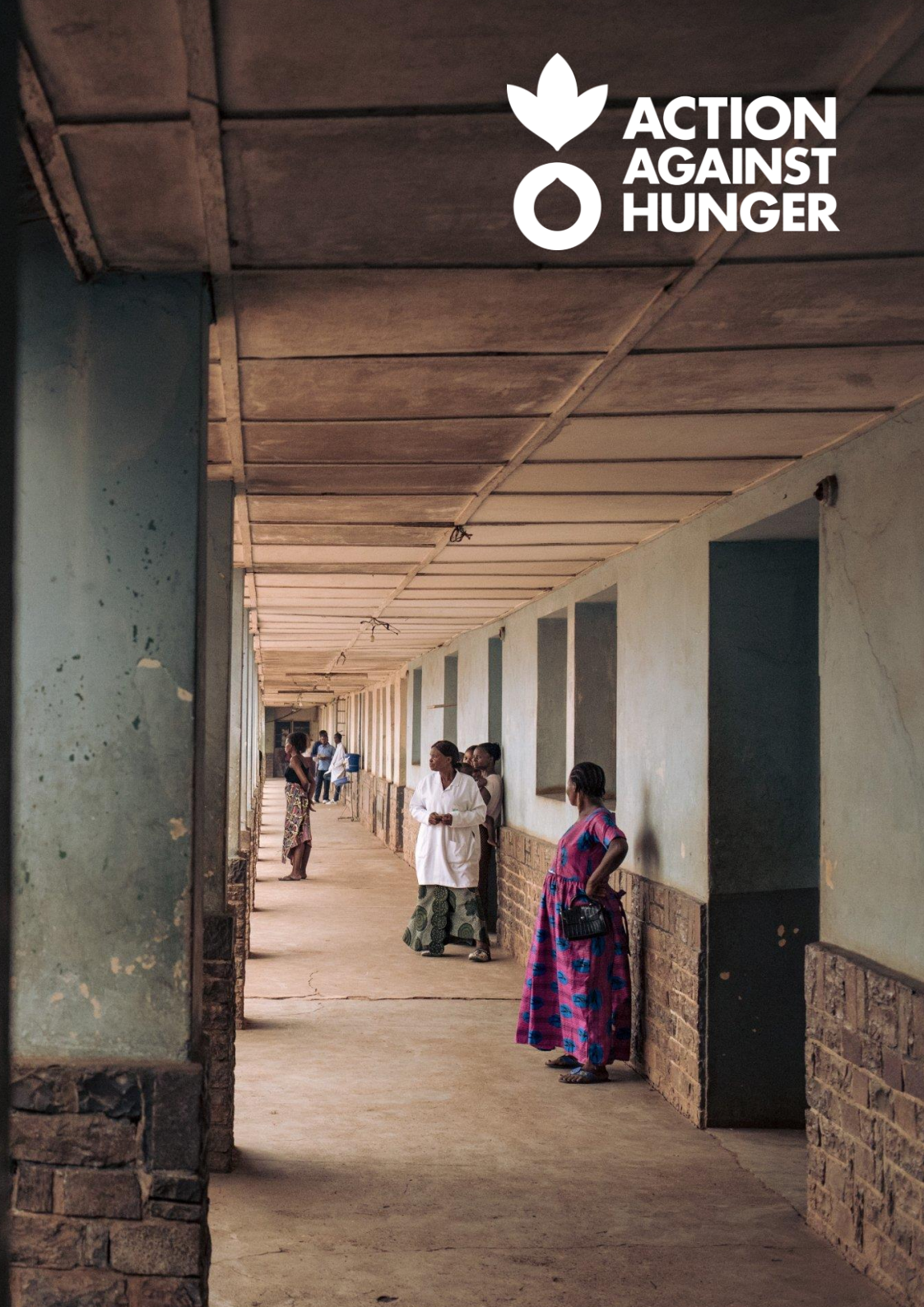


HEALTH SYSTEM STRENGTHENING FRAMEWORK



**ADVANCING TOWARDS
ACTIONS THAT DRIVE
SUSTAINABLE CHANGE**



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This document has been prepared by Action Against Hunger Spain, and the application of the principles and proposals it addresses is limited to the countries in which it operates, coexisting with the approaches of other offices within the organization.

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INTRODUCTION

ACTION AGAINST HUNGER'S ACTION IN HEALTH SYSTEMS

Nutrition and health are closely intertwined¹. On one hand, malnutrition and nutrient deficiencies can weaken the immune system, increase susceptibility to infections, lead to other types of diseases, heighten morbidity and mortality, and interfere with physical and cognitive development. On the other hand, physical and mental health problems and illnesses can disrupt caregiving and feeding practices, as well as the absorption and metabolism of nutrients.

Similarly, actions in nutrition and health are also interconnected: the coverage and quality of essential nutrition interventions depend on their integration into comprehensive health systems that can make universal health coverage a reality.

However, when the health system is weak, i.e. due to insufficient or inadequate funding, poor governance that fails to redirect efforts toward the most pressing health needs or to engage and mobilize communities, or a workforce that is poorly motivated or lacks the support needed to carry out its functions effectively, health and nutrition services struggle. In

fragile health systems, people are unable to access effective services such as breastfeeding and infant and young child feeding support, nutritional supplementation, malnutrition prevention in all its forms, or the diagnosis and management of acute malnutrition. The underlying causes may include limited coverage with no community outreach, a trust gap between communities and service providers, economic barriers to access, low quality and limited impact on hunger and malnutrition, or a system that cannot withstand the major shocks caused by epidemics, forced displacement, social unrest, or conflict in humanitarian crisis contexts.

That is why we fight hunger by investing in actions that contribute to the strengthening of health systems and the resilience of their healthcare services and public health functions² with the flexibility to combine short-term assistance with long-term goals, alongside efforts to strengthen social protection systems³ and support water and sanitation services⁴. To achieve this, we start with a thorough analysis of health systems and the planning of coherent strengthening strategies that integrate both nutrition-sensitive and nutrition-specific interventions⁵.

In recent years, progress has been made in the international network's commitment to strengthening health systems, yet we still face significant

¹ Action Against Hunger (2017). Nutrition security policy. A common multi-sectoral understanding and approach to address undernutrition.

² Action Against Hunger (2021). International strategic plan 2021-2025.

³ Action Against Hunger (2021). Social Protection Plan 2021-2025.

⁴ Action Against Hunger (2021). WASH Strategy 2021>2025.

⁵ Action Against Hunger (2017). ACF Health System Strengthening Approach Rationale.

internal challenges⁶. Tools have been developed for diagnosing and planning general health system strengthening actions at the district level, but their application is not always feasible; some contexts require more targeted tools that address specific issues. While multisectoral program approaches have been promoted, there is still a fragmented vision of how each sector pursues its own goals. Guidelines have been developed for intervention modalities related to supporting and strengthening health systems, but they often lack depth on methodologies for technical assistance or the evaluation of systems and services, for example. Health system strengthening has often been approached through technical support, without fully leveraging the organization's potential to integrate advocacy components; there remains untapped synergy between these two areas. Finally, these advances have occurred unevenly across different regions and countries where we work, with major disparities in capacity, experience, and readiness to implement health system support and strengthening actions.

Today, however, numerous opportunities are emerging to advance health system strengthening within Action Against Hunger, under the umbrella of our health strategies and through the operationalization of the humanitarian–development–peace nexus. Within this framework, it

becomes a priority to include components for strengthening local actors and the public health system in our humanitarian health programs, in order to address the structural problems underlying acute crises. Once the transition to early recovery is underway, we can deepen our engagement in transformative approaches and durable solutions to health needs.

AN AMBITIOUS GOAL

This document aims to empower our health and nutrition teams with the capacity and confidence to integrate health system strengthening components into nutrition and health programs in stable contexts, and especially during the transition from emergency interventions to recovery in protracted and chronic humanitarian crises.

To achieve this, the framework consists of:

A 1. **Conceptual framework (page 5)** that establishes the foundations of our logic of intervention in health systems.

An 2. **Operational framework (page 20)** outlining actions and monitoring mechanisms to implement our logic of intervention.

⁶ Many of these challenges and issues were discussed during a three-day workshop on capitalizing on health system strengthening actions, organized by Action Contre la Faim in Côte d'Ivoire from June 25 to 27, 2024.

1. CONCEPTUAL FRAMEWORK

FOR HEALTH SYSTEM STRENGTHENING

The conceptual framework lays the theoretical and conceptual foundations for our understanding of health, health action, health systems, and health system strengthening.

It defines the key principles and concepts that underpin our approach, including our understanding of health as a human right, the interdependence of the various components of health systems, and the importance of a holistic approach to strengthening those systems.

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A) OUR WAY OF UNDERSTANDING HEALTH AND HEALTH SYSTEMS

We must establish the theoretical and conceptual underpinnings of our understanding of health, health action, health systems, and health system strengthening. On this basis, we build the key principles and foundations that inform our approach, including how we understand health as a human right, the interdependence of the various components of health systems, and the importance of a holistic approach to strengthening these systems.

► HEALTH

At Action Against Hunger, we understand health as⁷:

- The highest attainable state of well-being and quality of life, achieved in a dignified and respectful manner, both individually and collectively, and in harmony with the environment.
- A state that is reached through the improvement of social conditions, respect for cultural diversity, and the promotion of a favorable environmental context. These actions foster the integral development of individuals and their communities, enabling them to enjoy a healthy and fulfilling life.

- A fundamental human right, sustained by the fulfillment of other rights such as the right to water, food, and a healthy environment.
- Something that is not only promoted and protected through healthcare services, but also through a multisectoral approach that addresses needs related to water, sanitation, food, livelihoods, protection, and more.

► PUBLIC HEALTH

At Action Against Hunger, we understand public health as an organized effort to prevent disease and to protect and promote the health of the population, led by duty bearers, supported by responsibility holders, and involving the participation and accountability of rights holders.

This effort is carried out through functions such as ensuring access to quality preventive and curative services, epidemiological surveillance, equity monitoring, assessment of the social determinants of health, research, analysis of the health system's capacity and performance, and the development and implementation of policies, plans, and laws related to healthcare, social determinants of health, the right to health, and good health system governance^{8,9}.

⁷ Acción Contra el Hambre. (2024). *Marco de trabajo en salud para el contexto de América Latina*.

⁸ World Health Organization (2024). *Application of the essential public health functions: an integrated and comprehensive approach to public health*.

⁹ PAHO, 2019. *The Essential Public Health Functions in the Americas: A Renewal for the 21st Century. Conceptual Framework and Description*.

► PRIMARY HEALTH CARE

We understand primary health care as an ambitious strategy to achieve health for all, built on the shared understanding of health as a human right and the need for global socio-economic transformation in favor of social justice and community empowerment. Primary health care is not merely an entry point to the system; it is the central function and core of a health system that embraces a holistic view of health and places power and control in the hands of the community^{10,11}.

► UNIVERSAL HEALTH COVERAGE

We understand universal health coverage as the goal that all people should have access to the full range of quality health services they need, when and where they need them, without experiencing financial hardship as a result¹².

We believe this goal should be understood as another determinant of health and framed within a strategy based on primary health care and public investment¹³.

► SOCIAL DETERMINANTS OF HEALTH

We understand the social determinants of health as the conditions in which people are born, grow, live, reproduce, care for others, work, and

age, as well as the inequalities in those conditions, often resulting from poor social policies, unfair economic arrangements, and inadequate political governance¹⁴.

