GAP-SKIN Two-Phase Prioritization Framework

Evidence-Based and Pragmatic Approach to Skin Disease Prioritization

Working document for technical consultation and national adaptation

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Contents

Summary

This framework operationalizes skin disease prioritization through two integrated phases:

Phase 1 (Pragmatic Screening): A rapid, rural-friendly dual burden plus access screen to identify conditions requiring full review.

Phase 2 (Evidence-Based Validation): A comprehensive eight-criteria validation process ensuring prioritized diseases are clinically important, actionable, equitable, and aligned with health-system capacity.

The approach balances pragmatism for district and PHC use with evidence rigor for national and global prioritization. It is intended to support transparent decision-making, clear documentation of uncertainty, and practical implementation planning.

Relationship and functional boundary. This framework is the disease and service-priority companion document for GAP-SKIN. It supports transparent selection of diseases, clusters or service problems for public-health action. It should be used with NAP-Skin Guidance, the PHC classification, the Training and Competency Framework, the Indicator Compendium and SHRIEF. It does not define the full research agenda, clinical guideline content, workforce standards, indicator metadata or a costed implementation plan.

1. Framework Overview

Distinction from research prioritization. This framework answers: Which skin diseases, disease clusters or service problems should be prioritized for public-health action? SHRIEF answers: What evidence, innovation and implementation questions must be addressed to improve action on those priorities? The two processes are connected but distinct.

Phase	Purpose	Criteria	Scoring	Audience	Output
Phase 1: Dual Burden Plus Access Screening	Rapid triage to identify conditions for full review	PHC visibility/burden; high consequence/impact; access barrier	0-2 per dimension; total /6	PHC teams, community, district planners	Shortlist for Phase 2
Phase 2: Eight-Criteria Validation	Comprehensive prioritization and defensible justification	Burden/distribution; severity; psychosocial/socioeconomic impact; equity; public health importance; intervention feasibility; health-system relevance; community priority/evidence need	1-5 per criterion; total /40	District, regional, national coordination	Final priority band + action package
National Adaptation	Contextualize priorities using country data and capacity	National epidemiology, service readiness, financing, community input, policy commitments	Documented reconciliation	National coordination mechanism	National priority package + implementation plan

2. Phase 1: Rapid Screening for Pragmatic Use

2.1 When to use Phase 1

Phase 1 is designed for:

PHC facilities and community health workers identifying locally visible conditions.

District health managers conducting rapid needs assessments.

Resource-limited settings where full criterion review is challenging.

Initial triage before full eight-criteria analysis.

Phase 1 is not a final ranking. It is a simple screen that keeps the full framework usable in rural and resource-constrained settings.

Use of the PHC classification. The Common Skin Diseases for Management or Referral at Primary Health Care Level guidance may inform Phase 1 by showing which conditions are commonly encountered, require referral or carry urgent risk. Its management categories are service-delivery categories, not priority rankings, and should inform rather than replace the prioritization process.

2.2 The three Phase 1 dimensions

Dimension	Operational Definition	Score 0	Score 1	Score 2
PHC Visibility / Burden	How often the condition is seen, recognized, reported, or managed at PHC or community level	Rarely seen or not usually recognized	Occasionally seen, localized, or recognized only by trained staff	Commonly seen, recognized, reported, or managed at PHC/community level

Dimension	Operational Definition	Score 0	Score 1	Score 2
High Consequence / Impact	The seriousness for health, psychosocial wellbeing, functioning, household cost, or public health action	Usually mild; limited complications or stigma	Moderate symptoms, recurrence, cost, or referral need	Causes disability, disfigurement, severe stigma, cancer, sepsis, death, or urgent referral
Access Barrier to Health Facility	Whether distance, cost, transport, insecurity, or weak referral access increases the need to prioritize locally	Facility or referral access generally available	Some distance, cost, transport, or referral barriers	Major barriers: remote, insecurity, high cost, seasonal isolation, or weak referral

2.3 Phase 1 decision rules

Total score 5-6: High screening priority. Move to Phase 2.

Total score 3-4: Moderate priority. Review at district level and move to Phase 2 if there is high consequence, high access barrier, an equity concern, or programme relevance.

Total score 0-2: Lower screening priority. Keep on the watchlist unless there is an outbreak, case cluster, political mandate, or strong community concern.

Override rule: Any condition scoring 2 for high consequence or access barrier should be reviewed, even if the total score is moderate.

2.4 Phase 1 quick scoring sheet

The quick scoring sheet is provided in Annex D as Tool D1, with the full implementation guide in Annex A.

3. Phase 2: Comprehensive Eight-Criteria Validation

3.1 The eight criteria: core questions and evidence

The eight criteria are scored independently. Each captures a distinct dimension of importance; high performance in one criterion does not substitute for weakness in another.

Evidence-gap documentation. For each criterion, reviewers should record the strength of available evidence and the main evidence gaps. Missing evidence should not automatically lower priority where severity, equity, lived experience or public-health importance indicates a need for action. Material gaps should be transferred to the SHRIEF-aligned research and learning agenda.

Code	Criterion	Core Question	Key Evidence Sources
B	Burden & Distribution	What is the population health loss and reach?	DALYs (preferred); prevalence/incidence fallback; geographic distribution
S	Severity & Health Consequences	How serious for an affected individual?	Mortality, disability, disfigurement, complications, chronicity, pain, functional loss
P	Psychosocial & Socioeconomic Impact	What are the lived and household consequences?	Quality of life, mental health, stigma, school/work loss, caregiver burden, financial impact
E	Equity & Vulnerability	Does it disproportionately affect underserved groups?	Poverty, remoteness, overcrowding, displacement, occupation, age, gender, access barriers
PH	Public Health Importance	Does it create externalities requiring collective action?	Transmission, outbreaks, elimination relevance, vectors, AMR, secondary infection implications
I	Availability & Feasibility of Interventions	Can effective action be delivered at scale?	Effective treatments/prevention, affordability, diagnostic simplicity, PHC/community delivery feasibility
H	Health-System & Policy Relevance	How strongly does prioritization support services and commitments?	PHC/UHC fit, integration opportunities, workforce gaps, service readiness, alignment with programmes
C	Community Priority & Evidence Need	Are affected communities identifying unmet need, and is burden being missed?	Community demand, lived-experience salience, under-recognition, surveillance gaps, research needs

3.2 Coding anchors for non-burden criteria

For each criterion except burden and distribution, assess three to four sub-indicators using the following coding anchors.

Score	Definition
2	Strong evidence or major impact; systematic documentation; affects multiple sub-indicators
1	Moderate evidence or impact; some documentation; affects select sub-indicators
0	Limited or no relevant evidence; minimal impact; sub-indicator not demonstrated
NA	Evidence not assessed or insufficient; score not assigned

Average the sub-indicator scores and convert them to the 1-5 scale below.

Average Sub-indicator Score	Final Criterion Score
0.00–0.24	1
0.25–0.74	2
0.75–1.24	3
1.25–1.74	4
1.75–2.00	5

3.3 Burden and distribution criterion scoring

Use DALYs as the preferred global measure. Where unavailable, use prevalence as fallback 1 or incidence as fallback 2. Geographic distribution is recorded descriptively and applied only as a documented tie-breaker when estimates are near a threshold.

Criterion B Score	DALYs	Prevalence (if DALY unavailable)	Incidence/Year (if neither above)
1	<50,000	<1 million	<100,000
2	50,000 to <250,000	1 to <10 million	100,000 to <1 million
3	250,000 to <1 million	10 to <50 million	1 to <10 million
4	1 to <5 million	50 to <200 million	10 to <100 million
5	≥5 million	≥200 million	≥100 million

Distribution tie-break rule: Where estimates lie within approximately 10% of a threshold, broad multi-regional distribution or a clear high-burden hotspot may support one-level upward adjustment, with written justification.

3.4 Worked example: Scabies Phase 2 scoring

Criterion	Sub-indicators Assessed	Average Score	Final Score	Evidence Note
B: Burden	5.3M DALYs (GBD 2021); 622.5M incident cases	—	5	Very high global burden across multiple regions
S: Severity	Complications (1), chronicity (2), functional impact (2), pain/itch (2)	1.75	5	Severe itch, secondary infection risk, recurrence common
P: Psychosocial	QOL (2), mental health (1), stigma (2), work loss (1)	1.5	4	Significant sleep disruption, social embarrassment, school impact
E: Equity	Poverty link (2), vulnerable groups (2), access barriers (2)	2.0	5	Concentrated in lowest-SDI regions; overcrowding fuels transmission
PH: Public Health	Transmission (2), outbreak relevance (2), prevention value (2), community spread (2)	2.0	5	Highly contagious; household/community outbreaks; universal prevention applicable
I: Feasibility	Treatment effectiveness (2), affordability (2), PHC delivery (2), supply security (2)	2.0	5	Permethrin available, cheap, simple topical delivery at PHC
H: Health-System	PHC/UHC fit (2), service gap (2), integration opportunity (2)	2.0	5	Critical PHC burden; integration with skin clinics strengthens systems
C: Community	Community priority (2), under-recognition (1), evidence gap (1)	1.33	4	High community concern in endemic settings;

Criterion	Sub-indicators Assessed	Average Score	Final Score	Evidence Note
				improving surveillance needed
			TOTAL: 36	Core Priority Band

3.5 Priority bands

Total Score /40	Priority Band	Interpretation	Suggested Action
34–40	Core Priority	Requires explicit strategic attention in global and national baseline	Include in minimum package: training, commodities, referral pathways, reporting
29–33	High Priority	Strong basis for inclusion and action with implementation planning	Include in PHC guidance, planning, targeted reporting if feasible; allocate resources
24–28	Important Priority	Material priority; may rise with national burden or strategic context	Monitor, refer, include in selected districts, review periodically
8–23	Context-Specific Priority	May warrant targeted focus in relevant populations or settings	Watchlist unless local outbreak, equity concern, or mandate exists

4. How Phase 1 and Phase 2 Connect

The two phases are complementary, not competing. Phase 1 protects usability; Phase 2 protects validity.

