PQMD · ALIGNED METRICS INITIATIVE

# Better measurement supports better access.

The Aligned Metrics Initiative is a practical framework for organizations involved in medical product donations to understand, improve, and communicate how donated products contribute to access and care.

SEVEN MODULES · THREE IMPACT AREAS · THREE PRIORITY INDICATORS · FOUR TOOLS

START HERE

## Getting Started with AMI

What is AMI and why does it matter?

Start where you are.

- Explore the modules
- Explore the framework
- See the priority metric cards
- Get the data collection templates

## AMI highlights three important impact areas for donations.

**Increase Availability of Priority Products**

Are donated products helping meet priority product demand identified by partners?

**Sustain Continuity of Care**

Are priority products consistently available over time?

**Expand Capacity to Deliver Care**

Is product support helping maintain, restore, or expand the volume of health services?

Different programs may reasonably contribute to and be able to measure one, two, or all three areas.

# How AMI Fits Together

The seven AMI modules build on one another and can be used flexibly.

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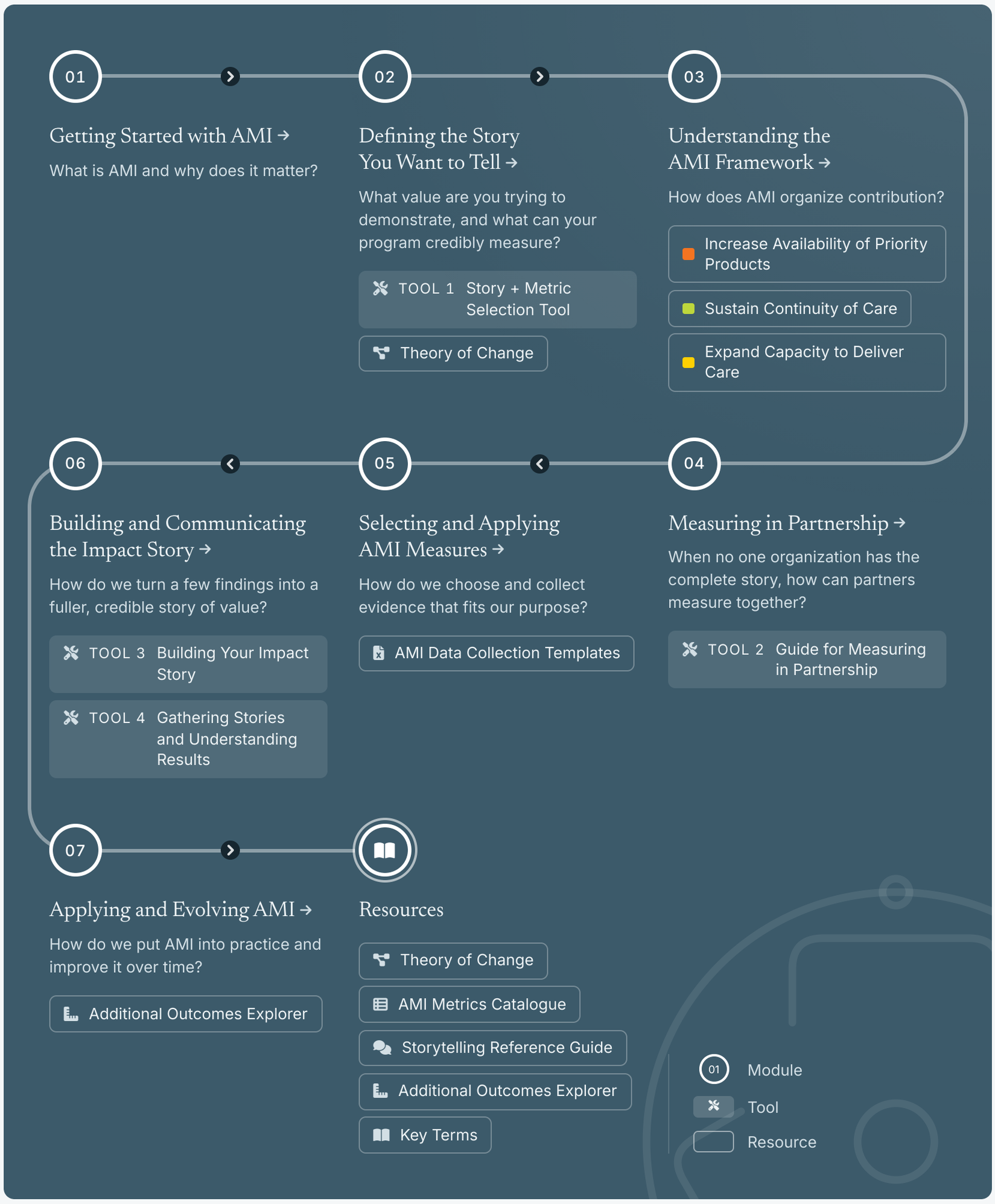
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01 Module
Tool
Resource

ORIENTATION

# How AMI Fits Together

*Keep this map with in mind as you move through the toolkit:*



PQMD / ALIGNED METRICS INITIATIVE

# How product donations contribute to care

A theory of change with shared activities and distinct evidence of contribution.

INPUTS

**DONATED PRODUCTS** | **PARTNER EXPERTISE + RELATIONSHIPS** | **FUNDING + OPERATIONAL RESOURCES**

ACTIVITIES + OUTPUTS

ACTIVITY

### Develop and sustain partnerships

Assess priorities; agree roles, plans and supply commitments.

OUTPUTS

**Partner needs documented; partnerships sustained**

Quantity / type of products requested
Implementers / facilities supported
Partnerships and active duration

ACTIVITY

### Source products; manage supply chain and logistics

Acceptance, storage, transport, clearance and distribution.

OUTPUTS

**Products delivered; geographic reach**

Quantities received by local partners
Countries and sub-country areas served
Shipments completed
Local partner receipt confirmed

ACTIVITY

### Protect product quality and usability

Check dating and documentation; protect stock through handling and manage unusable products.

OUTPUTS

**Dating, documentation and product losses recorded**

Donations with sufficient dating
Required documentation provided
Shelf life across the product journey
Quantities destroyed, with reasons

ACTIVITY

### Monitor stocks; forecast and replenish supply

Coordinate timely, predictable replenishment and ongoing supply commitments.

OUTPUTS

**Stock records updated; replenishments completed**

Stock observations / records
Replenishment quantities received
Consecutive years of product supply

ACTIVITY

### Support product use and delivery of care

Train health workers; support relevant service capabilities and deliver product-supported care.

OUTPUTS

**People reached with donated products**

Individuals treated / supported / reached
Health workers trained through donations
Product-supported services delivered
Equipment / facilities supported

SHARED PATHWAYS

## Increase Availability of Priority Products

**Priority products are available to meet locally defined demand.**

## Sustain Continuity of Care

**Supply is predictable, and priority products remain reliably available over time.**

## Expand Capacity to Deliver Care

**Product-related barriers to delivering care are reduced, enabling services to be maintained, restored or expanded.**

IMPACT

**Contributing to high-quality care and better health**

ASSUMPTIONS

**Products match local priorities, remain usable and reach intended partners. Partners can use them in care and coordinate supply.**

Workforce, infrastructure, financing and other service conditions influence results. Records support the selected measures.

MODULE 1

# Getting Started with AMI

*Better measurement supports better access.*

The PQMD toolkit for aligned metrics and storytelling gives medical donation programs an actionable set of common resources to simplify, enhance, and align data collection and reporting to demonstrate impact. AMI builds on the outputs and extensive data already being collected by donation programs.

AMI is a practical shared starting point for measuring through programs, partnerships, services, and systems.

Organizations already measure a great deal: products delivered, shipments completed, facilities and communities reached, partners engaged, training provided, and other measures of scale and activity.

> Those outputs matter.

It has typically been difficult to measure beyond outputs because products are only one part of care, the data sit across multiple partners, and health outcomes take time to emerge.

> Medical product donations create value long before a health outcome is visible; AMI can help you show that value.

## What is AMI?

The Aligned Metrics Initiative is a practical framework for organizations involved in medical product donations to understand, improve, and communicate how donated products contribute to access and care.

AMI creates shared structure and at the same time respects that donation programs have varying structure, operating models and purposes. It combines the information organizations already collect with a discreet number of shared outcome measures, qualitative evidence, partner insight, and context. You choose how to leverage

### AMI is a compass, not a prescription.

It provides a practical place to start, and room to grow with focus on the evidence that is most useful.

| ✓ AMI PROVIDES | – AMI DOES NOT |
|---|---|
| A practical way to build upon outputs | Replace your existing M&E system |
| Direction for measurement across different programs, organizations and partnerships | Recommend universal ranking or benchmarking |
| A way to connect outputs with strong evidence of contribution | Overclaim that donated products alone create health outcomes |
| A toolkit for longer-term learning, strategy, and communication | Recommend shipment-by-shipment outcome reporting |
| A way to build measurement practice over time | Teach the entire M&E discipline |
| A contribution framework that includes all partners and recognizes what it will take to move beyond outputs | Shift more data-collection responsibility to local partners |

These boundaries are a part of AMI by design.

## AMI highlights three important impact areas for donations.

INCREASE AVAILABILITY OF PRIORITY PRODUCTS

*Are donated products helping meet priority product demand identified by partners?*

SUSTAIN CONTINUITY OF CARE

*Are priority products consistently available over time?*

EXPAND CAPACITY TO DELIVER CARE

*Is product support helping maintain, restore, or expand the volume of health services?*

## Start where you are.

Different programs have different products, partnerships, operating models, goals, resources, and access to data. Everyone will not measure the same metrics and programs may reasonably contribute to and be able to measure one, two, or all three areas.

- Start where you are.
- Use what you know.
- Build an approach that is the most useful.

AMI is designed to help each program identify what it can measure credibly and usefully. A program with limited downstream visibility may begin largely with existing outputs and selected outcome evidence. Another with long-standing partnerships and repeated data may be able to measure change over time. Both approaches can be credible and valuable.

Begin with a meaningful question, measures that are realistic for your program and partners, and relevant to your strategy. Build from a smaller start and expect measurement can strengthen over time.

## How the toolkit works

The seven AMI modules build on one another and can be used flexibly. Technical detail sits primarily in the metric cards, tools, and supporting resources so modules are intentionally short and practical.

### The AMI experience walks organizations through:

- *What are we trying to understand?*
- *Where does our program contribute?*
- *What can we credibly measure?*
- *How do we measure it with partners?*
- *What does the evidence mean?*
- *What should we do with it?*

Use what applies to your program and informs the decisions you need to make.

AMI was designed to strengthen program-level outcome measurement among partners, while recognizing that many organizations in this space also contribute to national and regional access efforts; over time, the framework is intended to connect with and complement those broader efforts where useful.

RESOURCE

## How AMI Fits Together

Keep this map with in mind as you move through the toolkit:

1. **Define the story**

   What are we trying to understand, demonstrate, or decide?

2. **Determine the real contribution**

   Where does the program contribute the most value across the AMI impact areas?

3. **Select the evidence**

   Which priority indicator and supporting approach fit the program?

4. **Measure in partnership**

   What does each partner know, need, and realistically contribute?

5. **Collect and apply**

   Use the metric cards, templates, and evidence guidance.

6. **Build the impact story**

   Bring findings, what they enabled, context, partner experience and the decisions they can inform together.

7. **Learn and act**

   Use the evidence to inform programs, partnerships, communication, and next steps.

# Medical Product Donation Network

Globally, medical donations are carried out by a range of program types, that all aim to fill gaps in procurement for necessary products. Donation programs provide essential benefits and generate impact regardless of their size, depth, or particular product mix. Collaboratively accomplished by corporate donors, NGO distributors, and NGO program implementers, and local partners medical donation programs collectively identify needs, source products, and carry out the logistical operations to deliver needed products to where they are needed and can be utilized for patient care. As partnerships evolve, so do feedback systems which drive improved alignment between partners. This often leads to sustained and strengthened collaborations, and to increased expectations and improved systems

BEFORE YOU MOVE ON

Take a quick inventory:

> What do you already measure?

> What do those measures tell you well?

> What would you like to understand that they do not tell you today?

Metric selection comes next.

First comes a more important question.

NEXT

# Define the Story You Want to Tell

*What value are you trying to understand or demonstrate - and what decision do you want the evidence to support?*

→ Go to Module 2

MODULE 2

# Defining the Story You Want to Tell

*Start with what matters.*

Before choosing an AMI impact area or metrics, get clear on what you are trying to understand, demonstrate, or decide.

The same program can tell several different stories. AMI helps you choose the one (or ones) most useful and realistic.

The right outcome indicators depend on what your organization is trying to achieve as well as on how the program actually operates.

## What are you trying to understand?

### Start with the question you actually care about.

What decision should your information support?

| YOU MAY WANT TO UNDERSTAND... | BECAUSE YOU ARE INTERESTED IN |
|---|---|
| **Whether product support is aligned with priority demand** | Demand, planning, product mix, quantity, or timing |
| **Whether products are consistently available over time** | Understand product interruptions and continuity |
| **Whether product support is helping sustain or expand a health service** | Knowing what the products are enabling functionally |
| **Where gaps remain** | What additional support may be needed |
| **Whether a partnership model is working** | Effectiveness, roles, coordination, or investment |

### If you knew this, what might you do differently?

AMI supports decisions and keeps reporting focused on evidence that matters.

Collect information because it can help the program or partnership understand, decide, or act.

## Design metrics to fit your decision needs and match your program

Your strategy matters. So does your operating reality.

Some programs have predictable supply, long-term partnerships, defined services, and repeated access to data. Others work across changing products, partners, and geographies with lighter downstream visibility.

Some programs will be able to measure across impact areas, some programs will not. Use these questions to ground the choice:

| CONSIDER | ASK |
|---|---|
| **Strategy and purpose** | What is the program trying to achieve? |

| | |
|---|---|
| **Measurement motivation** | What value do we need to understand or demonstrate? Who needs to understand this? |
| **Program model** | How predictable is supply? How consistent are products, sites, and relationships? |
| **Partnership conditions** | Do we have enough shared planning and continuity to define and use the measure together? |
| **Evidence** | What can we already see? What can we realistically observe over time? |
| **Capacity and burden** | Do partners have the staff, systems, time, and resources to support the measure? |
| **Time and frequency** | What period matters? How often can evidence reasonably be collected or reviewed? |

> These conditions guide fit. They do not create a hierarchy.

The useful measure is the one that fits the program's strategy, operating model, evidence, and decision needs.

