

Towards a harmonized approach for Health Facility Assessments

Vision, Guiding Principles and Roadmap

**Outcome of a Technical Consultation
Geneva, 12-13 November 2014**

Final

Introduction

This document synthesises the vision, guiding principles, and priority actions agreed at the recent technical consultation “Towards a harmonized approach for health facility assessments”. The consultation, co-convened by WHO, The Global Fund, and The World Bank, brought together focal points from technical agencies involved in the development, implementation and support of health facility assessments at country level. Agencies included The Global Fund, The World Bank, USAID, GAVI, PEPFAR/CDC, UNICEF, UNFPA, UN MDG Health Envoy and WHO.

The meeting took place as a follow up to the multi-partner meeting on strengthening facility information systems, with the aim of advancing the agenda towards harmonization of health facility assessment modules and country implementation approaches. The meeting had four objectives:

1. Agree on objectives and principles of harmonized modular approach for health facility assessments;
2. Review draft toolkit of modules, indicators & assessment/measurement methods;
3. Discuss methodological issues and implementation issues for countries;
4. Discuss ways in which global partners can better support country –led system of health facility assessments.

Current global and country situation

Health facility assessments as critical part of health systems strengthening

Health facility assessments (HFAs) are implemented to collect information from health facilities that are not included in routine reports and provide a holistic picture of how inputs, processes and systems come together at a service site to influence outputs and outcomes. Key areas of focus of health facility assessments include assessment of quality of services, health care provider knowledge and practice, and patient perspective. They are also used to provide external validation of self-reported information on service delivery, system functioning and data reporting. A system of regular HFAs are needed as part of an health systems strengthening and an integrated health facility information system to monitor quality of service delivery and care provided, and data quality and identifying where change is needed to strengthen the overall health system.

Health facility assessment tools are multiple and diverse

Over the years, a number of health facility assessment methodologies and instruments have been designed and implemented to measure and improve health capacity to provide quality services. Some focus exclusively on specific service delivery components or donor-specific initiatives. Other facility assessments provide a more comprehensive approach to assessing service delivery. Many programmes and agencies have also developed separate tools for validating/verifying the quality of data from facility records.

Health facility assessment modules are at different stages of development, standardization and harmonization, particularly across topic areas. For example, WHO, USAID, The Global Fund and GAVI have made significant effort and investment in harmonizing both the content and assessment/measurement methods for the service availability and service readiness modules. There is similar ongoing work by WHO, GAVI and The Global Fund in the harmonization and standardization of data verification modules. While there is considerable experience and emerging standardization with expenditure modules (through the Public Expenditure Tracking Surveys), there is less experience on management practices and supervision. There is also a lot of interest and recent investments in developing health facility modules that assess quality of care. Most efforts to date have been piece meal, focusing on quality of care of one specific service area or another such as newborn and obstetric care or HIV, TB, or malaria. In many cases, assessment/measurement tools have not always been validated and applied in a consistent manner. Therefore, there is an urgent need to extend the harmonization and standardization of modules, including sections relating to quality of care.

Investments in country implementation of HFAs are often fragmented and inefficient

In most country settings, facility assessments are often duplicative and lack harmonization in their timing, as well as in the definitions of indicators. They often result in fragmented or conflicting information that make it difficult to obtain a full picture of a country’s service delivery system. Furthermore, many assessments are project- or donor-driven and not carried out with sufficient frequency to be useful for regular health sector management and monitoring.

Towards a harmonized approach

Vision

The vision is to move towards a more harmonized approach to health facility assessments that can be implemented in a modular way with standardized modules and indicators, and executed within a realistic timeframe that meets both country and partner/donor needs. Such an approach would:

1. Strengthen the methodology for HFAs, building on lessons learnt from survey methods and making maximum use of information collected across HFAs;
2. Improve the quality and comparability of results across time, geography, and survey;
3. Decrease duplication of country assessment efforts by agencies and increase efficiencies in investments.

