# Pillars of Health Facility Assessment

## An Illustrative Capacity-Building Curriculum for Mid- and Senior-Level Managers

**Bolaji Fapohunda**
**Beth Gragg**

**MEASURE** Evaluation
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*Cover photo by Simone D. McCourtie/World Bank.*

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## List of Acronyms

| | |
|---|---|
| DDIU | data demand and information use |
| EAC | East Africa Community |
| GPS | global positioning system |
| HFA | health facility assessment |
| HMN | Health Metrics Network |
| IHFAN | International Health Facility Assessment Network |
| JICA | Japan International Cooperation Agency |
| JSI | John Snow, Inc. |
| M&E | monitoring and evaluation |
| NGO | nongovernmental organization |
| SAM | Service Availability Mapping |
| SPA | Service Provision Assessment |
| R-HFA | Rapid Health Facility Assessment |
| USAID | U.S. Agency for International Development |
| WHO | World Health Organization |

# I. Introduction to Guide

## Overview of International Health Facility Assessment Network

The International Health Facility Assessment Network (IHFAN) seeks to strengthen health facility-based data collection and use, reduce duplication, and promote strategic liaisons around these activities. This commitment stems from the recognition of the importance of health facility assessment (HFA) as an established methodology designed to provide information for evidence-based decisions at all levels of the country health systems. Compared with other sources of health information, availability of HFA data is often not widely recognized, resulting in the underutilization of this data source for monitoring the development, rollout, and quality of health interventions at the facility level. Limited sharing of information by implementing agencies, exacerbated by the weak coordination of organizations participating in HFAs, is another challenge. Weak coordination among and across partners has created redundancies in data collection, with duplicates and multiple collections of similar data. This results in data not being compatible across different surveys. IHFAN is coordinated by MEASURE Evaluation, a monitoring and evaluation project financed by the U.S. Agency for International Development (USAID).

IHFAN was founded on the premise that the availability of sound and reliable data on the status and functioning of health facilities is essential for attaining and sustaining improved health system performance. The specific objectives of IHFAN are to:

- improve communication, coordination, and collaboration around HFA tools, indicators, and data availability and quality (global level);
- improve the knowledge of types of HFA approaches to data collection and their application for management decisions (global/national levels);
- establish and promote best practices around the design, implementation, and dissemination of HFA, including tools, methodologies, and guidance in developing HFAs (global/national levels); and
- advocate for the expansion of HFA data use for program management and health policies (national level).

**Membership—**IHFAN is a network of practitioners, with membership that includes individuals, technical organizations, and representatives from donors and multilateral organizations such as USAID, Japan International Cooperation Agency (JICA), The World Bank, World Health Organization (WHO), and United Nations Children's Fund; international nongovernmental organizations (NGOs) such as the MEASURE Evaluation consortium (University of North Carolina at Chapel Hill, The Futures Group International, ICF Macro, John Snow, Inc., Management Sciences for Health, and Tulane University), EngenderHealth, the Population Council; and other international partnerships such as the Health Metrics Network. IHFAN also works with national and regional governmental agencies and ministries of health. IHFAN is currently financed by USAID and managed as part of MEASURE Evaluation through USAID's cooperative agreement GHA-A-00-08-00003-00. MEASURE Evaluation is also a

USAID Leader with Associates award recipient.

**Areas of Work —** IHFAN works in three main areas:

- coordination and communication around HFA, including the identification of global best practices;
- provision of guidance and reference materials in support of HFA tools, methods, and best practices; and
- dissemination of standards and publication of technical papers.

**Coordination and Communication of HFA —** IHFAN provides technical leadership and coordination around HFA tools, indicators, and data availability and quality; and maintains strategic liaison with global partners. IHFAN also maintains an e-mailing list (listserv) that is used to announce HFA news, organize HFA professionals for ongoing mentorship through the dissemination of HFA implementation experience and data-use news, and to assist health professionals seeking HFA resources. This message platform also helps HFA developers, users, experts, and recent graduates to communicate more effectively among themselves. Technical work products are shared through strategic meetings; capacity building activities; Web-based communication outlets; and technical meetings, such as those sponsored by the Global Health Council and American Public Health Association.

**IHFAN Tool Development —** IHFAN develops strategic tools to support HFA data collection and use. These tools support IHFAN curricula for capacity building, an HFA logbook and question bank, and updated guidance to HFA methods.

**Technical Papers and Other Publications —** IHFAN draws upon the experiences and needs of its members by addressing specific technical issues. These efforts have produced several technical papers and other resources, including a flow chart of HFA that provides a step-by-step description of how to implement HFA, guidance to HFA research designs, and case studies with examples of effective data use. A profile of selected health systems, showing results from the application of different assessment methods across several countries, was finalized in 2009. These and other resources are available from the IHFAN Web site (www.ihfan.org) or from MEASURE Evaluation (www.cpc.unc.edu/publications). A detailed list of IHFAN publications also appear in Appendix C.

## Workshop Goals and Objectives

HIS strengthening faces multiple problems (Health Metrics Network, 2007). A key factor is the limited utilization of information. Reasons for the limited use have been widely documented. Given the nexus between information use and data demand and production, a limited use of data contributes to low HIS performance. A starting point for improving wider application and data use is to build the capacity of countries to implement HFA, ensure the quality of data generated, and use results to make effective decisions on programs. The main objective of the Pillars of HFA workshop curriculum is to contribute to the building of this capacity. The curriculum is designed to reinforce the importance of health facility data collection as an essential component of health information systems (HIS); with this knowledge, participants

will be in a position to better advocate for the conduct of HFA in their home-country contexts. Specifically, workshop participants will:

- learn about the different types of health facility assessments now in use;
- understand the main elements of HFA (data collection instruments, techniques, and core indicators derived from data);
- see actual results from HFA and the way they have and can be used to inform policy-making;
- learn to extract, analyze, and interpret real data, venturing implications for programmatic decision-making;
- understand better the role of HFA in HIS and health systems planning, monitoring, and evaluation, including advantages and limitations; and
- discuss options for funding and the potential for undertaking HFA in their countries.

Building local capacity for strengthening HIS and data use for decision-making is a key step in establishing sound systems for monitoring and evaluation (M&E). HIS and M&E are, in fact, interdependent systems. In the M&E model developed by MEASURE Evaluation, M&E is considered as a continuum of data demand and use. The fulfillment of this continuum requires that data production reinforces, and will be reinforced, by effective data use. This model is also consistent with the HIS objectives to collect, process, report, and use health information and knowledge to influence policy-making, program action, and research (AbouZahr and Boerma, 2005). This approach goes well beyond the traditional model in which M&E and HIS development is construed as completed once data collected at a lower level is reported to a higher level.

The workshops on which this curriculum is based were organized as IHFAN activities by MEASURE Evaluation in collaboration with various IHFAN members and network partners: WHO, Health Metrics Network (HMN), USAID, the USAID-funded MEASURE DHS project implemented through ICF Macro, and other USAID cooperating agencies. IHFAN is committed to strengthening health facility-based data collection and use worldwide through improved communication, coordination, and networking. The technical activities of the group include the development of resources to help users navigate existing health facility censuses and surveys including profiles of existing data collection methods and tools, HFA sampling approaches, and HFA repository of surveys; development of a core set of indicators for cross-country comparison of health systems performance; and technical assistance for developing training courses to improve country capacity to analyze and use health systems data. IHFAN team members also contribute towards the development and implementation of HFA tools, guidelines, and strategies to promote coordination of, and collaboration with, health facility-based data work worldwide.

## Participants

Course participants generally include:

- policy-makers and program managers responsible for the management of health services and health programs at central and peripheral levels, ministries of health,

and HIV/AIDS commissions;

- ❒ health program managers from ministries of health, NGOs, and private voluntary organizations responsible for HIS or health research and M&E;
- ❒ staff members of international organizations and donors committed to improving health system management; and
- ❒ researchers from universities and other bodies (e.g., HIV/AIDS commissions, national statistics offices).

## Workshop Design

The workshop has been designed to take advantage of the wide range of experience that participants bring to it. A pre-assessment exercise that allows facilitators to see how familiar participants are with critical concepts that will be covered during the workshop is sent home to the participants. The result of the assessment, collated from participants' responses, is reviewed as part of the first day sessions and used throughout the workshop to tailor the delivery of materials to the participants' expectations. Following sound learning principles, the workshop is designed to give participants several opportunities to build their confidence in using new technical information, sharing experiences, solving problems, and making decisions together. The small-groups methodology helps to foster the idea of networking, one of the goals of IHFAN. The final day of the three-day workshop is largely devoted to helping participants consider the actions that they will take to improve the collection, dissemination, and use of health facility targeted data to improve the availability of data for performance monitoring and, more broadly, to strengthen HIS in countries. This has proven to be an effective format for helping ensure that participants actually will be able to apply the lessons learned during the workshop.

