C4

Blood pressure control among people with hypertension

Purpose	To measure the effectiveness of clinical services to control BP among patients treated for hypertension
Definition	Proportion of people registered for hypertension treatment in the facility with controlled BP based on WHO or national treatment guidelines Based on WHO guidelines, BP is considered controlled when: • Systolic blood pressure (SBP) <140 mmHg and diastolic blood pressure (DBP) <90 mmHg • SBP <130 mmHg among people with history of CVD • SBP <130 mmHg among high-risk people with hypertension, i.e., those with high CVD risk, diabetes mellitus, chronic kidney disease (CKD) BP control criteria may be based on national guidelines
Numerator	Number of people registered for hypertension treatment in the facility whose BP was controlled at the last clinical visit in the reporting period, excluding those who were newly diagnosed with less than 3 months of treatment
Denominator	Total number of people registered for hypertension treatment in the facility, excluding those who were newly diagnosed with less than 3 months of treatment
Method of calculation	Numerator ÷ denominator × 100
Aggregation	District, province, state, country
Disaggregation	Where possible and applicable, stratify by health facility, provider ownership type (public/private), and patient characteristics such as age, sex, race/ethnicity, comorbidity status, high-risk groups, socio-economic status, residence type (urban/rural), and health insurance type
Sources of data	Health facility patient registers, patient records
Key data elements	Hypertension diagnosis, prescribed hypertension medication,visit date, SBP, DBP
Frequency of reporting	Annually
Users of data	Facility-level managers to assess the proportion of people with hypertension at their facility achieving the BP control goal District-level managers to assess the overall quality of hypertension treatment services, and to identify poorly performing facilities and rectify problems at an early stage
Limitations/ comments	People with unknown status of BP control (missed appointment/dropped out) and patients referred to a higher-level care facility will be counted in the denominator and their BP control status will be counted as not controlled Patients known to have transferred to another facility during the reporting quarter will be counted in the denominator and their last known status prior to transfer will be used For comparison with other healthcare facilities the indicator needs to be age-standardized
Related links	Guideline for the pharmacological treatment of hypertension in adults https://apps.who.int/iris/bitstream/handle/10665/344424/9789240033986-eng.pdf HEARTS technical package for cardiovascular disease management in primary health care: systems for monitoring http://apps.who.int/iris/bitstream/handle/10665/260423/WHO-NMH-NVI-18.5-eng.pdf;jsessionid=0ACE98717506BDB055D33488EC106A40?sequence=1

C1
Availability of diabetes core medicines

Purpose	To ensure uninterrupted supply of essential medicines and thereby improve patient treatment adherence
Definition	Proportion of health facilities that have diabetes core medicines based on WHO or national treatment guidelines Diabetes core medicines include: • Insulin • Metformin • Sulfonylurea
Numerator	Number of health facilities reporting “no stock-out” of diabetes core medicines in the reporting period
Denominator	Total number of health facilities
Method of calculation	Numerator ÷ denominator × 100
Aggregation	District, province, state, national
Disaggregation	Health facility, provider ownership type (public/private), facility location type (urban/rural)
Sources of data	Health facility medicine stock register, health facility reports, regional logistics information system or survey
Key data elements	Number of facilities reporting “no medicine stock-out”, count of total facilities
Frequency of reporting	Quarterly
Users of data	District-, province-, state-, and national-level managers to focus supervision on health facilities reporting medicine stock-outs, prevent medicine stock-out situations, and strengthen health systems to ensure uninterrupted medicine supply
Limitations/ comments	In some settings health facilities do not dispense medicines so the reporting units may be community medicine dispensaries/pharmacies The preferred data source among the sources listed for this indicator depends on the data source quality in the local context
Related links	HEARTS-D: diagnosis and management of type 2 diabetes https://www.who.int/publications/i/item/who-ucn-ncd-20.1 World Health Organization model list of essential medicines https://apps.who.int/iris/bitstream/handle/10665/325771/WHO-MVP-EMP-IAU-2019.06-eng.pdf