► ACTION TO IMPROVE HEALTH

At Action Against Hunger, we implement health-related lines of work that are adapted to people's needs according to their specific circumstances⁷, including:

- Covering basic needs and prioritizing life-saving interventions in emergencies and humanitarian crises.
- Enhancing resilience capacities and improving access to quality basic health services.
- Influencing systems and strengthening institutions to achieve substantial and lasting impact.

In this way, we tailor the approach of our health actions to contribute to increasing the resilience capacity of health systems, expanding coverage of basic health services and needs, promoting opportunities to develop healthy lifestyles, and fostering greater community and individual engagement and leadership.

¹⁰ WHO, 2018. *Declaration of Astana*.

¹¹ World Health Organization, 2024. *Implementing the primary health care approach: a primer*.

¹² World Health Organization, 2010. *The World Health Report 2010. Health Systems Financing: the Path to Universal Coverage*.

¹³ People's Health Movement, 2023. *The Universal Health Coverage / Primary Health Care divide*.

¹⁴ World Health Organization, 2010. *A conceptual framework for action on the social determinants of health*.

► PRINCIPLES OF HEALTH INTERVENTION

All of this is carried out within a framework of ten health intervention principles⁷, which form the foundation of how we engage in health-related actions, regardless of the type of intervention or the context in which it takes place:



► HEALTH SYSTEMS

We understand health systems as a key factor in people's health, made up of all organizations, institutions, and resources whose primary purpose is to carry out actions in health and nutrition. This includes healthcare services

(both curative and preventive), public health functions, and actions that influence other health determinants.

Within the system are not only authorities and service providers (both public and private), but also caregivers and health promoters, organized communities, and collective initiatives aimed at improving people's health. At the heart of the health system are individuals themselves, as protagonists of their own health, the health of their communities, and the health of their environment.

FRAGILE HEALTH SYSTEMS

In line with classical conceptual frameworks, such as those proposed by the World Health Organization¹⁵ and the World Bank¹⁶, we understand a fragile health system as one that fails to address the health of the population in an equitable and sustainable manner, cannot respond to the deterioration of other social determinants of health, and is unable to protect the population from public health risks. This occurs as a result of limitations in access, coverage, quality, or safety of services.

These limitations may stem from various causes, including insufficient resources (financial, human, and equipment) or inefficient use of those resources, poor planning, organization and management of services and information systems, and weak governance lacking transparency,

¹⁵ World Health Organization, 2007. *Everybody's business – strengthening health systems to improve health outcomes*.

¹⁶ World Bank, 2004. *Getting Health Reform Right: A Guide to Improving Performance and Equity*.

community empowerment, or adequate public policies addressing the full range of social determinants of health, disease, and hunger.

QUALITY HEALTH SYSTEMS

We understand that for a health system to be of high quality and truly have a positive impact on the health of the population, it must place at its core not only people's health, but also their economic well-being and their trust in the system¹⁷.

This also means that the resources, processes, and governance of the health system must be centered around all individuals: resources that are adequate to the population's needs, processes that result in quality healthcare experienced positively by the population, and governance based on accountability to a population that is aware of its rights and has opportunities to actively participate in the system. The outcome is an efficient, equitable, and crisis-resilient health system, capable of adapting and responding under any circumstances to the evolving health needs of the population. In turn, this population uses and values services that improve and maintain their health and trusts a system that treats them as holders of a fundamental right.

Developing and maintaining a quality health system is both a technical and political decision. Resources and capacity alone are not enough; strong commitment and coherent political will are also required. This is why our

action in health systems must include technical and resource support, as well as advocacy efforts.

► HEALTH SYSTEM STRENGTHENING

At Action Against Hunger, we are aware that developing and maintaining a quality health system is both a technical and political decision¹⁷. Resources and capacity alone are not enough; a strong commitment and political will to pursue the ultimate goal of improving and maintaining people's health are also essential.

This is why we understand health system strengthening as a combination of technical actions and advocacy efforts aimed at empowering people to drive change in health, achieve universal health coverage, and have decent living conditions.

PEOPLE WITH POWER TO DRIVE CHANGE IN HEALTH

We understand that a health system is not merely the sum of its services. Above all, it is made up of individuals who are holders of the right to health; not only users of health services, but people who have, and should have, significant influence over those services, their own health status, and the health of their communities.

For this reason, we believe that strengthening health systems must contribute to developing the potential of individuals within communities, guided by the principles and values of the primary health care strategy. It

¹⁷ Kruk, et al, 2018. *High-quality health systems in the Sustainable Development Goals era: time for a revolution.*

involves fostering a vision of health as a right and creating an enabling environment for empowerment.

We contribute by providing people with the capacity, means, and recognition to participate in oversight and decision-making mechanisms, in the analysis of problems and identification of solutions, and in the delivery of services for prevention, promotion, diagnosis, treatment, and rehabilitation. At the same time, we advocate for and promote the transformative potential of community health workers, ensuring they receive appropriate support, recognition, and incentives.

UNIVERSAL HEALTH COVERAGE

We aim for all people to have access to the full range of quality health services they need, when and where they need them, without experiencing financial hardship.

We also believe that the only way to achieve the goal of universal health coverage is through the strengthening of a predominantly public health system, based on a primary health care approach, which can leverage private resources without negatively affecting its governance, efficiency, or equity. For this reason, we not only support the improvement of services, but also advocate for strong and stable public investment in health systems that include all people, including the most vulnerable, that promote solidarity and equity, generate positive incentives among providers and insurers, and aim to respond to people's health needs with a high cost-effectiveness balance..

DECENT LIVING CONDITIONS

We understand that people's decisions about their health and the health of their communities largely depend on how they are affected by the social determinants of health, which in turn are shaped by social injustices, individuals' economic situations, and inequalities in power, wealth, and access to resources.

Therefore, and from the multisectoral perspective that characterizes our work in the fight against hunger, we take responsibility not only for addressing universal health coverage and the possibilities for community participation in health, but also for tackling water, food, and income security, gender inequality, environmental issues, social protection, and the policies that influence all these areas.

B) OUR WAY OF ADAPTING OUR HEALTH ACTIONS TO THE CONTEXT

All our health interventions are carried out with the intentional aim of strengthening health systems, adapted to the specific context. We always strive for our actions to contribute to the restoration of a quality health system as soon as possible.

To achieve this, we continuously assess the feasibility of combining humanitarian emergency response with early recovery elements that restore the system's capacity and functionality, and of progressively transitioning toward sustainable transformation and strengthening. This is always done through strategic adaptation to the context, needs, and opportunities.

► OUR ENTRY POINT INTO HEALTH IS USUALLY THROUGH HUMANITARIAN ACTION

We are a global humanitarian organization committed to ending hunger worldwide. This means that most of our health and nutrition interventions take place in humanitarian crisis contexts, where the consequences of conflict, forced displacement, or political and social instability often become protracted, persist over time, and generate cyclical vulnerability to food and nutrition insecurity, climate change, and inequality.

Although we also intervene in stable contexts with significant structural fragility, where it is both feasible and relevant to work with a transformative approach toward sustainable health system strengthening,

it is still more common for us to initiate and consolidate interventions with a humanitarian purpose.

WE STRIVE FOR OUR HUMANITARIAN ACTION TO HAVE POSITIVE IMPACTS ON HEALTH AND HEALTH SYSTEMS

In humanitarian emergencies where the health system does not exist, does not reach those in need, lacks the capacity to provide essential services, or is unwilling to do so, we take on the responsibility of temporarily establishing essential health services with a minimum level of availability and access. We also advocate for access both to and by the population, in order to immediately meet the most urgent needs and reduce public health risks.

When needs or the context allow, we seek to transition toward supporting the recovery of the health system. This contributes to restoring and sustaining community mobilization for health protection, the functional capacity of accessible essential health services, better protection against ongoing social, economic, and public health risks, and a minimum level of collective and institutional preparedness to respond more effectively to future shocks or the recurrence of the causes that triggered the humanitarian crisis. We avoid implementing health actions independently of public health services when such services exist and there is political will for collaboration, or the possibility of fostering it.

WE INTEGRATE TRANSFORMATIVE ACTIONS WHEN THEY ARE RELEVANT, FEASIBLE, AND RESPONSIBLE

To increase the resilience of the health system and reduce its vulnerability to new shocks and risk factors for acute deterioration, short-term actions

with a primarily humanitarian purpose are not enough. While these actions can have a positive effect on health systems, sustaining their achievements requires the incorporation, at least partially, of sustainable strengthening efforts, provided the necessary conditions are in place.

Therefore, once essential services are available and functional, we aim to shift toward a medium- and long-term transformative approach that seeks sustainable improvements in the performance, equity, quality, and efficiency of the health system. This is achieved through actions targeting governance, leadership, health policies, strategies, plans, internal organization, processes, and system functions. These actions reinforce the foundations of the system, support preparedness for future public health emergencies, and even contribute to generating stability, peace, and human security, reducing the risk of future crises.

► WE APPLY KEY CRITERIA TO INTRODUCE TRANSFORMATIVE ACTIONS IN HUMANITARIAN INTERVENTIONS

To consider the possibility of integrating health system strengthening into our humanitarian actions, we must assess the context and ensure that several conditions are met.

THE HEALTH SITUATION OF THE POPULATION

The primary objective of a health response during a humanitarian crisis is to prevent and reduce excess mortality and morbidity. In settings where the crude mortality rate exceeds the acute emergency threshold, a humanitarian approach must be prioritized. While this approach may include technical and financial support to help sustain the capacity,

functionality, and accessibility of the national health system, it should not divert scarce resources toward long-term goals.

However, once excess morbidity and mortality have stabilized, we must begin to integrate strengthening components that address the barriers preventing the recovery of the health system.

THE SITUATION OF THE HEALTH SYSTEM

As soon as the availability and functionality of the local health system begin to recover, it becomes possible to consider actions that strengthen the elements being stabilized and restored over the long term. In fact, focusing solely on short-term actions can have negative effects on the governance and reconstruction of a fragmented health system. When humanitarian support is reduced or withdrawn, the fragility of the health system may leave it vulnerable to new shocks and unable to fully recover.

THE INTERVENTION ENVIRONMENT

To introduce long-term health system strengthening components alongside our humanitarian actions, there must be an enabling environment that supports such integration. This means, at a minimum, that:

- a) There is political will from the authorities to strengthen the national health system and to receive external support for that purpose.
- b) Increasing support for public authorities and services does not conflict with our humanitarian principles of neutrality and

independence. It is essential to ensure that our actions do not imply taking sides in a conflict or submitting to political powers.

- c) Long-term strengthening actions contribute to addressing the priorities identified by the health cluster (or other sectoral coordination mechanisms) and the objectives set out in humanitarian response plans.

FUNDING OPPORTUNITIES

A key determinant is that long-term strengthening actions are at least partially aligned with the priorities of our potential donors, and that there are realistic prospects for securing funding for these components of our programs.

In general, most donors are committed to the humanitarian-development-peace nexus and to strengthening health systems.

For example, DG ECHO recommends in its sectoral guidelines that humanitarian actors systematically identify, and when possible, act on, opportunities to reduce vulnerability to future humanitarian crises without compromising humanitarian principles. In protracted humanitarian crises, development and resilience interventions should be identified before the gradual withdrawal of international support, and humanitarian health actions should be integrated into existing health services, contributing to strengthening the system's capacity.

In some cases, humanitarian donors place high value on the inclusion of actions that strengthen the health system's ability to withstand shocks and reduce the need for short-term humanitarian action in a sustained manner.