### DAY 1 — Session Title

1. **Welcome and introductions**
2. **Becoming familiar with interpretation and usage of HFA data**

*Break*

3. **Core indicators of health facilities' readiness to provide services**

*Lunch*

*Core indicators (continued): practical exercise*

4. **Overview of health facility assessments and their role in HIS**

*Evaluate/steering committee*

### DAY 2 — Session Title

*Recap previous day's work*

5. **Synopsis of instruments used in HFA**

*Break*

6. **Analyzing, translating and using HFA: country examples**

*Lunch*

7. **Practical exercise: analyzing, translating, and using HFA**

*Discussion of instruments and their use*

*Evaluate/steering committee*

### DAY 3 — Session Title

*Recap previous day's work*

8. **Data demand and use strategies**

*Break*

9. **Information packaging for diverse audiences**

*Lunch*

10. **Articulating regional/country plans**
11. **Presentation of recommendations and next steps**

*Evaluate and close workshop*

**Overview of Schedule —** A typical schedule for the workshop is shown above.

### Section References

AbouZahr C, Boerma T. Health information systems: the foundations of public health. *Bull WHO*. 2005;83(8).

Health Metrics Network. *Framework and Standards for Country Health Information Systems*, 2nd Ed. Geneva: World Health Organization; 2007.

# II. Preparation for Workshop

## Before the Workshop Begins

The success of this workshop depends on how committed stakeholders are to HFA and to the workshop itself. Previous experience of workshop organizers has yielded several lessons to consider in carrying out further workshops.

- ❒ Work collaboratively from the beginning with credible stakeholders to plan and organize the workshop. This includes regional entities as well as country-level ministries and the ministry of health of the country in which the workshop is being conducted.
- ❒ Organize the workshop with at least one person who has experience in the region in which the workshop will be held. Understanding the context of that region is critical, and having good relationships with decision-makers in the ministry of health and other agencies involved is also very helpful.
- ❒ The workshop includes presentations from selected country representatives. Preparation for those presentations needs to begin early and is a task that requires persistence, tact, and diplomatic follow-up, as well as a good understanding of the technical content. Be clear about what is expected of the presentations, support presenters with necessary resources, and be prepared to work with presenters to tailor the presentations so that they meet the objectives of the workshop — not the other way around!
- ❒ Start at least eight weeks before the workshop date to prepare. It is always a challenge to get an accurate list of participants from their sponsors, and the attendee list will change several times over the course of preparations. Leave plenty of time to start the invitation process so that a venue can be contracted and sufficient materials compiled and reproduced in a timely fashion.
- ❒ Develop a checklist of materials that need to be prepared and of other logistical tasks that must be carried out. Modify the checklist as needed, and use it with the organizing team to ensure that no details are overlooked.
- ❒ The organizing team ideally consists of three people, including a senior staff person who oversees all aspects, liaises with stakeholders, and makes decisions about content, presentations, etc. Another key person is someone who can handle logistical aspects of the workshop: identifying and contracting a venue, making travel arrangements as necessary, ensuring that visas are secured, etc. The third key person helps with workshop materials: compiling and reproducing all support materials and arranging for their shipment (if appropriate), as well as helping out with logistical details.
- ❒ Develop and send study materials to the participants at least two weeks ahead.

## During the Workshop

This workshop requires the input of many different technical experts. A lead facilitator should be engaged to help maintain continuity and to ensure that participants' learning needs are taken into consideration. This person's major responsibilities are to ensure the smooth operation of the workshop, and may also include facilitation duties such as leading discussions after small group work, summarizing discussions and lessons learned, and previewing the topics and issues that the participants will work on in future sessions.

The lead facilitator will work closely with the other technical experts/facilitators to ensure that she or he understands the purpose of the session and can support each technical expert/facilitator to keep to the objectives, manage time efficiently, and generally look out for both the facilitator's and the participants' interests. The lead facilitator also chairs the host team and steering committee, an important evaluation mechanism.

**The Host Team —** A host team is a group of participants that assumes responsibility for helping the facilitators with the daily management of the training. The host team:

- ❒ gets people started at the beginning of the day
- ❒ conducts energizers and ice breakers when needed
- ❒ reviews the past day's activities and links them with the current day
- ❒ provides information on current events
- ❒ manages daily schedules and acts as timekeeper
- ❒ collects feedback from other participants about the workshop
- ❒ attends steering committee meetings
- ❒ gives participants a voice in the course

**The Steering Committee —** At the end of each day, the host team meets with facilitators and course organizers for about 30 minutes to give feedback on the day. They talk about what went well, what could be improved upon, and any other suggestions. They discuss both what went on in the classroom and other issues, such as logistics. This meeting gives the course organizers a chance to learn about and respond to changes that can improve the course.

The advantages of the host team and steering committee are that these are composed of people to whom the facilitators can delegate certain responsibilities (thus easing some of their workload): it gives participants a chance to think about design issues and group dynamics, and to help resolve some of the issues that arise during the workshop. It also provides a valuable feedback mechanism for participants, as it gives them a voice and a way to resolve problems, if needed.

At the beginning of the first day, post a sign-up sheet and explain that three volunteers per day are needed to participate in the host team. Encourage participants to sign up at break time, and follow up with the group to ensure that the sign up sheet is completed by mid-day.

# III. Session Plans

The session plans for the three-day workshop are presented below, beginning with the first day. Specific examples of presentations that are given in each session appear in Appendix B.

## Day 1 Session Plans

| Time | Session Title | Person Responsible |
|---|---|---|
| 60 minutes | 1. Welcome and introductions | |
| 90 minutes | 2. Becoming familiar with interpretation and usage of HFA data | |
| 30 minutes | Break | |
| 60 minutes | 3. Core indicators of health facility readiness to provide services | |
| 60 minutes | Lunch | |
| | Domains and core Indicators (continued): practical exercise | |
| 60 minutes | 4. Overview of HFAs and their role in HIS | |
| | Evaluate/Steering Committee | |

## Session 1: Welcome and Introductions

**Learning Objectives —** The length of this session is 60 minutes. By the end of the session, participants will be able to:

- ❒ preview the objectives of the workshop and its regional and national significance
- ❒ identify workshop agenda items and schedules
- ❒ tell the names of at least five other participants

**Equipment and Materials —** Required equipment and materials are:

- ❒ overhead projector
- ❒ computer
- ❒ note pads
- ❒ pens

**Handouts —** Handouts should include:

- ❒ opening address
- ❒ program agenda

**Advanced Preparation Needed —** Distribute workshop agenda and background reading materials at least two weeks ahead so that participants are familiar with meeting schedules, time, and rooms where different meeting will be held as well as the content of the sessions.

For the opening icebreaker, prepare a small and fun game around which participants could gather and learn about one another. If materials are needed, such as the list of participant names in the example described below under "Participants' Introduction," be sure to have enough copies available. Procure simple, fun "rewards" for winners of the icebreaker (popular rewards are candy or a souvenir of the workshop site).

*Note:* For the practical exercises in this workshop, participants will work in small groups. Ask them to select a theme upon which they would like to work, (or feel mostly qualified to do so). Examples of thematic areas for small groups include, but are not limited, to:

- ❒ facility-level infrastructure, resources, and physical structures
- ❒ child health services
- ❒ maternal health and family planning services
- ❒ reproductive tract and sexually transmitted infections including HIV/AIDS, tuberculosis, and malaria

Post flipcharts with two columns: "Participant Name" and "Theme." To ensure relatively equitable distribution of participants within each group, write the desired number of participants per group in the "Names" column so that facilitators can monitor the number of participants in each group.

**Plan of Activities —** The following steps provide a plan of activities for Session 1.

*1. Participants' introduction (10 minutes)*

Where time permits, each participant could do a self introduction, otherwise a pre-opening event or ice breaker that enables participants to get to know each other should be selected and utilized.

One example of an easy icebreaker that is popular with participants is the following: Prepare a list of all conference participants ahead of time. The list is constructed such that names are not fully written: some names are missing the first names; while others are missing the last names. Every participant receives a list and is asked to move round, meet other participants, and collect as many of the missing names as possible. They must avoid collecting names from persons from their own organization. After five minutes, participants are asked to tally their list and the participants with the most complete names of their lists receive rewards.

*2. Official opening (remainder of the hour)*

Welcome protocols may differ from country to country. Following is one option:

- ❒ welcome address from host country representative (10 minutes)

- ❒ opening address by host country ministry of health representative (15 to 20 minutes)
- ❒ remarks by head of delegations and partners (15 to 20 minutes)
- ❒ group picture is taken (10 minutes)

*3. Break*

Before participants go to break, ask them to sign up for the practical exercise group of their choice. Emphasize that the group sizes are limited, so "early bird gets the worm" (or group of choice).

## Session 2: Becoming Familiar with Interpretation and Usage of HFA Data

**Learning Objectives —** This session takes about 90 minutes. By the end of the session, participants will be able to:

- ❒ describe the role of spatial data, including global positioning system (GPS) data, and the unique health facility survey identification (ID) in the collection, analysis, and use of health facility data.
- ❒ describe methods for defining unique IDs in a country and for collecting spatial data on health facilities
- ❒ identify key issues around GPS data collection and how they plan to address these issues in a country context

**Equipment and Materials —** Required equipment and materials are:

- ❒ overhead projectors
- ❒ computer
- ❒ flip chart stand and paper
- ❒ pens, markers, erasers, and note pads
- ❒ GPS equipment

**Handouts —** Handouts should include:

- ❒ examples of core indicator-based data tables from countries
- ❒ unique health facility identification guidance document
- ❒ examples of GPS coordinates and spatial data tables
- ❒ GPS equipment

**Advanced Preparation —** In each participants' packet, place a copy of *Signature Domain and Geographic Coordinates: A Standardized Approach for Uniquely Identifying a Health Facility*, a MEASURE Evaluation publication that can be downloaded from this link: http://www.cpc.unc.edu/measure/publications/pdf/wp-07-91.pdf.