Guiding principles

The current vision and momentum for a more harmonized approach to health facility assessments imply the need for a coordinated approach that adheres to a number of best practices and principles:

- **Standardized modules and indicators:** Health facility assessments are conducted using standardized modules and core indicators and definitions based on international expertise. A country would implement the modules most relevant to country priorities and available resources, and according to the magnitude of change feasible within a certain time period.
- **Harmonized country led plan:** Health facility assessments are carried out according to a country- led plan that specifies the timing for health facility assessments, includes specific details on contents, funding and execution and reduces duplications and inefficiencies. Ideally health facility assessments are timed in accordance with the national health planning cycles so that results feed into programme specific or health sector analytical reviews
- **Adherence to quality standards for data collection and management:** A harmonized approach adheres to minimum quality standards for data collection and management throughout the process from training and supervision of data collection, quality assurance, processing, analysis and dissemination of report.
- **Institutional capacity:** Health facility assessments should be managed by the country (Ministry of Health, Office of Statistics or other such body) with the assistance of a national institutes with experience and capacity to provide external review of the overall survey technical quality. If capacity does not exist, a regional or international organization should be used to provide capacity building or the monitoring of technical quality of the assessments.
- **Results, analyses and reports:** Results should be presented in both a timely and user-friendly manner. The results, recommendations and reports should feed into the decision making process and resources allocation by programme management
- **Open data access:** Data and reports are made publically available through central data repository /national website.
- **Governance:** Governance structures at country and global level exist to ensure overall coordination, and to provide technical oversight and to support identification of funds and resources.

Purpose and scope of health facility assessments

It is essential to keep in mind the overall purpose of the survey that will in turn determine the content, the assessment/measurement method and frequency for data collection as well as the level of effort required in terms of capacity, sampling design and available budget.

In general, health facility assessments are used to:

1. Assess and monitor the type, quantity, and quality of services actually available to a population on any given day.
2. Detect change and measure progress in strengthening health systems;
3. Provide external validation for self-reported information on service delivery, quality of care and system functioning.

Table 1: Purposes and scope of health facility assessments

Purpose		Measurement domains
Situation assessment of health service availability	Access	<ul style="list-style-type: none"> – Infrastructure – Staff availability – Services offered
Monitoring scale up in programme inventions/health systems strengthening	Inputs/outputs	<ul style="list-style-type: none"> – Service capacity /readiness (drugs, medicines, diagnostic capacity, trained staff)
Assess health systems functioning /efficiency	Processes	<ul style="list-style-type: none"> – Management – Finance – Health worker training/supervision – Health worker knowledge & competency – Worker absenteeism
Monitoring service quality	Performance	<ul style="list-style-type: none"> – Receipt of appropriate care; patient and family engagement; patient outcomes, patient satisfaction
Programme planning and evaluation	All	All

Prioritizing core modules and indicators

A prerequisite of a harmonized approach is to bring together existing indicators and data collection methods into a comprehensive set of modules with a standard set of indicator definitions and recommended assessment/measurement methods.

Modules and indicator domains

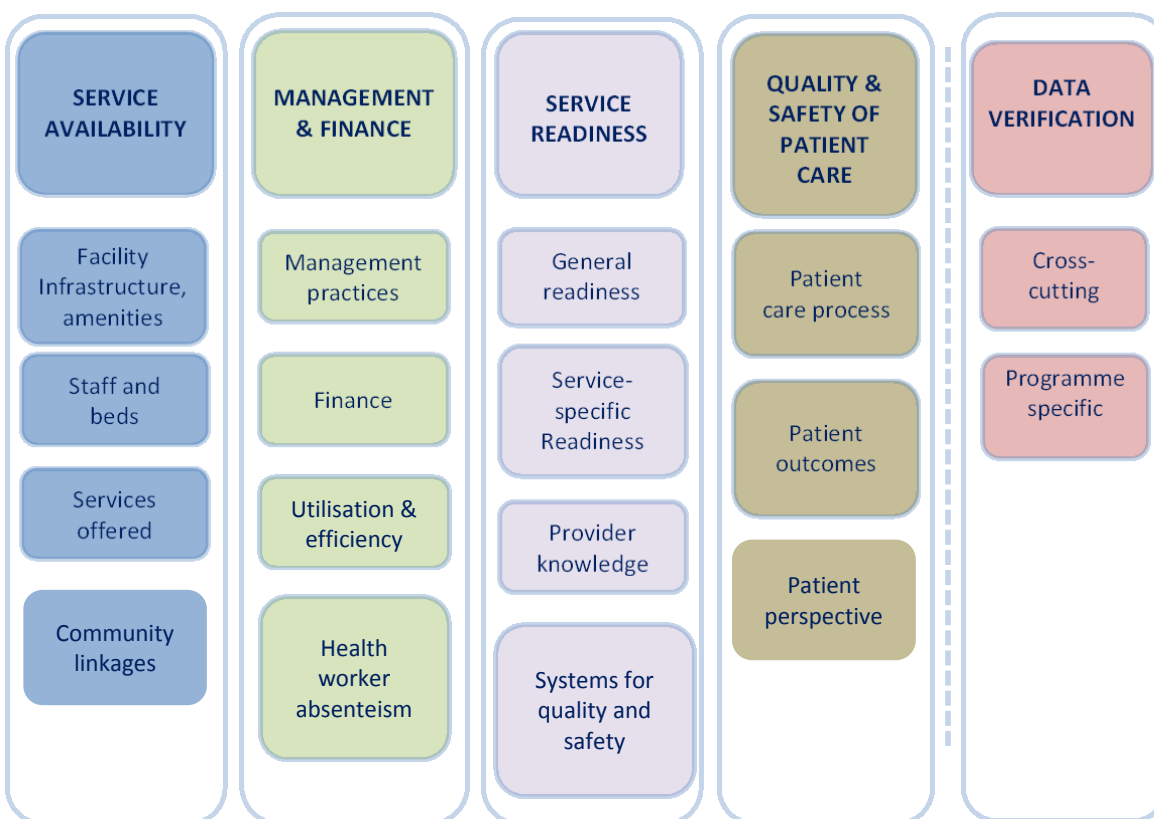
A module is defined as a set of questions that aim to collect information for a defined set of indicators in a specific topic area. The basic premise is that any item of data collected through a health facility assessment should be indicator- driven, according to clearly defined indicators and/or research questions. Harmonizing core indicators and grouping them by modules would provide a standard set of templates that can be used when developing a survey that meets the needs of a particular country.