RESOURCE
Theory of Change

## Choose the strongest measure your program can credibly support.

Availability, continuity, and service capacity require different kinds of evidence.

| AMI AREA | OFTEN FITS WHEN... |
|---|---|
| **Increase Availability of Priority Products** | Priority demand and fulfilled supply can be understood, even with limited downstream visibility |
| **Sustain Continuity of Care** | Product flow is consistent enough to observe stock status over time at facility/product use level |
| **Expand Capacity to Deliver Care** | Products influence service availability and service records and reporting are available through partnerships |

Choose the strongest measure your program can credibly support and work towards the ones you can grow into. AMI measures are not a hierarchy. AMI will continue to expand and offer more outcomes measures, consider where you want to grow your measurement.

Tool 1 helps you to: think through measurement:

- *Strategy*
- *intended outcome*
- *operating model*
- *partnership conditions*
- *evidence feasibility*
- *appropriate AMI measure*

*accompanying evidence*

Use it to connect what the program is trying to achieve with what the program and partnership can credibly measure.

TOOL 1

# Story + Metric Selection Tool

This exercise is for teams that are ready to move beyond outputs. It assumes you already report core program activity - reach, partners, geography, product volume/value, and related outputs - and are ready to understand a deeper dimension of what those efforts contribute to.

PQMD has established credible lines of contribution across medical product donation programs: availability of priority products, continuity of access over time, and product-supported service provision. Programs may also demonstrate outcomes in the quality of systems supporting products and care and, where the contribution pathway is sufficiently clear, specific health outcomes. Different programs will align with different outcome pathways.

## 1. Start with one program

Choose one program or program type for this exercise. Meant to be answered at the program level. At the core, what is this program trying to achieve?

| | |
|---|---|
| **What is this program trying to achieve?** | |
| **What are you already able to show through outputs?** | |
| **What deeper result do you want to understand?** | |
| **What decision would better evidence help inform?** | |
| **What is currently preventing you from understanding or demonstrating that result?** | |

Keep this program and these questions in mind as you move through Steps 2-5. The purpose is to identify the strongest outcome pathway that reflects what this program actually does.

## 2. How does this program operate?

| IF YOUR PROGRAM LOOKS MORE LIKE THIS... | CONSIDER... |
|---|---|
| **Product placement across a broad partner network**<br>The program operates through many partner relationships, can respond to episodic opportunities, place changing products, and fill gaps with agility across locations or partners. | Consider what the program can demonstrate over time about whether priority products are reaching identified demand, closing important gaps, and extending access more equitably across partners, geographies, or populations. |
| **Repeated product and partner pathways**<br>Product moves repeatedly through some of the same partner relationships, geographies, facilities, or program channels over time. Relationships and product flows have enough continuity to see patterns, even if supply is not fully predictable. | Consider whether repeated product and partner pathways allow you to understand availability and continuity over time. Are priority products more consistently available? Where do gaps persist? What does repeated support allow partners to rely on, plan around, or protect? |
| **Sustained product support with established local partners**<br>The program works consistently through established local partner relationships, with enough shared planning and visibility to understand how product access interacts with care delivery. | Consider what reliable product access enables within the local care context. Does it reduce interruptions? Support planning? Allow staff or resources to be used differently? Help maintain or restore care? |
| **Product support tied to a defined service**<br>Product provision is deliberately connected to a specific service or care pathway, with enough consistency to understand whether that service is available over time. | Consider outcomes related to product-supported service availability. Has the program helped maintain, restore, expand, or newly enable the service? |
| **Product support with workforce development**<br>The program includes training, competency-building, technical guidance, supervision, or other deliberate support to the people delivering care. | Consider what has changed in workforce capability because of that support. Can providers use the product safely and effectively? Has confidence, competence, or readiness changed in ways that matter to care delivery? |
| **Product support with systems investment**<br>The program deliberately strengthens systems or processes needed to manage, safeguard, distribute, maintain, or use products effectively. | Consider changes in the systems supporting donated products and care. These may include cold chain, storage, inventory, maintenance, forecasting, records, referral, supply-chain, or other relevant processes. |
| **Another pathway**<br>Your program may create value through a pathway not captured above. | Describe what is distinctive about how the program works and what outcome would best reflect that contribution. |

HEALTH & QUALITY OUTCOMES

Some programs may also have a sufficiently clear line of contribution to systems, workforce, quality of care, patient experience, or specific health outcomes. Keep that possibility in mind as you work through the exercise.

## 3. Connect your program to an impact area

Which outcomes reflect a credible line of contribution from this program? More than one outcome may be plausible.

| OUTCOME PATHWAY | WHAT THIS HELPS YOU UNDERSTAND | AMI PRIORITY OUTCOME METRIC |
|---|---|---|
| **Increase Availability of Priority Products** | Whether, over time, the program is helping priority products become available against identified demand and close important product gaps across partners, geographies, or populations. | Percent of identified priority product demand met through available supply received by the local partner |
| **Sustain Continuity of Care** | Whether priority products remain available consistently enough to support care over time, including whether repeated support reduces interruptions or creates greater reliability. | Priority Product Stockout-Free Reporting Periods |
| **Expand Capacity to Deliver Care** | Whether product support is connected to a change in volume of a defined product-supported service - maintained, restored, expanded, or newly available. | Percent change in volume of product-supported health services |
| **Other pathway** | The program may contribute to outcomes alongside or beyond these shared AMI impact areas. Use the outcome that best reflects the actual contribution. | Use a supporting outcome, health & quality outcome, or program-specific measure as appropriate. |

The priority metrics provide a shared quantitative anchor. Supporting outcomes and qualitative evidence help explain why the result matters, what contributed to it, what changed for partners or services, and what the program may be enabling.

## 4. Take stock and identify any gaps

| REFLECT ON THE PROGRAM TODAY | USE THE REFLECTION TO IDENTIFY... |
|---|---|
| **What can we already support?** | Which AMI outcome(s) can we already support with credible evidence? |
| **What do we want to understand more clearly?** | Which outcome questions matter most now? |
| **What is getting in the way?** | Data, access to information, consistency, definitions, time, partner alignment, program structure, resources, or another factor? |
| **What requires clarification?** | Where may stakeholder expectations need to be clarified? |
| **What is worth strengthening?** | Where could evidence, partnership, or the program itself deepen the contribution or make it more visible? |

By the end of this step, identify: the outcome(s) you can credibly pursue now; the most important evidence or partnership gaps; expectations that may require clarification; and one or two areas where further action could strengthen the impact strategy.

### 5. Exploring next steps

Use the reflection above to identify the next actions that will strengthen the program's impact strategy.

| | |
|---|---|
| **Strengthen the evidence** | Build the smallest credible evidence set for the outcome question: a priority metric where relevant, supporting outcomes and outputs, and qualitative evidence that helps interpret the result. Choose the strongest measure the program can credibly support. |
| **Strengthen the partnership** | Identify where shared definitions, data, interpretation, capacity, or resources across partners could strengthen the evidence and its use. |
| **Strengthen or explore the program** | Where the program is not structured to demonstrate an outcome over time, strong outputs may remain the right story. Where deeper outcome learning is a priority, consider a defined subset, pilot, or program change that can be followed over time. |

Next: Tool 2. Guide for Measuring in Partnership helps partners align on what to measure, what evidence already exists, what each partner can contribute, and a realistic plan.

## Use findings for decisions

- Review the priority result and the most relevant supporting outputs.
- Look for differences across products, sites, partners, geographies, or periods where the data allow it.
- Bring in qualitative evidence and local interpretation at the same level as the quantitative finding.
- Identify plausible explanations and other factors that shaped the result.
- Describe what donated products contributed without claiming they acted alone.
- Ask what the evidence means for the project, partnership, local capacity, organizational strategy, and future investment.
- Decide what to maintain, adapt, investigate, coordinate, complement, redirect, transition, or stop.
- Document what is still unknown and what should be learned next.

## Data is useful in every direction

| PATTERN | WHAT IT MAY MEAN |
|---|---|
| **Improvement** | Something may be working; identify what contributed and whether it can be sustained. |
| **Meaningful maintenance** | The program may have protected availability or services under pressure; understand what prevented decline. |
| **Stable high result** | The current model may be sustaining a strong condition; determine what is needed to maintain it. |
| **Stable low result** | A persistent constraint or mismatch may require adaptation, complementary support, or a different strategy. |
| **Decline** | Investigate supply, demand, distribution, service, staffing, financing, or contextual factors; do not assume the donation itself is the only cause. |
| **Variation** | Differences can reveal where the program works differently, where gaps are concentrated, or where definitions and data need review. |
| **No clear change** | The finding may still matter if the program prevented deterioration, or it may indicate that another factor is limiting impact. |

One or two meaningful outcomes metrics will anchor a rich impact story; outputs, qualitative evidence, partner experience, program context, and objectives explain why the findings matter.

BEFORE YOU MOVE ON

You should be able to answer three questions:

> What are we trying to understand or demonstrate?

> What decision needs more evidence?

> What can this program and partnership credibly measure?

Next, we look at how AMI organizes contribution across the three impact areas.

NEXT

## Understanding the AMI Framework

*Where does your program contribute - and which AMI area best reflects that contribution?*

→ Go to Module 3

MODULE 3

# Understanding the AMI Framework

*The Aligned Metrics Initiative (AMI) was developed because product donations create value long before a health outcome is visible. The framework outlines agreed-upon areas where medical product donations contribute to broader changes in health by responding to priority product demand from partners, stabilizing supply, contributing to the continuity of care, and supporting health services within a broader health system.*

Different donations create value in different ways. Programs are designed to achieve different results. For example, some programs deliver products around the world, and their partners trust them to delivery products that are most needed. Others combat specific diseases through a model that contains donations as a part of a complex solution. Both results are important and both deserve to be measured. AMI aligns the impact of all of these efforts into simplified and connected impact areas. Organizations will customize their use of AMI.

### Collect the stories alongside the number

Qualitative information sits alongside quantitative findings and helps explain what happened, why it happened, what people experienced, what the product contribution looked like in practice, and what the numbers alone cannot show.

Keep the program purpose visible. Use qualitative evidence to understand what product availability enabled in relation to that purpose.

> The AMI framework helps organizations identify and measure the types of outcome metrics that best reflect their strategy, contribution, partnership model, and available data. It provides a practical starting point for impact measurement while allowing flexibility. AMI is designed to help organizations consistently demonstrate and communicate how their efforts contribute to positive change over time.

## The AMI Impact Areas




AMI's enables discovery beyond what was donated, shipped, delivered, or counted and provides a practical way to understand, improve, and communicate how donated medical products contribute in three important ways around:

- availability of priority products,
- continuity of care, and
- capacity to deliver care.

These areas make up AMI's impact areas. Availability, continuity, and service capacity are distinct but connected contribution areas. AMI focuses on impact areas that are broadly applicable across donation models, products and partnerships.

Below is an overview of the impact areas and recommended priority indicators.

| IMPACT AREA | PRIMARY QUESTION | PRIORITY INDICATOR | WHAT THIS HELPS SHOW |
|---|---|---|---|
| **Increase Availability of Priority Products** | Are partners getting priority products? | Percent of priority product demand met through available supply | How closely available supplies meet partners identified priorities, and where there are gaps. |
| **Sustain Continuity of Care** | Can partners count on those products to keep care going? | Priority product stockout-free reporting period. | Whether priority products remain reliably available over time, and where interruptions threaten care. |
| **Expand Capacity to Deliver Care** | What care can partners provide because the products are consistently available? | Percent change in volume of product-supported health services | Where product support helps partners maintain, restore, introduce or expand health services. |

Go deeper: Explore the Priority Metric Reference Cards

**Increase Availability of Priority Products**

**Sustain Continuity of Care**

**Expand Capacity to Deliver Care**

## A small number of data points can support a much bigger story!

AMI is intentionally built around only a few shared priorities currently. These three indicators are anchors, not the only valuable measures. They were identified after review of a broad set of outputs and outcome indicators as the strongest shared place to begin across different programs, portfolios, organizations, and partnerships. Prioritization is intended to make outcome measurement more achievable, not to narrow the full story of donation impact. The impact areas are not intended to represent a continuum, and organizations do not need to measure in all areas.

## Outputs remain part of the impact story

> Outputs show scale. Outcomes show what the activity contributed to.

AMI uses familiar measurement terms in a simple way: inputs and activities produce outputs; outcomes help show what those activities contributed to; broader impact is shaped by many actors and factors.

| COMMON OUTPUT FAMILY | ILLUSTRATIVE EXAMPLES |
|---|---|
| **Product and supply** | Units, packs, courses, defined daily doses where relevant, product categories, value, volume, shipments, fulfilment, delivery, receipt. |

| | |
|---|---|
| **Reach** | Countries, partners, facilities, programs, geographic areas, patients or people served where responsibly estimated. |
| **Operations** | Lead time, fulfilment rate, on-time delivery, shelf life, logistics performance, emergency deployment, inventory movement. |
| **Program support** | Training, technical assistance, equipment, systems support, planning activities, partner coordination. |
| **Partnership** | Partners engaged, duration of support, joint planning activities, co-investment, local participation. |

Organizations should continue to invest in output reporting. Outputs remain essential because they show what was done, at what scale, and with what operational reach. They also help explain the mechanisms behind outcome findings.

## Health & Quality Outcomes Matter

> Health and quality outcomes may extend the impact story for programs with a sufficiently clear and credible line of contribution. Because these outcomes are further downstream and shaped by many factors beyond donated products, they will not be appropriate or feasible for every program.

Where the program design, data, and contribution pathway are strong enough, organizations can add relevant health and quality outcomes. AMI does not replace those measures. Instead,

AMI does not standardize a single health or quality measure across portfolios because the appropriate outcomes and methods vary substantially by product, disease area, service, population, and program model. Therefore they are not a fourth shared impact area, nor are they required to show impact.

Not every program should measure health and quality outcomes. Use them where the evidence can credibly support the connection.

## A Shared Language

One of the most important contributions of AMI is the development of a shared language.

Organizations measure differently, operate differently, and serve different populations. However, a common framework creates opportunities for greater alignment, learning, aggregation, and comparability over time.

Comparable does not mean identical. AMI enables organizations to describe how their donated medical products consistently contribute to care.