OUR CAPACITIES

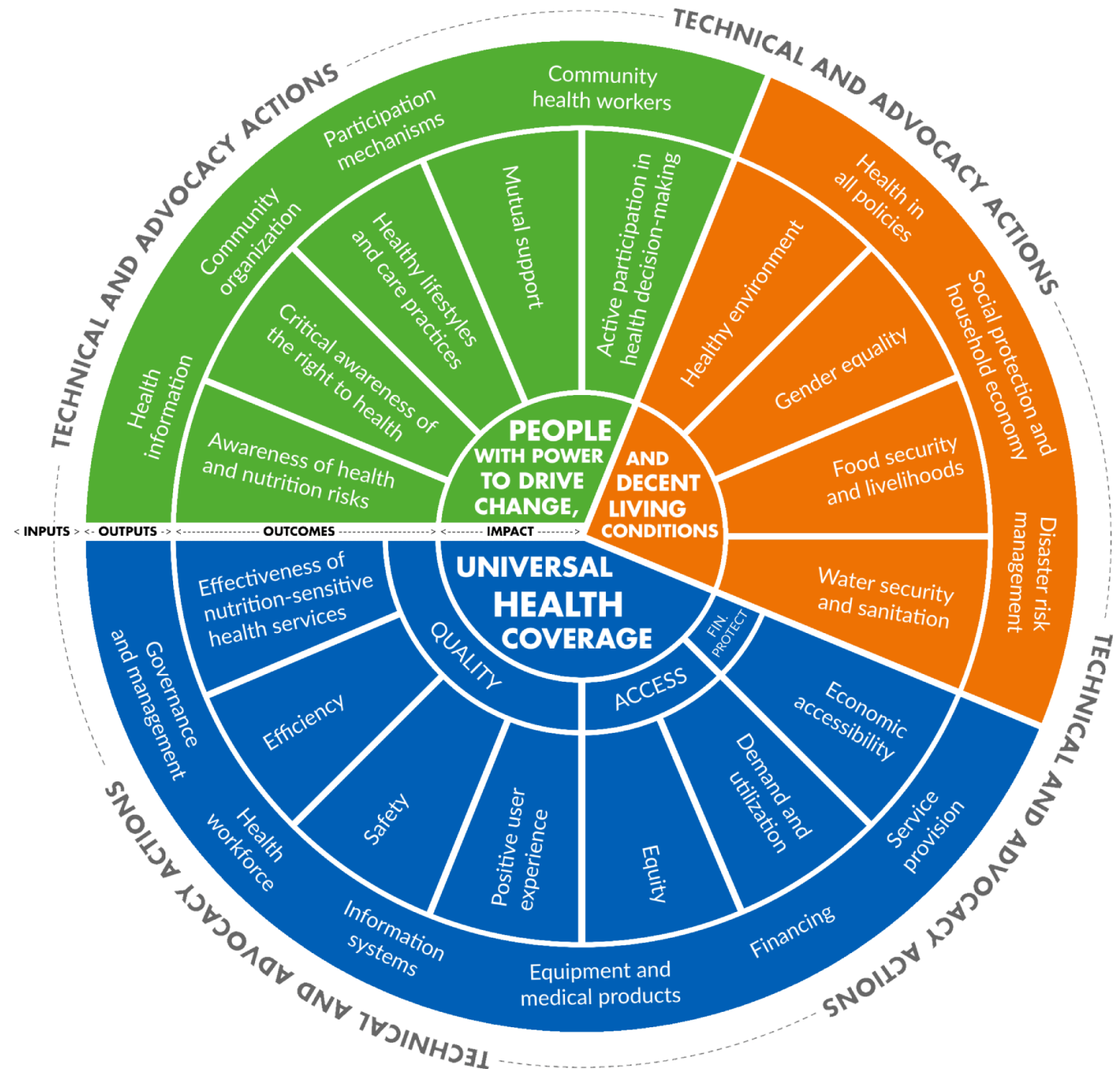
To effectively introduce strengthening and transformative components into our humanitarian interventions with an impact on health systems, we must ensure that we have the following: a well-established relationship with the Ministry of Health and relevant authorities; a solid understanding of how the health system functions and what its needs are, including the situation of the social determinants of health and the regulatory framework of relevant public policies; competent local staff with experience working in public health services and with communities; and the capacity to recruit specialized personnel for technical assistance and advocacy in health system strengthening, at least at the district level.

A thorough context analysis will allow us to make informed decisions on how to approach the potential inclusion of transformative actions for health system strengthening, or a possible progressive transition toward a coherent approach aligned with our intervention logic.

C) OUR LOGIC OF INTERVENTION

Our intervention logic is fundamentally based on the results we aim to achieve when engaging with a health system, across three levels: a) The first level refers to the capacity of the health system and its individuals (OUTPUTS). b) This enhanced capacity contributes to producing changes (OUTCOMES) in people's and communities' behaviors and attitudes, in the physical and environmental conditions of the settings where they live, and in the performance and resilience of health services. c) These changes result in a sustainable improvement (IMPACT) in our three objectives and in people's health.

The operational framework outlines the actions that, depending on the context, contribute to achieving these results, as well as the way each of these dimensions (OUTPUTS and OUTCOMES) is characterized and monitored.



► OBJECTIVE 1: PEOPLE WITH POWER TO DRIVE CHANGE

OUTPUTS:

Health information. People have expanded access to quality information on health and well-being, social determinants, the organization of the health system, available services, myths, beliefs, and healthy practices.

Community organization. The community strengthens its systems of collaboration, with women's groups, youth groups, and local associations becoming key actors in promoting health, healthy social norms and gender roles, and social cohesion.

Participation mechanisms. People are able to exercise their right to health and participate in the collection and monitoring of complaints and requests, or in formal health consultation mechanisms such as committees or citizen forums.

Community health workers. Communities have trained, recognized, motivated, and committed individuals who lead health promotion, epidemiological surveillance, and the management (identification, basic treatment, and referral) of key health problems and needs.



OUTCOMES:

Awareness of health and nutrition risks. People have sufficient knowledge about their own health needs and those of their family and community, as well as about the factors that may put them at risk. This includes aspects related to nutrition, sexual and reproductive health, maternal health, child health, mental health, and hygiene.

Critical awareness of the right to health.

People understand the basic aspects of their rights regarding health and healthcare provision, as established in public policies. This is the first step toward recognizing injustices, inequalities, and deficiencies in social protection and health systems, as well as toward actively and meaningfully demanding change and improvements.

Healthy lifestyles and care practices. People are able to consciously and freely choose healthy behaviors, practices, and attitudes during adolescence, pregnancy, childbirth, and the postpartum period, as well as during child-rearing. This includes respectful parenting and caregiving that involves emotional support, hygiene, nutrition, and appropriate care in general.

Mutual support. Community members, including health workers, create and maintain social support networks, a culture of solidarity, collective efforts for the common good (such as protection against epidemics), community-based protection systems for the most vulnerable, and even

initiatives for pooling health-related funds and risks, such as community health insurance schemes.

Active participation in health decision-making. Existing mechanisms must ensure equitable and effective representation of men, women, boys, girls, and groups with specific needs, including persons with disabilities, minorities, LGTBQ+ individuals, and migrants, among others, in decisions related to health policy development, the health system, and access to resources.

► OBJECTIVE 2: UNIVERSAL HEALTH COVERAGE

OUTPUTS:

Governance and management. Good governance includes strong strategic frameworks and regulations for the provision of health services and public health functions, as well as mechanisms that enable community participation, accountability, and transparency. It also involves systems and procedures to manage available resources, organize service delivery, monitor performance, and improve it.

Health workforce. The health workforce, including community health workers, must be sufficient and well-distributed, adequately paid, prepared to perform their duties, technically and emotionally supported, satisfied, motivated, and given opportunities to participate in improving the functioning of the system.

Information systems. Key health system functions depend on adequate epidemiological and risk surveillance (in the community and health units),

coordinated with animal and environmental health surveillance and control, and on the effective use of tools (digital or otherwise) for data recording, reporting, and analysis.

Equipment and medical products. The functionality of health services largely depends on the installation and maintenance of available non-medical infrastructure and equipment (electricity, preferably sustainable, water, sanitation, room and ward layout with privacy, communications, digital technologies, transportation, and protective equipment), as well as on the proper management of medical products such as essential medicines, disposable supplies, medical equipment, and anthropometric materials, from procurement to storage, distribution, and waste management.

Financing. Equitable access to health services is significantly influenced by out-of-pocket expenses, sources of funding and public investment, available budget and its administration, insurance modalities, systems of free care and co-payment, strategic purchasing of services, and the establishment of measures to control spending.

Service provision. The system must be designed so that services have the capacity to meet the health needs of the entire population. Key elements include nutrition, family planning, prenatal care, childbirth and postpartum care, neonatal care, management of acute malnutrition in the community, promotion of infant and young child feeding, preventive and curative care for children including vaccination, gender-based violence care, adult health, mental health, health promotion, epidemiological surveillance, referrals and counter-referrals. Services should be integrated and sectorized

(empanelment), adapted to climatic, seasonal, and demographic variations, based on primary health care, and with adequate distribution and coverage both within and beyond health facilities.

OUTCOMES:

Quality, through:

a) Effectiveness of nutrition-sensitive health services. Services considered essential due to their sensitivity to nutrition must follow clinical protocols and evidence-based recommendations, from diagnosis to treatment, and integrate gender and mental health considerations throughout.

b) Efficiency. Services and the personnel providing them must be available according to agreed planning, making rational use of medical products and other resources to ensure financial sustainability as much as possible, especially important in models based on decentralized cost recovery.

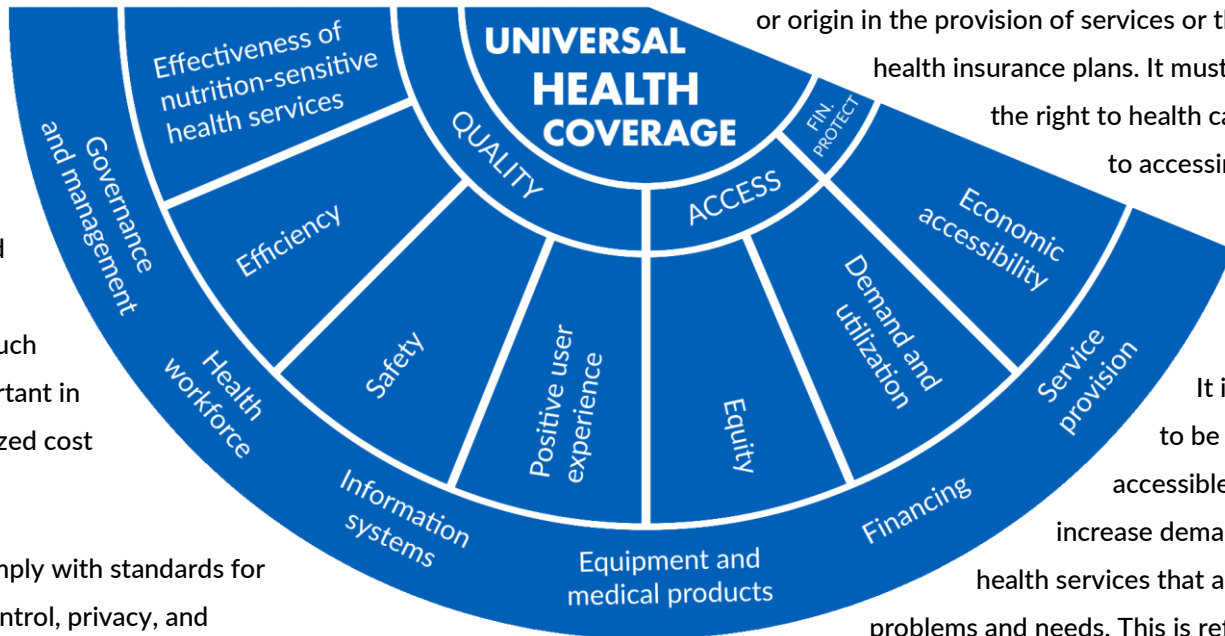
c) Safety. Services must comply with standards for infection prevention and control, privacy, and confidentiality, and incorporate basic protection principles (do no harm).

d) Positive user experience. A people-centered approach aims to ensure satisfaction of rights holders. This requires guaranteeing the cultural and social acceptability of services (e.g., personal treatment, waiting times, respect for individuals' dignity in health-related decision-making), trust in providers and authorities (e.g., clear communication of information, consistency in decisions, problem-solving), and effective use of existing mechanisms for submitting complaints and recommendations.