Step	Question	Decision
1. Screen (Phase 1)	Is the condition visible at PHC, high consequence, or worsened by poor access?	If yes or uncertain → Move to Phase 2
2. Validate (Phase 2)	Does the condition remain important after applying all 8 criteria?	If yes → Assign final priority band
3. Act	What action is needed based on the priority band?	Training, medicines, referral, awareness, surveillance, partner support, national planning
4. Feedback	What should PHC teams receive back?	Final list, referral guidance, commodities, reporting instructions, training plan

5. Evidence, Confidence and Data-Quality Rules

5.1 Evidence sources and documentation

Each score should be supported by an evidence note specifying the data source, data date, reviewer name, basis for judgement, and whether missing evidence could materially change the decision.

Common evidence sources include:

Routine PHC registers and CHW logs.

School health and outreach reports.

Referral records and medicine stock data.

Programme reports, including NTD, elimination and surveillance sources.

Local expert consultation and community or patient input.

WHO Global Health Observatory, Global Burden of Disease data, systematic reviews and national epidemiological studies.

5.2 Missing evidence

Missing evidence should be recorded as an evidence gap, not automatically scored as zero. A provisional score may still be assigned where adequate evidence exists for other sub-indicators, but the confidence flag should be reduced.

5.3 Confidence flags

Flag	Interpretation	Typical Application
A	Direct global DALY/prevalence evidence plus concordant official or systematic-review data	Scabies, atopic dermatitis, melanoma

Flag	Interpretation	Typical Application
B	Strong global or programme evidence with limited inference or minor proxy use	Leprosy, cutaneous leishmaniasis, pressure ulcers
C	Cluster- or proxy-based evidence with material uncertainty	Post-kala-azar dermal leishmaniasis, tungiasis, venous leg ulcers
D	Evidence dominated by expert judgement or major missing data	Poorly documented entities; use with caution

5.4 Disease clusters and proxies

A disease cluster, such as “fungal skin infections”, should be retained only if component conditions:

Share a practical delivery pathway.

Do not diverge substantially across most criteria.

Otherwise, score conditions separately or clearly mark the cluster as a proxy.

6. Governance and National Adaptation

6.1 Principles for national adaptation

Transparency: Use documented decision rules and disclose any national reweighting or substitutions.

Evidence-informed: Apply national epidemiology, service readiness, financing, community input and policy commitments.

Inclusive: Include clinical, public health and community voices.

Auditable: Maintain a decision trail and reconcile disagreements in writing.

Responsive: Allow results to update service packages, training, commodities, referral systems and reporting.

6.2 National process workflow

Establish scope: Confirm whether prioritization covers all skin diseases, NTDs plus priority dermatoses, or service packages.

Prepare evidence sheets: One per condition with definition, burden, delivery pathway, equity, programme relevance and data gaps.

Apply independent scoring: Two reviewers score each condition.

Reconcile transparently: Document discrepancies exceeding 1 point and record the agreed rationale.

Validate with communities: Review psychosocial impact, equity, stigma and evidence gaps.

Test weighting scenarios where justified.

Publish results with priority bands, confidence flags, evidence and further validation needs.

Connection to NAP-Skin. National adaptation should be conducted through the NAP-Skin or equivalent planning process. Final priorities should be linked to PHC and referral actions, workforce requirements, commodities, laboratory and surveillance needs, financing, indicators, partner roles and related research or learning questions.

6.3 Key governance recommendations

Use two independent reviewers where possible, ideally one public health/epidemiology reviewer and one clinical/programme reviewer.

Reconcile differences greater than 1 point on any criterion in writing.

Include community or patient input for psychosocial, equity and evidence-need dimensions.

Report confidence alongside the priority band.

Update service packages, training, commodities, referral pathways and reporting systems based on results.

Transparency and accountability. Countries should document who participated, what evidence was used, how uncertainty and disagreement were handled, how equity and community perspectives influenced decisions, and when priorities will be reviewed. The decision trail should be reproducible and available for technical review.

7. Proposed Outputs

Minimum prioritization output package. The process should produce: (1) a priority disease, cluster or service-problem list; (2) a concise justification and confidence flag for each priority; (3) documented uncertainty and evidence gaps; (4) implications for PHC, referral, workforce, commodities, laboratory and surveillance systems; (5) proposed indicators; and (6) associated SHRIEF research or implementation-learning questions.

Output	Produced By	Used For	Frequency
Facility screening list	PHC facility or community team	Identify locally visible, high-consequence, access-sensitive conditions	Annual/per cycle
District validated priority list	District health management team	Plan training, commodities, referral support	Annual with review
Regional synthesis	Provincial/regional team	Compare districts, identify common gaps	Bi-annual
National priority package	National coordination mechanism	Approve priorities, align with GAP-SKIN, mobilize resources, define reporting	3–5 yearly
Feedback package to PHC	National/regional/district teams	Communicate final list, referral guidance, reporting instructions, support plan	With national updates

8. Primary Health Care Considerations

PHC manageability complements but does not replace prioritization. Some common high-burden conditions can be assessed and managed at first contact when danger signs are absent, such as scabies, impetigo and superficial fungal infections. Other high-priority conditions require specialist or programme-based pathways, such as leprosy, onchocerciasis and mycetoma.

PHC evidence primarily informs:

Criterion I (Feasibility): PHC diagnostic and management capacity.

Criterion H (Health-System Relevance): Service demand and integration opportunity.

Common PHC-manageable conditions include:

Atopic dermatitis, contact dermatitis and seborrhoeic dermatitis.

Psoriasis, acne, urticaria and scabies.

Pediculosis, tinea corporis/cruris/pedis, pityriasis versicolor and candidal intertrigo.

Impetigo, cellulitis, folliculitis and abscess.

Viral warts, molluscum contagiosum, herpes simplex, herpes zoster and pityriasis rosea.

The implementation tools in Annex D provide practical forms and referral-oriented prompts for PHC and district teams.

9. Illustrative Global Priority Matrix

The matrix below applies the consolidated scoring using the most recent evidence synthesis. Results within the same band are broadly equivalent for global discussion; national adaptation is expected to modify priorities where evidence and policy needs differ.

Scores within the same band are broadly equivalent and should not be interpreted as strict rank ordering. National adaptation should review priorities against country evidence, capacity and policy needs.

Disease or Cluster	B	S	P	E	PH	I	H	C	Total	Band	Conf.
Scabies	5	5	4	5	5	5	5	4	38	Core	A
Bacterial skin infections	5	4	3	5	5	5	5	4	36	Core	B
Leprosy	2	5	5	5	5	4	5	5	36	Core	B
Lymphatic filariasis	3	5	5	5	4	4	5	4	35	Core	B
Onchocerciasis	3	5	4	5	4	4	5	4	34	Core	B
Yaws	2	4	4	5	5	5	5	4	34	Core	B
Cutaneous leishmaniasis	3	4	5	5	4	3	4	4	32	High	B
Post-kala-azar dermal leishmaniasis	1	4	5	5	5	3	4	5	32	High	C
Atopic dermatitis	5	3	5	3	1	4	5	4	30	High	A
Buruli ulcer	1	5	5	5	3	3	4	4	30	High	B
Pressure ulcers	3	5	4	4	2	4	5	3	30	High	B
Keratinocyte skin cancers	4	4	4	3	3	4	4	3	29	High	A
Tungiasis	2	4	4	5	3	4	4	4	30	High	C
Psoriasis	4	4	5	3	1	3	5	4	29	High	A
Mycetoma & deep mycoses	1	5	5	5	2	2	4	5	29	High	C

10. Recommended Wording for Adoption

“A two-phase prioritization approach is proposed for skin disease selection at national and global levels. In Phase 1, diseases are screened using a pragmatic dual-burden-plus-access lens assessing PHC visibility/burden, high consequence/impact, and access barriers to health facilities. This provides a rapid, rural-friendly method for identifying conditions warranting further review. In Phase 2, shortlisted conditions are validated using a comprehensive eight-criterion framework assessing burden and distribution, severity, psychosocial and socioeconomic impact, equity and vulnerability, public health importance, intervention feasibility, health-system relevance, and community priority or evidence need. This two-phase approach ensures that the final priority list is pragmatic for PHC implementation while remaining defensible for national planning and aligned with global health priorities and capacity constraints.”

Annexes

The annexes consolidate the detailed implementation material and templates. Repeated introductory text from the merged draft has been removed; the annexes now function as operational tools rather than a second framework narrative.

Annex	Purpose
Annex A	Phase 1 implementation guide
Annex B	Phase 2 implementation guide
Annex C	Data integration from Phase 1 to Phase 2
Annex D	Practical implementation tools and templates
Annex E	Illustrative full workflow
Annex F	National adaptation and sustainability
Annex G	Summary of key improvements
Annex H	References to key WHO and international guidance

Annex A. Phase 1 Implementation Guide

1.1 Phase 1 Purpose and Governance

When: Initial rapid screening, typically at PHC or district level Who: PHC facility staff, community health workers, district health managers Timeline: 2–4 weeks for facility/district screening; 4–8 weeks to compile district results Output: Pre-screened list of conditions advancing to Phase 2

1.2 Phase 1 Data Collection: Operational Definitions

Dimension 1: PHC Visibility / Burden

Operational definition: How frequently is this condition actively seen, managed, or reported at PHC or community level (not from referral data)?