RESOURCE
Theory of Change ›

RESOURCE
Additional Outcomes Explorer ›

## Primer on Measurement Terminology

Language is important, the AMI working group determined that the following definitions capture the collective understanding of medical donation program measurement. These are simple and straightforward definitions for measurement that every PQMD member organization can understand and utilize.

| Input | Activities | Output | Outcome | Impact |
|---|---|---|---|---|
| Resources used to carry out a program or partnership, such as products, funding, staff time, expertise, data, infrastructure, or relationships. | The actions carried out by a program or partnership to produce intended results, such as sourcing, shipping, training, coordination, or technical support. | A direct product, service, or reach measure produced by program activity, such as quantities delivered, people reached, partners supported, or health workers trained. | A change that occurs because of, or is supported by, program activities and outputs. In AMI, outcomes may relate to product availability, continuity, service capacity, health, or quality. | The broader or longer-term change to which a program or partnership may contribute. AMI uses contribution language and does not assume that donated products alone cause impact. |

## See your program in the framework

The three shared areas are a common frame, not the whole impact story. The questions below will help organizations overlay the framework to their programs and portfolios.

| THINK ABOUT YOUR PROGRAM | WHAT MAY MATTER IN THE IMPACT STORY |
|---|---|
| **Why was this program created?** | Expand access to essential products? Reach populations that otherwise go without? Protect an essential service? To eliminate or control a disease? Bridge an urgent or persistent gap? |
| **What does success look like?** | Wide reach? Deep impact in a defined population? Reliable access over time? Stronger service availability? Treatment quality, patient experience, disease control, or another health outcome? |
| **What role do donated products play?** | The primary strategy? One contribution within a larger program? A bridge while procurement or other systems develop? Support alongside training, workforce, infrastructure, equipment, financing, or other investments? |
| **What kind of change is the program designed to make visible?** | Placing donated products? Priority demand being met? Increased availability? Services maintained, restored, or expanded? Health outcomes? Health systems strengthening? Heath workforce support? Capacity building? Policy change? |
| **How broad or focused is the program?** | A wide portfolio spanning products, geographies, and partners? A targeted disease, population, geography or product program? A defined service model? A long-term access strategy with an explicit health or quality ambition? Other? |

READY TO GO FURTHER?

### Supporting Outputs + Outcomes Catalogue

Use the catalogue when the three priority indicators do not tell the whole story. It groups supporting outputs and additional outcomes by impact area so programs can add evidence that fits their strategy, decision, and data without being encouraged to measure everything.

BEFORE YOU MOVE ON

You should now be able to see which how the AMI framework overlays your programs and what is most relevant to the impact story you are aiming to tell.

NEXT

# Measuring in Partnership

*When no one organization holds the complete story, how can partners measure together?*

→ Go to Module 4

MODULE 4

# Measuring in Partnership

*Access to medicines depends on different kinds of expertise coming together and medical product donations operate within a complex ecosystem.*

## WHY IS MEASURING DONATION IMPACT SO DIFFICULT?

Products move across multiple organizations before reaching patients. Oftentimes measurement conversations do not explicitly happen and organizations end up contributing to the same program while collecting different information for different purposes.

### No one organization sees the whole picture. Start with a conversation.

Shared measurement begins by deciding what each partner needs to know, already knows, can contribute as well as discussion about how capacity, cost, burden and interpretation will be shared. These conversations will address the complexity as well as enable informed decisions and shared credible stories.

> Shared outcomes require shared measurement decisions.

### A shared indicator should not create an unshared burden.

### Evidence should travel back through the partnership, not only upward through it.

### Partners benefit from discussing expectations early and revisiting them over time.

Useful questions include:

- What story are we trying to tell?
- Which impact areas matter most?
- What data already exists?
- What data is feasible to collect?
- Who owns the data?
- How will the information be used?
- What level of effort is realistic?

Many measurement challenges can be avoided through early alignment. Check out the AMI tools for partnership alignment on metrics.

### Bring the story you defined into the partnership

You have already considered what you are trying to understand or demonstrate, what decision the evidence should support, and where your program may contribute.

> What do we already know across this partnership - and what could we understand better together?

## Different partners bring different perspectives and needs to measurement

Evidence often sits across organizations rather than in one place. So does its value: organizations often participate in the same donation programs for different reasons. Perspectives will overlap. Shared measurement helps identify alignment and differences.

| PARTNER PERSPECTIVE | EVIDENCE, EXPERIENCE AND CAPABILITIES THEY MAY BRING | WHY THIS EVIDENCE MAY MATTER |
|---|---|---|
| **Corporate donor** | Product and disease-area expertise; product characteristics and appropriate use; supply and forecasting; demand; access strategy; portfolio and partnership context; dating and documentation, fulfilment and dispatch, upstream timelines and corporate strategy | Understand whether products are contributing as intended; identify changing demand or gaps; inform product and access strategy; determine where product, coordination, complementary support, systems investment, or another approach may add value; strengthen stewardship and the internal case for social investment |
| **NGO / distributor / intermediary / implementer** | Technical expertise; close knowledge of requests and fulfilment; logistics and product movement; country requirements; partner characteristics and capabilities; direct service-delivery experience; program implementation; geographic reach; operational and contextual realities; service evidence where relevant; cross-program patterns, established relationships | Understand how products translate into access and care; identify persistent or seasonal gaps; strengthen implementation and service delivery; improve sourcing, allocation, timing, resource mobilization, and future program design, compare information across partners and products, identify where different support is viable |
| **Local / in-country partner** | Priority demand; receipt and stock status; service availability; patient and provider experience; service and patient data where appropriate; organizational and facility capabilities; operational barriers; community context; local planning needs | Make normalized and/or invisible needs visible; strengthen planning; and communicate local/regional priorities; show what sustained focus enables; identify constraints to care; demonstrate local capacity; shape future support and priorities; engage partners |
| **Ministry / public health authority, where relevant** | Public priorities and supply; policy; facility networks; population and service planning; workforce and infrastructure; health-system capabilities and constraints | Understand how external contributions align with public priorities and timelines; identify supply or capacity gaps; inform how external partners can complement national and local systems |

CHECK OUT AMI'S TOOL

### Guide for Measuring in Partnership

This exercise will help partners understand what is realistic together and agree on a meaningful shared measurement approach..

## Build from what already exists; starting small

Shared measurement can begin with evidence partners already hold: existing records, periodic observations, sampled reports, and some story capture (qualitative).

Partners likely already hold much of the evidence needed across routine program records, product and supply information, partner reporting, service data, observations, and existing qualitative evidence.

Start there. Measurement practices can strengthen through partnership over time.

> A lighter touch approach is honest, useful and preferable to technically ambitious systems that cannot be sustained.

Then ask what is missing. Some additional evidence may be easy to add. Other information may require new access, staff time, technical skills, systems, or budget.

## A shared indicator should not create an unshared burden.

If new evidence is needed, the partnership should be clear about who can reasonably provide it, what support is required, and whether the value of the evidence justifies the work involved.

### Capacity and budget are part of measurement design

Discuss the resources needed before assigning or assuming responsibility. Capacity includes staff time, systems, data access, technical skills, travel, translation, connectivity, supervision, analysis, and the ability to act on the findings.

| QUESTION | WHY IT MATTERS |
| --- | --- |
| **Is this information already collected?** | Reuse existing evidence before creating a new reporting requirement. |
| **What additional work would be required?** | Make staff time and operational burden visible. |
| **Who has the systems and skills to do the work?** | Do not assume the partner closest to the data has the capacity to compile or analyze it. |
| **What will it cost?** | Measurement may require direct budget, not only goodwill. |
| **Who will fund or support the added work?** | Shared outcomes should not shift unfunded work downstream. |
| **Will the evidence be useful to the local partner?** | Data should support local planning, negotiation, learning, or advocacy as well as upstream reporting. |
| **Can a lighter approach answer the question?** | Sampling, periodic observation, or fewer fields may be more proportionate. |

### Measure contribution, not sole attribution.

One of the most common challenges in donation measurement is attribution. Donated products rarely operate in isolation.

They are used alongside of provider expertise, local resources and procurement, government investments, shared investments, infrastructure and many other factors.

Naming those influences strengthens the story and showcases value while acknowledging the broader systems that absorb donations.

AMI helps organizations showcase their credible role within a broader set of actors, investments, systems, and conditions; not sole attribution.

### Evidence should be useful in every direction

> The people contributing to the metrics should also gain value from it.

Evidence may help a local partner make an unmet or normalized need visible, strengthen a planning case, demonstrate what sustained support has enabled, or shape what comes next.

For an NGO, it may reveal patterns across products, services, partners, and geographies; strengthen implementation decisions; or make the case for additional capacity and resources.

For a corporate partner, it may strengthen stewardship, product and access strategy, investment decisions, and understanding of where the product contribution is most useful.

Data should be interpreted and shared in the partnership; the meaning of the same finding may hold different value to each partner.

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BEFORE YOU MOVE ON

You began with the story you want to understand. You should now have a clearer shared view of:

> What do we already know together?

> What is still worth understanding?

> Who can reasonably contribute the evidence?

> What capacity or support will that require?

> How will the evidence be useful across the partnership?

> What decisions can the evidence unlock for different partners?

TOOL 2

# Guide for Measuring in Partnership

This exercise will help partners understand what is realistic together and agree on a meaningful shared measurement approach..

If you used Tool 1, bring forward the program purpose. If not, begin here by aligning on shared questions and what decisions data should support. More than one outcome may be relevant. The partnership does not have to measure everything; focus on the outcome question or questions that are useful enough and feasible enough to pursue together

## 1. Understand the context

For this partnership/program, work with your partners to plot approximately where the program is today. The purpose is to align on the realities of the program and begin conversations about where the program is headed.

| DIMENSION | | PLOT APPROXIMATELY WHERE YOU ARE | |
|---|---|---|---|
| **Product supply** | Variable / excess | | Planned / predictable |
| **Program Relationships** | Newer / | | Established / |
| **Partners Involved** | many partners | | Fewer sustained |
| **Visibility after products are received** | Limited / periodic / sampled | | Regular / repeated |
| **Existing data** | Sparse / fragmented | | Routine / aligned |
| **Reporting frequency** | periodic | | longitudinal |
| **Staff resources for measurement** | Few to no dedicated staff | | Dedicated staff and technical support |
| **Budget considerations** | No allocated M&E budget | | Full M&E budget |
| **Ability to influence measurement together** | Limited | | Strong |
| **Strategic tie** | Excess product / operational | | Purposefully tied to a broader impact strategy |
| | | | |
| | | | |
| | | | |

## 2. Compare perspectives

Understand partner needs and perspectives. Relabel the partner columns as needed. Differences are useful information for designing a workable approach.

| QUESTION | PARTNER 1 | PARTNER 2 | PARTNER 3 | WHAT DO WE NEED TO ALIGN? |
|---|---|---|---|---|
| **Are outputs enough for this program?** | | | | |
| **How would this evidence be useful for us?** | | | | |
| **Why does this program tie into a larger impact strategy?** | | | | |
| **What decision will the evidence inform, and how will it be useful?** | | | | |
| **What evidence already exists?** | | | | |
| **What type of data can we realistically access or collect?** | | | | |
| **Which partners have capacity for which measurement tasks?** | | | | |
| **What resources may be available?** | | | | |
| **What support may be required?** | | | | |
| **What burden would new collection create, if any?** | | | | |

MEASUREMENT CAPACITY

Have an open discussion about which partners are best positioned for which tasks—standardizing, collecting or accessing data, managing and calculating metrics, gathering qualitative information and stories, interpreting findings, and using or communicating results? Where would support make the work more realistic and who is willing to commit in what timeframe?

Given these conditions, what kind of measurement is realistic for this partnership?

## Capacity and budget are part of measurement design

If a measurement approach requires new downstream reporting, partners should discuss the resources needed before assigning responsibility. Capacity includes staff time, systems, data access, technical skills, travel, translation, connectivity, supervision, analysis, and the ability to act on the findings. Budget should be explicit when additional work is being requested.

| QUESTION | WHY IT MATTERS |
|---|---|
| **Is this information already collected?** | Reuse existing evidence before creating a new reporting requirement. |
| **What additional work would be required?** | Make staff time and operational burden visible. |
| **Who has the systems and skills to do the work?** | Do not assume the partner closest to the data has the capacity to compile or analyze it. |
| **What will it cost?** | Measurement may require direct budget, not only goodwill. |
| **Who will fund or support the added work?** | Shared outcomes should not shift unfunded work downstream. |
| **Will the evidence be useful to the local partner?** | Data should support local planning, negotiation, learning, or advocacy as well as upstream reporting. |
| **Can a lighter approach answer the question?** | Sampling, periodic observation, or fewer fields may be more proportionate. |

## 3. Agree on the approach

| WE AGREE ON... | DECISION |
|---|---|
| **Question we are trying to answer** | |
| **AMI impact area / priority indicator** | |
| **Existing evidence we will use** | |
| **Additional evidence genuinely needed** | |
| **Who provides what** | |
| **Who compiles / calculates** | |
| **Who adds qualitative context** | |
| **Who interprets the findings** | |
| **Reporting period / frequency** | |
| **Capacity or technical support needed** | |
| **Budget required and who covers it** | |
| **How local partners will use the findings** | |
| **How findings will be returned / shared** | |
| **When we will revisit the approach** | |

> These next steps can be developed incrementally. Start with what the program and partnership can support now, identify where you'd like to ultimately end up and strengthen it as the evidence, relationships, and capacity develop.

- Priority Metric Cards
- Planning and Making the Most of Your Impact Story
- Collecting Stories and Qualitative Evidence

NEXT

## Selecting and Applying AMI Measures

*How do we collect and apply the selected evidence credibly?*

→ Go to Module 5

MODULE 5

# Selecting and Applying AMI Measures

KEY QUESTION

*How do we choose and collect evidence that fits our purpose?*

Start with the outcome your program seeks and the decision the findings will inform. AMI's three metric cards provide shared starting points alongside your organization's own outcome measures. Choose a measure that fits the intended result, the program and your partners' records.

## Start with a metric card

Each card explains the priority metric, why it matters, how to calculate it, and what to consider when interpreting the result. Use it as your technical reference and review it with the partners closest to the evidence.

Open the three AMI metric cards and select the most relevant starting point.

**Increase Availability of Priority Products**

How does the share of identified priority product demand met through donated supply received by the local partner change over comparable periods?

**Sustain Continuity of Care**

How consistently do priority products remain available without stockouts at the service-delivery level?

**Expand Capacity to Deliver Care**

How does the volume of a defined product-supported health service delivered change over comparable periods?

These are connected outcome areas. Track each selected measure over comparable periods to understand improvement, maintenance, decline or variation. Receipt, stock availability and service volume each describe a different part of the contribution to care.

## Agree on a feasible collection plan

Use existing records and agree the product or service, sites, data source, responsibilities and reporting schedule with partners. Follow the selected card's definition, units and calculation. Establish a baseline and repeat the measure across comparable periods, including availability. Show starting and later values alongside the change.

