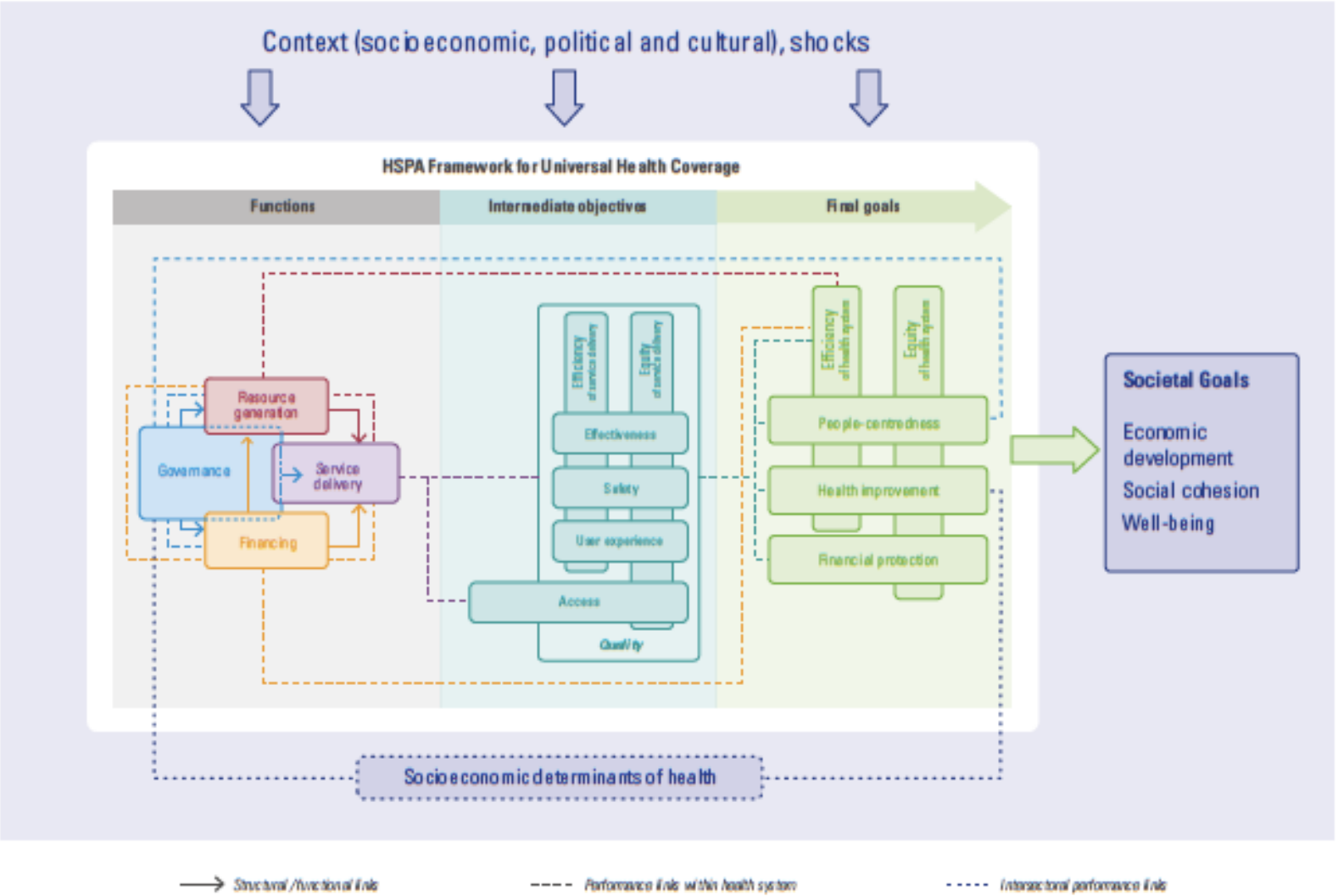


Source: WHO (2000).

1. What activities/services are part of PHC?
2. **What factors influence PHC performance?**
3. **What are the PHC system goals?**
4. **How do PHC performance factors link to PHC goals?**

Source: Papanicolas I, Rajan D, Karanikolos M, Soucat A, Figueras J, editors. Health system performance assessment: a framework for policy analysis. Geneva: World Health Organization; 2022 (Health Policy Series, No. 57). Licence: CC BY-NC-SA 3.0 IGO

Measuring PHC performance



1. What activities/services are part of PHC?
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Source: Papanicolas I, Rajan D, Karanikolos M, Soucat A, Figueras J, editors. Health system performance assessment: a framework for policy analysis. Geneva: World Health Organization; 2022 (Health Policy Series, No. 57). Licence: CC BY-NC-SA 3.0 IGO

Measuring PHC performance at the district level

- What are the different ways in which PHC performance is currently monitored in the district?

Current mechanisms for PHC performance measurement

PHC performance is being monitored at various levels through different mechanisms:

- State level
  - State health index
  - NHM conditionalities
  - NHM PIP meetings
- District
  - NHM conditionalities
  - Routine program reports
  - State review meetings
- Sub-district
  - Routine program reports
  - Sectoral meetings for review
- Facility
  - Routine program reports
  - Performance on team-based incentives

Example of monitoring mechanisms: NHM key deliverables

S No.	Indicator Type	Indicator Statement	Indicator	Unit	Target 2024-25	Target 2025-26	Source of data
110	Output	Provision of primary and secondary Geriatric health care services at District Hospital and below	**Numerator:** No. of DH with Geriatric Unit (at least10 beds) **Denominator:** No. of total DH in the state	Number	8	8	NPHCE QPR
111	Output	Provision of primary and secondary Geriatric health care services at District Hospital and below	**Numerator:** No. of DH with physiotherapy unit forelderly **Denominator:** No. of total DH in the state	Number	8	8	NPHCE QPR
112	Output	Provision of primary and secondary Geriatric health care services at District Hospital and below.	**Numerator:** No. of CHCs with physiotherapy unit **Denominator:** No of total CHCs in the state	Number	28	28	NPHCE report
National Programme for Non-Communicable Diseases (NP-NCD)							
113	Input	population (30+) registered for NCD Services	**% of population (30+) registered in the National NCD portal**	Percentage	12,50,230	12,61,700	National NCD Portal
114	Process	population screened for NCD	**% of population screened for Hypertension**	Percentage	12,50,230	12,61,700	National NCD Portal
115	Process	population screened for NCD	**% of population screened for Diabetes**	Percentage	12,50,230	12,61,700	National NCD Portal