Data collection method:

- Review PHC facility register (outpatient) for past 12 months
- Review CHW logs or community health worker reports for past 12 months
- Count the number of consultations mentioning the condition
- If <5 total cases in 12 months: likely Score 0
- If 5–50 cases in 12 months or monthly presence: likely Score 1
- If >50 cases in 12 months or weekly presence: likely Score 2

Scoring guidance (SPECIFIC THRESHOLDS):

Score	Definition	Operational Rule	Data Source
0	Rarely seen or not usually recognized	Condition mentioned in <5 PHC visits/year OR not recognized by facility staff without referral training	PHC registers (annual count)
1	Occasionally seen, localized, or recognized only by trained staff	Condition mentioned in 5–50 PHC visits/year OR recognized only after brief training OR concentrated in one geographic area	PHC registers + CHW reports
2	Commonly seen, recognized, reported, or managed at PHC/community level	Condition mentioned in >50 PHC visits/year (>4/month) OR routinely managed at first contact OR present in most geographic areas served	PHC registers + CHW logs + community perception

Example: If PHC register shows 12 cases of atopic dermatitis managed in 12 months and staff recognize it without training, the score is 1 (occasionally seen). If the register shows 85 cases and most are managed at first visit, the score is 2.

Dimension 2: High Consequence / Impact

Operational definition: Does this condition cause serious individual-level or family-level consequences (not frequency, but severity when it occurs)?

Data collection method:

- Review facility records for severity markers: hospitalizations, complications, disability, death, cost burden
- Ask 5–10 patients or carers: “What is the worst that happened to you/your family from this condition?”
- Document specific consequences observed

Scoring guidance (SPECIFIC INDICATORS):

Score	Definition	Operational Rule — Presence of ANY of the following	Data Source
0	Usually mild; limited complications or stigma	Condition typically self-limiting; complications rare; symptoms mild; no functional loss; no household disruption; no work/school loss	Clinical case notes; patient interview
1	Moderate symptoms, recurrence, cost, or referral need	Condition causes recurrent episodes; moderate pain/itch; occasional work/school loss (1–2 days/month); household	Facility records; patient cost data; referral tracking

Score	Definition	Operational Rule — Presence of ANY of the following	Data Source
		cost burden (5–10% of monthly income); OR requires referral in 10–25% of cases	
2	May cause disability, disfigurement, severe stigma, cancer, sepsis, death, or urgent referral need	Condition causes disability (ADL restriction); permanent disfigurement; blindness; mobility loss; cancer risk; sepsis/death risk; severe stigma (social withdrawal, refused marriage); OR requires urgent referral (ambulance/same day) in >25% of cases	Clinical case notes; severe outcome registry; patient/family interviews

Example: Scabies with secondary bacterial infection (sepsis risk) → Score 2. Mild acne without scarring → Score 0. Recurrent fungal infection with temporary work loss → Score 1.

Dimension 3: Access Barrier to Health Facility

Operational definition: Does poor access to diagnosis, treatment, or appropriate referral make this condition a priority for local PHC management?

Data collection method:

- Map travel time to nearest facility with capacity for this condition (e.g., specialist referral for advanced case)
- Assess transport cost, security, referral pathway, seasonal closure
- Document % of population with access barrier

Scoring guidance (SPECIFIC BARRIERS):

Score	Definition	Operational Rule — Presence of ANY of the following	Data Source
0	Facility or referral access generally available	Travel time <1 hour to PHC AND <3 hours to referral facility for most population; OR seasonal barrier <2 months/year; referral pathway functional and known	Travel time survey; facility mapping; referral tracking
1	Some distance, cost, transport, or referral barriers	Travel time 1–3 hours to referral facility; transport cost 5–15% of daily income; seasonal barrier 2–4 months/year; OR referral pathway exists but unreliable (>20% of referrals fail to reach facility)	Travel time survey; cost data; referral pathway audit
2	Major barriers: remote area, insecurity, high transport cost, seasonal isolation, or weak referral access	Travel time >3 hours to referral facility for >50% of population; OR transport cost >15% of daily income; OR seasonal closure >4 months/year; OR insecurity prevents travel; OR referral pathway broken/unknown (>50% referral failure)	Travel time survey; cost data; insecurity mapping; referral audit

Example: Rural area with 4-hour travel to nearest district hospital, unpaved seasonal road, transport cost 20% of daily wages → Score 2. Urban area with 30-minute travel, functional referral pathway, <5% transport cost → Score 0.

1.3 Phase 1 Scoring and Decision Rules

Calculation:

- Score each dimension independently (0, 1, or 2)
- Total = sum of three scores (range 0–6)

Decision rules:

Total Score	Recommended Action	Definition
5–6	ADVANCE TO PHASE 2	High priority for comprehensive review
3–4	CONDITIONAL ADVANCE	Review at district level; advance to Phase 2 IF any of: (a) score of 2 on consequence OR access dimension; (b) documented equity concern; (c) programme relevance (e.g., NTD focus); (d) stakeholder concern
0–2	WATCHLIST	Do not advance UNLESS: (a) outbreak/case cluster documented; (b) political/community mandate; (c) emerging public health threat

Override rule: Any condition scoring 2 on "high consequence" OR "access barrier" MUST be reviewed at district level, regardless of total score. If confirmed as high consequence or major access barrier, advance to Phase 2.

1.4 Phase 1 Data Collection and Compilation Process

Step 1: Facility Screening (Weeks 1–2) - Each PHC facility completes Phase 1 screening sheet - Data sources: Facility registers (past 12 months), CHW logs, staff interviews (30 min per facility) - Facility focal person records data and submits to district health office

Step 2: Data Compilation at District Level (Weeks 3–4) - District health officer receives facility submissions - Aggregate data into district-level matrix - Tabulate: total score per condition, frequency distribution, any anomalies - Identify conditions with:

- Consistent high scores (3+ facilities scoring ≥2 on any dimension)
- Access barriers in specific geographic zones
- Equity flags (concentrated in vulnerable populations)

Step 3: District Validation Meeting (Week 4) - Convene 5–7 district staff: health manager, clinician, CHW coordinator, (if available) epidemiologist - Review compiled data - Discuss outliers or conflicting facility scores - Document consensus and reasons for any score adjustments - Identify conditions advancing to Phase 2 - Note data quality issues (e.g., incomplete registers)

Output: District Phase 1 summary with:

- Ranked list of conditions by total score
- Data quality assessment
- Geographic variation (conditions with access barriers in specific areas)
- Equity flags
- Conditions advancing to Phase 2 (with justification if score <5)

1.5 Phase 1 Data Quality Assurance

Check:

1. Completeness: Are all three dimensions scored for each condition? (If not, mark as "insufficient data for Phase 1")
2. Consistency: Do related conditions show similar scores? (E.g., if "impetigo" scores 2 and "bacterial skin infections" scores 0, review case definitions)
3. Registry quality: Are facility registers legible and dated? (If registers are poorly kept, flag confidence as "C" — expert judgment used)
4. Geographic pattern: Does facility variation reflect true epidemiology or data quality differences? (If >2-fold variation unexplained, conduct spot check)

If data quality is poor:

- Supplement with rapid verbal autopsy or expert consultation (district clinician + 2 experienced CHWs)
- Document source of judgment
- Flag result as lower confidence
- Plan to strengthen registers for next cycle

Annex B. Phase 2 Implementation Guide

2.1 Phase 2 Purpose and Governance

When: Full validation of Phase 1 shortlist Who: Two independent reviewers per condition (public health specialist + clinician/programme lead) Timeline: 6–12 weeks (2–4 weeks per condition, depending on evidence availability and consultation complexity) Output: Priority band assignment with evidence trail and confidence flag

2.2 Phase 2 Criterion-by-Criterion Scoring

Each of the eight criteria is scored 1–5 using specific operational definitions and measurable sub-indicators. Scoring is independent across criteria: high burden does NOT automatically increase severity or equity scores.

2.2.1 CRITERION B: BURDEN AND DISTRIBUTION

Operational definition: What is the population health loss (measured by DALYs, YLDs, or proxy) and who is affected geographically?

Principle: Use quantitative thresholds with documented fallback rules. Do NOT use geography as a bonus; geography is context only.

Data hierarchy:

5. Primary: Global Burden of Disease (GBD) DALYs or YLDs (most recent year available)
6. Fallback 1: Prevalence (global or regional estimate, if DALY unavailable)
7. Fallback 2: Incidence/year (if prevalence unavailable)
8. Fallback 3: Programme proxy (e.g., cases reported to elimination programme; use only with confidence downgrade)

Scoring thresholds:

B Score	If DALYs Available	If Prevalence Used (Fallback 1)	If Incidence Used (Fallback 2)	Confidence Adjustment
1	<50,000 DALYs	<1 million people	<100,000 cases/year	No change (direct data)
2	50,000 to <250,000	1 to <10 million	100,000 to <1 million	No change
3	250,000 to <1 million	10 to <50 million	1 to <10 million	No change
4	1 to <5 million	50 to <200 million	10 to <100 million	No change
5	≥5 million	≥200 million	≥100 million	No change

If using fallback (prevalence instead of DALY): Note in confidence flag as “Burden measured via prevalence proxy, not DALY.”

Geographic distribution rule (NOT a score bonus):

- Document distribution as: global, multi-regional, regional hotspot, or highly focal
- Distribution is context only; it is used as a tie-breaker ONLY when two conditions score within ~10% of a threshold boundary
- Example: Condition A = 246,000 DALYs (borderline B=2/3); Condition B = 252,000 DALYs (similar boundary). If A is global and B is focal, neither gets an automatic uplift. Both remain at the naturally calculated score, with notation of distribution.

Data sources for Criterion B:

- Global Burden of Disease database (WHO/IHME) — preferred
- WHO Global Health Observatory
- WHO disease-specific fact sheets
- National epidemiological surveys
- Systematic reviews with global pooling

Documentation required:

- Source and year of burden estimate
- If DALY: from GBD (cite year and disease code)
- If prevalence/incidence: cite source study, population, and year
- If programme proxy: specify data (e.g., “cases reported to national leprosy programme, 2024”)
- Geographic distribution (which regions/countries affected)

Example scoring — Scabies:

- GBD 2021: 5.3 million DALYs → B = 5 ✓ (direct GBD data, highest confidence)

- Multi-regional distribution (Oceania, Sub-Saharan Africa, South Asia, Latin America) → geographic context noted, no bonus applied

Example scoring — Buruli ulcer:

- GBD 2021: ~1,800 DALYs OR 1,862 cases reported to WHO → B = 1 ✓ (rare condition, high burden/case due to severity captured in Criterion S, not B)
- Distribution: Primarily West Africa → geographic context noted

2.2.2 CRITERION S: SEVERITY AND HEALTH CONSEQUENCES

Operational definition: How serious are the individual health outcomes for a person with this condition?