Use the adaptable Excel data templates as supplied or modify them for your program, keeping the measure clearly defined. Add outputs where they explain scale and context. Agree what to measure now and what would strengthen future measurement, including staff time, systems and resources.

## Keep the evidence and its limits visible

Record where the data came from, what is missing, and any assumptions. Use consistent definitions across reporting periods. For continuity, missing observations cannot be counted as stockout-free periods. A stock check on one date cannot establish uninterrupted availability throughout a quarter.

For service volume, keep the service definition, counting unit and periods comparable. Report services delivered separately from unique patients. When the baseline is zero, describe the service as new or restored, report the current volume and establish the baseline for future comparison.

## Ask what the number cannot explain

Bring partner, provider, and patient perspectives alongside the quantitative finding. Their experiences can help explain the result, reveal barriers, and identify questions for further investigation. Clearly distinguish reported

experience from a measured change or a result established across the program.

Build a few focused questions into routine reports, partner calls, or visits:

- What did product support help providers or partners do, and what evidence supports that connection?
- Who still faced barriers to care, and what were those barriers?
- What else influenced the result, and what needs to happen next?

## Explore other outcome pathways where they matter

The three cards provide a shared starting point, while your program may also contribute to outcomes they do not capture. You may want to explore whether patients can obtain a full course of products when prescribed, whether travel or cost limits access, or whether service availability differs across locations.

These are questions for exploration, rather than additional AMI priority metrics. Choose one only if it matters to your program and partners. Define the expected change, how products and complementary support could contribute, and what evidence would show that change. Agree on a feasible measure and distinguish it from the standard metric on the card.

Use the outcome discussion to consider what would help the program achieve the result it seeks. Partners may identify changes in product planning, delivery timing, staffing or complementary support. Agree a feasible next step, who will support it and when to review both the program and its outcomes.

BEFORE YOU MOVE ON

Before moving on, you should have a selected card or clearly defined alternative measure, a feasible collection plan, and a few questions to help interpret the findings.

NEXT

## Building and Communicating the Impact Story

→ Go to Module 6

MODULE 6

# Building and Communicating the Impact Story

*How do we explain the outcomes of our work and what they mean for people and care?*

An impact story brings together the change a program seeks, the results over time and the experiences of the people involved. It explains what donated products and partnerships contributed, what helped the result and where further work could make a difference. Start with your program's purpose and the outcomes that matter to your organization and partners.

## Use outcome measures to show what changed

Delivery and reach figures describe the scale of your work. Outcome measures help you understand what changed or was sustained. Measure the same outcome across comparable periods so you can see progress, maintenance, decline or differences between settings. Even availability becomes a fuller story when you track how closely supply meets priority demand over time.

AMI offers three shared impact areas: Increase Availability of Priority Products; Sustain Continuity of Care; and Expand Capacity to Deliver Care. Use the relevant metric cards alongside other defined outcomes that reflect your program. Each story can connect with the areas that fit its purpose.

### Three fictional examples over time

**Availability**

the share of a clinic's recorded priority medicine demand met through donated supply rose from 60% in Year 1 to 80% in Year 2, while demand increased. The story can explore how product selection, quantities and timing changed and what the remaining gap meant for care.

**Continuity**

over a two-year review, a clinic had nine stockout-free months in the first year and 11 in the second. The story can explain what more reliable supply meant for refill arrangements and how donated products, purchasing and local planning contributed.

**Capacity**

a facility delivered 2,400 defined diagnostic tests in Year 1 and 3,000 in Year 2, a 25% increase in service volume. The story can examine how equipment, consumables, staff and maintenance contributed to that increase and which access barriers remained.

Keep definitions, units, locations and period lengths comparable. Show the starting and later values alongside the change. A first observation establishes a baseline for the next review. Track meaningful maintenance as well as improvement, with context about demand and operating conditions.

## Explain what the results mean

### Gather experiences alongside the numbers

Patients, caregivers, providers, supply teams and local partners can explain how the program worked in practice. Their experiences may reveal a change the metric misses, explain a pattern or lead you to reconsider an initial conclusion. Include perspectives from people with different experiences. Tool 4 provides the working questions, recording sheets and detailed guidance.

### Check the explanation with partners

Review the records and stories together. Be clear about what was measured, what people described and what you conclude. Check the assumptions behind the comparison, including complete records, consistent definitions, other sources of supply and whose experiences are represented. Record what has been checked and what still needs investigation.

Connect the findings to the outcome your program seeks. For example, stock records show product availability; provider and patient accounts help explain the experience of obtaining refills. Each adds a different part of the story. Credit local leadership, donated products and the other support that shaped the result.

## What format do you need to present your data in

Decide who will use the findings and what they need to understand. A program report may explain progress against outcomes; a partner discussion may focus on what to change; a leadership brief may support a resource decision; a public story may describe a person's experience alongside the wider result. Keep the underlying finding and its scope consistent across formats.

Agree the audience, timing, roles, requested content and review process early. Build on existing reporting arrangements and discuss the staff time, translation, collection and other costs with partners. Shared planning helps each organization use the same information well.

## Respect the people sharing their stories

Explain the purpose and intended uses, protect voluntary participation and record permissions for recording, quotations and images. Give contributors an opportunity to review their representation. Show people's knowledge, choices and agency; recognize local leadership and the partners involved. Protect personal information, check translations and follow local consent and safeguarding procedures. Return the finished story or findings to contributors in an accessible form.

## Use what you learn

Tool 3 is a review of the purpose, measures and partner decisions developed through the earlier tools. It brings the findings into a report or story. Tool 4 supports gathering and checking experiences, with a separate AMI Storytelling Reference Guide for detailed methods and examples. Together, they help you identify what to sustain, what to adjust and what further support could help the program achieve its intended outcomes.

RESOURCE

AMI Storytelling Reference Guide ›

TOOL 3

### Building Your Impact Story

Review your plans and findings and prepare the report or story you need

TOOL 4

### Gathering Stories and Understanding Results

Working pages for gathering and checking people's experiences

NEXT

## Applying and Evolving AMI

→ Go to Module 7

TOOL 3

# Building Your Impact Story

Review your plans and findings and prepare the report or story you need

Use this tool as a review. Bring forward the program purpose and selected measures from Tool 1, the partner agreements from Tool 2, and the findings from your metric records and Tool 4. Use the fields below to bring that work together. Where information is still needed, return to the relevant tool and update this review.

## 1 Review what your program is trying to achieve

**Program purpose and intended outcome**

What change is the program designed to make, for whom and where? Which organizational or partner priority does this support? Refer to your story and metric selection work in Tool 1.

**Connecting your efforts to a Metric**

Which metric will show whether you are achieving or sustaining the intended outcome over time? Use an AMI priority metric or a clearly defined measure for your own outcome. Record its definition, source and reporting periods.

**AMI impact areas**

- Increase Availability of Priority Products
- Sustain Continuity of Care
- Expand Capacity to Deliver Care

Identify the area or areas that connect with your work, where relevant. Add your own outcomes, including health or quality outcomes where your program and evidence support them.

**Review partner agreements**

From Tool 2, confirm the reporting schedule, responsibilities, resources, intended uses and who will review the findings. Record any changes needed.

WORKING RECORD

Program or story reference; author; date and version; partner reviewer. Keep links to source records and restricted permission records with the working copy.

## 2 Review what the findings tell you

**Results over time**

Record the starting and later values, units, sites and comparable periods. Describe improvement, maintenance, decline or variation. Add relevant outputs for scale and link the Excel records or other sources.

**What people experienced**

Bring forward the findings checked through Tool 4. What did the result mean for people and care? Include differing experiences and the people and settings represented. Link the source records.

**How your efforts contributed**

What did local teams, donated products and related support help achieve? What else shaped the result? How does this relate to the program purpose and your organization's priorities?

**Check the conclusion before drafting**

Review the comparison and interpretation with partners. Check data completeness, definitions, other contributions and how widely the accounts apply. The AMI Storytelling Reference Guide explains these checks. For each material assumption, record its status: checked, partly checked or still to test.

**Conclusion and open questions**

What can you say from the records and accounts together? Which assumptions or questions remain open, and how will the report reflect them?

**What should happen next**

What should continue or change to help achieve the intended outcome? Record the agreed action, owner, support required and review date. Return changes in program design or measurement to Tools 1 and 2.

## 3 Write for the format you need

**What format do you need to present your data in**

Who is the audience? Is this a program report, partner update, leadership brief, presentation or public story? What length, timing and decision does it need to support?

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**What to include**

Explain the program purpose and starting situation. Present the outcome across comparable periods. Describe what it meant in practice, how the program and partners contributed, and the important gaps. Close with the next action. Use a quotation or image where it adds understanding and the permissions cover the intended use.

**Fictional example of report language**

> Over two years, the clinic made the priority diabetes medicine more consistently available. Stock records show nine stockout-free months in Year 1 and 11 in Year 2. The pharmacy team linked the improvement to regular donated supply, earlier reordering and purchased stock used to cover delivery gaps. Six of eight patients interviewed described fewer extra trips to obtain the medicine; these accounts reflect the experience of those consulted. Together, the findings suggest that better supply coordination helped make refill arrangements more dependable. The clinic and its partners will retain the reorder schedule and review the remaining supply gap and patients' refill experiences next year.

All details are fictional. The example shows a measured outcome, reported experience, interpretation and action. The AMI Storytelling Reference Guide contains the underlying checks and reporting examples for availability and service capacity.

**Your report or story**

Draft here or link to the working document. Keep the numbers, meaning and source references consistent as you adapt it for different audiences.

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**Final review**

Check the headline, numbers, interpretation, captions and quotations against the sources. Confirm partner review, contributor permissions, credits and approval for the intended use. Share the finished material with the people and partners who contributed.

TOOL 4

# Gathering Stories and Understanding Results

Working pages for gathering and checking people's experiences

Use these two working pages when you need experiences to help explain an outcome. Your measure may be an AMI priority metric or one selected for your own program. Start with the purpose and partner agreements already developed through Tools 1 and 2. Return the checked findings to Tool 3 for reporting. The separate AMI Storytelling Reference Guide provides methods, ethics, analysis and worked examples.

## 1 Plan the conversations

**What do you want to understand**

Name the outcome, result or question, product or service, place and periods. What needs explaining about the change or maintenance over time?

**Whose experience will help**

Choose people with direct experience and include a different perspective. Record why each person or group is relevant, who was invited and who participated. Consider roles, sites and access barriers.

**How will you gather the accounts**

Choose an existing check-in, report, interview, group discussion, short survey or observation. Record the collector, timing, language, review date and resources agreed with partners.

**Choose two or three questions and follow up**

- Compared with [earlier period], what changed or stayed the same in obtaining [product] or providing or receiving [care]? Please describe a specific experience.
- What part did donated products or related support play? What else helped or made things difficult?
- What did this mean for you or the people receiving care? What should happen next?

Follow up with when, where and how the person knows. Match the questions to what each person can directly know. Ask about experiences that differ and keep wording consistent when you intend to compare accounts.

**Permissions and practical arrangements**

Explain the purpose, participation choices and intended use. Record the permission reference, privacy arrangements and any restrictions. Use the ethics guidance in the AMI Storytelling Reference Guide.

## 2 Record and compare what you hear

Copy the source record for each conversation, group discussion or observation. Keep the original notes and link each finding to its source. Use a participant code where personal information needs protection.

**Source record**

Source ID; role or group; site; date; period described; method; collector; language; questions used; permission reference.

**What the person described**

Record what changed or was sustained, a specific experience, what products and other conditions contributed, and any different or unexpected experience. Label exact quotations, paraphrases and your own observations.

**What you need to check**

Which stock, service or other records could help? What question should be followed up? Record allowed uses and any contributor review needed.

**Compare the accounts**

Read the notes, sort relevant passages under a few shared topics and compare across people, sites or periods. Include different and conflicting accounts. The AMI Storytelling Reference Guide explains the process and how to describe the scope of the finding.

**What the accounts and metric show together**

Summarize the pattern, differences and contribution of the program. State who was consulted and whose experience remains missing. Link the supporting records and source IDs.

**Partner review and next step**

Who reviewed the finding? What was corrected or remains unresolved? What assumption is checked, partly checked or still to test? Record the action, owner and review date, then bring the finding to Tool 3.

MODULE 7

# Applying and Evolving AMI

*Start where you are. Learn from use.*

## Starting where you are

Organizations can begin with existing records, periodic observations, sampled evidence, and a few focused qualitative questions. Measurement practice can strengthen through partnerships and over time.

An honest, lighter-touch approach is preferable to a technically ambitious system that partners cannot sustain.

## Weave AMI or shared measurement into conversations, starting today!

Choose an upcoming program review, partner conversation, or planning meeting where evidence could help inform a decision. Thoughtfully craft a starter question, share prior successes you have had with other programs, and agree on one action to support measurement.

Use the Additional Outcomes Explorer to support application and interpretation. If the conversation reveals a question your current measures do not answer, consult the AMI Metrics Catalogue. Return to Module 5 for guidance on selecting measures that fit.

RESOURCE
How AMI Fits Together ›

RESOURCE
AMI Metrics Catalogue ›

RESOURCE
Additional Outcomes Explorer ›

RESOURCE
Theory of Change ›

RESOURCE
AMI Storytelling Reference Guide ›

## Leverage your work to decide what comes next

Evidence can help partners decide whether to continue programs or plan future ones, adapt supply, coordinate complementary support, redirect resources, sunset a program, or investigate further.

## Revisit the process over time

As programs and partnerships change, measurement choices may change too. Discuss with partners:

- Is this still the result we need to understand?
- Is this still the right measure?
- Is the evidence useful enough to justify the burden?
- Do we want to trial something new?

Consistent use and learning will build expertise and enable you to distinguish yourself in the field.

## Continue the work together

PQMD recommends the three priority indicators as a shared starting point. The AMI Metrics Catalogue includes additional output and outcome measures to consider, and PQMD is committed to the future development of AMI.

> Interested in contributing to AMI's future? Join the Donations Impact Member Interest Group.

RESOURCE
Interest Group Form

Bring what you are learning, your successes, and your challenges to discussions with corporate and nonprofit partners. Let your experiences shape AMI.

## AMI is grounded in meaningful, feasible metrics!

- *Measure*
- *understand*
- *interpret*
- *decide*
- *communicate*
- *act*

IMPACT AREA: INCREASE AVAILABILITY OF PRIORITY PRODUCTS

PRIORITY OUTCOME METRIC

# Percent of priority product demand met through available supply

## DESCRIPTION AND PURPOSE

This measure will help organizations to understand whether the donated products align with and help fulfill priority product demands. It helps show the gap between what has been identified as a priority and what ultimately becomes available through donated supply for use.