Access, through:

a) Equity. The system must ensure the absence of discrimination based on gender, age, ethnicity, beliefs, income, insurance status, place of residence, or origin in the provision of services or the ability to enroll in health insurance plans. It must also practically recognize the right to health care and eliminate barriers to accessing health services and delivering services to the population.

b) Demand and utilization. It is not enough for services to be available or theoretically accessible. These are means to increase demand and utilization of health services that address people's health problems and needs. This is reflected in the number of outpatient visits, health-seeking behavior, and the experience of rights holders overcoming barriers or leveraging facilitators to use these services.

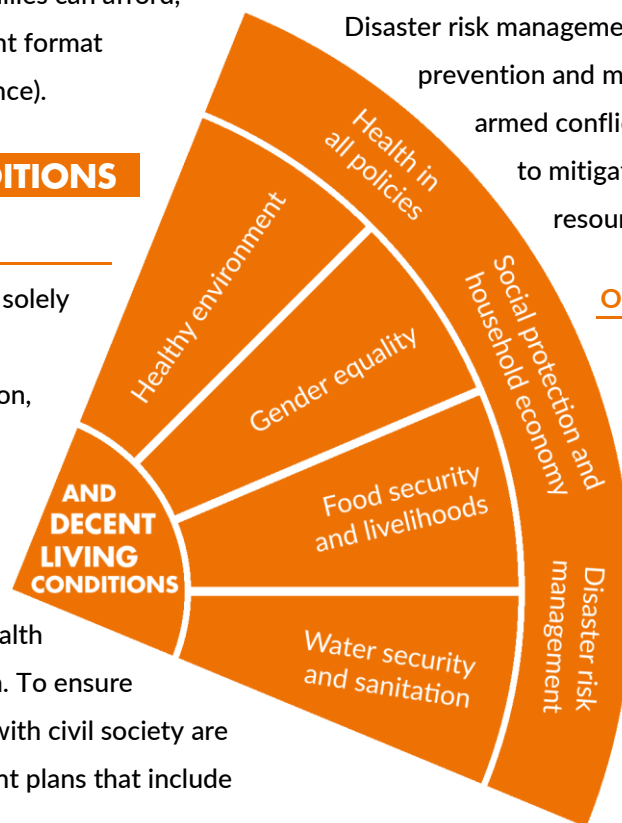


Financial protection against health expenditures, through economic accessibility. Access to health services is heavily influenced by direct costs (out-of-pocket payments and co-payments) and indirect costs (transportation, care for dependents, payments for covered but unavailable services and medical products, informal or illegal payments to healthcare providers). The system must offer health care that families can afford, both in terms of volume (subsidized costs) and payment format (prepayment and sustainable, accessible health insurance).

► OBJECTIVE 3: DECENT LIVING CONDITIONS

OUTPUTS:

Health in all policies. People's health does not depend solely on healthcare services. Public policy in areas such as housing, foreign affairs, trade, taxation, social protection, food, education, transportation, water, or the environment can have a profound impact on health determinants, barriers to developing healthy habits, and population health outcomes. Therefore, public policy must be formulated with consideration of its health implications and must avoid negative effects on health. To ensure this, mechanisms for participation and accountability with civil society are necessary, along with implementation and development plans that include adequate resource allocation.



Social protection and household economy¹⁸. Social protection is structured through norms and laws, social benefit plans, and basic public services. It helps protect individuals from risks they face throughout the life cycle and those related to their livelihoods, addressing poverty and ensuring universal access to essential services and the exercise of their rights.

Disaster risk management. The existence of strategies and plans for the prevention and management of risks related to natural disasters and armed conflicts, with adequate resource allocation, is essential to mitigate their impact on epidemic risks, lives, and the resources of individuals and communities.

OUTCOMES:

Healthy environment. Stopping environmental degradation, properly managing natural resources, and sustainably regenerating agricultural systems are crucial for health, understood from a One Health perspective where human health, animal health, and ecosystem health are interconnected. These factors also influence key health determinants such as food security, the sustainability of socioeconomic development, and even peace.

¹⁸ This falls under *Action Against Hunger, 2021. Social Protection Plan 2021–2025*, a document that defines how we understand social protection at Action Against Hunger, and how we frame universal health coverage under its umbrella.

Gender equality. Equal rights and opportunities for women, men, girls, and boys in terms of access to livelihoods, education, and decision-making power, along with the existence of policies and measures to combat gender-based violence, are key determinants of health and well-being for all individuals and communities. It is also essential to adopt an intersectional approach and recognize that gender interacts with other social determinants of health, such as socioeconomic status, age, ethnicity, disability, and sexual orientation, either amplifying or mitigating their effects on health.

Food security and livelihoods. Food and income security, through employment, entrepreneurship, and social protection including cash transfers, are key determinants of nutrition, care, health, and access to services.

Water security and sanitation. The lack of access to safe drinking water sources and secure sanitation facilities in households, communities, and public institutions, when not properly managed, is a determinant of diseases transmitted through fecal-oral routes, skin infections, and vector-borne illnesses. It is also a fundamental cause of malnutrition and morbidity and mortality.

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2. OPERATIONAL FRAMEWORK

FOR HEALTH SYSTEM STRENGTHENING

The Operational framework translates the principles, approaches, and intervention logic defined in the Conceptual framework into a set of actions and monitoring possibilities.

In this way, it facilitates the effective implementation of interventions that contribute to strengthening health systems in diverse contexts, especially in prolonged humanitarian crises and in the transition from post-emergency to the recovery of health system capacity.

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A) TECHNICAL AND ADVOCACY ACTIONS

This Operational framework proposes a general intervention logic that can be adapted to each context. Depending on the needs of the population, the overall intervention context, the capacities of the health system itself, and our means and possibilities, we can approach health system strengthening by employing different actions from the range available to us, in order to develop specific outputs.

► OBJECTIVE 1: PEOPLE WITH POWER TO DRIVE CHANGE

OUTPUTS	Health information
	Community organization
	Participation mechanisms
	Community health workers

ACTIONS FOR HEALTH INFORMATION

We can implement **technical**¹⁹ and **advocacy** actions²⁰ in humanitarian interventions that have a positive impact on health systems²¹ such as:

- Basic quantitative survey on knowledge, attitudes, and practices related to public health priorities, addressing the needs of men, boys, women, and girls²².
- General communication through posters, leaflets, and short video or audio messages on key public health and nutrition topics, including information about available health services.
- Targeted communication on public health and nutrition risks and recommendations for highly vulnerable individuals, delivered through active outreach in the community.
- Distribution of basic kits to promote personal and family hygiene and health²³. For example, child hygiene kits or menstrual hygiene kits.

¹⁹ When we talk about support actions, we generally refer to technical support (for example, technical assistance from specialized personnel), logistical support (for example, vehicle mobilization or warehouse provision), or financial support (such as contributing to a program fund or covering the cost of selected services).

²⁰ Actions considered essential for needs assessment and intervention identification are not included here, neither for this output nor for any other.

²¹ All humanitarian actions with a positive impact on health systems, across all outputs, should be carried out, whenever possible, in collaboration with district health authorities and local civil society organizations working in health. The goal is to build capacities and generate outcomes that remain within the community and the health system after the activities end.

²² Surveys and other studies conducted in humanitarian contexts can have a positive impact on health systems if local authorities and organizations are involved in their design and implementation, or if results are communicated jointly, with a shared analysis of response measures.

²³ The distribution of kits or other goods (including communication materials) in humanitarian contexts can also have a positive impact on health systems if their content is designed with community participation, and if local authorities and organizations are involved in their design and distribution, giving them visibility to improve public acceptance and trust.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- **Qualitative baseline studies and participatory action research on public health priorities, aimed at behavior change approaches.**
- **Cash and voucher assistance conditioned on attendance at preventive health services (such as prenatal care), to encourage these practices in contexts where there are no significant access barriers.**
- **Repeated and comprehensive targeted communication to segmented population groups, using periodic digital messages, group sessions, or scheduled group meetings.** For example, organizing “childbirth preparation classes” in public centers or sending reminders for the child vaccination calendar.
- **Support for school health promotion programs.**
- **Promotion of breastfeeding and proper feeding and care for infants and young children.**

ACTIONS FOR COMMUNITY ORGANIZATION

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- **Community mobilization campaigns for epidemic response and control.**

- **Awareness-raising, health promotion, and community mobilization activities with community and religious leaders, and in community gathering spaces.**

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- **Promotion, creation, and maintenance of in-person or digital peer support groups focused on health promotion.** For example, in-person groups for adolescents and young adults (on sexual and reproductive health and rights), or digital messaging groups supporting breastfeeding and childcare, among others.
- **Participation of experts in peer support groups to clarify doubts, debunk harmful myths, and identify cases that require individualized external support.**
- **Promotion of community-based income-generating activities to sustain community health programs.**
- **Technical and financial support for grassroots social organizations that promote health and defend the right to health.**
- **Encouragement of new or existing community dialogue spaces where health issues, the right to health, access to health services, or public health policies can be discussed.**

ACTIONS FOR PARTICIPATION MECHANISMS

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Creation or support of feedback and complaint systems regarding the quality, treatment, and acceptability of available health services.
- Support for rural health committees and health center management committees, and for their communication channels with subnational health authorities.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Analysis and evaluation of user experience and recommendations for improving health services, using qualitative methods and the collection of patient narratives.
- Promotion of community dialogue and citizen consultation spaces for participatory evaluation of health services and for the development and review of public health policies and action plans.

- Strengthening the capacities of grassroots social organizations that participate in consultations and spaces for the analysis and design of public health policies.
- Support for civil society movements and groups advocating for commitments toward subnational, national, and global health and nutrition goals.
- Community sessions and participatory workshops to foster leadership capacities among underrepresented individuals in decision-making spaces.

ACTIONS FOR COMMUNITY HEALTH WORKERS

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Identification and selection of community health workers²⁴.
- Basic training in health promotion, hygiene, and nutrition for community health workers.
- Training for community health workers in the management of acute malnutrition, common childhood illnesses, monitoring the well-being of pregnant women, individualized counseling on infant

²⁴ This action can have a positive impact on the health system if it is developed in collaboration with health authorities, integrating community health workers into public community health programs from the outset, or planning for their future integration when authorities have sufficient capacity to do so.

and young child feeding, and community surveillance of epidemiological and public health risks.

- Mobilization of community health workers through structured programs that include activity planning, provision of resources and equipment, incentives, performance supervision, and monitoring.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Development and improvement of supervision of community health workers by district-level officials.
- Integration of community health workers working with various independent organizations under the umbrella of the Ministry of Health and subnational authorities, with coordination mechanisms to harmonize programs.
- Research and learning linked to the evaluation of pilot experiences involving the mobilization of community health workers for the management of acute malnutrition or other innovative actions.
- Evaluation of the community health strategy or the district or national community health worker program, including identification of improvements, recommendations, and guidance for implementation.