Principle: Rate the worst-case and common complications, not the mildest presentation. Severity is independent of burden; a rare but devastating condition can score high.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. Acute severe complications or hospitalization risk	No acute life-threatening complications; self-limited disease	Occasional (5–25% of cases) complications requiring treatment intensification or hospital observation	Frequent (>25% of cases) complications requiring hospitalization, intensive care, or emergency intervention; mortality risk	Clinical case series; hospital admission records; mortality data
2. Irreversible morbidity or permanent disfigurement	No permanent consequence; fully reversible	Occasional scarring, minor functional loss, OR low risk of blindness/limb loss (<5% of untreated cases)	Permanent disfigurement, blindness, amputation, paralysis, or chronic disability in significant proportion of untreated cases (>10%)	Clinical outcomes studies; rehabilitation/disability registries
3. Chronicity, recurrence, relapse	Acute self-limited disease; resolves fully	Frequent recurrence (>50% of people) OR chronic symptoms lasting >6 months	High relapse rate (>70% within 2 years) OR lifelong chronic disease requiring ongoing management	Longitudinal clinical studies; treatment adherence/relapse data
4. Functional impairment, pain, itch, blindness, mobility loss, ulceration, sepsis, or amputation	Minimal or no functional impact; mild pain/itch that does not restrict activity	Moderate functional impact (restricts some ADL, school/work <10% loss); moderate pain/itch	Severe functional impact (restricts most ADL, >10% work/school loss); intolerable pain/itch; OR risk of sepsis/death	Patient-reported outcome measures; ADL/IADL scales; work loss data

Conversion to Criterion S score

Average the sub-indicator scores and convert them to the 1-5 criterion scale using the table below.

Average sub-indicator score	Final criterion score
0.00–0.24	1
0.25–0.74	2
0.75–1.24	3
1.25–1.74	4
1.75–2.00	5

Documentation required:

- For each sub-indicator: specific evidence source and data (not general statement)
- If unavailable for one sub-indicator: document as “NA” and explain why; lower confidence flag
- Example: “Sub-indicator 2: 30% of untreated leprosy develops permanent nerve damage [cite clinical trial]. Score 2.”

Example scoring — Leprosy

Sub-indicator	Score	Evidence
1. Acute complications	2	Borderline lepromatous disease can develop leprosy reactions with nerve inflammation (cited in WHO classification)
2. Permanent morbidity	2	30% of MB leprosy develops permanent nerve damage; blindness in 1–5% [Clinical Dermatology reference]
3. Chronicity	2	Lifelong disease without treatment; relapses occur despite cure in <5% if properly treated
4. Functional impairment	2	Nerve damage causes permanent hand/foot disability; inability to work/school in 10–20% [WHO guidelines]
Average:	1.75–2.00	S Score = 5

Example scoring — Mild acne

Sub-indicator	Score	Evidence
1. Acute complications	0	Acne is not life-threatening; severe infections rare
2. Permanent morbidity	0	Scarring occurs in <5% of mild acne; most resolves without permanent marks
3. Chronicity	1	Adolescent acne resolves by age 25 in >90%; chronic adult acne occurs in 10–15%
4. Functional impairment	1	Mild acne causes cosmetic concern but minimal ADL restriction; school attendance unaffected in most
Average:	0.25–0.74	S Score = 2

2.2.3 CRITERION P: PSYCHOSOCIAL AND SOCIOECONOMIC IMPACT

Operational definition: What are the lived consequences for the affected person and family, including mental health, quality of life, economic hardship, and social stigma?

Principle: Measure documented effects, not theoretical effects. Use validated quality-of-life scales where available.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. Health-related quality of life (QOL) impairment	QOL scores normal or near-normal (DLQI <5 if available); no itch, pain, or sleep disruption	Moderate QOL impairment (DLQI 5–10 or equivalent); itch/pain causes occasional sleep loss or social withdrawal	Severe QOL impairment (DLQI >10); severe itch/pain causes frequent sleep loss, social isolation, or inability to concentrate	DLQI/CDLQI or equivalent QOL scale; patient sleep/activity logs
2. Mental health effects or stigma-related distress	No documented depression, anxiety, or stigma; mental health unaffected	Mild to moderate depression/anxiety in 10–30% of patients (PHQ-9 score 10–20); occasional stigma experience (social awkwardness but functional)	Severe depression/anxiety in >30% or suicidality in some patients (PHQ-9 >20); severe stigma (social withdrawal, marriage refusal, occupational discrimination, refused school entry)	Depression/anxiety screening (PHQ-9, GAD-7); stigma scale; mental health comorbidity data
3. School or work loss	No documented loss; children attend school, adults work normally	Occasional loss (1–5 days/month) due to flares, treatment side effects, or clinic visits; OR reduced productivity; OR occupational restrictions (job changes needed)	Frequent loss (>5 days/month); OR long-term school dropout/work inability; OR major occupational restriction (loss of job category); OR caregiver burden preventing other family member work	School attendance records; workplace absence; occupational health data
4. Household financial or caregiver burden	Condition requires no out-of-pocket spending OR <1% of household income; no family caregiver need	Condition costs 1–10% of household monthly income for treatment/care/transport; OR requires part-time caregiver assistance	Condition costs >10% of monthly household income (catastrophic expense); OR requires full-time caregiver (loss of caregiver work income); OR household debt/asset loss due to condition	Household expenditure surveys; health facility cost data; caregiver burden assessment

Conversion to Criterion P score

Conversion to Criterion P score: Average the four sub-indicator scores → convert to 1–5 scale (same conversion table as Criterion S)

Documentation required:

- If using DLQI: report mean DLQI score in affected cohort
- If no formal QOL scale: document specific patient quotes or interview findings
- Example: “5 of 8 interviewed psoriasis patients reported sleep loss 3+ nights/week; 3 reported depression diagnosis (PHQ-9 >15). Score 2.”

Example scoring — Psoriasis

Sub-indicator	Score	Evidence
1. QOL impairment	2	Mean DLQI 13–18 reported in multiple studies; visible psoriasis (face, hands) causes significant burden

Sub-indicator	Score	Evidence
2. Mental health/stigma	2	10–15% of psoriasis patients have depression (PHQ-9 >15); 30–50% report stigma (job interviews, social events) [cite systematic review]
3. School/work loss	2	Visible plaques cause presenteeism; 5–10% workplace discrimination; 1–2 days/month clinic attendance
4. Financial burden	1	Topical therapies cost <5% household income in high-income settings; higher in low-income settings; biologic therapy not accessible to most
Average:	1.75–2.00	P Score = 5

2.2.4 CRITERION E: EQUITY AND VULNERABILITY

Operational definition: Does this condition disproportionately affect disadvantaged, excluded, or underserved populations?

Principle: Use population-level data (prevalence ratios) and structural markers (poverty, remoteness, displacement, discrimination). Perception alone is insufficient; use documented patterns.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. Social gradient or poverty link	Condition distributed equally across wealth quintiles (prevalence ratio Q5:Q1 ≈1) OR higher in wealthy populations (e.g., melanoma in high-income countries)	Condition more common in poorer quintiles (prevalence ratio Q1:Q5 = 1.5–2); or higher costs burden poorer households disproportionately	Strong poverty gradient (prevalence ratio Q1:Q5 >2); or catastrophic costs for poorest households (>20% income)	Disaggregated epidemiological data by wealth quintile; cost data by income group
2. Vulnerable populations disproportionately affected	No documented disparity in age, gender, occupation, disability, displacement; burden equal across groups	One vulnerable group disproportionately affected: e.g., children (>1.5x prevalence vs. adults), specific occupation (farmers, miners), recent refugees (>1.5x vs. general population)	Multiple or highly vulnerable groups affected: e.g., both children AND pregnant women AND displaced; OR very high burden in specific marginalized group; OR occupational exposure in low-protection sectors	Age/gender/occupation disaggregated data; census data; occupation exposure assessment
3. Barriers to diagnosis, treatment, or follow-up	Diagnosis and treatment accessible to all groups; diagnostic test available at PHC; medicines in EMML; no documented discrimination	Some groups face barriers: e.g., women travel restrictions (10–20% reduction in access), OR low literacy (<5 grade) makes self-management difficult, OR cultural stigma delays care-seeking (30–50% delayed)	Major barriers affecting majority: e.g., women cannot travel without male chaperone; diagnosis requires specialist (>3 hours away); treatment not in EMML; language barriers; OR active discrimination (denied school entry, employment, marriage based on condition)	Access audit (travel time, cost by population group); health facility accessibility assessment; cultural/social survey
4. Historical neglect or structural discrimination	Condition has received explicit policy attention and resource allocation; no historical exclusion documented	Condition has received limited policy attention; mentioned in strategy but not resourced; OR brief history of stigma now improving	Condition has long history of neglect (no guidelines, no trained staff, not in EMML); OR ongoing structural discrimination (not recognized in certain regions, affected people denied services); OR community perceives strong discrimination	Policy document review; guideline status; budget allocation; patient/community interviews

Conversion to Criterion E score

Conversion to Criterion E score: Average the four sub-indicator scores → convert to 1–5 scale

Documentation required:

- For each sub-indicator: cite specific data (prevalence ratio, % with barriers, policy status)
- Use PROGRESS-Plus framework if available:
- P = Place (rural/urban, geography)
- R = Race/ethnicity
- O = Occupation
- G = Gender
- R = Religion

- E = Education/literacy
- S = Socioeconomic status
- S = Social capital
- + = Plus: Disability, sexual orientation, displacement
- Example: “Leprosy prevalence in lowest-income quintile 4.2x higher than wealthiest quintile [national survey]. Affects predominantly rural populations (90% of cases). Ongoing social discrimination documented (60% marriage refusal in 3 communities surveyed). Score 2 for all sub-indicators.”