In addition, HFA modules should be available in both short and full/long versions. A set of short modules allows assessment and data collection on a large number of priority health topics, using a core set of indicators, without creating a very lengthy questionnaire. The information that can be generated should be specified to programme managers, policy makers, financial donors and other stakeholders.

Based on a review of existing and new data collection tools and approaches, potential modules for inclusion in a harmonized toolkit include:

- **Service availability:** Information relating to the physical presence of facilities, resources, and services (e.g., building and utilities infrastructure, staff, beds). This section will also include the availability of services offered.
- **Management & Finance:** Practices to support continuous service availability and quality (e.g. management practices and supervisory practices, finance, health worker perspective and absenteeism).
- **Service Readiness:** Capacity of facility to provide specific services to a defined minimum standard (e.g., trained staff, guidelines, drugs, supplies, diagnostics, equipment), appropriate service site systems to support quality and provider knowledge.
- **Quality & Safety of care:** Includes the receipt of appropriate, effective and timely care by patients and includes provider knowledge and practice while giving care, patient and family engagement, patient care outcomes and patient satisfaction .
- **Data verification:** Includes the validation of routine service statistics and self-reports on facility infrastructure, resources, and service provision status collected from patient encounters.

Figure 1 Illustrative toolkit of health facility assessment modules and indicator domains



Core priority indicators

A core set of indicators, aligned with global standards, defined and collected in the same way is critical in a harmonized approach and will accelerate the availability and quality of data as well as the production of nationally representative and comparable datasets. A preliminary list of core indicators proposed for inclusion in the modules (Annex 1 and Annex 2) is drawn from existing internationally tested health facility assessments tools, such as the USAID Service Provision Assessment, WHO/USAID Service Readiness Assessment and World Bank Service Delivery Indicators. The list also draws from other internationally agreed indicator reference lists such as the Global Core Reference List of Indicators, the Newborn Action Plan, among others, when relevant. Further review of the

preliminary list of core indicators by technical subject expert groups is needed to ensure uniformly defined and validated indicator definitions and recommended or preferred measurement methods.

Methodological considerations for a harmonized approach

In considering a modular approach for the implementation of health facility assessments, it is important to be guided by the feasibility and scalability of the data collection or measurement method, the level of expertise of the assessors and the data collectors, as well as consideration of recommended sampling strategy, optimal frequency and available resources.

Assessment/Measurement methods

Various methodologies can be used for a health facility assessment including facility audit, health provider interview, record review, patient exit interview, and observation of patient–provider consultation. For some indicators, there is often only one preferred method. For other indicators, several of the methods can be used. Some require high level of expertise among the assessors and the data collectors. Others require a minimum training. Some are much more time consuming than others and will have an implication on cost. Selection of the best data collection or assessment/measurement method is an important consideration that must be borne in mind when selecting & prioritising modules and indicators. Figure 2 provides an overview of the various measurement methods and considerations and implications for using each.