If any special software is needed for demonstrating spatial data collection (GPS) and use in

regard of the unique IDs, copies should be loaded into the participants' laptops ahead of time.

For the demonstration exercise, set up a series of "tasks" for the participants to carry out during the demonstration. Ideally, the demonstration should be conducted outdoors, so find an appropriate area and plan the demonstration accordingly.

**Plan of Activities —** The following steps provide a plan of activities for Session 2.

*1. Review key notes from the signature domain document (30 minutes)*

With any facility survey, the ability to identify a facility uniquely is vital to being able to use and analyze the data properly. This is especially true when making comparisons across surveys or years.

"Signature domains" ensure each facility can be uniquely identified. The following are the elements in the signature domain:

- ❒ date of the survey
- ❒ health facility country registry code
- ❒ health facility survey identification (ID)
- ❒ health facility name
- ❒ health facility contact information
- ❒ postal address (street number, city, postal code, other; in some circumstances, a facility may have some but not all of the postal address elements and in these cases the elements that are present should be recorded; if the facility has no postal address at all, this element would be omitted)
- ❒ main telephone number, main fax number, main e-mail address
- ❒ name of the director, director's telephone phone number
- ❒ facility's geographic administrative unit (at least first and second level)
- ❒ GPS coordinates (latitude, longitude waypoint ID)

*2. Hands-on demonstration of GPS (one hour, including exercise and discussion)*

Conduct a hands-on demonstration of GPS equipment as used for HFA. Before beginning the demonstration, ask participants to share previous experience with GPS for data collection and describe problems they have encountered, if any. After the demonstration is complete, lead a discussion using the following focus questions:

- ❒ What advantages do you see to this technology, as applied to HFA?
- ❒ What problems would you foresee if you used this technology in your own setting?
- ❒ How might you overcome those problems?
- ❒ Is this technology something that should be encouraged? (Do the benefits outweigh the disadvantages?)

## Session 3: Core Indicators of HF Readiness to Provide Services

**Learning Objectives —** This session takes about 60 minutes. By the end of the session, participants will be able to:

- ❒ explain the rationale for defining core indicators
- ❒ review sample core indicator data, including the unique ID in a country context
- ❒ identify issues around collecting the core indicators in a country context

**Equipment and Materials —** Required equipment and materials are:

- ❒ flip chart stand and paper
- ❒ overhead projector
- ❒ computer
- ❒ paper and pens for group members

**Handouts —** Handouts should include:

- ❒ session outline
- ❒ copy of presentation
- ❒ worksheets for questionnaire adaptation
- ❒ copies of core indicator findings
- ❒ table of HFA core indicators

**Advanced Preparation —** In each participants' packet, place a copy of:

- ❒ IHFAN core indicator guidance document entitled *Guidance for Selecting and Using Core Indicators for Cross-Country Comparisons of Health Facility Readiness to Provide Services*, available from the MEASURE Evaluation Web site at this link: http://www.cpc.unc.edu/measure/publications/pdf/wp-07-97.pdf.
- ❒ WHO health systems strengthening materials, such as Web-based materials on "service delivery," "human resources for health," and "medical products, vaccines and technologies," available at http://www.who.int/healthsystems/topics/en/.
- ❒ World Health Organization (WHO). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*. Geneva, Switzerland: WHO; 2007. Available at http://www.wpro.who.int/sites/hsd/documents/Everybodys+Business.htm.

Before the break, participants will have selected a small group for this session. Examples of thematic areas for small groups include, but are not limited to:

- ❒ facility-level infrastructure, resources, and physical structures
- ❒ child health services
- ❒ maternal health and family planning services

- ❒ reproductive tract and sexually transmitted infections, tuberculosis, malaria, HIV/AIDS

**Plan of Activities —** The following steps provide a plan of activities for Session 3.

Introduce the session by explaining that the session core indicators that have been developed for assessing the readiness of HF for providing quality services within and across countries. Emphasize that these indicators respond to users' requests at country and global levels, are linked to work at the global level by WHO, and are recommended for use in any HFA so that participants begin to see the relevance of the indicators for their programs and country contexts.

Next, the facilitator presents the core indicators; the rationale for these; issues around defining and collecting them; and checks and balances in place to ensure validity and reliability of the data collection process. Examples of analyses based on data is presented to illustrate the utility of the core indicators. The presentation could use the following outline:

- ❒ rationale for core indicators
- ❒ criteria and process for selection
- ❒ domains and components within domains
- ❒ improving validity and reliability of indicator data collection
- ❒ examples of core indicator data

After the presentation, the participants review sample core indicators in groups, focusing specifically on feasibility of these indicators in the context of their countries and steps for achieving common definitions for these indicators in the country context.

**Group Task —** Allow 15 minutes for this task. Based on this session's lecture, ask the group to discuss the following question: How would you use the core indicators to improve your estimation or interpretation of health system performance?

Also, be prepared to report your group's findings at the plenary session.

**Discussion of Exercises in Plenary —** When groups return to the plenary session, ask some groups to present their findings, and for other groups to add new information only. Keep the discussion focused on how the participants would use unique IDs and core indicators to improve their estimations or interpretations of health system performance data. Correct or clarify as necessary, making sure that participants do not leave with erroneous information or ideas about core indicators or unique IDs.

## Session 4: Overview of Health Facility Assessments and Their Role in Health Information Systems

**Learning Objectives —** This session is 60 minutes. By the end of the session, participants will be able to:

- ❒ identify the types of data that can be drawn from health facility assessments (HFAs)
- ❒ describe how health facility assessments fit into a country's health information system (HIS), and how this generally contributes to assessing health system performance
- ❒ identify implementation issues related to HFAs

**Equipment and Materials —** Required equipment and materials are:

- ❒ computer
- ❒ projector
- ❒ presentation

**Handouts —** Handouts should include:

- ❒ copy of presentation
- ❒ copy of WHO framework of HFA
- ❒ copy of *Profiles of HFA Methods*, 2006

**Advanced Preparation —** Copies of the presentation (by facilitator) should be prepared; and an overview document should be included in participant folders.

**Plan of Activities —** The following steps provide a plan of activities for Session 4.

*1. Introduction*

Introduce the session by explaining that this session presents an overview of the main elements of HFA, including a conceptual framework of how HFA fits with other HIS sources in a typical monitoring and evaluation (M&E) model.

*2. Interactcive lecture*

Conduct an interactive lecture, beginning with types of data collected in HFAs. Present a few data tables from data collected using a variety of approaches, such as Service Availability Mapping (SAM), Service Provision Assessmen (SPA), etc. Following this, ask the participants to discuss the data. The following sample questions may be asked to facilitate this discussion:

- ❒ What does the data tell us?
- ❒ How was the data collected?
- ❒ What is the geographical coverage of the data?
- ❒ What was the tool/HFA approach used in collecting it?

The responses to these questions are used to gauge the participants' familiarity with the

concepts so that the subsequent discussions can be correctly situated given the participants' level of knowledge. This information then forms the basis for discussing other elements, such as the following implementation issues:

- ❒ main sources of health facility information
- ❒ HFAs and the health systems performance monitoring
- ❒ how HFA fits into a country's health information system
- ❒ benefits of using multiple sources of data