## WHY THIS MATTERS

Shows how responsive the donation system is to local health partner priorities and helps build stronger partnerships and more consistent pipelines of priority products. This metric helps organizations see where donated supply is meeting identified demand, where gaps remain. This understanding drives deeper understanding of trends in priorities, as well as where sourcing, donor engagement, planning, or partnership decisions may need to change.

## WHAT THIS HELPS DIFFERENT ACTORS UNDERSTAND

### CORPORATE DONORS

a broader overall picture of partner priorities as well as the scale of those needs and if available donated supply aligns with prioritized product demand.

### NGOS

patterns across partners can inform sourcing, donor outreach, allocation, and future procurement strategy

### LOCAL/IN-COUNTRY PARTNERS

how much priority product demand exists that is being/not being met over the reporting period , as well as understand potential availability by procurement/partner type . Assists in communications related to planning and care.

## KEY QUESTIONS

- What patterns exist around identified priority product demand and delivery?
- What are the most prominent and consistent gaps in a given year, and year-over-year?
- How effective is the current donation system in meeting need, and what are the access and availability drivers of specific needed products?
- How does the match between identified demand and received supply change over time?

## RECOMMENDED FOR

- Produce-to-Give
- Recurring Excess Product Donations

## TYPICAL DATA SOURCES

- Partner priority-product demand records, requests, assessments, surveys or structured partner reporting
- Donation shipping, acceptance and receipt records
- Initial partnership documentation
- Distribution or delivery records confirming receipt by the local partner

## CALCULATION GUIDANCE

- Fix the reporting period and the product types..
- Identify priority product demand for the reporting period. Calculate by product type unless a finer level is needed and feasible.
- Identify the quantity of donated supply for the same product type that was acually received by the local/in-country partner during the same reporting period.
- Do not count supply as available for this metric until it has been received by the local/in-country partner.
- Calculate: received donated supply / identified priority product demand x 100.
- Report the result by product type, per reporting period.
- Repeat for each product type by partner.
- Examine % match over different product types, if applicable.
- Consider if there is an acceptable goal or % threshold.
- Analyze results over reporting periods and across years.
- Keep product types and reporting periods consistent across cycles.

## ADDITIONAL METRIC INFORMATION

| | |
|---|---|
| UNIT OF MEASURE | Percentage (%). Underlying quantities must use the same standardized unit or a defined count (items, kits, packages) for numerator and denominator. |
| NUMERATOR | Quantity of the relevant priority product type received by the local partner during the reporting period, in a standardized unit. |
| DENOMINATOR | Assessed demand for the same priority product type, reporting unity, and period. |
| DIRECTION | A higher percentage indicates that more identified demand was met. Interpret values in context; donation programs may not have access to all needed products and also % match should not exceed 100% |
| REPORTING FREQUENCY | A reporting period fixed in advance; often quarterly or annual, but another consistent period may be appropriate. Hold constant for year-over year analysis. |
| USEFUL DISAGGREGATION | Product type; product class/product where useful; local/in-country partner; geography; reporting period. |

## ASSUMPTIONS

- Identified priority product demand should be grounded as close to the community/local level as feasible and developed in coordination with the relevant local/in-country partner.
- Priority product types are linked to partner- and program-specific strategies.
- Results are most useful when tracked consistently over time.
- For medicine/pharmaceutical donations, programs may need to account for clinically appropriate substitution where products within the same class can meet the same treatment need.
- Some produce-to-give programs may achieve 100% match by design.
- The reporting period may be annual, another fixed period, or shipment-based, provided the same period is used for numerator and denominator.

## INTERPRETATION AND LIMITATIONS

- This metric measures alignment between identified demand and received donated supply; it does not measure total population need or imply that donated products should meet all need.
- Identified demand should be grounded in
- in-country partner context and should not be defined by what a donor has available.
- Programs may find it useful for the result to inform donation supply gaps.
- Substitution may be appropriate within a product class in some programs and should be documented where it affects interpretation.
- Use contribution language. Multiple actors, procurement systems, public supply, and other sources may influence overall product availability.

## DECISIONS THIS EVIDENCE CAN INFORM

- What is the broad demand for product types.
- Which procurement or partnership opportunities may be needed and when
- How to prioritize available donated supply across partners or geographies
- Some recurring donation programs may achieve 100% match by design
- Where donation supply is not an appropriate or sufficient response and other access strategies are needed
- Stories and qualitative data will add context to the analysis efforts

## WHAT THIS EVIDENCE HELPS YOU SHOW

How closely donated supply aligns with identified priority product demand, where gaps remain, and how the partners can respond strategically to those gaps.

## WHERE TO GO NEXT


**AMI Metrics Catalogue** →
Every output and outcome metric PQMD has catalogued, and where health and quality outcomes sit.

**Gathering Stories and Understanding Results** →
Tool 4: the human and program context that explains what this result means.

**Key Terms** →

The controlled definitions behind the words this card uses.

IMPACT AREA: SUSTAIN CONTINUITY OF CARE

PRIORITY OUTCOMES METRIC

# Stockout-Free Reporting Periods, for Priority Products

## DESCRIPTION AND PURPOSE

This metric measures reporting periods in which prioritized products remain available, without stockouts, at the service-delivery level. It provides a shared way to understand consistency of product availability over time and how donated products contribute to sustaining care.

## WHY THIS MATTERS

Stockouts interrupt care delivery, delay treatment, and place strain on providers and facilities and consistent access to priority products helps providers sustain treatment and plan care with greater confidence. Tracking stockout-free periods informs greater understanding of how donated supply supports this consistency. This metric also informs where recurring or prolonged interruptions may call for changes in supply planning, timing, or coordination in partnership.

## WHAT THIS HELPS DIFFERENT ACTORS UNDERSTAND

### CORPORATE DONORS

what scale is the demand for priority products at the service supply level; how reliably donated supply helps keep priority products available for ongoing care. Patterns over time inform donation timing, volume, commitments and partnerships that can strengthen supply between donations.

### NGOS/DISTRIBUTORS/INTERMEDIARIES

where donated supply supports consistent product availability across partners and where recurring gaps need additional support or coordination. This information also informs forecasting, shipment typing, allocation and complementary procurement to sustain supply.

### LOCAL/IN-COUNTRY PARTNERS

how often priority products remain continuously available, whether donated products can be counted on reliably to sustain treatment and plan upon. This information articulates timing and the consequences of supply gaps among partners.

## KEY QUESTIONS

- How consistently are priority product types available during the reporting period without stockouts?
- Are donated products helping reduce interruptions in access?
- Are facilities experiencing fewer shortages over time because of repeated donations?
- Which product types, facilities, or geographies experience recurring interruptions?
- Are stockout patterns improving, remaining stable, or worsening over time in regards to donation efforts?
- What changes in supply planning or partner mix and coordination could help sustain availability?

## RECOMMENDED FOR

- Produce-to-Give
- Recurring Excess Product Donations
- Programs where local inventory or stockout information is available

## TYPICAL DATA SOURCES

- Stock cards
- Facility inventory records including balance on hand and stockout date informatin
- Digital inventory or logistics management information systems
- Periodic partner reports where routine inventory data are not available

## CALCULATION GUIDANCE

- Define the priority product type and reporting period in advance. Use months where monthly data are reliable; otherwise use another consistent reporting period and state it clearly.
- For each valid observed reporting period, classify the product type as available without stockout or stocked out.
- Calculate: number of valid observed reporting periods without stockout / total valid observed reporting periods x 100.
- Also take note of length of stockouts/time to fulfill.
- Examine % and stockout free streaks by product type, per reporting period.
- Repeat for each product type of interest by service partner.
- Examine % stockout data over different product types, if applicable.
- Analyze results over reporting periods and across years.
- Keep product types and reporting periods consistent across cycles.
- Where possible, record donated and non-donated sources separately to help interpret the donation program's contribution to continuity.
- Stories and qualitative data will shape the context.

## ADDITIONAL METRIC INFORMATION

| | |
|---|---|
| UNIT OF MEASURE | Percentage (%) of valid observed reporting periods without stockout |
| NUMERATOR | Valid observed reporting periods in which the priority product type was available without stockout. |
| DENOMINATOR | Total valid observed reporting periods for the same product type, site/context. |
| DIRECTION | Higher percentage = more consistent product availability. |
| REPORTING FREQUENCY | Typically annual using repeated observations within the year; another fixed cycle may be used. |
| USEFUL DISAGGREGATION | Product type; facility/site; geography; reporting period; donated vs. other supply where available; time to restock/stockout length; reason for stockout (if inclusive of dates). |

## INTERPRETATION AND LIMITATIONS

- A stockout is zero usable available quantity of the defined priority product type during the reporting period used by the program.
- Calibrate granularity to local reporting capacity. Product type is the default level because clinically appropriate substitution may occur within a class or type.
- Missing observations should not be treated as stockout-free periods. Report valid observed periods only.
- Stockouts can be influenced by donated supply, procurement, public-sector supply, demand changes, inventory practices, logistics, and other factors.
- Interpret the metric as contribution to continuity, not proof that donations alone caused the result.

## DECISIONS THIS EVIDENCE CAN INFORM

- What is the relationship of ongoing donations to product consistency at the service level by product type?
- Which product types or partners would benefit from closer supply planning
- Where shipment cadence or replenishment timing is critical
- Where repeated interruptions warrant additional sourcing or other supply strategies
- Where deeper review of frequency, duration, or time to replenishment would be useful

## WHAT THIS EVIDENCE HELPS YOU SHOW

Whether priority products are reliably available over time and where recurring interruptions may threaten continuity of care. It also uncovers donations role by product type and service level.

## WHERE TO GO NEXT


**AMI Metrics Catalogue** →
Every output and outcome metric PQMD has catalogued, and where health and quality outcomes sit.

**Gathering Stories and Understanding Results** →
Tool 4: the human and program context that explains what this result means.

**Key Terms** →
The controlled definitions behind the words this card uses.

IMPACT AREA: EXPAND CAPACITY TO DELIVER CARE

PRIORITY METRIC

# Percent Change in the Volume of Product-Supported Health Services Delivered

## DESCRIPTION AND PURPOSE

This metric captures changes in the volume of a defined product-supported health service delivered during a reporting. It leverages existing service records and tracking consultations, treatments, tests, or procedures completed. Additional information adds context and indicates how reach and range of care were affected due to adding additional locations, more service days, or more care delivered within existing schedule

## WHY THIS MATTERS

Medical product donations create value when they enable care. Tracking service volume helps partners understand how product support translates into care delivered and can inform decisions about sustaining or expanding services. It provides practical evidence of service activity within the broader picture of capacity to deliver care.

## WHAT THIS HELPS DIFFERENT ACTORS UNDERSTAND

### CORPORATE DONORS

how donated products contribute to service-delivery capability, patterns, range or availability when combined with complementary support. This information can help guide future donations, investments and inform partnerships around service priorities.

### NGOS/DISTRIBUTORS/INTERMEDIARIES

where product donations with complementary support can sustain or expand services across partners and what patterns say about context and future needs. This understanding informs sourcing strategies, allocation management and coordination of products and support.

### LOCAL PARTNERS

demonstrate how product and other support strengthen capacity for services and at which levels. This understanding leverages mechanism to demonstrate success through partnership and make the case for appropriate next steps – whether in-kind support, complementary support or procurement otherwise

## KEY QUESTIONS

- How has the volume of defined product-supported health service delivery changed over time? maintained, restored, expanded, or newly available services?
- Did the change involve additional locations, more service days, or more care delivered within existing schedules?
- How did donated products and complementary support contribute?
- What other factors influenced service volume, including patient demand or interruptions?\
- What support is needed to sustain, restore, or expand services?

## RECOMMENDED FOR

- Produce-to-Give
- Recurring Excess Product Donations

## TYPICAL DATA SOURCES

| INFORMATION NEEDED | TYPICAL SOURCES |
|---|---|
| **Core: Number of services delivered** | Consultation registers, treatment logs, diagnostic records, procedure records, routine facility or program reports |
| **Context: Locations and service days** | Facility lists, clinic schedules, outreach calendars, operating logs |
| **Context: Products and partnership contributions** | Donation receipt and use records, partner reports, program records, brief discussions with service providers |
| **Optional: Unique patients served** | Patient registers or clinical records that allow repeat visits to be identified |

## CALCULATION GUIDANCE

- Define the health service (product-supported), the relevant service-delivery points or program, and the reporting periods.
- The service should be consistent and comparable across reporting periods. Specify the product-supported service, include locations, and reporting periods. Calculate separately for distinct services.
- Select the counting unit: consultations completed, treatments administered, diagnostic tests performed, or procedures completed. Use the same unit across locations and reporting periods. Calculate separately for distinct services.
- Count services delivered in each period. Use existing records to establish the prior-period and current-period totals. Where several locations are included, add their service counts, ensuring each service event is counted once.
- Calculate percentage change.
- Percent change = [(current-period service volume − prior-period service volume) ÷ prior-period service volume] × 100
- Report both period totals, the numerical change, and the percentage change.
- If no services were delivered in the prior period, report the current count and explain whether service delivery is newly established or restored. A percentage change cannot be calculated from zero. Missing baseline data should be reported as unknown.
- Report maintained, restored, newly available, and expanded service availability as counts or status descriptors alongside the percentage where they add useful context. Explain the change. Report changes in locations, service days or hours, and services delivered per day, where already recorded. Include patients served or encounters delivered as accompanying information.
- Check comparability. Use equal-length periods and consistent service definitions, counting units, and reporting coverage. Do not use the percentage-change calculation where the service itself or the reporting scope has changed substantially enough that the periods are not comparable.

**Calculation examples**

| RECORDED CHANGE | PRIOR PERIOD | CURRENT PERIOD | RESULT |
|---|---|---|---|
| **More consultations delivered** | 200 consultations | 300 consultations | 100 additional consultations; 50% increase |
| **Treatment activity maintained** | 200 treatments | 200 treatments | 0% change |
| **Fewer procedures delivered** | 200 procedures | 150 procedures | 50 fewer procedures; 25% decrease |
| **Service newly established or restored** | 0 tests | 120 tests | 120 tests delivered; percentage change cannot be calculated |

Use accompanying information to explain what contributed to each result. Maintaining service activity during a period of pressure may be an important achievement.

## DATA COLLECTION AND FREQUENCY

Establish a historical or prospective baseline using existing records, then collect totals at a consistent interval (quarterly, annually or other suited to the program). Use the same defined service defintion. For newly available services, begin tracking from launch and report them as newly available rather than calculating percentage change from zero.