- Evaluation of the national community health policy and identification of evidence-based recommendations for the formal recognition and public financial support of community health workers.
- Promotion of dialogue spaces, facilitation of alliances, and preparation of reports to encourage authorities to develop operational plans for implementing their policies and programs for community health workers, with appropriate national and subnational budget allocations.
- Promotion and support for the creation of community health worker associations that advocate for labor rights, institutional recognition, and participation in decision-making processes.

► OBJECTIVE 2: UNIVERSAL HEALTH COVERAGE

OUTPUTS	Governance and management
	Health workforce
	Information systems
	Equipment and medical products
	Financing
	Service provision

ACTIONS FOR GOVERNANCE AND MANAGEMENT

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Development of collaboration agreements and coordination mechanisms with district health authorities and health centers (ensuring adequate representation of women) for the implementation of support actions²⁵.
- Support for health center management committees.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Development and implementation of contingency plans and public health crisis management, in collaboration with health authorities.
- Development of training programs and support for administrative and management staff of subnational health authorities and health centers.
- Support for the development and implementation of policies, spaces, and mechanisms for the public coordination of

independent organizations working in health and private health service providers.

- Joint diagnostic and planning exercises developed together with district health authorities²⁶.
- Support for regional and district-level decentralization plans related to health competencies.
- Support for evaluations of progress toward subnational, national, and global health and nutrition goals, including identification of corrective measures.
- Support for transparency and accountability exercises led by health authorities.
- Creation of spaces for citizen and community participation in needs assessment and analysis of health system challenges, as well as progress in health and nutrition outcomes.

ACTIONS FOR HEALTH WORKFORCE

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

²⁵ To achieve a greater positive impact on the health system, these mechanisms may include not only action plans and the rights and responsibilities of each party in the implementation of activities, but also aspects related to monitoring, transition to an exit strategy, and an evaluation process that allows for the extraction of lessons learned.

²⁶ For this purpose, we have *Action Against Hunger, 2017. Health System Strengthening Guide: From Diagnosis to Planning*, which provides a methodology for exercises lasting several weeks or months.

- Short-term training (less than one week) for health and non-health staff in health services on priority topics.
- Supervision, direct support, and on-the-job training for health personnel.
- Payment of salaries, salary supplements, and performance-based incentives (or incentives linked to the provision of selected services) for health personnel.
- Psychosocial and mental health support for health personnel.
- Advocacy actions against targeted attacks on health personnel.

When relevant, feasible, and responsible, we should integrate transformative technical and advocacy actions to strengthen the health system, such as:

- Short-term training (less than one week) in communication skills, humanized healthcare (respectful treatment), and health promotion.
- Short-term training (less than one week) on patient safety and infection prevention measures in healthcare settings.
- Targeted communication using digital tools to health providers with key messages and reminders about healthcare protocols and clinical guideline recommendations.

- Evaluation of health personnel satisfaction and promotion and implementation of measures to improve workplace well-being.
- Development and implementation of policies to respect and protect the labor rights of health personnel, including community health workers.
- Development and improvement of human resource management tools and procedures, including staff terms of reference, recruitment processes, onboarding for new positions, regular performance evaluations, internal promotion programs, and career development, among others.
- Development or updating of accredited training programs and academic curricula for health system personnel.
- Development of staff accreditation programs within the health system.

- Support for the creation and maintenance of collaboration and coordination mechanisms between community health workers and health personnel in health units and subnational authorities²⁷.

ACTIONS FOR INFORMATION SYSTEMS

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Support in the collection of routine data at health centers and by mobile teams, and its reporting to health authorities.
- SMART surveys and coverage surveys of health and nutrition services.
- Support for early warning systems for the detection of potential events and the management of public health alerts and responses.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Support for the digitalization of health information systems and for the development or implementation of other digital tools, such as those used to assist health service providers in decision-making.
- Support for epidemiological surveillance systems, outbreak investigation, and case finding.
- Support for health authorities and health center management staff in conducting regular analysis of data collected through the health information system, as well as targeted analysis of surveys and special evaluations, to identify priorities, problems, and solutions.

ACTIONS FOR EQUIPMENT AND MEDICAL PRODUCTS²⁸

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Procurement²⁹ of medical equipment, supplies, and medicines³⁰ for mobile teams, health units, patient transport vehicles, and community health workers³¹.
- Setup and equipping of pharmacies in supported district health facilities, health units, and mobile teams.

²⁷ In some cases, during more or less prolonged humanitarian crises, there may be personnel who have been trained by independent organizations or who have developed professional experience that may not be recognized by the health system that existed prior to the crisis.

²⁸ Within the category of medical products, we include foods for special medical purposes, such as ready-to-use therapeutic food (RUTF).

²⁹ According to *Action Against Hunger's Standard Operating Procedure for the procurement of medical products*.

³⁰ On rare occasions, we may be able to procure vaccines, although these products are usually supplied directly by the Ministry of Health or UNICEF.

³¹ Generally, our work focuses on community and primary health services, limiting the equipment provided to hospitals and secondary or tertiary-level centers to certain services related to nutritional rehabilitation and the management of acute malnutrition in children with complications, in line with *Action Against Hunger, 2022. Nutrition-sensitive health services and related medical products* and the *Standard Model List of Medical Products of Action Against Hunger*.

- Stock control of medical products.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Training and supervision in medical product management in district warehouses and pharmacies, health units, and mobile teams.
- Development and implementation of strategies, systems, guidelines, and procedures for the acquisition, storage, distribution, monitoring, and overall management of medical products.
- Development and implementation of training plans and monitoring systems for the rational prescription of medicines.
- Development and implementation of strategies and plans for the reduction of medical waste and its environmental impact.
- Advocacy for the development, improvement, and implementation of policies and action plans to ensure access to medicines and efficient public investment in medical products.
- Advocacy for the inclusion of specific products in national essential medicines lists.
- Support for national regulatory authorities in the control of manufacturing, sale, and distribution of medical products.

ACTIONS FOR FINANCING

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Inclusion of vulnerable and refugee populations in existing public and community-based health insurance schemes.
- Contribution to the payment or reimbursement of costs related to the provision of priority health services, to ensure these services are free of charge (or involve the lowest possible co-payment).
- Support through unconditional cash transfers and vouchers, either restricted to services (such as childbirth care or emergency patient transportation), to specific goods (such as mosquito nets), or designed with a multipurpose approach to cover indirect costs of healthcare.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Cost-effectiveness evaluations of health interventions or innovative service delivery models, and assessments of the socioeconomic impact of health issues and epidemics.
- Implementation of performance-based financing or provider incentive models that generate positive incentives to increase productivity and quality of care.

- Support for the creation and maintenance of community-based health insurance schemes.
- Promotion of dialogue spaces, facilitation of partnerships, and drafting of reports to advocate for increased quantity and quality of public investment in health and nutrition services.
- Advocacy for universal health coverage grounded in strong governance and public investment, with a solid foundation in primary health care and health equity principles.
- Support for fiscal space assessments and analysis of innovative health financing models.

ACTIONS FOR SERVICE PROVISION

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Selection and prioritization of an essential health services package to support or provide, integrating essential nutrition services.
- Organization and deployment of mobile health teams to serve populations without continuous access to static health services³².
- Support to authorities in developing vaccination campaigns, epidemic prevention and response actions, and other public health

campaigns (such as distribution of insecticide-treated mosquito nets).

- Support for patient referral and counter-referral systems.
- Studies analyzing barriers and facilitators to access and use of health services.
- Rehabilitation and maintenance of essential health infrastructure that is damaged or in poor condition, including buildings, access roads, vehicles, furniture, electrical networks, communication infrastructure, and water and sanitation systems.
- Establishment of temporary infrastructure to provide essential health services until permanent infrastructure is rehabilitated or in good condition.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Expansion of the package of nutrition-sensitive and nutrition-specific health services to cover the needs of women, men, girls, and boys.

³² This action can have a positive impact on health systems if developed in coordination with health authorities, as an extension of existing public health services, using a model that can remain in place as part of a contingency plan after the end of the project.

- Development of district or national strategies and plans for risk communication and health promotion in health facilities and communities.
- Implementation of accreditation systems for authorized health service providers.
- Support for the development and improvement plans of the health service network.
- Support for certification actions of health units and services (e.g., “baby-friendly hospital”).

► OBJECTIVE 3: DECENT LIVING CONDITIONS

OUTPUTS	Health in all policies
	Social protection and household economy
	Disaster risk management

ACTIONS FOR HEALTH IN ALL POLICIES

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- **Advocacy for humanitarian access to populations in need and for their access to essential health services.**

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- **Promotion of interministerial spaces for intersectoral coordination in the development of public health policies, plans, and programs.**
- **Advocacy for the integration of gender analysis and a transformative gender perspective into policies across multiple sectors that impact public health** (e.g., combating gender-based violence, promoting shared caregiving responsibilities, improving access to water and energy to reduce burdens on women and girls, or promoting access to education for women and girls, among others).

ACTIONS FOR SOCIAL PROTECTION AND HOUSEHOLD ECONOMY

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- **Rehabilitation of essential water and sanitation infrastructure, including community-based works.**
- **Assistance through multipurpose cash transfers.**

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Support to authorities in improving the water and sanitation network.
- Initiatives for job creation.
- Development of rural savings and loan associations.
- Advocacy for the development, improvement, and implementation of social protection policies.
- Advocacy for the integration of a transformative gender perspective into social protection policies (e.g., improving access to childcare and early education to facilitate women's participation in the labor market, pension and social/health insurance systems not dependent on individual labor contributions, inclusive employment policies, or parental leave schemes).
- Group sessions and community workshops to address gender power imbalances in household decision-making.

ACTIONS FOR DISASTER RISK MANAGEMENT

We can implement **technical** and **advocacy** actions in humanitarian interventions that have a positive impact on health systems, such as:

- Support to municipalities in monitoring and managing geological and climate-related risks.

When relevant, feasible, and responsible, we should integrate transformative **technical** and **advocacy** actions to strengthen the health system, such as:

- Participatory community analysis of potential events and mobilization for risk management.
- Support for multisectoral public contingency and crisis response mechanisms.
- Community management of silvopastoral systems through holistic approaches.
- Development, improvement, and construction of climate-resilient water and sanitation infrastructure.
- Strengthening of veterinary services.

B) MONITORING, EVALUATION AND LEARNING

We need to evaluate health systems, monitor progress and achievements, assess results, and learn from our experience and interventions.

A FLEXIBLE AND ADAPTABLE MODEL

Our model allows us to focus on the outputs and outcomes we intervene in, and which therefore need to be analyzed. The way we characterize and measure them must also respond to the specific context and the stage of the project cycle we are in:

- During the needs assessment stage, we need to understand the situation of each health system output and outcome, at least in general terms.
- During the intervention identification stage, we must be able to identify priority outputs and outcomes, understand the causes and determining factors of their current status, and identify the most viable actions that can contribute to change.
- During project implementation, we must be able to understand how progress is being made toward achieving outputs and outcomes, and what is facilitating or blocking that progress.
- For evaluation and learning, we must be able to analyze which actions have achieved the expected changes and which have not, understand why, and identify potential areas for improvement and innovation for future or alternative interventions.

CHARACTERIZATION AND MEASUREMENT

For each output and outcome, a suggested approach is provided to characterize, analyze, and understand it, along with a method to measure it using an indicator.