Figure 2 An overview of facility assessment/measurement methods and issues for consideration

Assessment/Measurement methods	Domains of quality of care	Considerations and implications
Facility Audit	Inputs, resources, service delivery systems, management related to service capacity / readiness to provide services	-Data collection expertise minimal -Does not measure actual quality – but pre – requisites for quality
Provider interview	Provider knowledge of protocols and standards Health worker training/supervision Health worker caseload, absenteeism, retention Health worker attitude and motivation	-Multiple respondents feasible -Data collection expertise minimal -Knowledge is not practice
Clinical vignette	Decision making and accuracy when faced with vignette patient conditions—a proxy for actual service provision Flow charts and check lists	-Knowledge is not practice -Clinical expertise needed
Patient interview	Patient perception of services and examinations received. Adherence to guidelines for assessment, diagnosis on many conditions Patient satisfaction (utilization factors)	-Information on multiple patients --Expertise minimal - Limited by patients/ conditions on day of visit - May not accurately reflect care process
Record review	The documentation of history and physical findings of the care process. Adherence to standards and the quality of assessment and diagnostic practices. Measures pattern of care over time	-Assess QoC for many patients (not just those interviewed/observed on day of visit) -Records commonly incomplete -Expertise needed -Time consuming
Observation of patient/provider interactions	Observe actual care process including sharing of information -adherence to standards in practice -collection and sharing of information	-Limited by patients and conditions arriving on day(s) of observation -Expertise needed -Potential for Hawthorne effect
Rexamination		-Gold Standard -High level expertise -Time consuming

Sampling

Determining the sampling strategy for a facility assessment will depend on the objective of the survey, the unit(s) to be sampled (e.g. health facility, patient, provider), the sampling frame, the desired or acceptable precision or margin of error, the analytical domains, and the desired frequency and amount of resources available¹.

Starting from the master list of facilities that will underpin the sampling frame, three broad principles that were discussed are the notions of stratification/clustering, analytical domains, and precision of estimates. Stratification allows us to address different universes more efficiently and potentially at lower costs (e.g. rural/urban for equity considerations or different facility levels). Stratification is also linked to the analytical domains as it is often the reflection of these domains in the sample design. Without agreeing on an absolute level of precision, the participants agreed that estimates needed to be sufficiently precise to allow for comparisons across groups and in time (given the explicit focus on integrating the HFA into national planning cycles).

Demand for subnational estimates is high and efforts should be made to accommodate this within reason. The size and complexity of the HFA will likely rule out producing estimates at very fine levels. Effective use of stratification and clustering may allow for limited subnational estimates with relatively smaller increases in sample sizes.

One key challenge for countries in developing a sampling frame for a facility assessment is the lack of complete and up to date master facility list. Lists of private facilities in particular are often unavailable. Also measures for determining the number of staff and patients within a facility are often unavailable or incomplete. In this regard, countries should consider the establishment of a master facility list or register, either through undertaking a baseline census of all facilities or through a regular district updating exercise².

Quality Assurance

To reduce errors relating to poor implementation of surveys, utmost attention should be paid to quality assurance at all stages of the survey process including:

Design/planning: This includes the development and country adaptation of the data collection instruments. It is important to strike the right balance between the quantity of data desired and the quality of data. There is consensus that minimal data quality standards must be enforced. Experience in household surveys has demonstrated a negative relationship between interview length and quality (i.e. internal consistency).

As a general rule of thumb, facility assessments should be implemented in such a way that the surveyors do not spend more than one day per facility. In addition, the measurement of absence rates require an unannounced visit of about 1-2 hours. The lion's share of the survey implementation budget is required for salary, per diem's and transport of the survey field workers. There was agreement on maximizing the number of field staff per vehicle to reduce transportation costs and speed survey work in the facilities.

The indicators also should be well defined and tested prior to use in the survey. In general, the indicators should be drawn from the standard templates, but when customizing for a country context, comprehensive definitions should be used and tested. Implementers should also take care when translating tools into local languages to maintain fidelity to the definitions/indicators

Field implementation: Adequate training of the survey team is paramount, and sufficient time must be dedicated to training data collectors and supervisors on all aspects of the data collection instruments. Two to three weeks are current standards of training.