Source: NHM Administrative Approval (RoP) FY 2024-25-FY 2025-26 for a state

Example of monitoring mechanisms: NHM conditionalities

- One of the monitoring frameworks used by MoHFW to disburse funds to the States
- Includes indicators directly assessing the PHC system performance- AAM scoring

Annexure 3: Conditionalities Framework 2024 - 2026

Full Immunization Coverage (%) to be treated as the screening criteria. Conditionalities to be assessed only for those EAG, NE and hilly states which achieve at least 85% full Immunization Coverage. For rest of the States/UTs, the minimum full Immunization Coverage to be 90%.

S. No.	Conditionalities	Indicators of 2024-26	Source of verification	% Incentive/Penalty
		Based on overall score of AAM conditionality (out of 100 marks)		
1.	AAM State/UT Score	a. Score more than 75: +25 b. Score more than 50 or less than or equal to 75: +15 c. Score more than 25 but lessthan or equal to 50: -15 d. Score less than or equal to 25: -25	AAM portal	+25 to -25
		DVDMS implementation up to		
2.	Implementation of DVDMS or any other logistic management IT softwarewith API linkages to DVDMS up to PHC level	**AAM-SC** a. In 100% **AAM-SHC**: +5 b. 80% or above but less than 100%: +3 c. 50% or above but less than 80%: 3 In less than 50%: -5	DVDMS Portalor Any other similar systemwith API linkages to DVDMS	+5 to -5

Source: NHM Administrative Approval (RoP) FY 2024-25-FY 2025-26 for a state

NHM conditionalities- AAM scoring

Ayushman Arogya Mandir Scoring for NHM Conditionality FY 2024-25 and 2025-26

Method for giving Score to the State for AAM (it has two Parts):

1. Indicator for achieving State Level AAM operationalization Targets:
   a. State level 100% of AAM operationalization against latest RHS – 15 marks
   b. Creation of regular cadre of CHO - 10 marks
2. AAM functionality - 75 marks, consists of 9 indicators – Average scoring of all the functional AAM will be taken to arrive at the same.

SN	Indicator	Unit	FY 2024-25		FY 2025-26		Source
			Max Scorefor SHC-AAM/U-AAM	Max Score for PHC-AAM/UPHC	Max Score for SHC-AAM/U-AAM	Max Score for PHC-AAM/UPHC	
1	AAM-01: Functional AAM providing all 12 expanded range of services	%	10	5	10	5	AAM Portal
2	AAM-02: Functional AAM reporting at least average footfall as per (norm of 60 footfalls per 1000 population): - Rural: SHC-AAM @ 300/month; PHC-AAM @ 1800/month - Urban: U @ 1200/month; UPHC-AAM @ 3000/month - Tribal: SHC-AAM @ 180/month; PHC-AAM @ 1200/month	%	10	10	10	10	AAM portal
3	AAM-03: AAM fulfilling expanded range of medicines and diagnostics as per Essential list of both (Medicines: SHC-AAM- 105; PHC-AAM-171 & diagnostics: SHC- AAM- 14; PHC-AAM- 63)	%	10	5	10	5	AAM Portal
4	AAM-04: AAM providinga minimum of 10 Wellness sessions per month	%	10	10	10	10	AAM portal
5	AAM-05: Functional AAM scoring more than70% in Kayakalp peer assessment	%	10*		10*		Kayakalp report
6	AAM-06: Utilization of National NCD App for screening and tracking of all NCD patients.	%	5	10	5	10	National NCD Portal
7	AAM-07: % of operational AAM providing active Teleconsultation services	%	5*		5*		e- Sanjeevani application
8	AAM-08: Functional AAM with JAS constituted and conducted at least 10 meetings in a year.	%	10	10	10	10	AAM portal
9	AAM-9: AAM whose primary healthcare teams have received timely incentives *(Performance Linked Payment and Team Based Incentives) at* least 10 times a year	%	5	10	5	10	AAM portal

* For Kayakalp and teleconsultation any AAM (SHC or PHC) fulfilling the criteria are scored.

- Comprises 9 indicators assessing performance of AAM facilities

Source: NHM Administrative Approval (RoP) FY 2024-25-FY 2025-26 for a state

Summary: PHC performance measurement

1. Important to measure PHC performance to understand the gaps for improvement, compare performance across units, and relate health system performance with population health.

2. While measuring PHC performance we must consider-
   - What are the system/program boundaries?
   - What are the system/program goals?
   - What factors influence system/program performance?
   - How do performance factors link to system/program goals?

3. Existing monitoring frameworks provide a partial view of PHC system/program performance assessment.

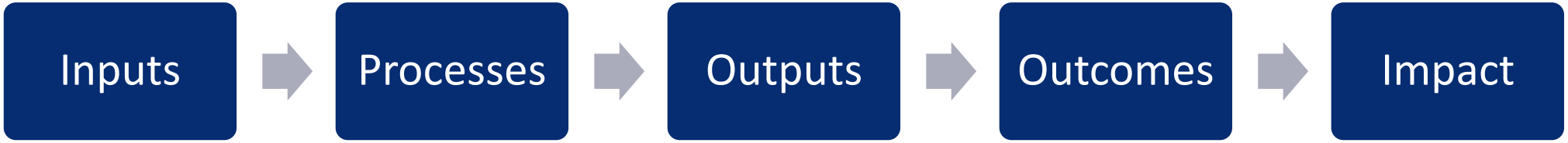
Break

Duration: 10 min

Session 2:
Logic model framework for measuring PHC performance

Duration: 30 min

Logic model framework



- A logic model is defined as a graphical/textual representation of how a program is intended to work and links outcomes with processes and the theoretical assumptions of the program.