- Good characterization is key to understanding the context in which an indicator is produced, as indicators alone can be difficult to interpret correctly. This may require direct observation, literature and document review, or the use of qualitative and quantitative data collection and analysis tools such as interviews or surveys.
- The calculation and analysis of indicators is necessary to facilitate comparison and communication of information. Depending on the indicator, it is recommended to use questionnaires, ordinal scales (from 1 to 4), qualitative scales (based on predefined criteria assessed through qualitative methodology), expert judgment (from at least three evaluators), and analysis of statistical records from health centers. Indicators should be useful, easy to calculate, and action-oriented.

Table 1: Summary of indicators for objective 1: people with power to drive change.

	DIMENSION	INDICATOR	DATA SOURCE
OUTPUTS	Health information	Basic health and nutrition knowledge index	Questionnaire
	Community organization	Proportion of adults and youth participating in community initiatives with health impact	Questionnaire
	Participation mechanisms	Inclusivity and deliberative quality index of citizen participation processes in health	Expert evaluation
	Community health workers	Functionality index of the community health worker program	Expert evaluation
OUTCOMES	Awareness of health and nutrition risks	Health and nutrition risk awareness index	Questionnaire
	Critical awareness of the right to health	Percentage of people who can identify at least three fundamental health-related rights and describe how to exercise one of them	Questionnaire
	Healthy lifestyles and care practices	Exclusive breastfeeding during the first six months of life	Questionnaire
	Mutual support	Social capital and social cohesion index	Questionnaire
	Active participation in health decision-making	Index of citizen participation in health decision-making and implementation of changes and improvements	Expert evaluation

► OBJECTIVE 1: PEOPLE WITH POWER TO DRIVE CHANGE

MONITORING OF HEALTH INFORMATION

To characterize this output, it is recommended to explore the health and nutrition knowledge held by community members. This requires examining their approximate level of education, the sources of health information they have access to (ranging from educational materials distributed by health and nutrition actors, to media, social networks, and direct contact with peers, community health workers, or health personnel, for example), the ease or barriers they encounter when seeking answers to specific health and nutrition questions, their ability to understand the health information they access (e.g., a primary care medical report or the

instructions on a nutritional supplement package), their confidence in their own knowledge and ability to care for their own health and that of their dependents, and their perceived ability to clearly explain a health issue during a medical consultation.

Given the absence of a standardized indicator, the use of a basic health and nutrition knowledge index is suggested. This should be constructed from a questionnaire with questions on topics such as knowledge of the benefits of preventive health services (e.g., prenatal care or childhood vaccination), practices like birth spacing, early initiation of breastfeeding, or condom use during sexual relations, and awareness of available relevant health services (e.g., the availability of a weekly sexual and reproductive health

consultation, the phone number for gender-based violence support, or the name and contact method of the community health worker in their area)³³.

This approach complements those used to assess the awareness of health and nutrition risks (which focuses more on knowledge and responses to acute health risks), and healthy lifestyles and care practices (which focuses more on practices, attitudes, and behaviors).

MONITORING OF COMMUNITY ORGANIZATION

To characterize this output, it is recommended to explore the various collective health-related initiatives and activities taking place in the community, how different individuals participate in them, their satisfaction with how these initiatives are coordinated or led, and their satisfaction with the achievements and their impact on public health.

Given the absence of a standardized indicator, it is suggested to use a scale from 1 (very low) to 4 (very high) to estimate the proportion of adults and youth participating in community initiatives with health impact (such as women's and youth associations, or volunteering as health promoters). To calculate the indicator, several questions can be used in a gender- and age-disaggregated quantitative population survey, adapted from the following: *"Do you participate in any association, initiative, or community activities that help improve the health of people in your community?"* (Yes / No) *"What do*

these activities consist of, and what is your role in them?" (Open response or multiple-choice characterization) *"How involved are you, in general, in the activities you mentioned?"* (Very little / Some / Quite a bit / A lot)³⁴.

MONITORING OF PARTICIPATION MECHANISMS

To characterize this output, it is recommended to explore aspects related to the existence of mechanisms and channels for citizen participation in analyzing health system outcomes, policies, and services, as well as identifying and monitoring applications for improvement. It is also important to assess the inclusivity of these mechanisms (including representation of people especially affected by health issues or traditionally excluded), the quality of information flow (ensuring participants have access to information adapted to their level of understanding regarding the topics discussed, the consultation process, and its expected scope), the deliberative quality and feasibility analysis of proposals, satisfaction with these mechanisms, and the level of trust in health authorities³⁵.

Given the absence of a standardized indicator, it is suggested to use a qualitative ordinal scale based on expert judgment to quantify an inclusivity and deliberative quality index of citizen participation processes in health within a health area.

³³ The *Indikit.net* tool, developed by the Czech humanitarian organization *People In Need*, includes a multilingual database with recommended questions (and methods for evaluating possible responses) on this and other relevant topics.

³⁴ In cases where this is a priority outcome, more advanced evaluation options can be explored, such as a qualitative ordinal scale (from 1 to 4) based on predefined criteria assessed through qualitative methodology, and expert judgment (with at least three evaluators analyzing the available information and reaching a written consensus on each criterion).

³⁵ For the development and adaptation of this scale to the intervention context, the following reference can be used: *Francés-García y La Parra-Casado, 2022. Herramienta multidimensional para la medición de la calidad de la participación en salud.*

This approach complements those used to monitor active participation in health decision-making (which focuses more on how agreements are reached and the institutional commitment to implement them with appropriate resource allocation), and those used to monitor governance and management (which includes aspects such as accountability and transparency in improving the health system and its services).

MONITORING OF COMMUNITY HEALTH WORKERS

To characterize this output, it is recommended to explore the factors that determine the functionality of a community health worker program³⁶ (from their roles to how they are equipped, supervised, and incentivized and especially how the health system supports them (through resources, management procedures, and good governance³⁷).

As an indicator, it is suggested to use the functionality index of the community health worker program, calculated as the average of results obtained across ten dimensions using a qualitative ordinal functionality scale (from 1 to 4), evaluated by experts³⁶.

ASSESSMENT OF AWARENESS OF HEALTH AND NUTRITION RISKS

To characterize this outcome, it is recommended to explore key knowledge, behaviors, practices, and attitudes related to responses to acute health problems and major health risks. It is important to adapt the characterization to the epidemiological risks of each context. This helps

avoid asking about generic or less relevant topics, and instead focuses on individual and collective behaviors that are meaningful for addressing real health issues in that context (e.g., seeking medical care in response to danger signs during pregnancy or early childhood), or in response to actual public health risks (such as intimate-partner gender-based violence or ongoing/potential infectious disease outbreaks).

Given the absence of a standardized indicator, it is suggested to use a health and nutrition risk awareness index. This should be constructed from an individual questionnaire administered to a representative sample, in which the interviewer asks a predefined set of questions related to context-relevant topics and records the quality of the responses, either dichotomously (correct/incorrect) or on a continuous scale (e.g., from 1 to 4, ranging from completely incorrect to completely correct). Questions may address topics such as knowledge of danger signs during pregnancy, in newborns³³, and in children under five with severe acute malnutrition, as well as the epidemiological importance (in terms of frequency and severity) of endemic infectious diseases, and the importance and correct application of control measures for these and other diseases with epidemic potential, depending on the context..

This approach complements those used to monitor health information (which focuses more on general health and nutrition knowledge), and those

³⁶ To support this, we have access to a highly comprehensive tool: Community Health Impact Coalition, 2018. *Community Health Worker Assessment and Improvement Matrix (CHW AIM): Updated Program Functionality Matrix for Optimizing Community Health Programs*.

³⁷ Additionally, we have a complementary tool: World Vision International, 2023. *Health Systems Assessment and Improvement Matrix (S-AIM): A tool for assessing and improving health systems in support of community health worker programmes*.

used to assess healthy lifestyles and care practices (which focus more on practices, attitudes, and behaviors)

ASSESSMENT OF CRITICAL AWARENESS OF THE RIGHT TO HEALTH

To characterize this outcome, it is recommended to explore people's knowledge of their fundamental health-related rights, such as the right to information, access to health goods and services, participation in health, non-discrimination, informed decision-making about their own health, privacy and confidentiality, and accountability of authorities. It is also important to assess the specific national and local frameworks for exercising these rights, perceptions of equitable access to quality services, sources of information on the right to health, barriers to accessing and understanding this information, and the level of confidence people have in their ability and power to exercise these rights or to act in response to violations.

Given the lack of a standardized indicator to address such a complex concept, it is suggested to use the percentage of people who can identify at least three fundamental health-related rights and describe how to exercise one of them. This indicator can be assessed through a survey question such as: *"Can you mention any health-related rights that you*

consider important? Any others? And how do you think you could exercise this right in your community?" The interviewer should provide a well-informed evaluation of the response, using a clear guide to determine whether the answer is satisfactory. This indicator is simple, relevant, and easily adaptable to different intervention contexts.

ASSESSMENT OF HEALTH LIFESTYLES AND CARE PRACTICES

To characterize this outcome, it is recommended to explore key practices and behaviors that contribute to good health. These include infant and young child feeding practices³⁸, childcare practices³⁹, and many others such as personal hygiene, safe sexual practices, treatment adherence, health-seeking behavior and home management of common health problems (e.g., oral rehydration therapy for acute childhood diarrhea), physical activity, substance use, stress and emotional management, and prevention of environmental risks in the home and surrounding areas. For certain key behaviors and practices, characterization can be complemented with formative research and barrier analysis studies if deemed particularly relevant⁴⁰.

As an indicator, it is suggested to use the practice of exclusive breastfeeding during the first six months of life⁴¹. Although this indicator

³⁸ There are several recommended tools for evaluating different aspects and approaches to infant and young child feeding, available in the corresponding modality pages of the Technical Programming Framework.

³⁹ A useful resource is the guide *WHO and UNICEF, 2022. Nurturing care handbook. Strategic action 4: monitor progress. How to monitor populations, implementation and individual children's development*, which addresses various dimensions of nurturing care. Another valuable tool is *ACF, 2013. Manual for the integration of child care practices and mental health into nutrition programs* (page 56), which focuses on evaluating caregiver-infant interactions.

⁴⁰ We also have our own comprehensive manual with detailed guidance: (*Action Against Hunger, 2020. Behaviour change: A step-by-step guide for interventions*), in addition to the behaviour change modality guide within our Technical Programming Framework.

⁴¹ The correct methodology for using the indicator is well explained in *WHO and UNICEF, 2021. Indicators for assessing infant and young child feeding practices: definitions and measurement methods*.

focuses on a single practice and does not cover the full range of healthy lifestyles and care behaviors, it has several advantages: it is widely used, easily comparable across populations, aligns with Action Against Hunger priorities, and is influenced by numerous socioeconomic and cultural barriers. In some contexts, this indicator may be replaced by a composite index that measures a broader set of healthy practices and behaviors.

This approach complements those used to monitor health information (which focuses more on general health and nutrition knowledge), and those used to assess awareness of health and nutrition risks (which focuses more on knowledge and responses to acute health problems or risks).

ASSESSMENT OF MUTUAL SUPPORT

To characterize this outcome, it is recommended to explore aspects related to social capital and social cohesion within the community. These go beyond the mere existence of associations, community networks, or participation mechanisms, and focus on individuals' perceptions of complex dimensions such as: social cohesion (the sense that the community shares a common purpose and is willing to cooperate to achieve it); trust that others in the community do not intend harm; the existence of collectively accepted moral norms; a shared sense of identity and belonging to a group (including people with different values, identities, and lifestyles); and collective civic engagement⁴².