Systematic supervision and feedback are critical in the survey design and implementation. Data collectors should have regular contact with their supervisors to ensure they are on track and maintaining quality. Ongoing data quality checks should also be built into the system. Ideally a small percentage (5-8%) of the surveyed facilities should be visited a second time for validation by a third party.

¹ Sampling strategies for health facility surveys. A paper prepared by Drs Saifuddin Ahmed, Amy Tusi and Qingfeng Li, Johns Hopkins Bloomberg School of Public Health for the technical consultation.

² Creating a master facility list. World Health Organization, January 2013.

Tabulation and data analysis: Standard tabulation and guidance for analysis are also important to assure quality and comparability of results.

Country ownership and institutional capacity building

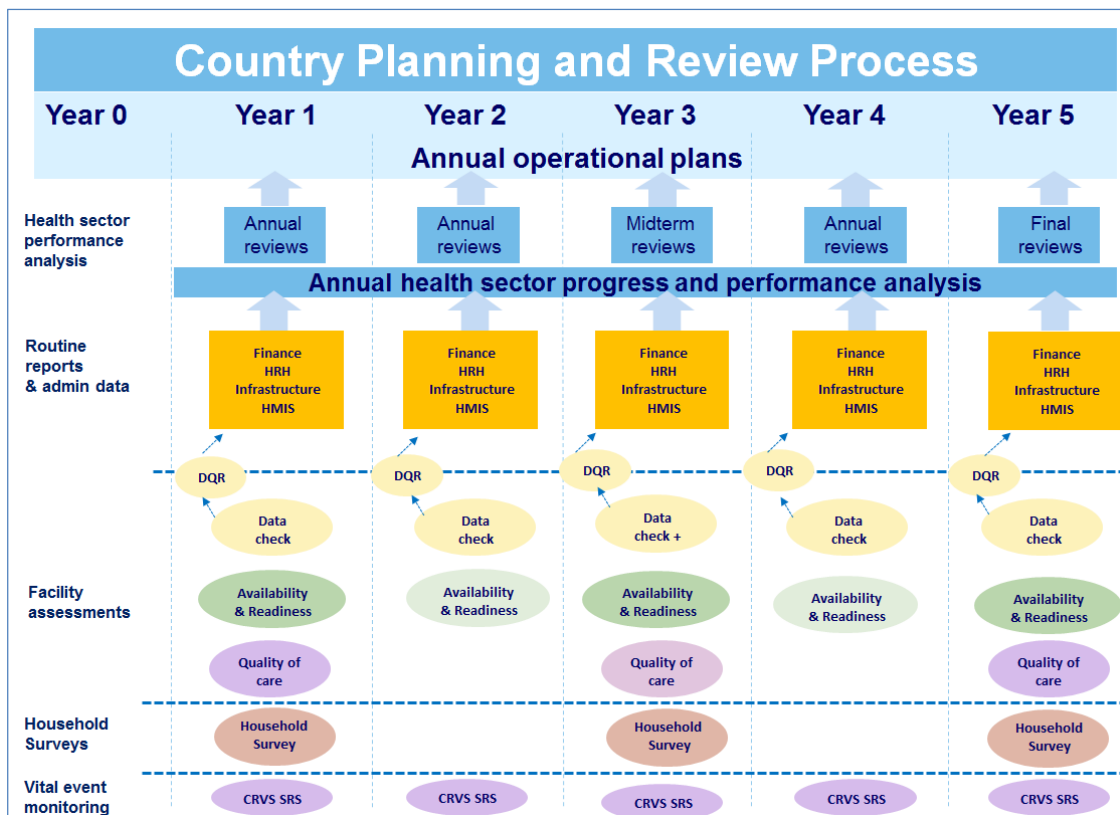
The vision of the harmonized approach is to strengthen country ownership and build institutional capacity for monitoring and evaluation based on data from health facility assessments. Key considerations should include:

- Country led coordinating body involving multistakeholder groups (programme and partners)
- Harmonized country led plan for health facility assessments , as an integral component of national health monitoring and evaluation plans;
- Country adaptation process of survey tools is critical, as long as assessment of minimum standards is not compromised.
- Involvement and capacity building of national institutes for implementation and quality assurance of the health facility assessment. National capacity building can include both public and private sector institutes and civil societies and regional institutes (cross –country capacity building),
- Multi-stakeholder involvement (e.g. programme managers, health advisors, possibly Ministries of Finance and Planning) in the interpretation and use of the results. A specific and prioritized action plan should be developed jointly to ensure follow-up.
- It is important that national programme managers reconcile data from health facility assessments with all other sources of data to obtain as accurate a picture of health system performance and monitor trends over time.
- Publication of results in different products adapted for different audiences (short fact sheets, full report,) and feedback loops to districts.