Source: Kellogg, W. K. (2004). Using Logic Models to Bring Together Planning. Evaluation, and Action: Logic Model Development Guide.

Logic model: NHM key deliverables

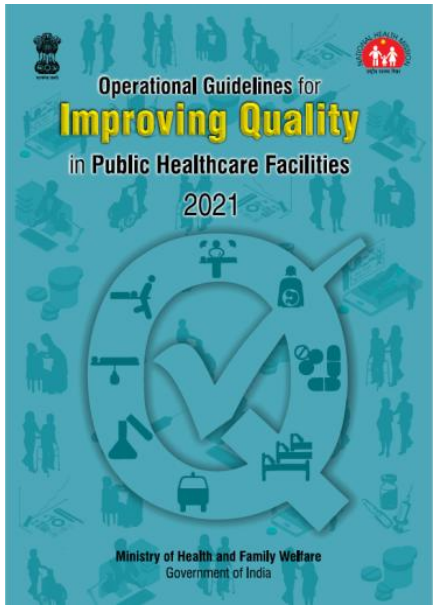
NHM key deliverables

- Example of NCD program indicators

National Programme for Non-Communicable Diseases (NP-NCD)							
113	Input	population (30+) registered for NCD Services	% of population (30+) registered in the National NCD portal	Percentage	12,50,230	12,61,700	National NCD Portal
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115	Process	population screened for NCD	% of population screened for Diabetes	Percentage	12,50,230	12,61,700	National NCD Portal
116	Output	Patient put on treatment	% of people on standard of care for Hypertension against target population	Percentage	98,560	1,08,416	National NCD Portal

Source: NHM Administrative Approval (RoP) FY 2024-25-FY 2025-26 for a state

Logic model - NQAS



Guidelines for NQAS certification

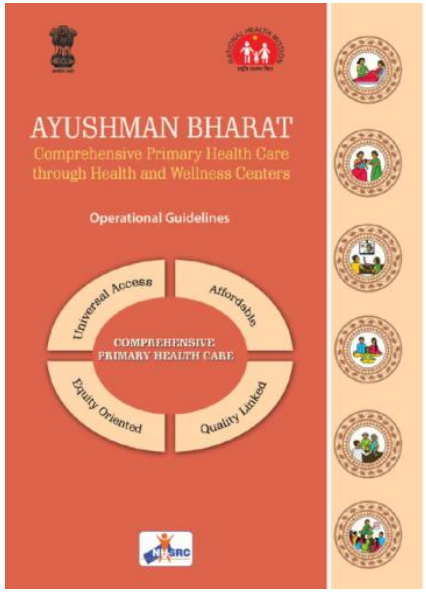
- Quality of care described in terms of 'inputs', 'processes', and 'outcomes'

Source: Operational guidelines for improving quality in public healthcare facilities, MoHFW, 2021

Table 2.1: QOC IN TERM OF INPUTS, PROCESS & OUTCOME

Stakeholders	Inputs	Process	Outcome
Patients' Expectations	• Barrier Free Access - Prompt & courteous services - No exclusion based on caste and socio-economic status • Clean & Inviting environment at the health facility • Availability of services • Availability of drugs and consumables	• Minimal waiting time & Prompt referral, if required • Good behaviour by service providers • Privacy & confidentiality • Grievance Redressal • Access to Information and involvement in decision making for the care	• No out-of-pocket expenditure • Availability of services as guaranteed • High Patient Satisfaction • Treatment and Cure
Service Providers Requirements	• Adequate and planned infrastructure • Serviceable & calibrated Equipment • Availability of Quality Drugs • Human Resource in numerical adequacy with knowledge and skills • Enabling Work Environment	• Adherence to clinical Protocols • Infection Control Practices • Training and Skill Development • Safe and effective Nursing care	• Low Mortality, Morbidity, complications, and Referrals, etc. • Effectiveness of the care in term of average length of stay, bed occupancy, etc • Low Adverse drug reactions and Hospital acquired infection • High Employees' Satisfaction
Health Systems Requirements	• Allocation of adequate resources • Facilities provide full range of services • Adequate Technical Support	• Efficient logistics management • Monitoring and Supervision • Effective implementation of programmes	• Optimal utilization of resources • Measurable deliverables of programmes • Improvement in Health Indicators • Enhanced Productivity in terms of volume

Logic model - AAM Operational Guidelines



2.2. Inputs for Health Wellness Centres

The ***key inputs*** to be provided at a HWC are listed below:

2.2.1 **Primary health care team** to deliver the expanded range of services.

a. **At the upgraded SHC** – A team of at least three service providers (one Mid-level provider, at least two (preferably three) Multi-Purpose Workers – two female and one male, and team of ASHAs at the norm of one per 1000.

b. **At the strengthened PHC –** PHC team as per IPHS standards. Although all the PHCs have been expected to provide 24*7 nursing care, this has not been possible in several states for variety of reasons. In 24*7 PHCs having inpatient care, an additional nurse should be posted where cervical cancer screening is being undertaken/ planned. In PHCs that are not envisaged to provide inpatient care, the existing nurses should receive modular training in certificate course for primary care. In urban areas, the team would consist of the MPW- F (for 10,000 population) and the ASHAs (one per 2500).

2.2.2 **Logistics** – Adequate availability of essential medicines and diagnostics to support the expanded range of services, to resolve more and refer less at the local levels, and to enable dispensation of medicines for chronic illnesses as close to communities as possible.

2.2.3 **Infrastructure –** Sufficient space for outpatient care, for dispensing medicines, diagnostic services, adequate spaces for display of communication material of health messages, including audio visual aids and appropriate community spaces for wellness activities, including the practice of Yoga and physical exercises.

2.2.4 **Digitization –** HWC team to be equipped with tablets/smart Phones to serve a range of functions such as: population enumeration and empanelment, record delivery of services, enable quality follow up, facilitate referral/continuity of care and create an updated individual, family and population health profile, and generate reports required for monitoring at higher levels.