Example scoring — Leprosy

Sub-indicator	Score	Evidence
1. Social gradient	2	Leprosy concentrated in lowest-income countries/regions; higher prevalence in poverty zones
2. Vulnerable populations	2	Affects indigenous groups, displaced populations, poorest regions disproportionately; occupational exposure in low-protection sectors
3. Barriers to access	2	Patients travel >3 hours for diagnosis/treatment; cultural stigma delays care; women face family restrictions
4. Structural neglect	2	History of isolation/segregation; ongoing social exclusion; some countries still lack guidelines; discrimination in employment
Average:	2.0	E Score = 5

2.2.5 CRITERION PH: PUBLIC HEALTH IMPORTANCE

Operational definition: Does this condition create population-level externalities or require collective action (transmission, vector/reservoir involvement, outbreak capacity, antimicrobial resistance, prevention value)?

Principle: Individual clinical seriousness is Criterion S. Public health importance is about externalities and collective action needs.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. Person-to-person transmission or community externality	No transmission (non-communicable disease with no household/community clustering); OR transmission blocked by simple measures (hand hygiene)	Limited transmission: secondary attack rate <20% among household contacts; OR transmission occurs but easily interrupted by simple measures (e.g., topical barrier)	High transmissibility: secondary attack rate >50% in household/community; OR transmission difficult to interrupt (respiratory, contact despite hygiene efforts)	Outbreak investigations; secondary attack rate studies; transmission studies
2. Outbreak, elimination, or eradication relevance	No outbreak capacity or epidemic potential; sporadic cases only	Occasional outbreaks documented in institutional settings (schools, prisons, barracks) or outbreak risk in specific populations; OR elimination technically possible but not a global priority	Frequent outbreaks (seasonal or recurrent); outbreak investigations documented; OR elimination achievable within timeframe (10–30 years) with resources; OR eradication feasible (similar to smallpox)	Outbreak reports; programme documentation (WHO NTD, elimination programs); epidemiological analysis
3. Vector, reservoir, AMR, secondary infection, or climate sensitivity	No vector/reservoir role; no AMR implications; secondary infection risk <5%	Vector-borne (e.g., onchocerciasis, leishmaniasis) or animal reservoir exists but manageable; OR 5–20% risk of AMR-relevant secondary infection (e.g., scabies → impetigo); OR climate sensitivity (geographic range shifting with temperature)	Strong vector or reservoir role requiring environment/animal control; OR frequent secondary infection with AMR organisms (>20% of cases); OR highly climate-sensitive with range expanding due to warming	Entomological surveys; zoonotic transmission reports; secondary infection microbiology; climate sensitivity modeling
4. Value of community-wide or population-level prevention	Prevention is individual-level only (no population benefit from treating individuals); OR prevention ineffective at scale	Community prevention has moderate value: e.g., water/sanitation improves some conditions; mass drug administration reaches 50–70% compliance	Community-wide prevention is essential: e.g., mass drug administration required for elimination, environmental control required for vector control, universal hand hygiene programs needed for outbreak control	Prevention efficacy studies; implementation experience

Conversion to Criterion PH score

Conversion to Criterion PH score: Average the four sub-indicator scores → convert to 1–5 scale

Documentation required:

- For transmission: cite secondary attack rate data (not anecdote)
- For outbreak: cite specific documented outbreaks (date, location, size, response)
- For AMR: cite organism and resistance pattern data
- For vector: cite vector species, distribution, control measures

Example scoring — Scabies

Sub-indicator	Score	Evidence
1. Transmission	2	Secondary attack rate in household contacts >50%; high transmissibility in crowded settings
2. Outbreak relevance	2	Frequent outbreaks in institutions; elimination campaigns document rapid control (e.g., Fiji elimination efforts)
3. Secondary infection/AMR	2	30–50% of scabies cases develop secondary bacterial infection (impetigo); increasing MRSA in secondary lesions [cite microbiology data]
4. Community prevention value	2	Mass treatment + environmental measures (hygiene, laundry) highly effective; community-based campaigns documented to interrupt transmission
Average:	2.0	PH Score = 5

2.2.6 CRITERION I: AVAILABILITY AND FEASIBILITY OF INTERVENTIONS

Operational definition: Can effective treatment, prevention, or safe referral be delivered at scale (affordability, supply security, PHC feasibility, diagnostic simplicity)?

Principle: Feasibility is independent of burden. A rare condition requiring complex specialist intervention can have low I score; a common condition manageable at PHC can have high I score.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. Intervention effectiveness and WHO guideline status	No effective intervention exists; OR WHO guideline rates effectiveness as low; OR intervention highly toxic/unacceptable side effects	Moderately effective intervention exists (>60% cure/improvement rate); OR WHO guideline rates as conditional or limited evidence; OR efficacy varies widely	Highly effective intervention (>80% cure/improvement); AND WHO guideline recommends (strong recommendation); AND evidence base is robust	WHO guidelines; RCT data; systematic reviews; clinical trial efficacy
2. Affordability and supply security	Intervention costs >20% household monthly income; OR chronic shortage (stock-outs >3 months/year); OR not on WHO EMML	Intervention costs 5–20% monthly income; OR occasional shortages (stock-outs 1–3 months/year); OR restricted supply in some regions; OR generic available but not universally	Intervention costs <5% monthly income; AND supply secure and available (stock-outs <1 month/year); AND on WHO EMML or widely available generics	WHO EMML; market pricing data; supply chain audits; stock-out tracking
3. Diagnostic simplicity and PHC/community delivery feasibility	Diagnosis requires specialist expertise or advanced laboratory (e.g., biopsy, histology, specialist imaging); OR treatment requires hospitalization or specialist supervision	Diagnosis requires basic lab (microscopy, culture) or trained clinician; treatment requires supervised clinic visits but can occur at district level or PHC with training; 50–80% of cases manageable at PHC	Diagnosis is clinical or simple field test (e.g., skin scraping, KOH); treatment is topical/oral medication manageable by CHW or patient; >80% of cases manageable at PHC or community	Clinical diagnostic criteria documentation; diagnostic algorithm; PHC feasibility assessment
4. Commodity and supply chain status	Essential medicines/diagnostics not available in-country; OR supply chain non-existent; OR requires import with long lead times; OR unaffordable at retail	Medicines available but supply inconsistent; diagnostic tests available in limited locations; procurement requires special ordering; availability 50–80% across facilities	Medicines/diagnostics available in EMML, regularly procured, available in >80% of PHC facilities; supply chain stable; affordable; rapid resupply	National medicine list status; supply chain audit; facility stock surveys; procurement records

Conversion to Criterion I score

Conversion to Criterion I score: Average the four sub-indicator scores → convert to 1–5 scale

Documentation required:

- WHO guideline recommendation strength (strong/conditional/weak)
- Intervention cost as % of household income or absolute price
- Supply chain data (stock-out frequency in last 12 months)
- % of facilities stocking intervention (from supply audit)

Example scoring — Scabies

Sub-indicator	Score	Evidence
1. Effectiveness	2	Permethrin 5% cure rate >90%; WHO strong recommendation [cite guideline]
2. Affordability/supply	2	Permethrin costs $0.50–1.50 per treatment (<0.5% monthly income in most settings); widely available, generic, stable supply
3. Diagnostic simplicity	2	Diagnosis clinical (burrow, mite) or simple mite-finding prep; PHC staff can train in 2 days; >90% manageable at PHC
4. Supply chain	2	Permethrin in WHO EMML; regularly procured; available in 95% of surveyed PHC facilities in endemic region
Average:	2.0	I Score = 5

Example scoring — Mycetoma

Sub-indicator	Score	Evidence
1. Effectiveness	1	Treatment options exist (surgery, antifungals) but cure rates 40–60%; surgery requires specialist; outcome variable
2. Affordability/supply	0	Antifungal agents (itraconazole) cost >$5–10/month (5–10% income in low-income settings); specialized surgeons rare; not in all national formularies
3. Diagnostic simplicity	0	Diagnosis requires imaging (ultrasound/CT) and specialist examination; culture takes weeks; PHC staff cannot diagnose
4. Supply chain	0	Surgical expertise not available in most settings; limited access to advanced imaging; supply irregular
Average:	0.25–0.74	I Score = 2

2.2.7 CRITERION H: HEALTH-SYSTEM AND POLICY RELEVANCE

Operational definition: How strongly does prioritizing this condition support existing health-system priorities, PHC/UHC goals, service readiness, and policy commitments?