Country implementation of a harmonized system of health facility assessments

A harmonized plan of regular health facility assessments should be an integral component of the monitoring and evaluation plan of the national health sector plan. Based on planning/implementation needs, health facility assessments are timed in advance of national health planning cycles so that results feed into programme specific and/or health sector analytical reviews. A country could envisage implementing annual facility assessments of data verification, service readiness and alternate with modules on quality of care on a biennial basis. More resource intensive modules such as observation could be implemented less frequently – once every 5 years for example. Another possible format would be long and short versions of the assessment where the short version would be undertaken more frequently – such as annually and the long version could be every 2-3 years. A facility census of all facilities to undertake a full situation assessment of service availability could be envisaged on a 5-7 year cycle.

Table 2: Country implementation of health facility assessments linked to country planning & review



Priority actions and roadmap

The current demand for better results and accountability at country and global levels, including the increased demand for information on quality of care and the momentum towards better alignment of investments to support country systems implies the need for a more harmonized and efficient approach in the way in which health facility assessments are implemented in countries.

Key recommendations and priority actions for advancing the agenda towards a harmonized approach are as follows:

Short term (through June 2015)

1. Finalization of the modules, including review of indicators and preferred assessment/measurement methods and identification of core or short list of indicators. **(Lead : WHO, Nancy Fronczak: November- December 2014)**
2. Final review and validation of indicators and methods by technical reference and expert groups. **(January 2015)**
 - HIV, TB, malaria – (Lead – WHO/TGF/USAID)
 - RMNCAH – (Lead – WHO, UNFPA; UNICEF)
 - Quality and safety of care – (Lead – WHO)
 - Management and finance (Lead: World Bank/WHO)
 - Identify priority countries (across interested agencies) and develop a calendar of country planning and review processes such as annual health sector reviews. **(Lead WHO– November 2014).**
3. Alignment and harmonization of data collection instruments (both paper based and electronic tools). **(Lead : WHO, N. Fronczak/UNMDGEnvoy/UNFPA: Jan- March 2015)**
4. Establish a mechanism for communication/coordination to guide the development of the harmonized approach (long term) and the pilot testing in 2-3 countries (short term) **(Lead- WHO/USAID – Jan 2015)**
5. Finalize paper on sampling strategies for health facility surveys **(Johns Hopkins/WHO — to be confirmed).**
6. Develop a tool for budgeting for health facility assessments, with variations for sample sizes, number of teams and timeframe. **(Lead WHO/UNMDGEnvoy- Jan – Feb 2015).**
7. Establish a list of national, regional and global institutes to support facility assessments and guidance on accessing technical assistance. **(Lead WHO with partners – Jan- Feb 2015).**
8. Develop joint guidance for minimum standards for quality assurance for design and implementation of facility assessments, including data processing, analysis and use **(Lead: USAID & World Bank).**
9. Explore options for coordinated funding to support the harmonized approach in countries. **(TGF; GAVI, WB, and others: - Jan- April 2015).**
10. Undertake reference implementation (demonstration) of harmonized approach in 2-3 countries with selected priority modules. **(Joint partner approach: April – June 2015).**

Mid-term –longer term

1. Strengthening of country led M&E plans to include harmonized plan for health facility assessments over 5 year period **(Lead: WHO & partners – country planning cycles)**.
2. Develop automated tools for analytical outputs **(Lead: WHO /UNMDG)**
3. Develop guidance on data analysis and communication for different audiences: 1) - guidance on Using and Adapting the HFA tools and methods for sub-national use, implementation research & programme evaluation **(Lead: UNICEF)**.
4. Establish, strengthen a broad network of national, regional and global institutes to support facility assessments **(Lead: WHO + all)**.
5. Develop joint curriculum and capacity building programmes. **(Lead: WHO + all)**.
6. Global repository of reports and datasets leveraging existing tools (e.g. NADA) and web resources. (e.g. Statcompiler) **(Lead: ???)**.
7. Undertake global analysis of service delivery and quality based on existing country datasets **(WHO, WB; USAID tbc)**
8. Establish a technical coordinating group for health facility assessments to provide overall coordination and technical oversight; and a mechanism for regular communication (Lead- WHO/USAID – Jan 2015)

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