2.2.5 **Use of Telemedicine/IT platforms –** At all levels, teleconsultation would be used to improve referral advice, seek clarifications, and undertake virtual training including case management support by

2.4. Essential Outputs of HWC

2.4.1 **The HWC Data Base:** Population enumeration and empanelment implies the creation and maintenance of database of all families and individuals in an area served by a HWC. This is planned such that every individual is empanelled to a HWC. This also involves active communication to make residents aware of this facility.

2.4.2 **Health Cards and Family Health Folders:** These are made for all service users to ensure access to all health care entitlements and enable continuum of care. The health cards are given to the families and individuals. The family health folders are kept at the HWC or nearby PHC in paper and/or digital format. This ensures that every family knows their entitlement to healthcare through both HWC and the Pradhan Mantri Jan Arogya Yojana or equivalent health schemes of state and central government.

2.4.3 **Increased Access to Services:** HWCs would provide access to an expanded range of services indicated in Box 2.2. The availability of services would evolve in different states gradually, depending on three factors- the availability of suitably skilled human resources at the HWC, the capacity at district/sub-district level to support the HWC in the delivery of that service, and the ability of the state to ensure uninterrupted supply of medicines and diagnostics at the level of HWC. States will also have the flexibility to expand the range of service to address local health problems as defined by disease prevalence.

2.5. Outcomes

2.5.1 **Improved population coverage:** Active empanelment and HWC database will improve the population coverage. The HWC database would enable HWC staff to monitor and identify the left out population and improve coverage of national health programmes.

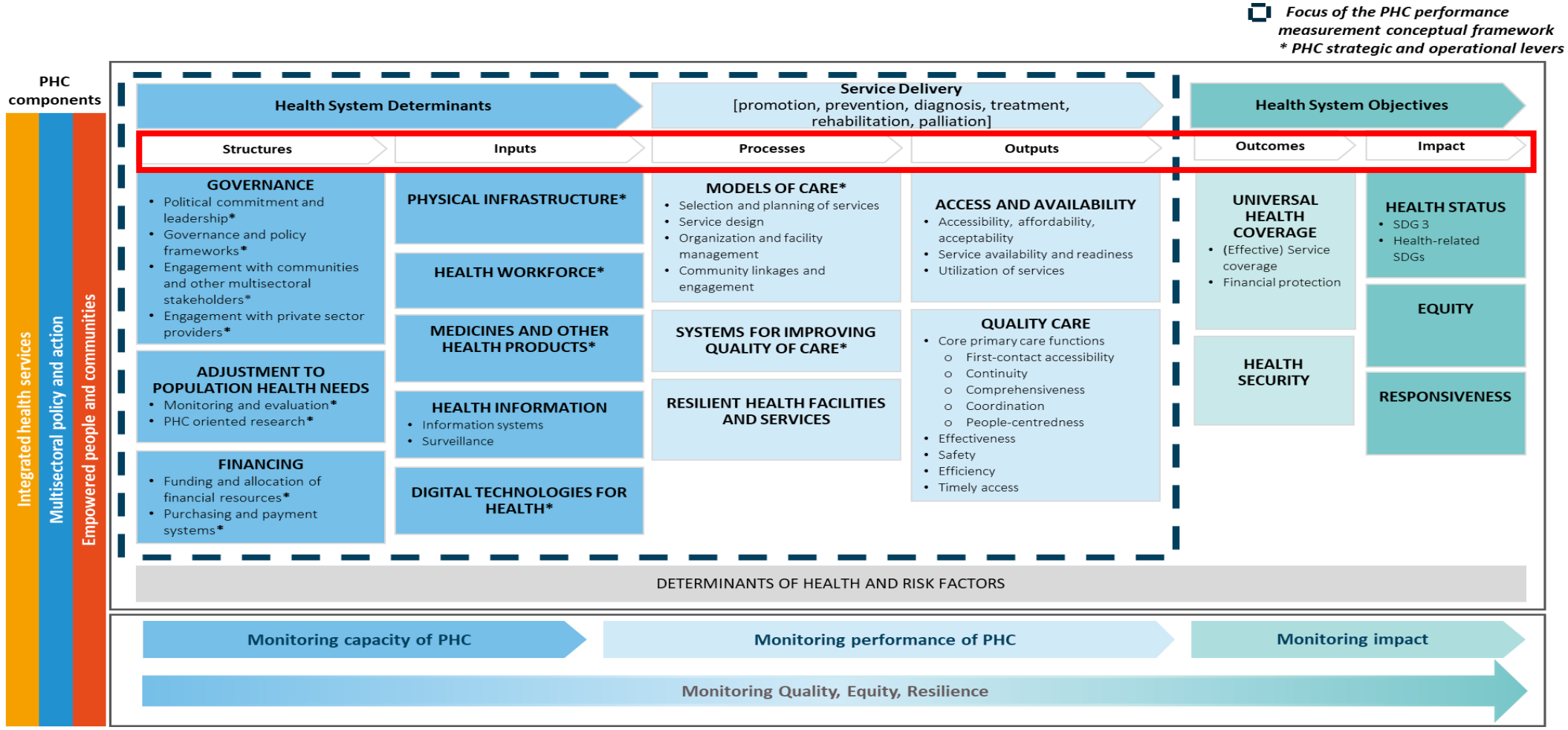
2.5.2 **Reduced out of pocket expenditure and catastrophic health expenditure:** Improved access to expanded services closer to the community, assured availability of medicines and diagnostic services and linkages for care coordination with Medical Officers/specialists across levels of care will reduce financial hardships faced by community.

2.5.3 **Risk factor mitigation:** Health promotion efforts by primary health care team would support in addressing the risk factors for diseases.

2.5.4 **Decongestion of secondary and tertiary health facilities:** A strong network of HWCs at the sub district level would facilitate resolving more cases at primary level and reduce overcrowding at secondary and tertiary facilities for follow up cases as well as serve a gate keeping function to higher-level facilities.