Principle: Health-system fit is not about burden; it is about strategic alignment. A common condition poorly integrated into systems may have high H score if integration is achievable.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. PHC/UHC fit and integration opportunity	Condition does not align with PHC/UHC service model; limited integration opportunity; requires specialist pathway	Condition partially aligns with PHC/UHC (some cases manageable at first contact, some need referral); moderate integration opportunity with training	Strong alignment with PHC/UHC model; high proportion of cases manageable at first contact; clear integration opportunity with existing services (e.g., maternal health, child health)	National health policy; UHC service package documents; PHC guidelines
2. Service gap or avoidable service readiness barrier	Service currently adequate; no major diagnostic, trained staff, or referral gap; >80% of facilities have capacity	Moderate gap: <50% of facilities have trained staff, OR diagnosis/treatment inconsistently available, OR referral pathway unreliable in >30% of attempts	Major gap: <30% of facilities have trained staff for this condition; diagnosis not available; treatment shortage frequent; OR referral pathway broken in >50% of cases	Service readiness assessment; facility capacity survey; health workforce audit
3. Workforce, diagnostic, or referral development opportunity	Addressing this condition requires new workforce cadre (nurses, specialist doctors) unlikely to be developed; OR requires new diagnostic infrastructure	Addressing this condition can strengthen existing workforce (CHW upskilling, midwife training) or upgrade existing diagnostics (add microscopy); OR referral system clarification	Addressing this condition strengthens PHC workforce with feasible tasks (CHW medication distribution); upgrades existing diagnostics; improves referral pathways; aligns with other programme strengthening efforts	Human resources strategy; diagnostic strategy; referral protocols

Sub-indicator	Score 0	Score 1	Score 2	Data Source
4. Alignment with national and global commitments	Condition not mentioned in national health policy, NTD strategy, or global commitments (WHO, SDG, WHO programmes); not a priority elsewhere	Condition mentioned in some policy documents (e.g., national cancer plan, adolescent health strategy) OR aligns with one global programme (NTD, maternal health)	Strong policy alignment: mentioned explicitly in national health policy AND aligns with multiple global commitments (e.g., GAP-SKIN, UHC, NTD, WHO programmes); OR elimination commitment exists	National health policy documents; NTD strategy; WHA resolutions; national programme documentation

Conversion to Criterion H score

Conversion to Criterion H score: Average the four sub-indicator scores → convert to 1–5 scale

Documentation required:

- Policy document: cite specific reference to condition
- Service gap: cite data from service readiness assessment (e.g., “28% of facilities trained to manage condition”)
- Commitment: cite WHA resolution, national policy page, programme goals

Example scoring — Scabies

Sub-indicator	Score	Evidence
1. PHC/UHC fit	2	Scabies directly aligned with PHC service model; >90% manageable at first contact; integrates with child health, nutrition programs
2. Service gap	2	Rapid needs assessment shows 35% of PHC facilities have trained staff for scabies management; major gap to address; integration achievable
3. Workforce opportunity	2	CHW training (2 days) enables community treatment; no new cadre required; existing supply chains can accommodate permethrin
4. Policy alignment	2	Mentioned in GAP-SKIN framework; aligns with WHO NTD agenda, WHA skin disease resolution; national neglected disease priorities
Average:	2.0	H Score = 5

2.2.8 CRITERION C: COMMUNITY PRIORITY AND EVIDENCE NEED

Operational definition: Are affected communities identifying an unmet need? Is significant disease burden being missed by routine surveillance?

Principle: Community voice is essential; under-recognized conditions deserve evidence attention. This criterion flags gaps in the evidence base, not just disease frequency.

Community and lived-experience evidence. Community priority should include documented perspectives of people affected, caregivers, frontline workers and underserved populations. Evidence need should include under-recognition, surveillance gaps, implementation uncertainty and unanswered questions that materially affect policy or service decisions.

Four sub-indicators (score each 0–2, then average):

Sub-indicator	Score 0	Score 1	Score 2	Data Source
1. Community-identified priority or lived-experience salience	Community surveys show no concern about condition (<10% mention condition when asked about health priorities); OR not raised in focus groups	Condition mentioned in some community consultations (10–30% mention when asked about health issues); OR documented in patient interviews but not volunteer concern	Condition frequently raised by affected communities (>30% mention spontaneously or when asked); OR strong lived-experience priority documented; OR patient advocacy group exists	Community perception surveys; focus group discussions; patient interviews; patient advocacy presence
2. Under-recognition or hidden burden	Condition recognized equally by health staff and community; no diagnostic delay documented	Diagnostic delay observed (average delay 1–6 months before PHC attendance); OR 20–40% of cases not recognized as health condition (treated as cosmetic only, or normalized)	Significant diagnostic delay (average >6 months); OR >40% of cases unrecognized; OR affected people delay seeking care due to shame/stigma; OR condition only recognized after complications (e.g., secondary infection	Diagnostic delay studies; symptom interpretation surveys; health-seeking behavior data

Sub-indicator	Score 0	Score 1	Score 2	Data Source
			sought treatment, not primary scabies)	
3. Surveillance gap or weak monitoring	Condition included in routine HMIS; data consistently reported; trend monitoring possible	Condition partially included in HMIS (some facilities report); OR data sporadic; OR surveillance possible but not implemented; OR limited disaggregation (not by age/gender/location)	Condition not in HMIS or surveillance severely limited (no consistent reporting); OR surveillance data suggests significant under-reporting (10–50% of true burden captured); OR no disaggregation, preventing equity monitoring	HMIS structure; surveillance audit; capture-recapture studies if available
4. Major research or policy evidence gap	Sufficient evidence exists for decision-making (burden clear, intervention efficacy documented, cost-effectiveness analyzed); no major gaps	Some research gaps identified: burden estimate in some regions unclear, OR intervention efficacy varies by context, OR cost-effectiveness not studied in all settings	Major evidence gap that constrains policy decisions: global burden uncertain (wide confidence intervals), OR interventions not adequately tested, OR cost-effectiveness unknown, OR affected communities not heard in research agenda	Systematic reviews; health research priority-setting publications; WHO research agenda

Conversion to Criterion C score

Conversion to Criterion C score: Average the four sub-indicator scores → convert to 1–5 scale

Documentation required:

- Community survey data: cite % reporting concern
- Diagnostic delay: cite mean/median delay in months
- HMIS status: cite whether condition is in national HMIS form
- Evidence gap: cite specific missing data (e.g., “no RCT evidence for intervention X in South Asia”)

Example scoring — Leprosy

Sub-indicator	Score	Evidence
1. Community priority	2	In endemic regions, communities identify leprosy as priority health issue; high stigma awareness; patient advocacy groups active
2. Under-recognition	2	Diagnostic delay 1–2 years documented (case-finding studies); patients often concealed diagnosis due to stigma; complications led care-seeking
3. Surveillance gap	2	Leprosy included in HMIS in endemic countries but significant under-reporting (case-finding campaigns identify 2–3x more cases); limited equity disaggregation
4. Research/policy gap	1	Burden estimates available; interventions well-documented; knowledge about implementation gaps (case-finding, adherence) emerging
Average:	1.75	C Score = 4

2.3 Phase 2 Scoring Workflow and Data Compilation

Step 1: Evidence Sheet Preparation (Weeks 1–4) - For each condition advanced from Phase 1, prepare comprehensive evidence sheet - Lead reviewer (epidemiologist or public health specialist) assembles evidence:

- Burden data (DALYs, prevalence, incidence) from GBD or sources
- Clinical outcome data (severity, complications)
- Psychosocial/QOL data (published scales like DLQI if available)
- Equity data (disaggregated prevalence, poverty gradient)
- Public health evidence (transmission, outbreak data)
- Intervention efficacy (RCT data, WHO guidelines)
- Health-system data (service readiness, policy status)
- Community priority (consultation data or surveys)
- Compile sources in annotated reference list

Step 2: Independent Scoring by Two Reviewers (Weeks 5–8) - Reviewer 1: Public health/epidemiology specialist scores Criteria B, E, PH, H, C - Reviewer 2: Clinician or programme lead scores Criteria S, P, I, H - Both reviewers score Criterion H (health-system relevance) separately - Each reviewer completes evidence sheet with sub-indicator scores and justification - No discussion between reviewers until independent scoring complete

Step 3: Comparison and Reconciliation (Weeks 9–10) - Reviewers compare independent scores - Discrepancies >1 point on ANY criterion trigger written reconciliation:

- Reviewers meet to discuss evidence interpretation
- Document agreed score and reason for change
- If disagreement persists, use third-party decision rule:
- Clinical severity (S, P): defer to clinician reviewer
- Burden/epidemiology (B, E, C): defer to epidemiologist reviewer
- Health-system fit (H): consensus or average
- If still unresolved: assign score mid-point and flag as “reviewer disagreement noted”

Step 4: Quality Assurance and Confidence Flag Assignment (Week 10) - Assign confidence flag (A, B, C, D) based on:

- A: Direct global evidence (GBD DALY, strong RCT, large epidemiological study); low uncertainty
- B: Strong programme evidence with minor inference; or cluster/proxy with documented assumptions
- C: Cluster- or proxy-based scoring with material uncertainty; major data gaps; expert judgment used
- D: Reserved for poorly documented entities; evidence dominated by expert judgment; use with caution
- Document reason for confidence flag
- Identify Criterion(s) with greatest uncertainty

Step 5: Compilation and National Decision Meeting (Weeks 11–12) - Compile scores into national priority matrix - Calculate total score for each condition - Assign priority band:

- 34–40: Core Priority
- 29–33: High Priority
- 24–28: Important Priority
- 8–23: Context-Specific Priority
- Prepare summary with:
- Priority band assignment
- Total score and individual criterion scores
- Confidence flag and evidence gaps
- Key evidence citations
- Recommendations for implementation

Output:

- National Phase 2 summary document with priority matrix
- Evidence trail for each condition (one-page evidence summary + references)
- Confidence assessment
- Implementation recommendations per priority band

Annex C. Data Integration: Phase 1 to Phase 2

3.1 How Phase 1 Data Feeds Phase 2 Scoring

Phase 1 results directly inform Phase 2 in three ways:

3.1.1 Verification of PHC Visibility Signal

Phase 1 finding: Facility scoring identifies conditions frequently seen at PHC (Dimension 1: PHC Visibility/Burden)

How it informs Phase 2:

- PHC visibility score from Phase 1 is context for Criterion I (Feasibility) scoring
- If Phase 1 shows high PHC visibility (score 2), this supports evidence that:
- Diagnosis can be clinical (no advanced lab needed) → higher I score
- PHC staff can recognize condition → supports feasibility claim in I score
- Supply chain can function through PHC (no specialist supply needed) → higher I score
- Example: Phase 1 identifies scabies seen in 200+ PHC visits/year across district. Phase 2 reviewers cite this as evidence for I score: “High PHC visibility confirms that >90% of cases can be managed at PHC level without specialist input.”

If Phase 1 shows low PHC visibility (score 0), Phase 2 reviewers question whether feasibility is truly high:

Why is PHC visibility low if diagnosis and management are simple?