## ADDITIONAL METRIC INFORMATION

| | |
|---|---|
| UNIT OF MEASURE | Percent change in the volume of a defined product-supported health service delivered across comparable reporting periods. Use a consistent unit, such as consultations completed, treatments administered, tests performed, or procedures completed. |
| NUMERATOR | Current-period service volume minus prior-period service volume, summed across included service-delivery points. |
| DENOMINATOR | Prior-period service volume within the same defined reporting scope. |
| CALCULATION | [(Current-period service volume − prior-period service volume) ÷ prior-period service volume] × 100. Report both service counts alongside the percentage. |
| ZERO BASELINE | Where prior-period service volume is zero, report the current count and explain whether service delivery is newly established or restored. A percentage change cannot be calculated. |
| DIRECTION | An increase indicates more of the defined service was delivered. Maintaining or restoring service delivery can also represent important results. Interpret changes alongside patient demand and other conditions affecting delivery. |
| REPORTING FREQUENCY | Typically quarterly or annually, using equal-length reporting periods, a defined baseline, and a consistent measurement approach. |
| USEFUL DISAGGREGATION | Facility/site; geography; relevant product type; patient group, where routinely recorded and relevant. Calculate separately for distinct service types or counting units. |
| SUPPORTING INFORMATION | Use existing information on locations, service days or hours, service interruptions, patient demand, and product and partnership support to explain changes in care delivered. Report unique patients separately from service encounters where reliable data are available. |
| INTERPRETATION | Service volume shows care delivered. It provides evidence relevant to capacity to deliver care, while available or unused capacity requires separate measurement. |

## ASSUMPTIONS

- Results are most useful when reported consistently over time using the same defined counting unit, reporting scope and measuring methods across equal periods.
- A percentage-change figure requires a baseline and at least two comparable reporting periods.
- Existing service records are complete enough to establish a baseline and current-period count (if not, focusing on adequate records will build capacity for future metrics).
- Unique patients and service encounters are counted separately; one patient may receive several services.
- New service types are reported separately using their own counting units. Where prior-period service volume is zero, report the current count and establish a baseline for future comparison.
- Missing data remain visible. Identify incomplete records and explain their effect on the comparison.

## INTERPRETATION AND LIMITATIONS

- Service volume is measuring care delivered.
- A donated product-supported health service is one whose effective delivery depends in whole or in part on the donated product; losing the product would meaningfully diminish the volume or quality of care.
- The metric should not imply that growth is always the desired outcome. Maintaining an essential service under pressure may be a significant result.
- Maintaining or restoring a product-supported service can be a positive result; growth is not the only meaningful direction of change.
- This priority indicator measures change in volume of that product-supported service across service-delivery points (facilities, days, etc).
- Interpret change as contribution, not attribution; workforce, infrastructure, financing, diagnostics, referral systems, public supply, and other factors also influence service availability.
- Service Availability Context: These descriptions provide context; they do not determine the percentage change in service volume.

| SERVICE STATUS | EXAMPLE |
|---|---|
| **Newly available** | Service was not available in the prior period and is now available at one or more service-delivery points. Report as newly available; do not calculate % change from zero. |
| **Maintained** | Service remained available at the same service-delivery points across periods. |
| **Restored** | Service had previously become unavailable and is available again. |
| **Expanded** | Service is now available at more service-delivery points than in the prior period. |
| **Reduced/lost** | Service is available at fewer service-delivery points, or is no longer available. |

**This table connects some concepts of dimensions of service delivery for this purpose of establishing**

| DIMENSION | MEASURE | ROLE |
|---|---|---|
| **Where care is available** | Service-delivery points | Context |
| **How often care is available** | Service days or hours | Context |
| **How much care was delivered** | Completed consultations, treatments, tests, or procedures | Core measure |

## DECISIONS THIS EVIDENCE CAN INFORM

- Where donated products, along with complementary support, directly enable or protect services?
- Whether to invest in additional locations, more service days or hours, or greater treatment capacity?
- Which services or sites may need additional product or complementary support
- Where expansion to additional service-delivery points is feasible and where maintaining existing service availability is the priority
- Where product supply or complementary support needs strengthening to sustain or expand service delivery
- How partners can coordinate support to sustain capacity and respond to local priorities for service.

## WHAT THIS EVIDENCE HELPS YOU SHOW

How much of defined product-supported service was delivered and how that changed over time. Supporting information helps explain whether changes involved additional locations, more service days, or greater activity within existing schedules, and how products and partnerships contributed. Together, this evidence informs the broader understanding of capacity to deliver care.

## WHERE TO GO NEXT


**AMI Metrics Catalogue** →
Every output and outcome metric PQMD has catalogued, and where health and quality outcomes sit.

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PQMD / ALIGNED METRICS INITIATIVE

# Additional Outcomes Explorer

## *Current AMI priority indicators and additional measures to explore*

PQMD recognizes that AMI is only a starting point and that organizations are already measuring outputs and some outcomes. This resource lists the three impact areas, PQMD's priority metrics, as well as other potential outcomes indicators organizations may wish to explore that would contribute to the impact area. PQMD's AMI is an ongoing effort to align perspectives in a streamlined approach to outcomes measurement. PQMD's Donations Impact Group will continue to explore, discover, and publish their work on this site.

SHARED OUTPUTS

**Partner needs + relationships**

Product needs / requests documented

Partners / facilities supported

**Products + geographic reach**

Receipt confirmed

Countries / sub-country areas served

**Dating + documentation**

Dating / documentation confirmed

Shelf life; quantities destroyed

**Monitoring + replenishment**

Stock records updated

Replenishment; years of supply

**People reached + care support**

People reached with donated products

Workers trained; services delivered

### Increase Availability of Priority Products

AMI PRIORITY INDICATOR

**Percent of priority product demand met through available supply**

PROPOSED OUTCOME MEASURES

- Proportion of received products usable for their intended purpose
- Proportion lost through expiry, damage or other causes
- Patient-reported affordability of needed products
- Travel time to obtain needed products or treatment

SUPPORTING OPERATIONAL MEASURES

- Request-to-receipt time
- Deliveries received in the agreed quantity and time window
- Usable shelf life at receipt

### Sustain Continuity of Care

AMI PRIORITY INDICATOR

**Stockout-Free Reporting Periods for Priority Products**

PROPOSED OUTCOME MEASURES

- Days of product unavailability
- Treatment or service interruptions associated with product shortages
- Time to restore availability after a stockout
- Full-course product supply available at the time of prescribing

SUPPORTING OPERATIONAL MEASURES

- Replenishment lead time
- Variation in replenishment time
- Replenishments received before stocks run out

### Expand Capacity to Deliver Care

AMI PRIORITY INDICATOR

**Percent Change in the Volume of Product-Supported Health Services Delivered**

PROPOSED OUTCOME MEASURES

- Product-supported service days maintained or restored
- Change in service hours or locations
- Provider-reported ability to deliver the supported service
- Differences in product-supported service availability across regions

SUPPORTING OPERATIONAL MEASURES

- Equipment functioning when needed
- Relevant staff available
- Time from product receipt to service use

IMPACT

**Contributing to high-quality care and better health**

## HEALTH AND QUALITY EVIDENCE

Additional measures to explore, where relevant

### QUALITY OF CARE

- Provider ability to deliver care according to defined standards
- Supported care meeting defined standards
- Fewer delays, interruptions or preventable care-related incidents
- Patient-reported confidence and trust in care

### HEALTH OUTCOMES

- Achievement of defined treatment outcomes
- Change in symptoms or functioning
- Patient-reported health or well-being

ANNEX

# AMI Metrics Catalogue

*PQMD recommends the three priority indicators as a shared starting point. The AMI Metrics Catalogue includes additional output and outcome measures to consider, and PQMD is committed to the future development of AMI.*

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME | IMPACT AREA |
|---|---|---|---|
| 1.A | **Percent of priority product demand met through available supply**<br>PRIORITY METRIC<br>WHAT THIS REPRESENTS<br>This measure will help organizations to understand whether the donated products align with and help fulfill priority product demands. It helps show the gap between what has been identified as a priority and what ultimately becomes available through donated supply for use.<br>WHY IT MATTERS<br>Shows how responsive the donation system is to local health partner priorities and helps build stronger partnerships and more consistent pipelines of priority products. This metric helps organizations see where donated supply is meeting identified demand, where gaps remain. This understanding drives deeper understanding of trends in priorities, as well as where sourcing, donor engagement, planning, or partnership decisions may need to change. | Outcome | Availability of Product |
| 2.A | **Stockout-Free Reporting Periods, for Priority Products**<br>PRIORITY METRIC<br>WHAT THIS REPRESENTS<br>Stockouts interrupt care delivery, delay treatment, and place strain on providers and facilities. Donated products help provide product access. Stockout-free reporting periods help show whether donated products contribute to sufficient/ consistent product supplies to support continuity of care. This metric also informs where recurring or prolonged interruptions may prompt larger conversations about in supply, expectations, planning, or partnership.<br>WHY IT MATTERS<br>Stockouts interrupt care delivery, delay treatment, and place strain on providers and facilities. | Outcome | Continuity of Care |

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME | IMPACT AREA |
|---|---|---|---|
| 3.A | **Percent Change in the Volume of Product-Supported Health Services Delivered**<br>PRIORITY METRIC<br>WHAT THIS REPRESENTS<br>Reflects improvements in access to care, as a result of medical product provision, either directly or indirectly. Captured by comparing facility/site utilization.<br>WHY IT MATTERS<br>Medical product donations create value when they enable care. Tracking the availability of product-supported health services moves the evidence beyond products delivered to what local/in-country partners are able to provide to patients and communities. | Outcome | Capacity to Deliver Care |
| 1.1 | **Quantity and type of products requested by local health partners**<br>WHAT THIS REPRESENTS<br>This metric represents demand/need by type of product that donors placed with local health partners, and context around it's availability via gaps in local procurement, costly, or other reasons relating to availability, affordability, and access.<br>WHY IT MATTERS<br>Quantifying product demand/need by trusted local health partners is an important approach to understanding true community need. | Output | Availability of Product |
| 1.3 | **Financial cost of shipping and distribution**<br>WHAT THIS REPRESENTS<br>Represents the step-by-step transportation and logistics costs to deliver medical products from supplier to facilities/NGO implementers.<br>WHY IT MATTERS<br>Donations cannot be utilized unless they are successfully delivered to local health partners, and this key process has real costs that must be budgeted for and tracked. | Output | Availability of Product |
| 1.4 | **Average time, in days, from receipt of donation need to donation ship date**<br>WHAT THIS REPRESENTS<br>This would track the responsiveness and efficiency of donors/ suppliers to meet expressed need with available product. For available products, this would be the turnaround time in days for when the product is fulfilled in the donor logistics system.<br>WHY IT MATTERS<br>Delivering donations where they are needed in timely manner is crucial for serving community health needs, as well as avoiding donation waste for products that expire . | Output | Availability of Product |

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME | IMPACT AREA |
|---|---|---|---|
| 1.5 | **Percent of donations with sufficient dating, and correct documentation for supporting donation**<br>WHAT THIS REPRESENTS<br>This reflects the minimum information necessary to effectively import, store, use, and maintain donations An output metric could be created for each area listed, and could be decided on depending on the product type.<br>WHY IT MATTERS<br>Donations must be accompanied by a minimum amount of information to allow for correct management (clearance, storage, use, maintenance). Use by dates help organizations prioritize use and destruction. Without proper dating on products, and inclusion of important documentation to ensure safe use among communities, donations risk being wasted. | Output | Availability of Product |
| 1.6 | **Percent and days of shelf life , by donation prodcut category, remaining at each stage of the product journey** | Outcome | Availability of Product |
| 1.7 | **Number of countries and sub-country level geographies served/reached**<br>WHAT THIS REPRESENTS<br>Represents geographic reach across the globe, as well as in-country breadth of coverage<br>WHY IT MATTERS<br>This is a high-level measure of geographic access, allowing easy comparison and aggregation across program and project types. | Output | Availability of Product |
| 1.8 | **Quantity of product delivered to each partner over time**<br>WHAT THIS REPRESENTS<br>This represents the product provided to the final organizational recipient.<br>WHY IT MATTERS<br>This metric demonstrates the scale of donations verified to reach trusted local health partners. | Output | Availability of Product |
| 1.9 | **Quantity of product destroyed, and reason over time (e.g. expired, improperly stored, etc.)**<br>WHAT THIS REPRESENTS<br>Product unused, wasted (negative). Reflects quantity utilized on-time/ within use window. The units of measure can be weight, units of individual product, doses, kits, packages.Suppliers/donors, NGO distributors, and NGO/facility implementers would be responsible for reporting.<br>WHY IT MATTERS<br>It is important to understand how much of donated products are not utilized as intended (i.e. in the provision of care for someone in need), and what factors contributed to the waste of that treatment opportunity. | Output | Availability of Product |
| 1.2 | **Number of consecutive years of supply of necessary medicines and products**<br>WHAT THIS REPRESENTS<br>This reflects the ability of the donation system to consistently meet national level/population priority needs. On a country-specific basis, identify needed medicines/products and whether or not they are being provided via a donation program NGO/Facility implementer would report this. | Output | Availability of Product |

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME | IMPACT AREA |
|---|---|---|---|
| 1.B | **Percent of local health partners achieving or staying below an [industry-determined] destruction percentage of donated product**<br>WHAT THIS REPRESENTS<br>This would showcase the timeliness and effectiveness of the donation process, with an emphasis on the quality of the process. While it would summarize the “end of the product journey”, it is a metric that is shared by all member types (donor, distributor, implementer).<br>WHY IT MATTERS<br>Low wastage by local health partners signifies well-matched supply to utilization projections, and sufficient long-dating of products to allow flexible utilization over time. While the metric is assessed at the “end of the product journey”, it is collectively shared by all partners and reflects good communication, quality product donation practices, and strong systems. | Outcome | Availability of Product |
| 2.1 | **Number of local health partners supported by donation programs**<br>WHAT THIS REPRESENTS<br>Reach of locations where donations are utillized. NGO distributor would be responsible for reporting.<br>WHY IT MATTERS<br>This quantifies the organizations responsible for processing donations at the last step of the donation chain before they are utilized by patients. | Output | Continuity of Care |
| 2.2 | **Number of partnerships betweenl health partners, and average length of active partnerships**<br>WHAT THIS REPRESENTS<br>Reflects the coverage and strength of relationships necessary for local organizations to secure quality products, consistently.<br>WHY IT MATTERS<br>The quantity of partnerships between NGOs and local health organizations represents the network that facilitates access. The length of partnerships is a proxy for strength of relationships necessary for local organizations to secure quality products consistentl. | Output | Continuity of Care |
| 2.B | **Percent of partnerships that maintain or change the scale, scope, or value of delivered products year-over-year.**<br>WHAT THIS REPRESENTS<br>Reflects the growth in partnerships as measured by sustained donations, increasing donation quantity, increasing donation product diversity, or increasing donation value.<br>WHY IT MATTERS<br>This represents increased commitments as a function of the relationship and trust built over time. | Outcome | Continuity of Care |
| 3.1 | **Number of individuals or patients treated/supported/reached with donated products**<br>WHAT THIS REPRESENTS<br>Reflect the reach of the, attributable, to donated product.<br>WHY IT MATTERS<br>This metric highlights the strength of access that a local health partner has to community members and highlights a baseline potential for understanding future donation potential. | Output | Capacity to Deliver Care |