Source: Ayushman Bharat- Operational guidelines for Comprehensive primary health care through Health and Wellness Centres, NHSRC, 2018

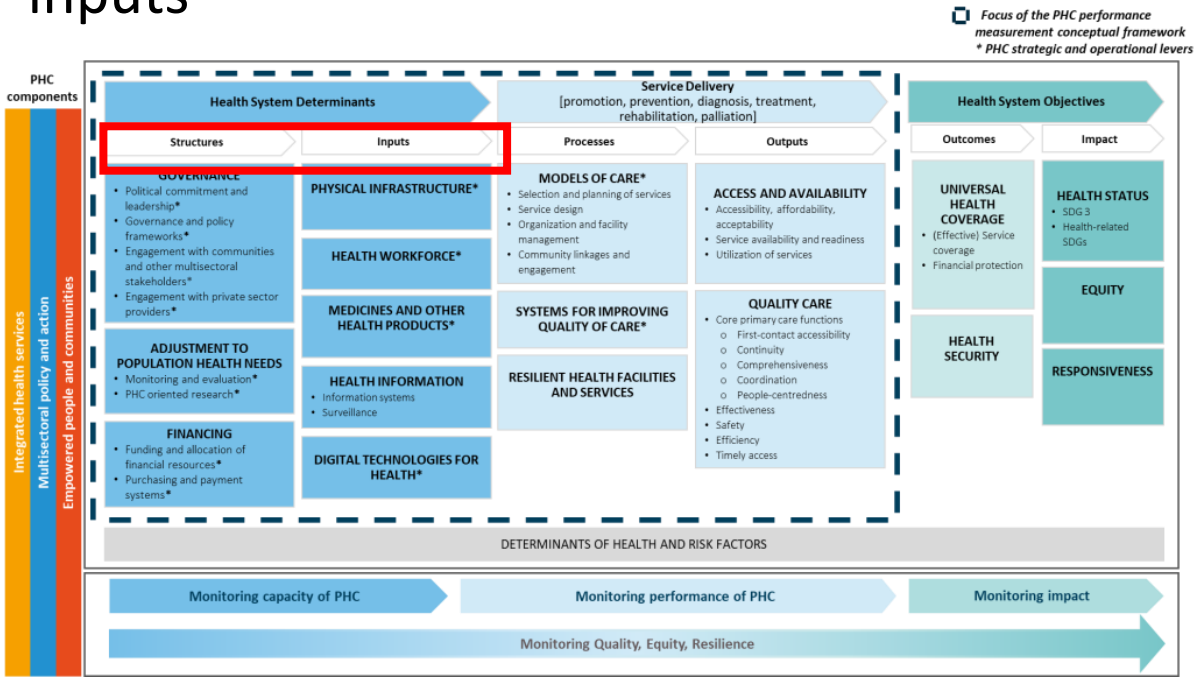
Logic model - WHO-UNICEF PHC Performance Measurement Framework (2022)



Source: World Health Organization, & United Nations Children's Fund (UNICEF). (2022).

Logic model framework :Inputs

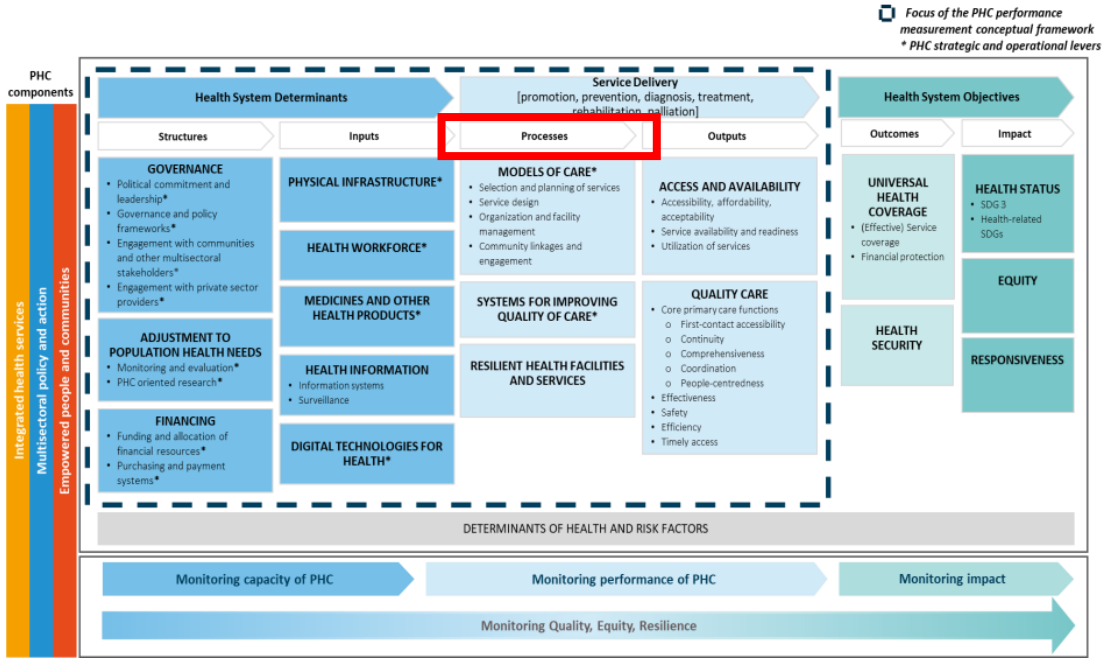
- Resources a program uses to achieve program objectives.
- Which resources are required for the PHC system?
- Examples of sub-domains included under ‘inputs’
  - Governance
  - Financing
  - Infrastructure
  - Human resources
  - Medicines, equipment, and supplies
  - Digital infrastructure
  - Data systems



Sources: 1. United Way of America. (1996). Measuring program outcomes: A practical approach. Alexandria, VA: United Way of America.
2. World Health Organization, & United Nations Children’s Fund (UNICEF). (2022).