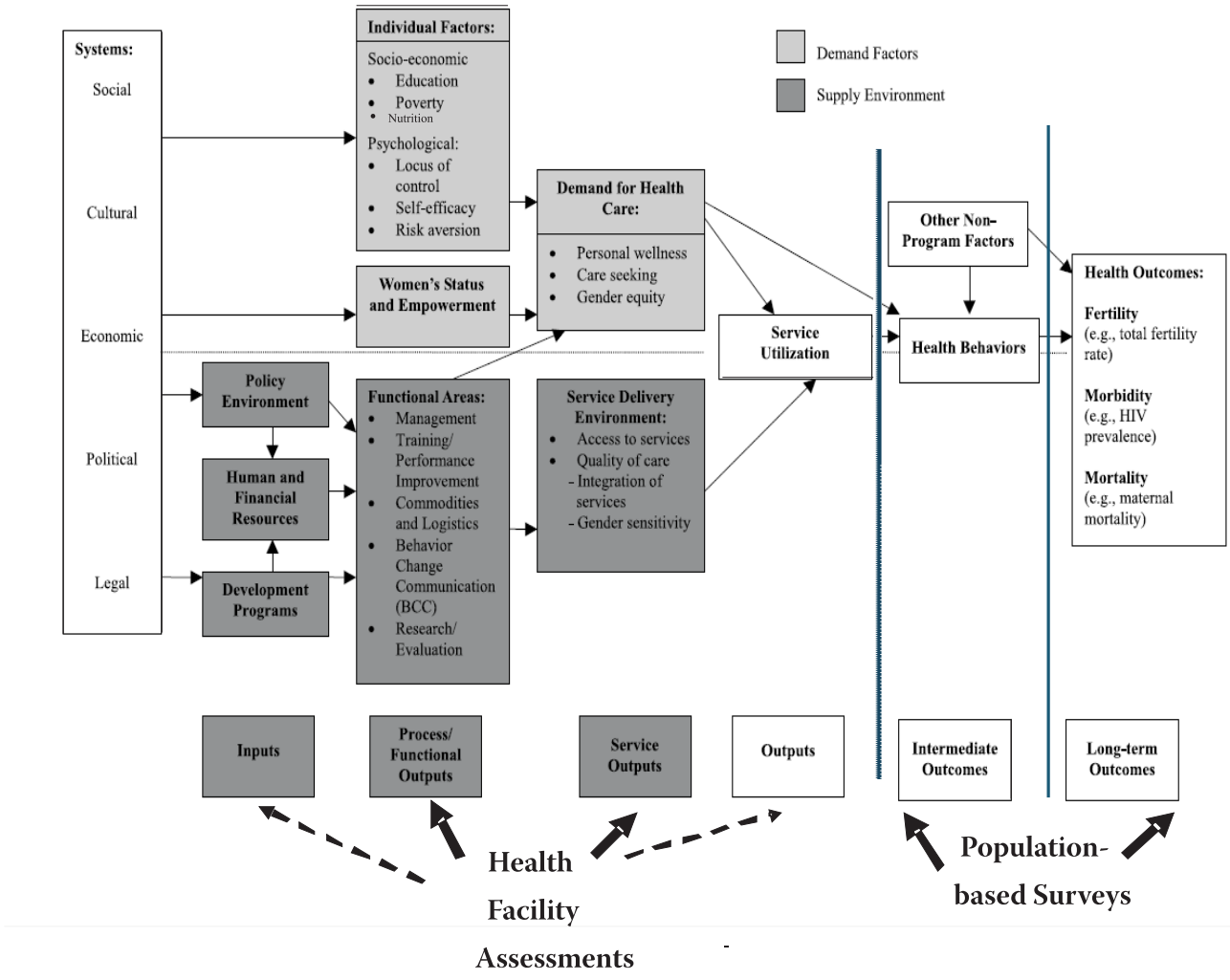
*Note to facilitators:* An implementation of this workshop design for the East Africa region in partnership with the EAC indicates that the use of models/charts that clarify the role of HFA within the broader M&E (see Figure 1) systems, establishes linkages between the HFA and other HIS sources, and clarifies the role of HFA in HSS (Figure 2) are very useful in clarifying the concept for the participants. Examples of framework/models utilized in the IHFAN/EAC workshop are presented below.

*3. Summarize the day's sessions*

Ask for participants to help in summarizing key points covered during the day's session and then ask them what questions they still have about today's topics.

Provide answers as possible. For those that cannot be answered immediately, let participants know whether the answers to those questions will likely occur during later sessions of this workshop or if there are other sources of information that might be helpful.

*Homework:* For Day 2 sessions, provide to all participants graphics, results, and any outlines or country presentations. Instruct participants to review the materials to get a sense of how information is presented in different ways and how the interpretation will vary depending on the context.




Source: Bertan J, Escuero G. *Compendium of Indicators for Evaluating Reproductive Health Programs.* Chapel Hill, NC: MEASURE Evaluation; 2002.

Figure 1. Relationships between contextual and individual factors, the health system and health outcomes.

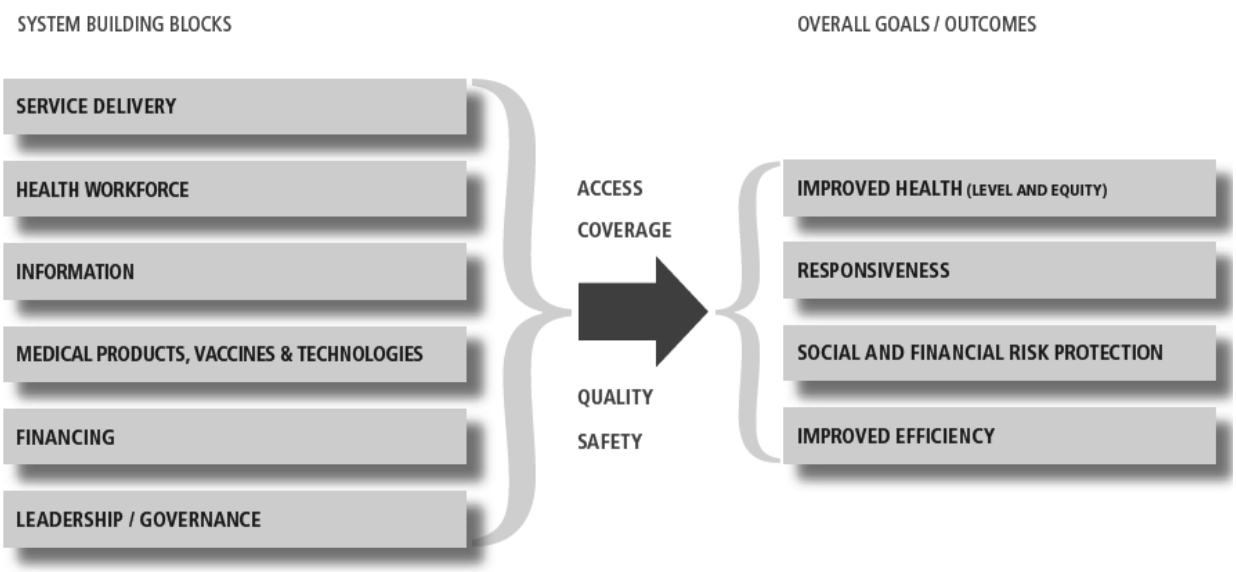



Figure 2. The WHO framework depicts the significance of health facility-based information.

Source: World Health Organization (WHO). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*. Geneva, Switzerland: WHO; 2007;3.

## Day 2 Session Plans

| Time | Session Title | Person Responsible |
|---|---|---|
| 15 minutes | Recap of previous day's work | |
| 60 minutes | 5. Synopsis of instruments used in HFA | |
| 30 minutes | Break | |
| 75 minutes | 6. Country examples: analyzing, translating, and using HFA | |
| 60 minutes | Lunch | |
| | Domains and core Indicators (continued): practical exercise | |
| 120 minutes | 7. Practical exercise: analyzing, translating, and using HFA<br><br>Discussion of instruments and their use | |
| | Evaluate/Steering Committee | |

Begin Day 2 with a brief recap of the previous day (15 minutes), preferably made by a member of the previous day's host team. Ask the presenter to include any issues that were discussed at the steering committee's meeting the evening before, and the resolutions that the group developed to address those issues. This helps the participants to see that the organizers and facilitators are considering their feedback and will encourage others to give constructive feedback to the current day's host team.

## Session 5: Synopsis of Instruments and Methods Used in HFA

**Learning Objectives —** This session is 60 minutes. By the end of the session, participants will be able to:

- ❒ describe the key questions answered by HFA
- ❒ profile the principle HFA tools and their management utility
- ❒ discuss the key methods of data collection within specific approaches
- ❒ discuss the methodological and crosscutting implementation issues associated with specific approaches
- ❒ discuss the implications of this information for specific country context

**Equipment and Materials —** Required equipment and materials are:

- ❒ flip charts, paper, and markers

- ❒ overhead projector
- ❒ computer
- ❒ session presentation
- ❒ note pads
- ❒ pens

**Handouts —** Required handouts are:

- ❒ session outline
- ❒ copy of presentation
- ❒ *Profiles of Health Facility Assessment Methods*
- ❒ map of completed HFA around the world

**Advanced Preparation —** Ensure that a copy of the presentation is loaded into the computer so that it can be projected on-screen.

*Note:* A good resource for developing this session is *Profiles of Health Facility Assessment Methods,* available at http://www.cpc.unc.edu/measure/publications/pdf/tr-06-36.pdf.

**Plan of Activities —** The following steps provide a plan of activities for Session 5.

*1. Introduction*

Introduce the session by explaining that it will focus on the profile of key HFA tools, including their advantages and disadvantages. It will describe the key questions that are answered by population-based information and, showing the types of data collected in the HFA, demonstrate that this is not sufficient to answer key questions regarding the outcomes of health systems strengthening interventions. The session also elaborates the key methods of data collection, including facility audit, record review, health worker interview, observation, and client interview.

*2. Profiles of methods*

The following are recommended for inclusion in the mix of methods to be profiled:

- ❒ integrated approaches such as Service Provision Assessment (SPA), Service Availability Mapping (SAM), Facility Audit of Service Quality (FASQ), Health Facility Census (HFC);
- ❒ single subject approaches such as Human Resource for Health Survey (HRHS), Rapid-Health Facility Assessment (R-HFA), Evaluation of Long Acting and Permanent Methods Services (ELMS) suite; and
- ❒ other special topic surveys, such as Abt Associates' health facility-based survey of human resources for health, ACQUIRE LAPM evaluation (EgenderHealth), and Logistics Indicator Assessment Tool (LIAT)

*3. Discussion*

Engage participants in an interactive discussions of the methodologies using the following

focus questions:

- ❒ Which HFA surveys have been already conducted in your country?
- ❒ What types of data were generated?
- ❒ Which methodology was used to generate specific information?

Table 1 presents illustrative examples of the types of materials that are covered in the profile of a method.