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME | IMPACT AREA |
|---|---|---|---|
| 3.2 | **Number of healthcare workers trained as part of a donated product program**<br>WHAT THIS REPRESENTS<br>Count of health workers trained as component of a product donation program. This would be more applicable to donation programs centered around specific products or devices that require training for correct utilization.<br>WHY IT MATTERS<br>This metric captures a key component of health systems strengthening that may be directly affected as a result of a product donation program. | Output | Capacity to Deliver Care |
| 3.B | **Percent year-over-year change in local health partner capacity by donation implementation support area, including: workforce capability; physical infrastructure; inventory tracking systems; device/product maintenance capacity**<br>WHAT THIS REPRESENTS<br>This metric reflects the changes that result either directly or indirectly from medical product donations and medical donation partnerships. There are areas of a local health organization's capacity that are influenced and can develop as a function of the provision of a donation.<br>WHY IT MATTERS<br>This metric is important for estimating and understanding how product donations can influence and contribute to service provider systems strengthening, and how improvements in capacity can influence how local health partners plan for future service delivery. | Outcome | Capacity to Deliver Care |

## Health & Quality Outcomes

> Health and quality outcomes may extend the impact story for programs with a sufficiently clear and credible line of contribution. They are not a fourth shared AMI impact area and are not standardized through this supporting catalogue.

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME |
|---|---|---|
| 4.A | **Percent change in a specific health status among patients treated with donated products**<br>WHAT THIS REPRESENTS<br>Reflects the direct effects of donated products on patients receiving or having received treatment with those products Possible options include: disease status (e.g. viral suppression, improved A1C, progression of disease).<br>WHY IT MATTERS<br>This metric represents human-level health impact, which can have significant knock-on effects across other areas of well-being, quality of life, and livelihoods among individuals and households. | Outcome |

| METRIC ID | METRIC NAME | OUTPUT / OUTCOME |
| --- | --- | --- |
| 4.B | **Percent change in a health outcomes among a population accessing health services from a local health partner**<br><br>WHAT THIS REPRESENTS<br>Reflects the effects of donated products on communities where significant numbers of individual patients are receiving or have received treatment with donated products, the effects could be direct or indirect. Possible options include: Quality Adjusted Life Years, Disability Adjusted Life Years, reduction in disease burden. Publicly available administrative data would be used to track progress.<br><br>WHY IT MATTERS<br>This metric represents human-level health impact at scale, which can have significant knock-on effects across other areas of community well-being, quality of life, and livelihoods. | Outcome |

Not every program should measure health and quality outcomes. Use them where the evidence can credibly support the connection.

RESOURCE

# AMI Storytelling Reference Guide

*Qualitative methods ethical practice and fictional reporting examples*

Use this guide alongside Tool 4 Gathering Stories and Understanding Results and Tool 3 Building Your Impact Story. It explains how to gather and compare accounts, check interpretations and report outcomes over time.

Use this section when you need help completing the working pages. Agree one shared collection request across program, measurement, local and communications teams. Set a realistic reporting schedule and discuss staff time, translation, travel and other collection costs with partners.

## Choose people and methods

Pharmacy and supply staff can explain product availability; providers and service managers can explain care arrangements; patients and caregivers can describe their own experience. Include people across the conditions relevant to your question, including those facing barriers. Record the selection approach and missing perspectives. A small group can provide useful insight when you clearly describe whose experience it covers.

A routine check-in can answer a focused question. Individual interviews allow depth and privacy. Open survey questions gather comparable accounts from several settings. Observation and program records help establish context. Group discussions explore shared experiences and differences; consider whether differences in authority or care relationships could affect candor, and offer individual follow-up.

### Running a group discussion

Explain the purpose, use and limits of group privacy. Agree respectful participation. A facilitator can guide the core questions while a note-taker records examples, differences and whose views they reflect. Invite each person to contribute, explore contrasting experiences and summarize what you heard for checking. Keep individual and shared views distinct.

## Respect the people sharing their experiences

Explain topics, time, audience, storage and use before collection. Confirm that declining, stopping or skipping a question preserves access to care and support. Offer choices about setting and interviewer where possible. Record separate permissions for participation, recording and identifiable quotations or images. Explain withdrawal options and practical limits after distribution; reconfirm permission for a changed use.

Follow local and organizational safeguarding and consent procedures, including guardian consent and child assent as applicable. Be attentive to distress, stigma and power relationships. Use an interviewer and setting that support candid responses. For sensitive or formal research, use the appropriate review process.

Show people’s expertise, aspirations and agency. Keep their meaning and voice intact, check translations, and offer review of their representation. Credit local leadership and the partners who helped shape the result. Return findings and finished stories in an accessible form. Protect identities through secure storage, restricted permissions records and attention to clues such as location, role, diagnosis or image.

### Photographs and quotations

Use images to document the setting, service, equipment or supply conditions relevant to the result. Keep the date, place, photographer, accurate caption and allowed uses. A quotation should add a specific experience or explanation. Keep consent, confidentiality and participant review attached to the material as it moves between teams. Follow organizational retention and deletion arrangements.

## Reference guidance for understanding the findings

### Organize and compare accounts

Read each full account before selecting extracts. Choose a few topics tied to your question, such as product fit, supply timing, refill arrangements, service volume or access barriers. Give each topic a short definition. Mark the

relevant passages and add topics that emerge. This sorting is often called coding. Ask a second reviewer to examine a selection and discuss differences.

Compare accounts within each site first, then across sites, roles and periods where appropriate. Include accounts that challenge the first explanation. Record “unasked” or “unknown” separately from an account of no change. Preserve source IDs so each finding can be traced to the full notes.

| TOPIC AND SETTING | ACCOUNT AND DIFFERENCES | SOURCE AND RECORD CHECK | INTERPRETATION |
|---|---|---|---|
| **[Enter]** | [What people described] | [Source IDs and records] | [Meaning or open question] |
| **[Enter]** | [A different experience] | [Source IDs and records] | [Meaning or open question] |

### Be precise about who the finding describes

“Six of eight patients interviewed described fewer extra trips” identifies the group and the pattern. Explain how those eight were chosen. Use counts only when responses were gathered and recorded consistently. In group discussions, describe views expressed and important disagreement; count individual responses when each person was asked separately. A repeated quotation keeps its original source ID.

### Test the explanation

Compare the accounts with the outcome result and relevant records. Ask what supports the proposed contribution and what other explanation could fit. An assumption is something your conclusion relies on being true. For each important assumption, record checked, partly checked or still to test, the supporting source and the next check.

#### Completeness

compare expected and received records. Keep missing observations visible; use the metric card’s rules when calculating. A two-year window describes the review period even when some records remain missing.

#### Comparability

check the same product or service, counting unit, sites, period length and data method. Explain changes in demand and operating conditions.

#### Contribution

examine donated supply alongside procurement, staffing, financing, planning and other influences. Distinguish what records establish, what people report and your interpretation.

#### Scope

describe whose experience was gathered, the selection approach and perspectives still needed. Keep individual experience and wider patterns clear.

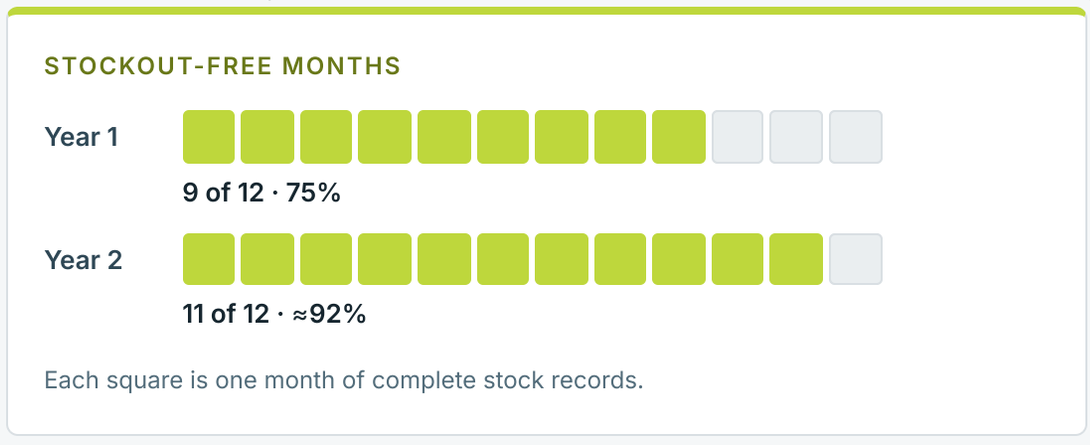
Review the interpretation with local partners, record corrections and retain meaningful disagreement. Use the finding for local planning as well as reporting. Agree the next program or measurement action and the support required.

## Fictional continuity example over two years

All program details, numbers, accounts and reporting language in these examples are invented. Use the approved metric card for your calculation and the counting unit agreed with partners.

### What was measured

A clinic reviews one priority diabetes medicine over 24 months. Complete stock records establish nine stockout-free months out of 12 in Year 1 and 11 out of 12 in Year 2: 75% and approximately 92%. Each month uses the same stockout definition, and records cover the full month. The result describes improved product availability over time.



### What the team gathered and checked

The team interviews the pharmacist and two nurses involved in refills. All three describe earlier reordering; the pharmacist also describes purchased stock covering delivery gaps. Monthly stock, donation receipt and procurement records support these accounts. Donation supply, local purchasing and planning all belong in the explanation.

The team also invites eight patients with direct experience across both years, deliberately including people who experienced a stockout. Six describe fewer extra trips to obtain the medicine; two describe continued travel difficulties. The team records permissions and source notes and sorts the accounts under supply timing, refill arrangements and travel. These eight patients provide a range of experiences rather than a population estimate.

### How the review changes the story

The pharmacy lead confirms the comparison and purchased supply. Staff accounts support the explanation that coordination helped; patient accounts add experience of obtaining medicines. The two accounts of travel difficulty show a remaining barrier. The story describes improvement in product availability and explains the care experience within the people consulted.

> REPORTING EXAMPLE
>
> Over two years, the clinic made the priority diabetes medicine more consistently available. Stock records show nine stockout-free months in Year 1 and 11 in Year 2. The pharmacy team linked the improvement to regular donated supply, earlier reordering and purchased stock used to cover delivery gaps. Six of eight patients interviewed described fewer extra trips to obtain the medicine, while two described continuing travel difficulties. These experiences suggest that more dependable supply helped patients obtain refills, alongside barriers that still need attention. The clinic and its partners will maintain the reorder schedule and review the remaining supply gap and travel barriers in the next reporting cycle.

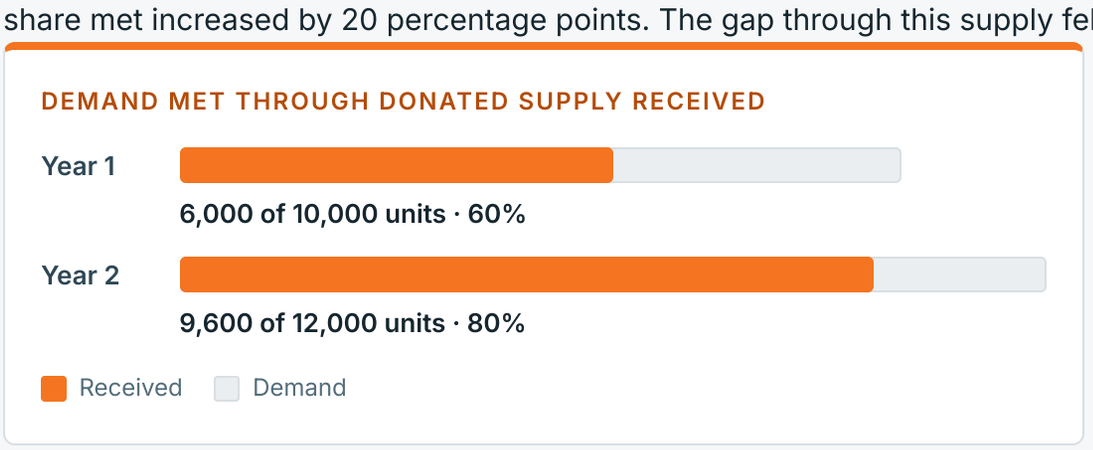
### What happens next

The pharmacy lead and partner program manager agree who will review delivery timing, stock coverage and patient feedback and when. They identify the resources needed to keep records current and consider how supply and service arrangements could better support the intended outcome.

## Fictional availability and capacity examples

### Increasing availability as demand grows

**Outcome:** the share of locally recorded demand for one defined priority medicine met through donated supply received by the clinic rose from 60% in Year 1 to 80% in Year 2. Demand was 10,000 units and then 12,000; receipt was 6,000 and then 9,600 units. The same product, unit and annual periods are used. Demand grew 20%, while the share met increased by 20 percentage points. The gap through this supply fell from 4,000 to 2,400 units.

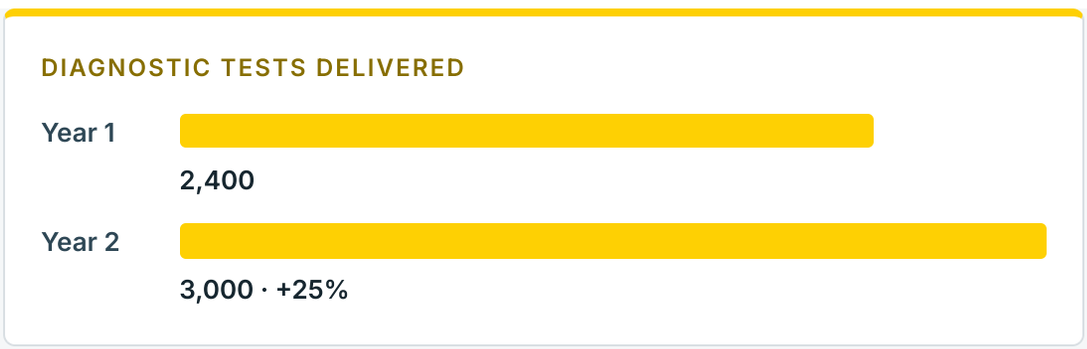



**Gather and check:** pharmacy and prescribing staff describe revised quantities and delivery timing. Compare request, receipt, prescribing and purchase records to check the explanation and how the remaining gap was managed. If the story concerns patients obtaining medicines, include their accounts or relevant service records.