Logic model framework : Processes

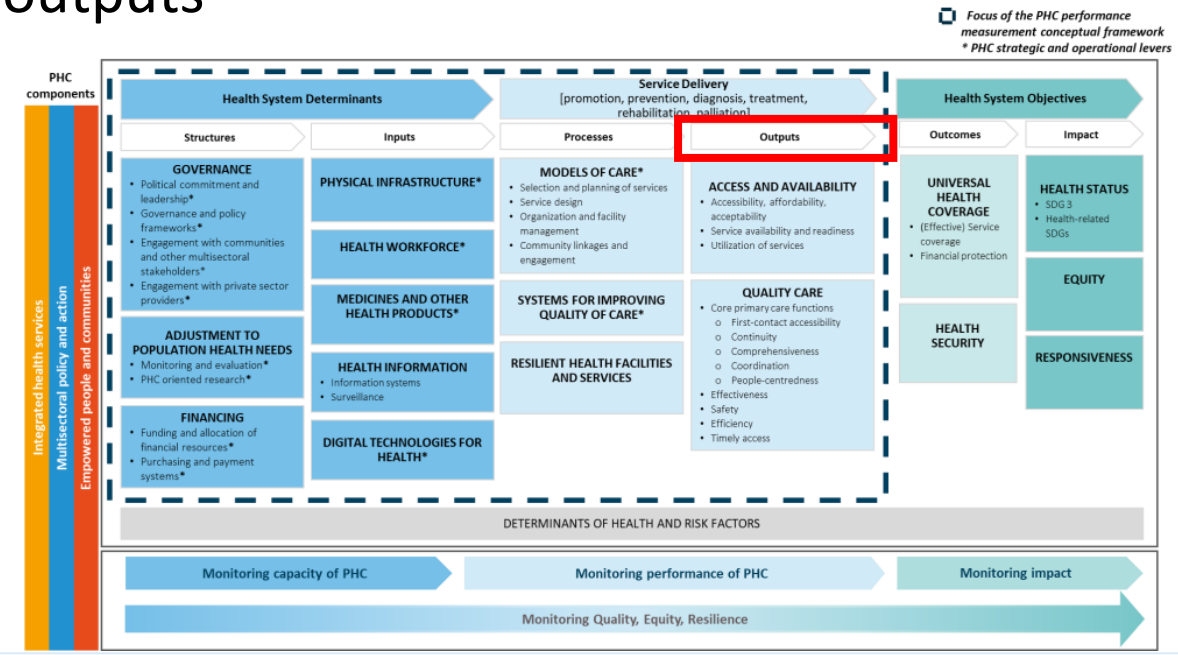
- What the program does with the inputs; the actions that are an intentional part of the program implementation
- Which activities are implemented?
- Examples of sub-domains included under ‘processes’
  - Service delivery
  - Monitoring systems
  - Community engagement
  - Quality improvement processes



Sources: 1. United Way of America. (1996). Measuring program outcomes: A practical approach. Alexandria, VA: United Way of America. 2. Savaya, R., & Waysman, M. (2005). The logic model: A tool for incorporating theory in development and evaluation of programs. *Administration in Social Work*, *29*(2), 85-103. 3. World Health Organization, & United Nations Children’s Fund (UNICEF). (2022).

Logic model framework : Outputs

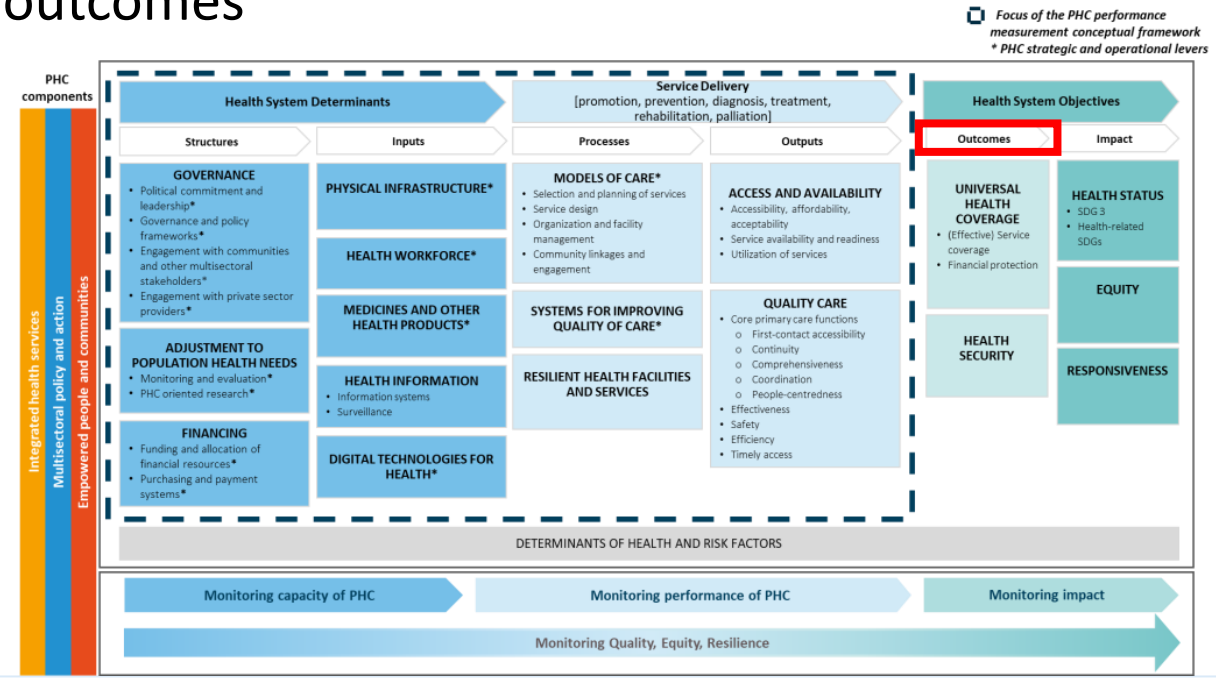
- Direct products of program activities.
- What are the immediate products of program implementation?
- Examples of sub-domains included under ‘outputs’
  - Availability of services
  - Service utilization
  - Service quality



Sources: 1. United Way of America. (1996). Measuring program outcomes: A practical approach. Alexandria, VA: United Way of America. 2. Savaya, R., & Waysman, M. (2005). The logic model: A tool for incorporating theory in development and evaluation of programs. *Administration in Social Work*, *29*(2), 85-103. 3. World Health Organization, & United Nations Children’s Fund (UNICEF). (2022).