Table 1. Profile of Health Facility Census Examples

| | |
|---|---|
| **Purpose** | Provides information for policy, planning, and management of health system development with particular focus on the area of physical assets. |
| **Key areas of information** | • availability and conditions of physical assets<br>• location of health service delivery points<br>• availability and type of health services<br>• headcounts of health workers |
| **What it does** | • provides information on conditions and distribution of physical assets in all health facilities<br>• provides cost estimates for future capital investment requirements |
| **What it does not do** | • does not collect information on service quality, patient satisfaction, and details of human resources |
| **Most relevant program context** | Best at the preparation phase of a national strategic planning cycle, especially when basket funding is being introduced and cost estimation for capital investment is required; in regions/sub-regions where reliable information on available health resources, their conditions, and locations is lacking. |

In the presentation, it is also recommended that the presenters include examples of data presentations as they are very helpful to facilitate understanding of the adult learning context. Lessons from previous training indicate that maps (Figure 3) are good tools for presenting the data to the participants.

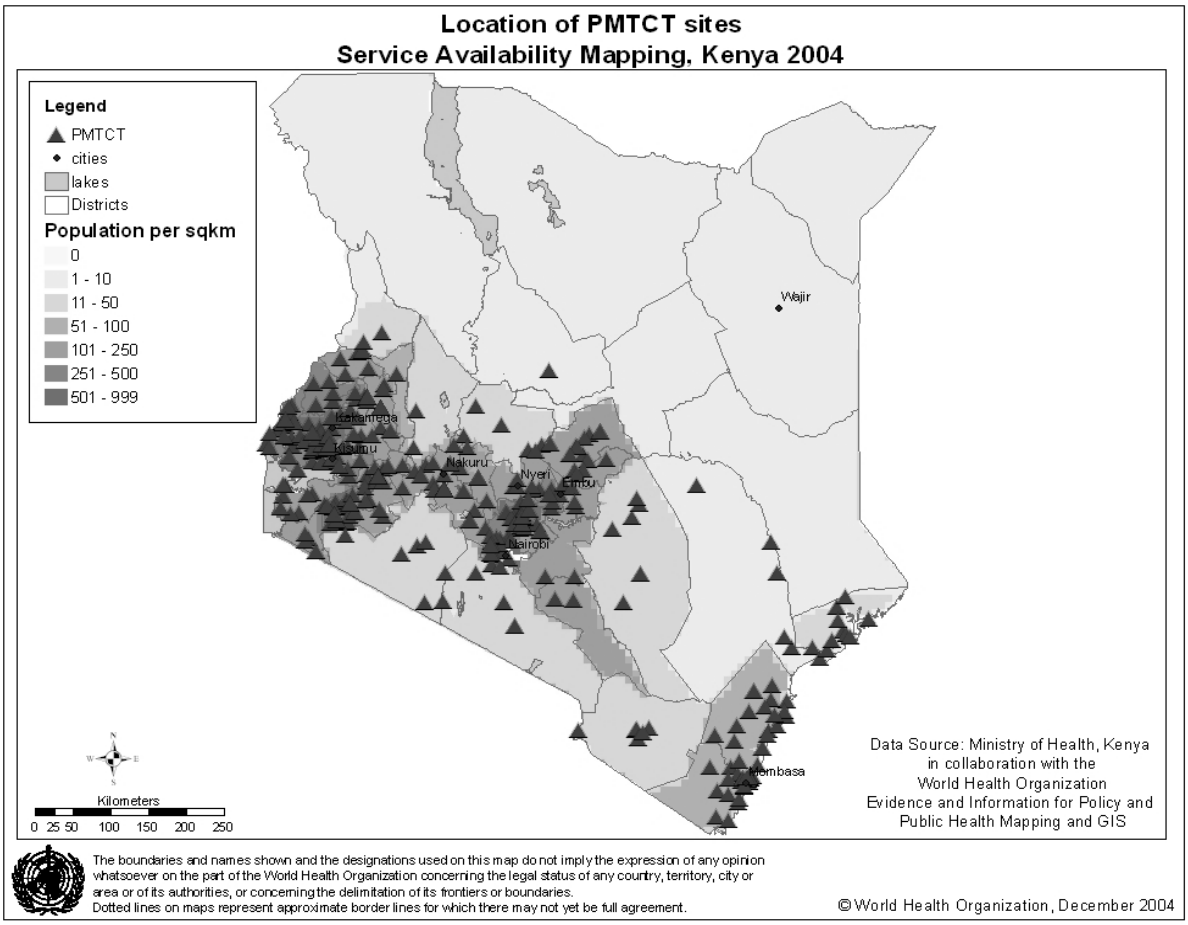



Figure 3. PMTCT sites in Kenya, using SAM.

## Session 6: Country Examples — Analyzing, Translating, and Using HFA

**Learning Objectives** — This session is 60 minutes. By the end of the session, participants will be able to use illustrative data tables from key HFA approaches, including SPA, SAM, Rapid-HFA, and HRHS to:

- ❒ learn of the need to analyze and interpret the data in light of the sociocultural conditions, policies, and program environment in the regions and country;
- ❒ use the presentations and group work to find the several areas of need resulting from an HFA; and
- ❒ understand the need to use data to prioritize funding and design of programs/interventions to address some of the needy areas.

**Equipment and Materials** — Required equipment and materials are:

- ❒ projector
- ❒ computer

**Handouts —** Required handouts are:

- session outline
- copy of presentation

**Advanced Preparation —** In advance, provide graphics, results, and any outlines presented by participants to all participants. They should be instructed to study these materials as homework the previous evening. The materials will give them a sense of how information is presented in different ways and how the interpretation will vary depending upon the context.

For example, there are differences in availability of supplies and equipment within a country. Once that information is digested, participants can compare an individual item across different countries, to see where there is a relative weakness. Also, within a country, results are presented by facility type (i.e., hospital, health center, etc.). Participants will be able to assess which types of facilities have more of or are lacking a specific item.

**Plan of Activities —** The following presents a step-by-step plan of activities.

*1. Introduction*

Introduce this session by explaining that country representatives have been asked to give presentations on instruments and how they have used them in their contexts. Following this session, there will be small group work in which participants apply concepts presented by the panelists in the next session.

Explain that the presentations should give participants a sense of how information is presented in different ways and how the interpretation will vary depending on the context (such as the example, above involving differences in availability of supplies and equipment within a country).

*2. Presentations*

Be sure to invite papers from at least three countries in order to give participants a broad reach of information on instruments and data use within different contexts.

Give parameters for presentations, such as the amount of time each country has to present and how questions will be handled (for example, questions will be allowed immediately after each presentation, as they come up during the presentation, or participants should make notes and can ask questions after the entire session is completed).

Ask participants to listen to their colleagues' presentations carefully and to keep in mind the questions they will work on during an upcoming small-group work sessions. Those questions are the following:

- What types of data are presented?
- How would you use/analyze these data in policy-making or in practice?
- Are the data in the table easy to understand? If not, what types of improvement would you like to see?

## Session 7: Practical Exercise — Analyzing, Translating, and Using HFA Data

**Learning Objectives —** This session is two hours (an hour for small-group work, followed by an hour for presentations and discussions in plenary, and ending with a brief summary of key points from the Day 2 sessions). By the end of the session, participants will be able to:

- ❒ read, interpret, and understand HFA tables and have increased knowledge and use of HFA results; and
- ❒ interpret findings in HFA reports within the context of background characteristics, national expectations, and international standards.

**Equipment and Materials —** Required equipment and materials are a flip chart stand and paper.

**Handouts —** Required handouts are:

- ❒ four HFA cases
- ❒ other reference materials for the participants
- ❒ task assignment sheet

**Advanced Preparation —** Participants will work in groups they signed up for on Day 1. Participants are encouraged to familiarize themselves with the section of an HFA report for a particular country (e.g., an SPA report for a specific country) from which the exercises are drawn, including main tables in the body of the report and appendix tables. This will give them a sense of how information is presented in different ways and how the interpretation will vary, depending on the content.

**Plan of Activities —** This session involves small group work followed by discussion of each group's findings during a plenary session. A brief summary of key points from all the day's sessions concludes this final session of Day 2.

*1. Small group work (one hour)*

Divide the plenary into the same small groups as on the previous day. Divide the four different cases on data analysis and use among the groups, given the instruments discussed in country presentations.

*Notes:* The number of groups is flexible, but will depend upon the total number of participants. For instance, if there were 35 participants, then seven groups of five each would foster better interaction among group members than using fewer groups with more members. However, that would also require more time for seven group presentations as opposed to using fewer but larger groups (five groups of seven participants each, for example).

Four cases for more than four groups means that some cases will be discussed by more than one group. Consider asking for report-backs that build upon one another, encouraging groups not to repeat details already presented by another group. For instance, if groups one and two discussed the same theme, group one can present its small group findings while group two adds findings from its own discussions that were missing or help to clarify what has been presented by group one.

Decide how to assign practice data from one or two approaches. The number of approaches from which data are assigned is not the important thing (although it is best for the participants to work with as many methodologies as possible), but the critical objective is to get the participants to experience translating data from tables to useful information, and to practice applying that information to decisions involving hypothetical situations.

*2. Discuss group work (one hour)*

*Note:* The following discussion topics are provided as an illustration. The actual topics arising in the plenary discussion of the group findings will depend upon the context of the four HFA cases and countries involved in the workshop.