Consider alternative explanations: poor training, lack of awareness, supply shortage, or genuinely rare condition

Adjust I score accordingly

3.1.2 Equity and Access Barrier Verification

Phase 1 finding: Dimension 3 (Access Barrier) identifies facilities with major geographic or financial barriers

How it informs Phase 2:

- Phase 1 access barrier scores feed directly into Criterion E (Equity) and Criterion H (Health-System Relevance) scoring
- If Phase 1 shows barriers concentrated in specific populations/areas (score 2), Phase 2 reviewers investigate:
- Does the condition show equity gradient matching access barriers? → higher E score
- Is PHC capacity low in barrier zones? → identifies service gap for H score
- Should this condition be prioritized to address equity gap? → informs national policy weighting
- Example: Phase 1 identifies 4-hour travel time to referral in rural area; scabies visibility score is 2 (common). Phase 2 reviewers note: “Major access barrier + high local burden → strong case for local PHC management capacity to prevent treatment delay.”

3.1.3 Geographic Variation and Hidden Burden

Phase 1 finding: District-level compilation reveals that conditions have variable scores across facilities (geographic clustering)

How it informs Phase 2:

- Geographic variation can signal:
- Genuine epidemiological variation (hotspot with high burden justifies higher priority in that region)
- Data quality variation (some facilities have better registers; variation is artifact)
- Access barrier effects (low scores in remote areas may reflect barriers, not low burden; Phase 2 investigators conduct targeted inquiry)
- Under-recognition/hidden burden (low scores in low-capacity facilities may hide true burden) → feeds Criterion C score
- Phase 2 reviewers use Phase 1 geographic variation to flag evidence gaps:
- “Phase 1 shows scabies underreported in 3 low-capacity facilities despite high regional burden. Criterion C: major under-recognition gap identified.”

3.2 Data Linkage Table: Phase 1 → Phase 2

Phase 1 Dimension	Phase 1 Data Collected	Phase 2 Criterion	How It Informs Scoring
PHC Visibility/Burden	Annual case count per facility; proportion managed at PHC	Criterion I (Feasibility)	If PHC visibility high (score 2), provides evidence that diagnosis/management is feasible at PHC; supports higher I score
		Criterion H (Health-System)	PHC caseload indicates service integration opportunity; high burden indicates service gap
High Consequence/Impact	Complications, hospitalizations, disabilities recorded in Phase 1 data	Criterion S (Severity)	Specific complications/outcomes from Phase 1 provide evidence for S sub-indicator scores
	Referral rates documented	Criterion I (Feasibility)	High referral rate may indicate low PHC feasibility; informs I scoring
Access Barrier	Travel time, transport cost, seasonal closure, referral pathway status	Criterion E (Equity)	Access barriers concentrated in specific populations flag equity gradient; supports higher E score
		Criterion H (Health-System)	Access barriers identify service gap and opportunity for strengthening; informs H score
Geographic variation	Facility scores vary across district (clustering analysis)	Criterion C (Community/Evidence)	Geographic clustering may signal under-recognition in low-capacity areas; identifies evidence gap
		Criterion E (Equity)	Variation by remoteness/poverty confirms equity gradient

3.3 Phase 1 Data Quality Assurance and Documentation for Phase 2

Critical: Phase 2 reviewers must know the quality of Phase 1 data to weight it appropriately.

For each Phase 1 dimension forwarded to Phase 2:

- Document the source: “Cases counted from facility register” (high quality) vs. “staff recall in district meeting” (lower quality)
- Record completeness: “28 of 30 facilities submitted Phase 1 data” (note gap; flag as lower confidence)
- Note any adjustments: “Facility X reported 0 cases; clinical review suggests likely data entry error; District team adjusted to 8 cases based on staff interview” (transparent about process)

Phase 2 confidence flag adjustment based on Phase 1 data quality:

- If Phase 1 data is strong and consistent (A-level confidence), Phase 2 confidence for I, H, E, C can reflect that
- If Phase 1 data is weak (C-level: based on expert judgment, incomplete registers), Phase 2 scores relying on Phase 1 data should be downgraded (e.g., if I score relies heavily on Phase 1 visibility signal but Phase 1 confidence is low, flag Phase 2 I score as lower confidence)

Annex D. Practical Implementation Tools

Tool D1. Phase 1 Quick Scoring Sheet Template

Condition	PHC Visibility (0-2)	High Consequence (0-2)	Access Barrier (0-2)	Total (/6)	Move to Phase 2?	Comments

4.1 Phase 1 Data Collection Form

FACILITY PHASE 1 SCREENING FORM

Facility name: _____ District: _____ Date: _____ Completed by: _____ Title: _____

Condition name: _____

1. PHC VISIBILITY / BURDEN How many times did you see, diagnose, or treat this condition at this facility in the past 12 months? - Total cases in past 12 months: ____ - Average per month: ____ - Is condition recognized by facility staff without additional training? ☐ Yes ☐ No - Is condition included in facility outpatient register/data? ☐ Yes ☐ No

Score: ☐ 0 (rarely seen) ☐ 1 (occasionally seen) ☐ 2 (commonly seen)

Evidence note (facility staff): _____

2. HIGH CONSEQUENCE / IMPACT What is the most serious outcome you have seen from this condition in this facility? - ☐ No complications; condition self-limited - ☐ Moderate symptoms; occasional referral needed - ☐ Serious outcome: (check all that apply) - ☐ Hospitalization required - ☐ Disability (restriction of activity) - ☐ Permanent disfigurement/scarring - ☐ Blindness or loss of limb - ☐ Death - ☐ Severe stigma/social withdrawal - ☐ Long-term work/school loss

Score: ☐ 0 (usually mild) ☐ 1 (moderate impact) ☐ 2 (serious consequences)

Specific example: _____

3. ACCESS BARRIER TO HEALTH FACILITY For someone with this condition at this facility's catchment area, what are the barriers to getting appropriate care?

Travel time to referral facility for this condition: ____ hours Transport cost (round trip): _____ (local currency) = ___% of daily wage Seasonal accessibility: ☐ Always accessible ☐ Barrier <2 months/year ☐ Barrier 2–4 months/year ☐ Barrier >4 months/year Security concerns: ☐ None ☐ Occasional ☐ Frequent Referral pathway: ☐ Known, functional ☐ Unclear, sometimes functional ☐ Unknown or broken

Score: ☐ 0 (access good) ☐ 1 (some barriers) ☐ 2 (major barriers)

FACILITY TOTAL PHASE 1 SCORE: ____/6

Will this condition advance to Phase 2? ☐ Yes ☐ No ☐ Conditional (note: _____)

Data quality assessment:

- Register quality: ☐ A (complete, legible, dated) ☐ B (mostly complete) ☐ C (incomplete/unclear)
- Staff knowledge: ☐ High ☐ Moderate ☐ Low
- Any concerns?: _____

4.2 Phase 2 Evidence Sheet Template

CONDITION PHASE 2 EVIDENCE SHEET

Condition: _____ Date: _____ Reviewer 1 (Public Health): _____ Reviewer 2 (Clinician): _____

CRITERION B: BURDEN AND DISTRIBUTION

Data source and burden estimate:

- [ ] GBD DALYs: _____ (year:) [Primary — highest priority]
- [ ] National prevalence: __ million (year:) [Fallback 1]
- [ ] Incidence: __ cases/year (year:) [Fallback 2]
- [ ] Programme proxy: __ (specify: _____) [Fallback 3 — lowest confidence]

Geographic distribution: ☐ Global (all regions affected) ☐ Multi-regional (3+ regions) ☐ Regional (1–2 regions) ☐ Highly focal (one country/area)

B Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Evidence justification: (cite source, not generic statement) _____

CRITERION S: SEVERITY & HEALTH CONSEQUENCES

Sub-indicator 1: Acute severe complications or hospitalization risk Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Irreversible morbidity or disfigurement Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: Chronicity or recurrence Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: Functional impairment or pain/itch Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ S Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CRITERION P: PSYCHOSOCIAL & SOCIOECONOMIC IMPACT

Sub-indicator 1: Health-related QOL impairment (DLQI if available: _____) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Mental health or stigma (PHQ-9 if available: _____) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: School or work loss Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: Financial or caregiver burden Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ P Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CRITERION E: EQUITY & VULNERABILITY

Sub-indicator 1: Social gradient / poverty link (Prevalence ratio Q1:Q5 = _____) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Vulnerable populations affected (Which groups?: _____) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: Barriers to diagnosis/treatment/follow-up Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: Historical neglect or discrimination Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ E Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CRITERION PH: PUBLIC HEALTH IMPORTANCE

Sub-indicator 1: Transmission or community externality (Secondary attack rate: ____%) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Outbreak / elimination relevance Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: Vector / reservoir / AMR / secondary infection Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: Community prevention value Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ PH Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CRITERION I: AVAILABILITY & FEASIBILITY

Sub-indicator 1: Intervention effectiveness & WHO guideline status (WHO recommendation: Strong / Conditional / Weak) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Affordability & supply security (Cost as % monthly income: ____; stock-out frequency: ____) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: Diagnostic simplicity & PHC feasibility (% manageable at PHC: ____%) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: Commodity & supply chain status (On EMML?: ☐ Yes ☐ No; availability in facilities: %) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ I Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CRITERION H: HEALTH-SYSTEM & POLICY RELEVANCE

Sub-indicator 1: PHC / UHC fit and integration Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Service gap or avoidable barrier (% facilities with trained staff: %; availability: %) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: Workforce / diagnostic / referral opportunity Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: National & global policy alignment (Policy documents: _____) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ H Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CRITERION C: COMMUNITY PRIORITY & EVIDENCE NEED

Sub-indicator 1: Community-identified priority (% mentioning in survey: %) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 2: Under-recognition or hidden burden (Diagnostic delay: ___ months; % unrecognized: %) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 3: Surveillance gap (In HMIS?: ☐ Yes ☐ No; under-reporting %: ____%) Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Sub-indicator 4: Major research / evidence gap Evidence: _____ Score: ☐ 0 ☐ 1 ☐ 2

Average sub-indicator score: _____ C Score (1–5): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

OVERALL SCORING SUMMARY

Criterion	Score
B (Burden)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
S (Severity)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
P (Psychosocial)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
E (Equity)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
PH (Public Health)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
I (Intervention)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
H (Health-System)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
C (Community)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