Logic model framework: Outcomes

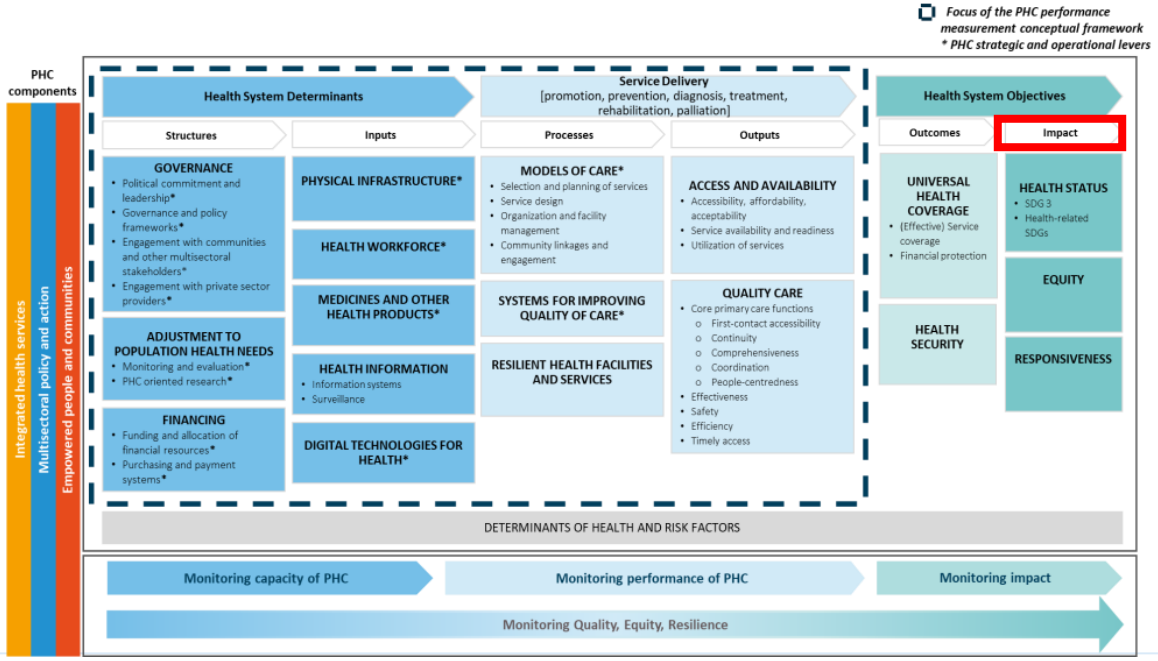
- Benefits or changes in the program's target population
- What would be the benefits in catchment population?
- Examples of sub-domains included under 'outcomes'
  - Immunization coverage
  - Screening coverage for hypertension



Sources: 1. Savaya, R., & Waysman, M. (2005). The logic model: A tool for incorporating theory in development and evaluation of programs. *Administration in Social Work*, *29*(2), 85-103. 2. World Health Organization, & United Nations Children's Fund (UNICEF). (2022).

Logic model framework : Impact

- Benefits at the population level
- What would be the changes at population level?
- Examples of sub-domains included under ‘impact’
  - Health status
  - Financial protection



Sources: 1. Savaya, R., & Waysman, M. (2005). The logic model: A tool for incorporating theory in development and evaluation of programs. *Administration in Social Work*, *29*(2), 85-103. 2. World Health Organization, & United Nations Children’s Fund (UNICEF). (2022).

Exercise: Interpreting the logic model framework

Discuss and classify each indicator into one of the below five categories that make up the logic model

- inputs
- processes
- outputs
- outcome
- Impact

List of indicators

No.	Indicator
1	Proportion of PHCs compliant to Indian Public Health Standards
2	Percentage of health facilities implementing the DVDMS
3	Percentage of pregnant women registered for ANC in 1st trimester
4	Number of maternal deaths per 100,000 live births during a given time period
5	Proportion of infants 9-11 months old who have received BCG, 3 doses of DPT, 3 doses of OPV and measles against estimated number of infants during a specific year.

Strengths and limitations of logic model

Strengths

- Easy to use and understand
- Helps explain the program to those not directly involved, e.g., community, funder etc.
- Builds common understanding of goals, processes, and resources.

Limitations

- Limited attention on interaction between the intervention and the context
  - ➢ May not explain the processes involved in complex interventions that adapt to the context
- Programs are not linear and rarely follow a sequential order
  - ➢ Alternate pathways of change can be missed
  - ➢ Logic model focuses on expected outcomes, neglecting the unintended/unexpected outcomes.

Key takeaways: Logic model for PHC performance measurement

1. A logic model is a graphical/textual representation of how a program is intended to work and links outcomes with processes and the theoretical assumptions of the program.
2. It is a commonly used, and simple framework for monitoring.
3. Sub-domains under each component of logic model can be identified based on the context and purpose of monitoring.
4. Logic models are linear, have limitations in understanding complex interventions.

References

1. NHSRC (2018), Operational guidelines for comprehensive primary health care through health and wellness centres
2. Murray and Evans (2003), Health Systems Performance Assessment.
3. Kellogg, W. K. (2004). Using Logic Models to Bring Together Planning. Evaluation, and Action: Logic Model Development Guide.
4. United Way of America. (1996). Measuring program outcomes: A practical approach. Alexandria, VA: United Way of America
5. Savaya, R., & Waysman, M. (2005). The logic model: A tool for incorporating theory in development and evaluation of programs. *Administration in Social Work*, *29*(2), 85-103.

Group exercise: Developing a logic model framework for an existing PHC program in the district

Duration: 40 min

Instructions

- Participants will be divided in five groups. Each group will work on one public health program.
- Suggested options for programs
  1. **NCD services**
  2. **Pregnancy care**
  3. **Leprosy services**
  4. **Tuberculosis services**
  5. **Malaria services**
  6. **Immunization services**

- **The same groups will continue to work together throughout the training for module exercises and for final presentation**.