**Topic:** *Interpreting and using HFA data for research and policy-making*

In attempting to interpret HFA data, the policy-maker needs to be aware of the contextual factors present in regions and in the country. Some examples include socioeconomic difficulties in accessing health facilities, the conditions of roads, and cultural practices favoring or hampering the use of services. Also, results need to be seen in a programmatic light (for example, whether stock-out of an item coincided with a budget shortage or a natural disaster, etc.).

**DAY 2 — Session 7**

**GROUP TASK**

Review the cases that you have been provided previously. Consider your own experience and the experiences reflected in the cases. Based on that experience, answer the following questions:

1. How would you use/analyze these data in policy-making or in practice?
2. What are the issues to bear in mind in translating data to information and using them in policy/program context?1. How would you use/analyze these data in policy-making or in practice?

Inform the groups that they should be prepared to report their findings back to the plenary; and that they have one hour for the small group discussions.

**Topic:** *Determining priorities in context of low resources and multiple deficiencies*

More often than not, assessments will find several systems, items, or conditions missing within a facility. For example, there might be serious deficiencies in the infrastructure (no privacy, inadequate storage for medicines, waiting area without a roof, etc.), coupled with a lack of supplies (lapses in contraceptive injectables, etc.), and insufficient training of staff (lack of training on HIV counseling, etc.). When that happens, policy-makers need to weigh carefully the different options at hand in order to prioritize and plan appropriately for where and when the next investment of scarce resources will go. A few considerations are typically useful:

- **Simplicity:** Simple interventions are nearly always better than more complex ones. For example, a roof made of local roofing materials, although less durable than other options, may meet the need for shelter in the waiting area quicker than waiting for corrugated aluminum from central stores (and sometimes may be more culturally appropriately).
- **Return of investment:** If an intervention has more probability of increasing

the number of clients or their satisfaction, it is worth considering. For example, if constructing a small pharmacy and supplying it with essential pharmaceuticals would improve the likelihood that patients buy their medicines locally rather than traveling a great distance, and they would also be able to pay less for expensive medicines than they would at a distant pharmacy, then this intervention is worth considering.

- **Cost:** A more costly intervention is less preferred than a cheaper one. For example, buying propane refrigerators may be more cost-effective than buying a generator for electric refrigerators. Always consider the long-term cost-effectiveness of interventions. An initially costly measure may have advantages (either immediately or over time) that make it the most desirable option. For example, buying an electric generator for refrigerators could be used to supply electricity for other needs, such as lighting or sterilizing equipment.
- **Critical needs:** An intervention, even if costly, may still be warranted or urgently needed. For example, immediate training in HIV counseling and testing may be vital in a setting where few professionals are trained in this area, yet there has been a spread of HIV infections in recent years.

Other criteria for setting priorities may be used, such as acceptance by the community, opportunity provided by investors/donors, long-term strategic planning, and availability of technology. In any case, criteria based upon personal biases or preferences, such as an inclination for a certain technology or intervention when other options may be better, or favoritism to sereve a particular area, should be avoided at all costs.

*3. Summarize the day's sessions (briefly)*

Ask participants to help in summarizing key points covered during the day's sessions and then ask: What questions do you still have about today's topics?

Provide answers as possible. For those questions that cannot be answered immediately, let participants know if these questions can be answered before the three-day workshop ends or if there are other sources of information that might be helpful in finding the answers.

## Day 3 Session Plans

| Time | Session Title | Person Responsible |
|---|---|---|
| 15 minutes | Recap the previous day's work | |
| 90 minutes | 8. Data Demand and Use Strategies | |
| 15 minutes | Break | |
| 60 minutes | 9. Information packaging for diverse audiences | |
| 60 minutes | Lunch | |
| 120 minutes | 10. Articulating regional/country plans | |
| 15 minutes | Break | |
| 120 minutes | 11: Presentation of recommendations, next steps | |
| | Evaluate/close workshop | |

Begin Day 3 with a brief (15 minute) recap of the previous day, preferably made by a member of the previous day's host team. Ask the presenter to include any issues that were discussed during the steering committee meeting the evening before, and any resolutions that the group developed to address those issues. This helps the participants to see that the organizers and facilitators are considering their feedback and will encourage others to give constructive feedback to the current day's host team.

### Session 8: Data Demand and Use Strategies

**Learning Objectives —** This session should last about 90 minutes. By the end of the session, participants will be able to:

- ❒ describe the three categories of constraints to using data and information
- ❒ identify the three components of decision making
- ❒ identify the fours steps in data demand and information use
- ❒ describe tools and strategies that can help facilitate use of information for decision-making

**Equipment and Materials —** The following will be needed:

- ❒ flip charts stand and paper
- ❒ overhead projector
- ❒ computer

**Handouts —** Copies of the session's outline and presentations are needed for each participant.

**Advanced Preparation —** As relevant, participants are to review workshop materials ahead of time to familiarize themselves with the materials and be able to make informed contributions.

**Plan of Activities —** Participants will be asked to provide examples of the decisions they make, the barriers they have faced in using data, and the solutions that could have been used to address the constraints. This will increase awareness of the types of decisions people make to stimulate thinking about barriers that they face to using information for decision-making, and encourage problem solving to address the barriers.

**DAY 3 — Session 8**

**GROUP TASK**

Ask participants to think about country context and barriers facing use of information. They list as many as possible. Using one of the examples in their list, participants in their small group discuss what can be done to eliminate these constraints.

Each group should be prepared to discuss the group's findings in an interactive plenary session.

Allow 40 minutes for this task.

A data use strategy is a systematic effort to identify opportunities for and constrains to effective and strategic data collection, analysis, availability, and use. To support evidence-based decision-making, MEASURE Evaluation has developed a conceptual framework (Figure 4) and set of tools to aid policy-makers and stakeholders in implementing data use strategies. This session presents the conceptual framework of data demand and information use (DDIU) and introduces strategies and tools that can help facilitate use of information for decision-making.

As shown in Figure 4, DDIU is presented as a cycle that connects demand to use through the intermediate steps of data collection and analysis, actions which ensures the availability of health information, and the commitment to improving the quality of data upon which it is based. The data use process is presented as a cycle rather than a linear process, such that increased information use in turn stimulates greater demand for data, with the decision-makers and the decisions they make being the heart of the process.


Figure 4. The DDIU conceptual framework.

Source: Foreit K, Moreland S, LaFond A. *Data Demand and Information Use in the Health Sector A Conceptual Framework.* Chapel Hill, NC: MEASURE Evaluation; 2006; 3.

## Session 9: Information Packaging for Diverse Audiences

**Learning Objectives —** This session lasts 60 minutes. By the end of the session, participants will be able to:

- ❒ identify main audiences for HFA results
- ❒ describe approaches for communicating with different audiences
- ❒ identify the advantages and disadvantages of each approach in terms of influencing policy decisions
- ❒ identify outstanding questions and potential resolution
- ❒ consider the implications this information has for their own context

**Equipment and Materials —** The following are required:

- ❒ flip charts stand and paper
- ❒ projector
- ❒ note pad

**Handouts —** Copies of presentations and background materials are needed.

**Advanced Preparation —** Before coming to the meeting, participants should give some thought to examples in their own experience where data presentation had an impact (positive or negative) on decision-making in health. Examples could include decisions taken at district or national levels. Participants should say why, in their view, the data dissemination affected decision-making. Alternatively, they may prefer to use examples where decisions were not affected despite the availability of data that should have had an influence.

**Plan of Activities —** Do the following:

- ❒ Ask participants to volunteer examples of data influencing decision-making (this should take about 10 minutes). Keep copies or a record of the examples, using a flip chart.
- ❒ Give a Microsoft PowerPoint presentation on data dissemination (15 minutes).
- ❒ Hold a general discussion (30 minutes).
- ❒ A facilitator summarizes the three or four major "take away" points from the session. (five minutes).

## Session 10: Articulating Regional/Country Plans

**Learning Objectives —** This session should take about two hours. By the end of the session, participants will be able to:

- ❒ identify country needs for data and the strategies for collecting the needed data, primary collection versus secondary analysis of available data;
- ❒ reflect on country capacity to collect the required data and potential technical assistance needs
- ❒ reflect on funding for HFA, the sources, timing, of these funds and activities needed to attract them
- ❒ discuss collaboration for sounder, more collaborative, data collection and use in countries
- ❒ as relevant, be able to outline plans for using HFA to strengthen HIS in countries, including this HFA training at the country level, and any resources that the countries may require for any follow-up work

**Equipment and Materials —** The following are required:

- ❒ flip chart stand and paper
- ❒ projector
- ❒ note pads

**Handouts —** Provide enough copies of the following handouts:

- ❒ background materials distributed in previous sessions
- ❒ conclusions and action plans derived from small group discussion in Days 1 and 2
- ❒ relevant country-level white papers on HIS

**Advanced Preparation —** Participants sign up in country-specific work groups.

**Plan of Activities —** The participants break up into country groups to brainstorm on needs and opportunities for the use of HFA in specific counties (their own countries). The following issues are suggested for discussion (participants are free to discuss other issues):

- ❒ What are the key constraints to analyzing data and what would it take to resolve these in countries?
- ❒ What are the most important issues to bear in mind when putting out research or policy-related questions to guide HFA analysis plan?
- ❒ Do country decision-makers feel like they have what it takes to conduct the relevant analysis to inform appropriate research and policy-related decisions? If not, what are the gaps and how would they address these?
- ❒ What are the sources of funding for HFA activities in countries?
- ❒ Given what the participants have learned, how do the participants plan to use HFA to influence HIS strengthening in countries?