> REPORTING EXAMPLE
>
> The clinic’s donation partnership met a larger share of its priority medicine demand in Year 2, even as recorded demand increased. Supply received covered 80% of demand, compared with 60% in Year 1. Pharmacy staff described how revised quantities and delivery timing helped them plan medicine provision alongside purchased supply. Partners will use the remaining 2,400-unit gap and prescribing trends to plan the next year’s support.

### Increasing the volume of a defined service

**Outcome:** a facility delivered 2,400 defined diagnostic tests in Year 1 and 3,000 in Year 2, a 25% increase in service volume. Partners use the same test definition, counting method and annual periods. Service registers establish tests delivered. Unique patients are counted separately, since one person may receive more than one test.




**Gather and check:** speak with the service manager, technician and referring providers, and include people facing access barriers. Compare service registers with accounts of how donated equipment, consumables, staffing, maintenance and referral patterns influenced the volume delivered. Check for changes in reporting or demand that may also explain the increase.

> REPORTING EXAMPLE
>
> The facility delivered 3,000 diagnostic tests in Year 2, compared with 2,400 in Year 1, an increase of 25%. The service team linked the increase to donated equipment and consumables, additional staff time and local maintenance support. The team also identified transport as a continuing access barrier. Partners are reviewing referral records and patient feedback to understand who is using the service and how it could reach more of the people it was intended to serve.

## Resources

The settings draw on public member descriptions; every example result and account is fictional. The older storytelling resource informed partner planning, proportionate requests, resourcing, recognition and ethics. The guidance uses AMI's three current shared areas and also supports organization-specific outcomes.

ETHICAL PRACTICE

| | |
|---|---|
| **Voice of Witness principles** | (https://voiceofwitness.org/resource-library/ethical-storytelling-principles/) |
| **Global Health Partnerships** | (https://www.globalhealthpartnerships.org/ethical-storytelling-at-thet/) |
| **Medical Teams International** | (https://www.medicalteams.org/blog/ethical-storytelling/) |

PRIMER ON MEASUREMENT TERMINOLOGY

# Aligned Metrics Initiative Terms Defined

*Language is important, the AMI working group determined that the following definitions capture the collective understanding of medical donation program measurement. These are simple and straightforward definitions for measurement that every PQMD member organization can understand and utilize.*

## A

| | |
|---|---|
| **Activities** | The actions carried out by a program or partnership to produce intended results, such as sourcing, shipping, training, coordination, or technical support. |
| **Available supply** | For the AMI priority availability indicator, donated product is counted as available supply when it has been received by the local partner. This is distinct from product that has only been offered, allocated, fulfilled, or shipped. |

## D

| | |
|---|---|
| **Donated product-supported health service** | An available health service whose effective delivery depends in whole or in part on a donated medical product. The donated product is a significant input to the health service, and losing it would meaningfully diminish the volume or quality of care. |
| **Donation** | A specified allotment of a medical product provided to an NGO or local health partner free of charge. A donation is defined at the product/item level; a single shipment may bundle several donations (see Shipment). |
| **Donation acceptance** | A recipient organization's confirmation that it will receive an offered allotment of medical products and is able to legally import, store, and use them. |
| **Donation costs** | The costs incurred to move a donation from donor to point of use, reported per a standard unit, like cost per unit weight or cost per treatment course, and disaggregated into upstream (donor → NGO) and downstream (NGO → facility) legs.<br>**Note:**<br>– A shipment may combine products from multiple donors — agree one denominator (units, weight, or volume) for splitting shared/mixed-shipment costs.<br>– Logistics costs are scale-dependent and not directly comparable across organizations (established lanes vs. a one-off shipment), so treat figures as within-program trends, not cross-org benchmarks.<br>– More than one cost sub-metric may be needed. Align cost categories with Relevant cost / Total cost. |
| **Donation need** | The portion of a population's unmet need that a specific donation program intends to fill. Assessed at the catchment-population level (the population a facility is responsible for), not only patients currently receiving care. |
| **Donation request** | A recipient's formal, itemized ask for specific products in specific quantities from a donor or supplier. The request may reflect absolute need, or be limited by the products made available by donors or NGO supplier. |
| **Donation shipment** | A shipment (see Shipment) consisting of donated product. Counted as "shipped" at the point it leaves the warehouse / point of origination (see Ship date). |

| | |
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| **Dose** | A single measured amount of a medicine intended for administration (one dose given to one patient at one time). For cross-organization comparison, express quantities using a standardized unit: WHO Defined Daily Dose (DDD) or a treatment course rather than “dose” alone. |

## E

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| **Essential medicines** | A specific, definable subcategory of medicines: those recognized on an authoritative Essential Medicines List (EML) like the WHO Model List of Essential Medicines or a national/regional EML. A subset of priority products, referenced where precision about EML-listed medicines is required. Where used for counting, the referenced list should specify medicine, formulation, and dosage. |

## F

| | |
|---|---|
| **Fulfilment** | The completion of a donation request: the requested product is supplied and dispatched to the recipient. The fulfilment date is the date this occurs. |

## I

| | |
|---|---|
| **Impact** | The broader or longer-term change to which a program or partnership may contribute. AMI uses contribution language and does not assume that donated products alone cause impact. |
| **Input** | Resources used to carry out a program or partnership, such as products, funding, staff time, expertise, data, infrastructure, or relationships. |

## L

| | |
|---|---|
| **Local partner** | The partner organization operating in the country or community context where donated products are received, managed, distributed, or used to support care. Depending on the program, a local partner may be a health facility, health organization, implementing organization, public-sector entity, or other recipient partner. |

## M

| | |
|---|---|
| **Medical product** | A specific, individual donated medical item at the most granular level of the classification hierarchy (e.g., enalapril). The thing measured in Units. Medical donation products as a whole are referred to collectively as Priority products.<br>**Hierarchy for reference:** category → type → class → product → unit (pharmaceutical → anti-hypertensive → ACE inhibitor → enalapril → pills/bottles). |

## N

| | |
|---|---|
| **Need** | The total quantity of health products (by type) a population requires for quality care, ideally derived from epidemiological data and disease burden. Where comprehensive population data are unavailable, estimates from local health partners (with data-quality caveats) may be used; prefer Ministry of Health data, national Technical Working Groups (TWGs), and program-level aggregation over individual-facility reporting. |

## O

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|---|---|
| **Outcome** | A change that occurs because of, or is supported by, program activities and outputs. In AMI, outcomes may relate to product availability, continuity, service capacity, health, or quality. |

| | |
|---|---|
| **Output** | A direct product, service, or reach measure produced by program activity, such as quantities delivered, people reached, partners supported, or health workers trained. |

## P

| | |
|---|---|
| **Priority outcome indicator** | One of AMI's three shared outcome indicators, aligned to Increase Availability of Priority Products, Sustain Continuity of Care, and Expand Capacity to Deliver Care. These indicators receive full AMI reference cards. |
| **Priority product demand** | The quantity and type of priority products identified through the partnership as relevant to the program during a defined reporting period. It should be grounded in local partner context and should not be defined by what donors happen to have available. |
| **Priority products** | The general term for the medical donation products a program provides and tracks, spanning medicines, devices, consumables, and supplies. Used throughout the AMI metric cards as the standing term for donated products in scope (e.g., “Increase Availability of Priority Products”). Priority products are the collective set of Products (individual items), defined below. |
| **Produce-to-give** | A medical product donation program where the type and quantity of medical product to be donated is specified in advance and clear expectations on product use and reporting are made explicit at the outset. |
| **Product category** | The broadest grouping of products by nature or use. E.g., pharmaceuticals, medical devices, non-pharmaceutical consumables.<br>**Hierarchy for reference:** category → type → class → product → unit (pharmaceutical → anti-hypertensive → ACE inhibitor → enalapril → pills/bottles). |
| **Product class** | A therapeutic or functional grouping within a product type. E.g. ACE inhibitors within anti-hypertensives, or proton-pump inhibitors within GI medicines. |
| **Product hierarchy** | AMI uses the hierarchy: category → type → class → product → unit. Example: pharmaceutical → anti-hypertensive → ACE inhibitor → enalapril → pills/bottles. Measures generally use product type where a shared level is needed, with finer detail where useful and feasible. |
| **Product type** | A sub-grouping within a product category. E.g., anti-hypertensives (within pharmaceuticals) or bandages (within non-pharmaceutical consumables).<br>**Hierarchy for reference:** category → type → class → product → unit (pharmaceutical → anti-hypertensive → ACE inhibitor → enalapril → pills/bottles). |

## R

| | |
|---|---|
| **Reach** | The count of unique individuals who receive a health service. |
| **Recurring Excess Product Donation** | A medical product donation program that sources donation types and quantities as they are available on a specified cycle (e.g. year-to-year). As such the specific quantities and types of donated products can vary (often significantly) from year to year. |
| **Relevant cost** | The costs directly attributable to a specific donation activity that a program counts for a given metric (e.g., shipping and distribution), drawn from an agreed set of cost categories and excluding ineligible overhead. |
| **Request date** | The date a recipient’s donation request is received by the donor or NGO supplier. |

## S

| | |
|---|---|
| **Service-delivery point** | A defined facility, site, clinic, mobile service location, or other point within the agreed reporting scope where the product-supported health service is available. |
| **Shelf life** | The period during which a product remains safe and effective, from manufacture (or as labeled) to expiry. |
| **Ship date** | The date the donated product leaves the donor, supplier, or distribution point en route to the next recipient in the supply chain (not necessarily the final recipient). |
| **Shipment** | A quantity of donated product dispatched together as a single consignment; may contain multiple donations and, in mixed shipments, products from more than one donor. |
| **Stockout** | A period in which zero usable quantity of the defined priority product type is available at the reporting location. Programs should define the reporting period and product level consistently. |
| **Sub-country level** | Any administrative or operational level below national, including: region, state, county, or district at which data are collected or reported. For any geography-based metric, the reporting level must be fixed in advance (e.g., district) so counts are comparable. |
| **Substitution** | The provision or reporting of a therapeutically equivalent product, within the same product class, in place of a specifically requested product (e.g., when the requested item is unavailable). Relevant to product-class-level reporting and to interpreting match/fulfilment. |
| **Sufficient dating** | A condition in which a product arrives with enough remaining shelf life to be received, distributed, and used before expiry. “Sufficient” should be set by the destination country’s minimum-dating import requirement or, where none exists, by an agreed default. E.g., at least 12 months of remaining shelf life, or at least two-thirds of total shelf life, on receipt. |
| **Supporting outcome** | An outcome measure or outcome area that can deepen the AMI impact story beyond the priority indicator. Supporting outcomes are not standardized through full AMI metric cards in this release. |
| **Supporting output / measure** | A complementary output or operational measure used to provide scale, context, or explanation alongside an AMI priority outcome. Supporting measures use lighter catalogue guidance rather than full priority metric cards. |

## T

| | |
|---|---|
| **Total cost** | The full value of all costs associated with a donation, direct and in-kind, expressed in a common currency using an agreed valuation method, and built from the same cost categories used for Relevant cost (specifying eligible vs. ineligible costs). |

## U

| | |
|---|---|
| **Units** | The standard count used to measure a quantity of product — e.g., individual items, pills, bottles, doses, kits, or packages. These can be defined per product so quantities are comparable. For medicines, prefer a standardized comparator (treatment course or WHO Defined Daily Dose) where cross-program comparison is intended.<br>**Hierarchy for reference:** category → type → class → product → unit (pharmaceutical → anti-hypertensive → ACE inhibitor → enalapril → pills/bottles). |
| **Unmet need** | The portion of Need not met through routine procurement or local supply. I.e. Need minus what a health system regularly obtains on its own. |

ALIGNED METRICS INITIATIVE

# About the Toolkit

*PQMD's Aligned Metrics Initiative (AMI) Toolkit helps organizations tell a clearer, more credible story about the contribution of medical donation programs. It offers a shared, practical approach for moving beyond outputs—such as products delivered—toward outcomes that reflect increased availability of priority products, continuity of care, and expanded capacity to deliver care. The toolkit helps users choose what is appropriate for their program, build on information they already have, and make measurement manageable, useful, and proportionate.*

## What's in the Toolkit

- Seven flexible modules that can be followed in sequence or explored as needed.
- Practical tools for selecting metrics, measuring in partnership, interpreting findings, planning impact stories, gathering qualitative evidence, and exploring outcomes.
- Shared foundations, including key terms, three priority impact areas, and a theory of change.
- Ready-to-use resources, including metric cards, a filterable metrics catalogue, guidance, fillable PDFs, and editable data-collection spreadsheets.

## How It Was Developed

AMI was developed with over 30 stakeholders at every level of the medical donation continuum, including corporate donors, NGO distributors, implementing partners, in-country practitioners, measurement experts, and those delivering care. The first phase combined a landscape and document review with key informant interviews to understand current practices, challenges, opportunities, and the measures stakeholders considered relevant, feasible, and meaningful. The second phase moved from research to intensive alignment: a steering group reviewed and refined the findings through a sustained series of working meetings, tested priorities, and built consensus around a shared approach. PQMD then synthesized the full body of input and translated it into the practical guidance, tools, and resources in this toolkit.

ALIGNED METRICS INITIATIVE

# Acknowledgements

*The Aligned Metrics Initiative would not have been possible without these organizations contributing financial support and valuable time and experience.*

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## Funders

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Pfizer
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The Max Foundation
USA for UNHCR
Village Reach
World Vision

## Principal contributors

A special thanks also to the principal contributors to this toolkit.

Alicia Annamaly, Muhammad Atieh, Nour Awad, Matthew Barnes Mwilah Chaloba, Jacob Gomez, Jon Hicks, Julie Jenson, Venancio Kapalamula, Nisreen Khalaf, Noah Laird, Ted Miles, Tapiwa Mukwashi, Adam Schwartz, Janet Thomason, Juliemarie Vander Burg, and Maria Verbanac.

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