The recommended indicator is social capital and social cohesion index, developed from a locally adapted version of a pre-existing questionnaire

with 15 questions related to individual perceptions of cohesion, trust, norms, belonging, identity, and civic engagement in the community⁴².

ASSESSMENT OF ACTIVE PARTICIPATION IN HEALTH DECISION-MAKING

To characterize this outcome, it is recommended to explore aspects related to how institutions and community representatives are perceived to make decisions that affect population health and health services, the institutional commitment to assume and implement those decisions with adequate resource allocation, and the actual changes in health policies or health system functioning that have been influenced or catalyzed (at least partially) by the community, including the factors that have determined success or failure in the past³⁵.

Given the absence of a standardized indicator, it is suggested to use a qualitative ordinal scale based on expert judgment to quantify an index of citizen participation in health decision-making and implementation of changes and improvements within a health area.

This approach complements those used to monitor participation mechanisms (which focus more on the opportunities and channels for participation, and the level of inclusivity, information flow, and deliberative quality), and those used to monitor governance and management (which include aspects such as accountability and transparency in improving the health system and its services).

⁴² For the characterization and the calculation of the related indicator, we suggest *Mercy Corps, 2020. Social capital and social cohesion measurement toolkit for community-driven development operations.*

Table 2: Summary of indicators for objective 2: universal health coverage.

	DIMENSION	INDICATOR	DATA SOURCE
OUTPUTS	Governance and management	Leadership, management, accountability, transparency, and institutional respect for primary health care principles index	Expert evaluation
	Health workforce	Health worker density (per 10,000 population)	Analysis of official records
	Information systems	Percentage of weekly epidemiological surveillance reports for early warning and response submitted on time from one level to the next	Analysis of official records
	Equipment and medical products	Percentage of days in the past month when essential medicines were unavailable	Analysis of official records
	Financing	Average out-of-pocket expenditure per primary health care consultation	Exit surveys with patients
	Service provision	Index of availability of health services and public health functions at the health unit	Analysis of official records and questionnaires
OUTCOMES	Effectiveness of nutrition-sensitive health services	Percentage of children with adequate growth monitoring and follow-up among those who received the third dose of DTP	Analysis of official records
	Efficiency	Average number of medications prescribed per medical consultation	Analysis of official records
	Safety	Percentage of patients who know the correct dosage and usage of the medications they received	Exit surveys with patients
	Positive user experience	Health service user satisfaction index	Exit surveys with patients
	Equity	Difference in average out-of-pocket health expenditure between insured and uninsured individuals	Exit surveys with patients
	Demand and utilization	Demand for family planning satisfied with modern methods	Patient surveys
	Economic accessibility and financial protection	Percentage of households that postponed or avoided primary health care consultations due to costs in the past 3 months	Patient surveys

► OBJECTIVE 2: UNIVERSAL HEALTH COVERAGE

MONITORING OF GOVERNANCE AND MANAGEMENT

To characterize this output, it is recommended to explore health policies and action plans, the day-to-day management and administration of health centers, efforts to improve performance, and the existence and functioning of management committees with citizen participation.

Given the absence of a standardized indicator, it is suggested to use a qualitative ordinal scale based on expert judgment to quantify a leadership, management, accountability, transparency, and institutional respect for primary health care principles index for a health administrative area.

This approach complements those used to monitor participation mechanisms (which focus more on the opportunities and channels for participation, and the level of inclusivity, information flow, and deliberative

quality), and those used to monitor active participation in health decision-making (which focus more on how agreements are reached and the institutional commitment to implement them with adequate resource allocation)⁴³.

MONITORING OF HEALTH WORKFORCE

To characterize this output, it is recommended to explore, during visits to each health center, basic aspects such as the number of health professionals working at the center, disaggregated by occupation, sex, and whether they are permanent or visiting staff⁴⁴. It is also advisable to complement the analysis with literature review and individual or group qualitative interviews with health personnel to explore in depth key and complex aspects such as: perceptions of risk and protection (related to healthcare delivery, violence, harassment, conflict, work-related stress, and mental health); inclusion (equal rights and fair treatment without discrimination based on sex, age, or other factors); support received (including training and technical support, financial compensation, working conditions and non-financial factors, social protection, and satisfaction with the work environment); and labor rights (including the right to freedom of association for collective bargaining, protection when reporting irregularities and rights violations, and the possibility of participating in decision-making on health system matters that affect them). It is also important to understand whether centers are prepared to rapidly scale up

staffing during seasonal disease peaks, and the reasons for any staff shortages (permanent or seasonal).

As an indicator, it is suggested to use health worker density (per 10,000 population), disaggregated by occupation (medical, nursing and midwifery, dentistry, and pharmacy) and sex. A minimum threshold of 23 has been established to achieve adequate health coverage, but occupations and thresholds should follow the guidance of the respective WHO regional offices. This indicator is included in the Sustainable Development Goals (SDG 3.c.1).

MONITORING OF INFORMATION SYSTEMS

To characterize this output, it is recommended to study the resources, tools, and capacity of the system to generate information about population health and health service performance. This analysis should support public health threat response and generate knowledge for better decision-making in health⁴⁵. Specifically, it is particularly relevant to understand how, on what topics, and with what level of quality information is collected about health centers, population health issues, and epidemiological surveillance that enables risk and emergency management in public health. In humanitarian and resource-limited contexts, where not all standard epidemiological surveillance functions are feasible, the essential component may be the implementation and maintenance of an early

⁴³ For monitoring this output, as well as the other outputs under this objective, the following reference is recommended: *World Health Organization and UNICEF, 2022. Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens.*

⁴⁴ Among the many existing tools that can provide guidance, we recommend using Chapter 3 (health workforce) of *World Health Organization, 2023. Harmonized Health Facility Assessment (HHFA) Module 1: Service availability.*

⁴⁵ As an analytical framework, the following is recommended: *World Health Organization, 2012. Framework and Standards for Country Health Information Systems.*

warning and response system, which at minimum allows for the identification of potential public health events, alert management, and guidance for outbreak control measures⁴⁶.

As an indicator, it is suggested to use the percentage of weekly epidemiological surveillance reports for early warning and response submitted on time from one level to the next. This is a recommended indicator in the Sphere Standards, with a target of 80%. Its calculation requires defining the validity period (e.g., allowing a maximum of 24 hours from the end of the reporting period) and the levels from which reports are submitted to the next level.

MONITORING OF EQUIPMENT AND MEDICAL PRODUCTS

To characterize this output, it is recommended to explore the condition of all possible categories of equipment. These include: basic infrastructure and services (communications, IT equipment and internet connectivity, electricity supply, rooms and facilities, access routes, waiting areas, transportation for staff and patients, cleaning and maintenance); water and sanitation infrastructure; infection prevention and control conditions (disposal of general and biomedical waste, and disinfection and sterilization of reusable medical products); and medical products (vaccines, medicines, supplies, and medical equipment). Additionally, it is essential to study and understand how the medical supply chain operates and is managed, including selection, needs quantification, procurement, inventory strategy,

storage and stock control, distribution to pharmacies and micro-pharmacies, and dispensing to patients. This also involves assessing the performance of responsible personnel, guidelines and procedures, therapeutic guides, and essential medicines lists, among many other aspects.

As an indicator, it is suggested to use the percentage of days in the past month when essential medicines were unavailable. This indicator should be calculated using a reference list of at least ten priority medicines, selected from the national essential medicines list and appropriate to the type of health unit being evaluated. It is a widely used and recommended indicator in the Sphere Handbook, with a target of fewer than 4 days out of the last 30. Depending on the context and intervention, it may be appropriate to include certain priority supplies or therapeutic foods.

MONITORING OF FINANCING

To characterize this output, it is recommended to explore the primary health care financing model, including: the existence and functioning of social protection and insurance schemes; public investment and its mechanisms; co-payments and cost-recovery systems; available budget and its management; strategic purchasing of health services; and measures in place for cost control and sustainability of the model⁴⁷. Many of these

⁴⁶ As an analytical framework, the following is recommended: World Health Organization, 2023. *Early warning alert and response (EWAR) in emergencies: an operational guide*.

⁴⁷ Although understanding health financing often requires specialized analysis, the following reference is recommended as a framework: WHO, 2020. *Country assessment guide: the Health Financing Progress Matrix*.

aspects should first be analyzed at the national level before moving to regional, municipal, or individual health unit levels.

Given the lack of standardized indicators that are easy to use at the health center level, it is suggested to use the average out-of-pocket expenditure per primary health care consultation. This indicator can be measured through exit surveys with patients following curative consultations.

MONITORING OF SERVICE PROVISION

To characterize this output, it is recommended to explore the availability, readiness, capacity, and functioning of the essential services offered at health units. This assessment should also consider service integration, understanding how and to what extent services meet the health needs of the entire population, the relationship between different levels of care, the distribution and coverage of services, their ability to adapt to climatic and demographic variations, and the existence of protocols to ensure continuity of primary health care services in times of crisis or emergency⁴⁸.

As an indicator, it is suggested to use an index of availability of health services and public health functions at the health unit. This index should be calculated based on a predefined and locally adapted list of essential health services and essential public health functions. Essential health services include, for example, initial emergency care, management of severe acute

malnutrition, routine prenatal care, routine childbirth care, mental health, family planning and contraception, gender-based violence case management, malaria treatment, and general vaccine administration⁴⁹.

Essential public health functions may include health promotion, epidemiological surveillance, investigation of epidemiological alerts, and monitoring of service capacity and performance quality⁵⁰. To calculate the index, it is necessary to first define the essential package and the criteria by which the availability, readiness, capacity, and functioning of each selected service will be assessed^{iError! Marcador no definido.}.

ASSESSMENT OF EFFECTIVENESS OF NUTRITION-SENSITIVE HEALTH SERVICES

To characterize this outcome, it is recommended that at least two evaluators visit each health center to assess key health services that should integrate nutrition sensitivity, such as maternal and child health services. The goal is not merely to observe whether resources and means are available, but to determine whether services are properly delivered, contributing to the resolution of health problems and the improvement of patient well-being.

As an indicator, it is suggested to use the percentage of children with adequate growth monitoring and follow-up among those who received the third dose of DTP vaccine (DTP3). Although this is an uncommon indicator,

⁴⁸ For planning the continuity of essential services during public health emergencies, the recommended framework is: WHO, 2021. *Health service continuity planning for public health emergencies. A handbook for health facilities*.

⁴⁹ For selecting priority health services to include in this index, the following is recommended: WHO, Global Health Cluster, 2024. *Preliminary guidance for a package of high-priority health services for humanitarian response (H3 package)*.

⁵⁰ For identifying public health functions to be assessed at the district level, the recommended tool is: WHO, 2022. Joint external evaluation tool: International Health Regulations (2005), third edition.

it allows us to assess whether routine child health services (such as vaccination) are properly integrating essential nutrition services (such as growth monitoring). “Adequate growth monitoring and follow-up” is defined as: clear and correct recording of age, weight, and height in the child’s health record; evidence of initiation of treatment or nutritional counseling in cases of underweight or acute malnutrition; and documented efforts to address the issue if recovery does not occur.

ASSESSMENT OF EFFICIENCY

To characterize this outcome, it is recommended to explore the rational use of resources, including budgets, personnel, and medical products. A key aspect of this analysis is the quality of prescriptions and rational use of medicines (i.e., administering the right medicines to the right patients, in the right doses, for the right duration, and at the right cost). Overuse and misuse of medicines (especially antibiotics) not only increase morbidity and mortality and the risk of antimicrobial resistance, but also represent a major source of resource waste. Issues such as polypharmacy or inappropriate use of medicines and their generic versions also impose significant costs on health systems and families, particularly when these are paid out-of-pocket⁵¹.