After the group work, the participants will make presentations, followed by interactive discussion on presented topics.

## Session 11: Presentation of Recommendations and Next Steps

Learning Objectives — This final session takes about two hours. By the end of the session, participants will be able to:

- ❒ present the outcome of their country action planning for how they expect to use HFA to strengthen national HIS systems once they get back (they will also be able to obtain the inputs of their peers); and
- ❒ if a regional-level of representation is involved, contribute towards the development, refinement, and finalization of a regional plan or concept.

**Equipment and Materials —** Any materials or equipment needed for presentations prepared by the participants.

**Handouts—** No handouts are required (copies of country action plans may be distributed if available).

**Advanced Preparation —** At the end of Day 2, participants should sit together in their groups to review presentation material in Day 1 and Day 2, and summarize thoughts that could guide Day 3 action planning. A facilitator should announce this process in Day 1 and continue to remind the participants through Day 1 and Day 2. To facilitate this planning, participants should receive a checklist of questions that are to guide their brainstorming at the end of Day 2. This type of advanced planning will assist in improving the quality and the outputs of the deliberation in Day 3.

**Plan of Activities —** Each country group will make a presentation, followed by a question and answer session.

This concludes the workshop.

# Appendix A. Opening Statement Example

*The following is a transcript of the opening speech for a Pillars of Health Facility Assessment and Information Use workshop held June 17–19, 2008, at the Imperial Resorth Beach Hotel, Entebbe, Uganda. The opening remarks were made by Edith Katembe-Kasaijja, director, Ministry of East Africa Community Affairs, Republic of Uganda.*

Chairman, distinguished delegates, ladies and gentlemen.

I am greatly honored to be here to open the first EAC workshop on Pillars of Health Facility Assessment and Information Use. I wish to first thank the organizers of this workshop for selecting Uganda to host this important meeting. As you will soon discover, they could not have selected a better venue than this one. I would also like to welcome you all to Uganda, the pearl of Africa, and to encourage you to explore and enjoy the beauty of this country.

The objectives of this workshop are to:

- learn different types of health facility assessments currently in existence
- understand the role of HFA in HMIS and health system planning, monitoring and evaluation, including advantages and limitations
- understand the main elements of a HFA: data collection instruments, techniques and core indicators derived from data.
- see actual results from HFA and the way they have been used for informed policy-making and monitoring
- learn to extract, analyze, and interpret real data, and their implications for programmatic decision-making
- explore options for funding and undertaking HFA in countries.

This is therefore a capacity-building workshop designed for public and private health sector and related stakeholders in the field of national health information systems and National delegates from each of the five EAC partner states, have been carefully selected to represent priority areas of our major concern.

These priority areas include HIV/AIDS, maternal and child health, immunization, health management information systems, national bureau of statistics, and monitoring and evaluation. The representation from nongovernmental (NGO) and faith-based (FBO) organizations demonstrates an important collaboration between government and NGOs in support of implementation of major government health programs.

The expectations from the five EAC partner states on the dissemination and use of health facility assessment data cannot be over emphasized. We know that EAC partner states have in the past utilized effectively information and data obtained from studies conducted in the region. These include:

- the development and implementation of prevention of mother-to-child transmission of HIV/AIDS (PMTCT) strategy following clinical trials of

nevirapine in Mulago Hospital, Uganda;

- the change of malaria treatment from chloroquine and fansidar to coartem from studies conducted in Uganda, Kenya, and Tanzania on drug resistance of malaria parasite; and
- the improvement of HIV/AIDS prevention strategy from ABC to ABC+C, where A is abstinence, B is be faithful, C is condom use, and +C is circumcision.

Therefore, this workshop has taken place at a time when the EAC partner states have already been sensitized on the use of data and are ready to use the health facility assessment data in order to improve the quality of health care delivery system in our region.

Finally, I would like to thank USAID and EAC for providing financial and technical resources which have enabled us to conduct this important workshop.

I wish you fruitful deliberations and we look forward to receiving a comprehensive report from the EAC partner states' country representatives.

Thank you.

For God and my country.

# Appendix B. Examples of Session Presentations

*The following are examples of session presentations from the 2008 workshop held in Entebbe, Uganda. The session numbers refer to the outline of sessions found on page 4.*

## Session 2 (Day 1): Becoming Familiar with Interpretation and Usage of HFA Data

**Signature Domain and Geographic Coordinates —** This session introduces participants to the IHFAN working paper "The Signature Domain and Geographic Coordinates: A Standardized Approach for Uniquely Identifying a Health Facility," available at http://www.cpc.unc.edu/measure/publications/pdf/wp-07-91.pdf. These notes and slides are based upon a presentation given by Nathan Heard in Entebbe.

With any facility survey, the ability to identify a facility uniquely is vital to being able to use and analyse the data properly. This is especially true when making comparisons across surveys or years. The presentation introduces the creation of a "signature domain" to ensure each facility can be uniquely identified. The followings are the elements in the signature domain:

- date of the survey
- health facility country registry code
- health facility survey identification (ID)
- health facility name
- health facility contact information
- postal address (street number, city, postal code, other; in some circumstances, a facility may have some but not all of the postal address elements and in these cases the elements that are present should be recorded; if the facility has no postal address at all, this element would be omitted)
- main telephone number, main fax number, main e-mail address
- name of the director, director's telephone phone number
- facility's geographic administrative unit (at least first and second level)
- GPS coordinates (latitude, longitude waypoint ID)

The following outline could be used for the presentation of this session:

- signature domain
- geographic coordinates (a case study)
- steps for geo-enabling health facility data
- discussion

A demonstration of linking data from different sources in a GIS should be included in the presentation to facilitate the understanding of the use of GPS data (Figure B1).

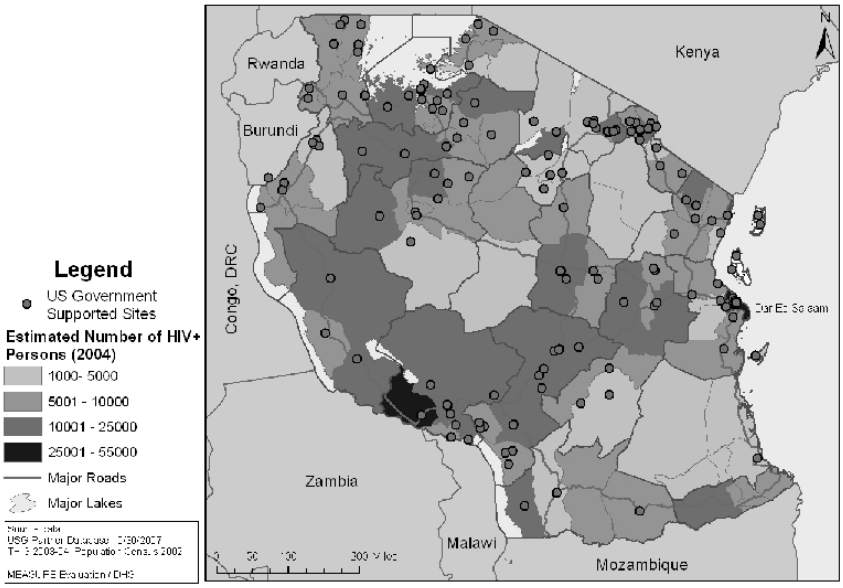



Figure B1. Linking health facility GPS data with data from different sources.

After the presentation, special data use case from participants should be solicited and the country application be discussed to promote the use of data.

## Session 3 (Day 1): Core Indicators of HF Readiness to Provide Services

This outline is based on a presentation by Nancy Fronczak at the Entebbe workshop. In response to users' requests for a set of core indicators for cross-country comparisons of HFA, IHFAN drafted a set of minimum core indicators that can be collected with any HFA approach (these indicators are found in *Guidance for Selecting and Using Core Indicators for Cross-Country Comparisons of Health Facility Readiness to Provide Services*, described on page 11). Further work to define the indicators has been integrated into global level initiatives led by WHO to specify core indicator and monitoring strategies for assessing all six functional areas of the health systems (governance, financing, human resource, information, service delivery and medical products, vaccines and technologies). This presentation shares the core indicators recommended in any HFA; the rationale for these; issues around defining and collecting them; and checks in place to ensure validity and reliability of indicators and the data collected. Examples of analyses based on data are presented so that participants see the utilization of indicators.

The presentation could use the following outline:

- rationale for core indicators
- criteria and process for selection
- domains and components within domains (IHFAN and WHO)

- improving validity and reliability of indicator data collection
- examples of core indicator data

After the presentation, the participants review sample core indicators in groups, focusing specifically on the feasibility of these indicators in the context of their countries and steps that in achieving common definitions for these indicators in the country context.

## Session 4 (Day 1): Overview of Health Facility Assessments and Their Role in HIS

This session, based on a presentation by Bolaji Fapohunda at the 2008 Entebbe workshop, presents an overview of the main elements of HFA, including a conceptual framework of how HFA fits with other HIS sources in a typical M&E model.