Instructions

- Using the inputs-process-outputs-outcome logic model framework, select sub-domains under each domain, as relevant to your program. For example, under the domain of inputs, sub-domains could include human resources, funds, drugs, diagnostics, buildings and infrastructure, basic amenities like water and electricity etc.
- This framework represents a conceptual model for your program at the district level and will be the basis for your monitoring and evaluation plan.
- Identify assumptions and contextual factors that affect the program.

Domain	Sub-Domain
Inputs	Human resources Infrastructure Medicines …..
Processes	Sub-domain1 Sub-domain 2…..
Outputs	Sub-domain1 Sub-domain 2…..
Outcomes	Sub-domain1 Sub-domain 2…..
Impact	Sub-domain1 Sub-domain 2…..

Example- Routine immunization program

Inputs	Processes	Outputs	Outcomes	Impact
Governance • Availability of District immunization officer	Service delivery • RI sessions conducted at facilities	Service utilization • No. of children immunized • No. of AEFI cases reported	Service coverage • Full immunization coverage • Zero-dose coverage • Pentavalent drop-out rate	Health status • Incidence of vaccine preventable diseases • IMR • U5MR
Financing • Salary for ANMs • Incentives for ASHAs • Cost for logistics	Community engagement/ community outreach • VHND sessions			
Infrastructure • Availability of space at AWCs for conducting sessions • Availability of cold chain points	Quality improvement processes • AEFI events documentation • Infection prevention control practices			
Human resources • Availability of ANMs at SCs and PHCs • Human resources trained in RI, AEFI	Facility management • Vaccine indenting and supply • Planning for RI sessions			
Equipment and supplies • Vaccine availability • Availability of ILR with stabilizer • Availability of required consumables	Monitoring • Frequency of monitoring visits to SCs and VHNDs			
Data systems • Recording formats/registers • eVIN, UWIN	Reporting • Frequency of reporting by SCs			

Template for selecting the sub-domains

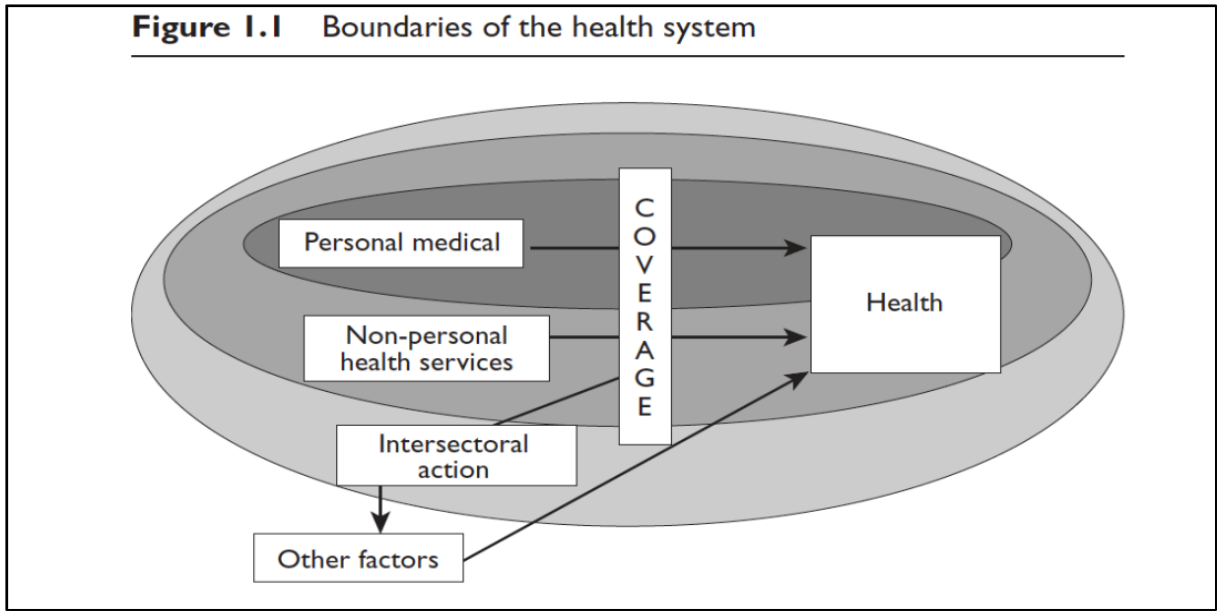
Inputs	Processes	Outputs	Outcomes	Impact
Governance	Service delivery	Availability of services	Service coverage	Health status
Financing	Community engagement/ community outreach	Service utilization		Financial protection
Infrastructure	Quality improvement processes	Service quality		Equity
Human resources	Facility management			
Medicine	Monitoring			
Equipment and supplies	Reporting			
Digital infrastructure				
Data systems				

Key takeaways- Monitoring PHC program performance

- Why measure PHC performance?
  - ➢ to understand the gaps for improvement, compare performance across units, and relate health system performance with population health.

Key considerations while measuring PHC performance:

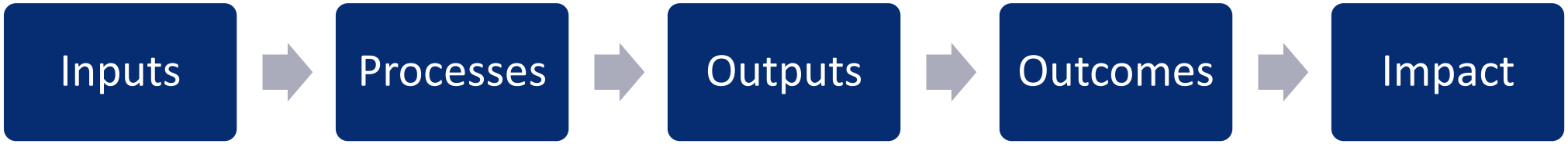
1. What activities/services are part of PHC?



Key takeaways- Monitoring PHC program performance

Key considerations while measuring PHC performance:

2. What factors influence PHC performance?
3. What are the PHC system goals?
4. How do PHC performance factors link to PHC goals?



Thank You