TOTAL SCORE: _____/40

PRIORITY BAND:

- ☐ Core Priority (34–40)
- ☐ High Priority (29–33)
- ☐ Important Priority (24–28)
- ☐ Context-Specific Priority (8–23)

CONFIDENCE FLAG:

- ☐ A — Direct evidence, low uncertainty
- ☐ B — Strong evidence with limited inference

- ☐ C — Cluster/proxy with material uncertainty
- ☐ D — Expert judgment dominant; high uncertainty

Reason for confidence rating: _____

Key evidence gaps: _____

Reviewer 1 (Public Health) signature: _____ Date: _____

Reviewer 2 (Clinician) signature: _____ Date: _____

Reconciliation notes (if scores differed >1 point): [Reviewers document discussion and final agreement]

_____

4.3 Phase 1 to Phase 2 Transition Checklist

- ☐ Phase 1 screening completed in all facilities (or documented sampling)
- ☐ District validation meeting held; Phase 1 results reviewed
- ☐ Data quality assessment completed; any outliers investigated
- ☐ Conditions for Phase 2 identified (score ≥5, or conditional with justification)
- ☐ Phase 1 summary report prepared including:
- ☐ District-level ranking by total score
- ☐ Geographic variation analysis
- ☐ Equity flags (barriers concentrated in specific populations)
- ☐ Data quality assessment (confidence by facility)
- ☐ Phase 1 data forwarded to Phase 2 team with:
- ☐ Raw scores by facility and condition
- ☐ Evidence notes (case counts, complications, barriers documented)
- ☐ Data quality metadata (register quality, staff knowledge level)
- ☐ Geographic variation summary
- ☐ Phase 2 team confirms Phase 1 findings:
- ☐ Uses Phase 1 PHC visibility to inform Criterion I scoring
- ☐ Uses Phase 1 access barriers to inform Criterion E scoring
- ☐ Flags geographic variation as evidence gap in Criterion C
- ☐ Documents Phase 1 confidence in Phase 2 scoring confidence flag

Annex E. Illustrative Example: Full Workflow

Case Study: Scabies in Rural District

Phase 1: Screening Phase (Weeks 1–4)

Facility A (urban, good registers):

- PHC Visibility: 85 scabies cases in 12 months (common, Score 2)
- High Consequence: 45% had secondary bacterial infection (impetigo), 3 hospitalizations (Score 2)
- Access Barrier: 30-minute travel, 2% transport cost (Score 0)
- Total: 4 → Conditional advance

Facility B (rural, remote):

- PHC Visibility: 12 cases in 12 months, staff recognize without training (Score 1)
- High Consequence: All uncomplicated; 1 secondary infection (Score 1)
- Access Barrier: 4-hour travel to referral, 25% transport cost, seasonal road closure (Score 2)
- Total: 4 → Conditional advance

Facility C (very remote):

- PHC Visibility: 3 cases in 12 months, staff not trained to recognize (Score 0)
- High Consequence: No severe cases seen (Score 0)
- Access Barrier: 6-hour travel, 30% transport cost, 5-month seasonal closure (Score 2)
- Total: 2 → Watchlist

District compilation:

- Average Phase 1 score across 20 facilities: 3.2
- Geographic variation: Urban areas average 4.5; remote areas 2.0
- Equity flag: Access barrier concentrated in remote populations
- Decision: Advance scabies to Phase 2 (score ≥3 across district, clear access equity concern)

Phase 2: Comprehensive Validation (Weeks 5–12)

Reviewer 1 (Epidemiologist) & Reviewer 2 (Dermatologist) independently score:

Criterion B (Burden):

- GBD 2021: 5.3 million DALYs globally
- Phase 1 shows high burden in rural area (12 cases/year in small facility)
- Both reviewers: Score 5 (highest burden category)

Criterion S (Severity):

- Sub-indicator 1 (acute complications): 2 (30–50% secondary infection risk)
- Sub-indicator 2 (permanent): 1 (no permanent disfigurement from scabies alone)
- Sub-indicator 3 (chronicity): 1 (usually cured; relapse possible if exposed)
- Sub-indicator 4 (functional): 1 (mild itch; temporary work loss)
- Average: 1.25 → Score 4 (Reviewer 2 initially scored 5; reconciliation discussion clarified that recurrence is not permanent disability, supporting Score 4)

Criterion P (Psychosocial):

- Sub-indicator 1 (QOL): 2 (poor sleep, distress reported by patients interviewed)
- Sub-indicator 2 (mental health/stigma): 2 (moderate stigma in 40% of Phase 1 interviews; 2 reported depression)
- Sub-indicator 3 (school/work): 1 (some school absence for treatment, but not prolonged)
- Sub-indicator 4 (financial): 1 (treatment costs ~$1, acceptable; caregiver burden minimal)
- Average: 1.5 → Score 4

Criterion E (Equity):

- Phase 1 shows 4x higher burden in remote populations (12:3 cases in rural vs. urban facilities)
- Travel barriers and transport cost major barriers in rural areas (Phase 1 flagged)
- Crowding and poor sanitation associated with scabies (documented in national health survey)
- All sub-indicators score 2
- Average: 2.0 → Score 5

Criterion PH (Public Health Importance):

- Sub-indicator 1: Secondary attack rate >50% in households (published data)

- Sub-indicator 2: Elimination campaigns successful (Fiji, other regions documented)
- Sub-indicator 3: Secondary MRSA infections emerging (surveillance data)
- Sub-indicator 4: Community treatment highly effective (mass treatment trials)
- All sub-indicators score 2
- Average: 2.0 → Score 5

Criterion I (Intervention Feasibility):

- WHO strong recommendation for permethrin 5%
- Cost <$1 per treatment (WHO EMML status)
- Diagnosis clinical; PHC training feasible (Phase 1 supports: Facility A manages 85 cases/year)
- Supply chain stable in this district
- All sub-indicators score 2
- Average: 2.0 → Score 5

Criterion H (Health-System Relevance):

- Aligns with PHC/UHC (skin complaint is first-contact issue)
- Service gap: Phase 1 showed only 60% of rural facilities trained (opportunity)
- CHW training (2 days) is feasible; can strengthen community health
- Mentioned in national NTD strategy and WHA resolution
- All sub-indicators score 2
- Average: 2.0 → Score 5

Criterion C (Community Priority & Evidence Need):

- Community consultation: 65% of surveyed rural families cite scabies as health priority
- Phase 1 suggests under-recognition in very remote areas (Facility C staff unaware)
- Scabies in HMIS but under-reported (capture-recapture suggests 2x true burden)
- Evidence base strong for intervention; research gaps on prevention at community scale
- Sub-indicator 1: 2; Sub-indicator 2: 2; Sub-indicator 3: 2; Sub-indicator 4: 1
- Average: 1.75 → Score 4

Overall Scoring Summary

Criterion	Score
B	5
S	4
P	4
E	5
PH	5
I	5
H	5
C	4
TOTAL	37/40

Priority Band: CORE PRIORITY

Confidence Flag: A (Strong GBD evidence, robust clinical literature, phase 1 data supports PHC visibility and equity findings, WHO guidelines clear)

Evidence Gaps Identified:

- Prevention efficacy data at community scale limited
- Cost-effectiveness in low-income settings not quantified (for Phase 2 follow-up)

Implementation Recommendation:

9. Include scabies in national minimum PHC package
10. Train all CHWs (2-day standard protocol identified)
11. Ensure permethrin supply in all facilities (supply chain audit shows 85% coverage; target 100%)
12. Establish community-based mass treatment in outbreak zones
13. Strengthen HMIS reporting (register improvement planned)
14. Research: conduct cost-effectiveness trial in 2 endemic districts

Annex F. National Adaptation and Sustainability

6.1 Timeline and Resource Requirements

Phase 1:

- Duration: 2–4 weeks (facility screening) + 4–8 weeks (compilation and validation)
- Effort: 1 district health officer (part-time) + 1–2 facility staff per site (1 day per facility)
- Resources: Printed forms, basic data compilation tools (Excel), 1 district validation meeting (1 day)
- Cost: ~$200–500 per district (printing, meeting logistics)

Phase 2:

- Duration: 6–12 weeks (2–4 weeks per condition depending on evidence availability)
- Effort: 2 independent reviewers per condition (10–20 hours each), 1 coordinator for compilation (80–120 hours total)
- Resources: Evidence database access (GBD, WHO documents, published reviews), evidence sheet templates, reconciliation meeting
- Cost: ~$2,000–5,000 per district (reviewer time, meeting costs, literature access)

National Adaptation:

- Duration: 3–6 months (after completion of Phase 1–2 in all districts or representative sample)
- Effort: 1 full-time national coordination officer, 3–5 reviewers for national validation, stakeholder consultation
- Resources: National synthesis meeting (2 days), expert panel (5–8 members), community consultation workshops (2–3 regions)
- Cost: $10,000–20,000 (staff, meetings, stakeholder engagement)

6.2 Sustainability and Review Cycles

Annual light review: Update Phase 1 screening in facilities with new data (10–20% effort of full Phase 1)

3–5 year full review: Repeat Phase 1 and Phase 2 across district/country when significant burden shifts, new interventions emerge, or evidence quality improves

Continuous monitoring: HMIS data tracking to validate priority decisions (track prevalence, service coverage, outcomes)

Annex G. References to Key WHO and International Guidance

WHA78.15: Skin diseases as a global public health priority (2025)

WHO Global Action Plan on Skin Diseases: Skin Health for All 2026–2035 (draft for review)

Global Burden of Disease 2021 skin disease analyses

WHO Global Health Observatory and essential medicines lists

WHO fact sheets on individual skin NTDs (leprosy, yaws, onchocerciasis, etc.)

WHO front-line skin recognition and PHC management guidance

NICE clinical knowledge summaries and treatment guidance

Primary Care Dermatology Society guidance

Cochrane reviews on skin disease interventions