As an indicator, it is suggested to use the average number of medications prescribed per medical consultation. This indicator can be complemented and contextualized with others, such as percentage of medications prescribed by generic name, percentage of consultations in which an

antibiotic or injectable medication is prescribed, or percentage of prescribed medications included in the national essential medicines list. It is easy to calculate and provides data that is easily comparable across health centers or before and after interventions aimed at improving prescription quality and rationality. It should be calculated by reviewing all prescriptions over a defined time period and dividing by the number of consultations. It can refer to all consultation types or be specific (e.g., acute diarrhea in children). It is independent of whether patients actually obtained the medications (which can bias patient surveys). Some local adaptation is required to ensure comparability (e.g., how to count combination drugs; usually as one), and to define targets and change objectives.

ASSESSMENT OF SAFETY

To characterize this outcome, it is recommended to explore compliance with infection prevention and control standards, the clarity of communication regarding safe medication use, privacy and confidentiality, and how basic protection principles are mainstreamed.

As an indicator, it is suggested to use the percentage of patients who know the correct dosage and usage of the medications they received⁵¹. This indicator goes beyond measuring a health center’s capacity to ensure patient safety. It also evaluates the quality of medical consultations, including the time spent with patients, the effort made to inform and

⁵¹ For the study of this output, particularly regarding the rational prescription of medicines — it is recommended to use: WHO, 1993. *How to investigate drug use in health facilities: selected drug use indicators*.

ensure understanding, and even the privacy and comfort in which the provider–patient dialogue took place⁵².

ASSESSMENT OF POSITIVE USER EXPERIENCE

To characterize this outcome, it is recommended to explore, with service users (ideally upon exiting the health facility), their perceptions and opinions regarding: resources (e.g., staff, facilities, availability of medical products); processes (e.g., waiting times, quality of treatment received, clarity of information, opportunities to ask questions and receive reliable and understandable answers, and mechanisms for submitting complaints); outcomes (e.g., satisfaction with expectations, resolution of health problems, and contribution to preventing future health issues); and willingness to return to the health facility or recommend it to others⁵³.

As an indicator, it is suggested to use a health service user satisfaction index, obtained through a quantitative survey of a sample of health service users after their visit.

ASSESSMENT OF EQUITY

To characterize this outcome, it is recommended to explore discrimination and access barriers, especially financial ones. It is particularly important to accurately characterize the volume of out-of-pocket health expenditures (outside of insurance, prepayment models, or other social protection systems), including direct costs (e.g., official consultation fees, informal

payments to providers, medications, lab tests, diagnostics, and medical procedures) and indirect costs (e.g., transportation, lost income opportunities, food, accommodation, childcare, and communication). Even just estimating these actual out-of-pocket expenses (not theoretical ones) provides a measure of how equitable or inequitable the health system and its financing model are. Disaggregating this data by sex, type of consultation, ethnic group, insurance status, legal status, or geographic origin helps identify the determinants of inequity.

As an indicator, it is suggested to use the difference in average out-of-pocket health expenditure between insured and uninsured individuals. This builds on the indicator used for health financing (average out-of-pocket expenditure per primary health care consultation) and measures the gap between more and less vulnerable groups. Depending on the context and data availability, disaggregation can be adapted — for example, comparing refugees and host communities, rural and urban populations, those covered by non-contributory vs. contributory health insurance, or those with community-based vs. public insurance.

ASSESSMENT OF DEMAND AND UTILIZATION

To characterize this outcome, it is recommended to explore what determines health care demand across different population groups and services. This includes studying health-seeking behaviors, barriers and

⁵² Other alternative indicators may also be considered, such as the percentage of adequate compliance with hand hygiene recommendations (which requires direct observation by specifically trained personnel and is therefore more prone to measurement errors), or the percentage of consultations in which current medication use is inquired about (also requiring direct observation).

⁵³ For the evaluation of patient satisfaction with health services, the following reference is recommended: WHO, 2021. *Patient satisfaction and experience at migrant health centres in Turkey*, which in turn uses tools originally designed for Yemen.

facilitators to access and use of services, and interventions that can positively influence them.

As an indicator, it is suggested to use the demand for family planning satisfied with modern methods. This widely used indicator, included in the Sustainable Development Goals, helps monitor demand and utilization of nutrition-sensitive health services within the framework of sexual and reproductive rights.

It is calculated by dividing the number of women of reproductive age (15–49 years) using a modern contraceptive method by the total number of women in that age group who are either using any method (modern or traditional) or have unmet needs, i.e., women who are sexually active or in a union, not using contraception, and who wish to delay or avoid pregnancy, as well as those whose current or past pregnancy was unwanted.

ASSESSMENT OF ECONOMIC ACCESSIBILITY AND FINANCIAL PROTECTION

To characterize this outcome, it is recommended to explore the perceived and actual level of financial protection offered by the health system, and people's effective ability to afford health care costs.

Due to the complexity of calculating indicators like catastrophic health expenditure (which requires complex survey questions and is more relevant to secondary and tertiary care), an alternative is proposed: the percentage of households that postponed or avoided primary health care consultations due to costs in the past 3 months. This indicator, easily measurable through a community survey, provides insight into users' perceptions and real experiences of financial protection related to health care costs. It complements the indicators on equity and health financing.

Table 3: Summary of indicators for objective 3: decent living conditions.

	DIMENSION	INDICATOR	DATA SOURCE
OUTPUTS	Health in all policies	Index of political commitment oriented towards primary health care and universal health coverage	Expert evaluation
	Protección social y economía familiar	Women's dietary diversity index	Questionnaire
	Gestión de riesgo de desastres	Percentage of subnational areas where a health vulnerability and risk analysis and mapping has been conducted	Records
OUTCOMES	Medio ambiente saludable	Environmental health perception index	Questionnaire
	Igualdad de género	Index of equal participation in household decision-making for family health	Questionnaire
	Medios de vida y seguridad alimentaria	Food Insecurity Experience Scale (FIES)	Questionnaire
	Seguridad hídrica y saneamiento	Community water, sanitation and hygiene security index	Expert evaluation

► OBJECTIVE 3: DECENT LIVING CONDITIONS

MONITORING OF HEALTH IN ALL POLICIES

To characterize this output, it is recommended to explore public health policy (policies, strategies, plans, and monitoring reports that allow for the evaluation of effective resource allocation, implementation, progress, and achievements), as well as the integration of population health outcomes from policies in other sectors such as housing, trade, taxation, social protection, water, or the environment, for example.

The suggested indicator is the use of an index of political commitment oriented towards primary health care and universal health coverage. This

indicator can be measured using a qualitative ordinal scale evaluated by experts, based on predefined criteria related to the existence of national health policies, their orientation towards universal health coverage, the presence of a coherent strategic vision, implementation, monitoring and evaluation plans, resource allocation at the subnational level, the alignment of these policies with the principles of primary health care and equity, and the mainstreaming of health in other policies⁵⁴.

MONITORING OF SOCIAL PROTECTION AND HOUSEHOLD ECONOMY

To characterize this output, it is recommended to explore (through literature review and interviews) the regulations, laws, plans, budgets, and

⁵⁴ It is recommended to use, as a starting reference framework, the chapter dedicated to the assessment of vision and policies within the health governance framework from WHO, 2022. *Health system performance assessment: a framework for policy analysis*.

coverage of social benefits and basic public services that protect people from poverty and crises, as well as the coping strategies used by households⁵⁵ and the dietary diversity of different population groups.

The suggested indicator is the women's dietary diversity index. This indicator provides a measure of the effects of food insecurity on diet quality and the diversity of food groups consumed by women of reproductive age.

MONITORING OF DISASTER RISK MANAGEMENT

To characterize this output, it is recommended to explore the existing local capacity in subnational administrative divisions (provinces, states, municipalities, or districts) to anticipate and respond to health risks and threats that have been previously identified.

The suggested indicator is the percentage of subnational areas where a health vulnerability and risk analysis and mapping has been conducted. This indicator is closely linked to the prior completion of a comprehensive risk assessment for health emergencies, thereby facilitating the implementation of preparedness and response measures⁵⁶.

ASSESSMENT OF HEALTHY ENVIRONMENT

To characterize this outcome, it is recommended to explore the state of the environment, natural resources, and their sustainability.

Given the absence of a standard indicator, the suggested indicator is the environmental health perception index. This index could be calculated through a quantitative survey directed at the general population, with a question such as: *"How would you rate the quality of the following environmental factors in your surroundings, on a scale from 1 (very poor) to 5 (excellent)?"* The question should be followed by context-adapted factors such as: water quality (bad taste, turbidity, strange odors, and distrust of its origin or safety); air quality (bad odors, and smoke, dust, or haze from pollution causing coughing or eye irritation); climate stability (increase in heatwaves, droughts, heavy rains, storms, or changes in the timing of seasons); exposure to waste or chemical and toxic substances (such as pesticides or hazardous waste from industry, mining, or landfills); food safety and production (deterioration of soil quality and availability of water or land for cultivation, and food contamination); preservation of the natural environment and biodiversity.

ASSESSMENT OF GENDER EQUALITY

To characterize this outcome, it is recommended to explore existing gender dynamics within the community, inequalities in rights and opportunities among women, men, girls, and boys, and differences in access to and control over resources, decision-making, health-seeking behaviors, and caregiving roles, for example. These differences and inequalities are key determinants of health and well-being for all individuals.

⁵⁵ It is recommended to use, as a reference framework for the application of this indicator: WFP, 2008. *The coping strategies index – field methods manual*.

⁵⁶ This indicator, recommended in WHO, 2024. *Health system resilience indicators: an integrated package for measuring and monitoring health system resilience in countries*, is based on the use of tools equivalent to those in WHO, 2021. *Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment*.

The suggested indicator is the index of equal participation in household decision-making for family health. This index allows for the evaluation (at least partially) of women's empowerment and their involvement in household decision-making regarding critical aspects such as product consumption, management of financial resources, care for dependents and sick individuals, and reproductive decisions, all of which have a clear impact on health⁵⁷.

ASSESSMENT OF FOOD SECURITY AND LIVELIHOODS

To characterize this outcome, it is recommended to explore the level of food security and household income, supported by employment, entrepreneurship, social protection, and cash transfers, and how these contribute to improved diet, nutrition, and health.

The suggested indicator is the Food Insecurity Experience Scale (FIES). This indicator enables the study of the frequency and severity of five coping strategies employed by the household in the past week: using cheaper, less preferred foods; seeking help from friends and family; limiting portion

sizes; restricting adult consumption; and reducing the number of daily meals.

ASSESSMENT OF WATER SECURITY AND SANITATION

To characterize this outcome, it is recommended to explore access to safe water facilities for drinking and other uses, sanitation infrastructure and its management, as well as other hygiene conditions in the household and surrounding environment, as determinants of the risk of transmission of zoonotic, vector-borne, and waterborne diseases.

The suggested indicator is the community water, sanitation and hygiene security index, calculated using a qualitative ordinal scale that quantifies the level of various dimensions, such as access to safe water, access to improved sanitation, solid waste management, availability of hygiene resources, performance of community management in the operation and maintenance of facilities and services, and environmental conditions that pose significant health risks.

⁵⁷ It is recommended to use, as a reference framework for adapting the calculation method of this indicator, the "Household Decision Making" module from the Action Against Hunger Technical Programming Framework, specifically the "Household Decision-Making Index Kit", and the guide from which it was extracted: Oxfam, 2017. A 'How To' Guide to Measuring Women's Empowerment.



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