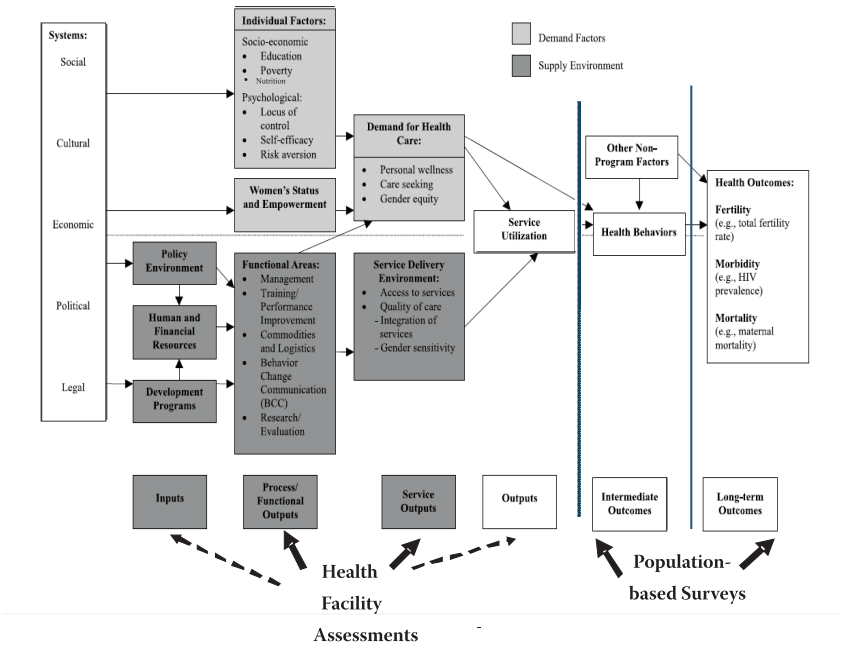
Topics presented could use the following outline:

- types of data collected in HFAs
- main sources of health facility information
- implementation issues
- HFAs and the health system
- how HFA fits into a country's health information system
- benefits of using multiple sources of data

Under types of data presented, the author presents a few data tables from data collected using a variety of approaches, such as SAM, SPA, etc. Following this, the participants are asked to discuss the data. The following sample questions may be asked to facilitate this discussion:

- What do the data tell us?
- How were the data collected?
- What is the geographical coverage of the data?
- What was the tool/HFA approach used in collecting data?

The responses to these questions are used to gauge the participants familiarity with the concept so that the subsequent discussions can be correctly situated given the participants level of knowledge. This information then forms the basis for discussing other elements such as the implementation issues, the role of HFA in health systems performance monitoring, the fit between national HMIS and the country's health information system, and the benefits of using multiple sources of data. An implementation of this workshop design for the East Africa region in partnership with the EAC indicates that the use of models/charts that clarify the role of HFA within the broader M&E systems (see Figure B2), establishes linkages between the HFA and other HIS sources, and clarifies the role of HFA in HSS (Figure B3) are very useful in clarifying the concept for the participants. Examples of framework/models utilized in the IHFAN/EAC workshop are presented below.




Source: Bertan J, Escuero G. *Compendium of Indicators for Evaluating Reproductive Health Programs.* Chapel Hill, NC: MEASURE Evaluation; 2002.

Figure B2. Relationships between contextual and individual factors, the health system, and health outcomes.

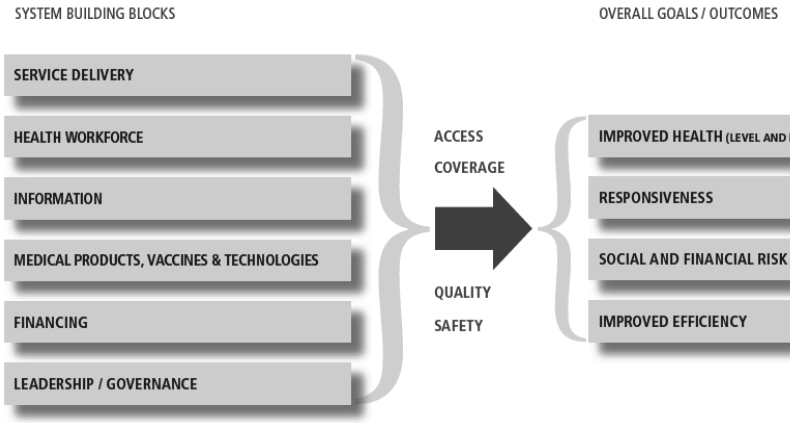



Figure B3. The WHO framework depicts the significance of health facility-based information.

Source: World Health Organization (WHO). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*. Geneva, Switzerland: WHO; 2007;3.

## Session 5 (Day 2): Synopsis of Health Facility Assessments Methods

This session, based on a presentation by Bolaji Fapohunda and Shanthi Noriega-Minichiello, profiles the major HFA approaches, including key questions answered by HFA, major HFA tools and their management utility, methods of data collection (i.e., facility audit, record review, health worker interview, observation, and exit interview); and covers other methodological and cross-cutting implementation issues associated with HFA. The following outline could be used for the presentation of this session:

- key questions answered by population based surveys
- key information provided by HFA and the significance
- profiles of the key HFA methods, e.g. SAM, SPA, Facility Audit of Service Quality (FASQ); other special topic surveys (e.g. Abt Associates health facility-based survey of HRH, ACQUIRE LAPM evaluation [EgenderHealth], and Logistics Indicator Assessment Tool [LIAT])
- data collection, and methodological and cross-cutting issues around these, and ways to address them

Table B1 presents illustrative examples of the types of materials that are covered in the profile of a method.

Table B1. Profile of Health Facility Census – Example

| | |
|---|---|
| **Purpose** | To provide information for policy, planning, and management of health system development with particular focus on the area of physical assets |
| **Key areas of information** | • Availability and conditions of physical assets<br>• Location of health service delivery points<br>• Availability and type of health services<br>• Headcounts of health workers |
| **What it does** | • Provides information on conditions, distribution, of physical assets in all health facilities<br>• Cost estimates for future capital investment requirement |
| **What it does not do** | Does not collect information on service quality, patient satisfaction, and details of human resources |
| **Most relevant program context** | Best at the preparation phase of a national strategic planning cycle, especially when basket funding is being introduced and cost estimation for capital investment is required; in regions/ sub-regions where reliable information on available health resources, their conditions, and locations is lacking |

In the presentation, it is also suggested to include examples of data presentation as they are very helpful to facilitate the understanding in adult learning context. Lessons from previous training indicate that maps (Figure B4) are good tools for presenting the data to the participants.

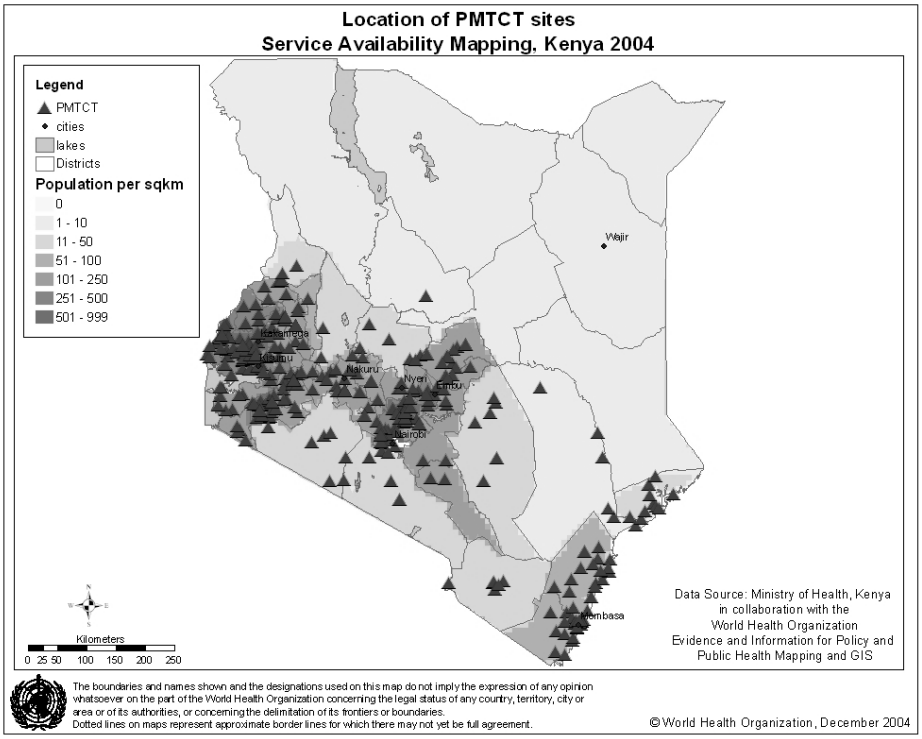



Figure B4. Location of PMTCT ties, SAM, Kenya, 2004.

The following discussion questions have proven useful in helping participants summarize their background in HFA and reflect on their needs vis-à-vis their expectation of the skills to be impacted at the workshop:

- Which HFA surveys have been already conducted in your country?
- What kinds of data are needed in your country?
- Which HFA surveys are suitable to collect the data?
- Which methodologies are suitable to collect the data?

A good resource for developing this session is the profiles of HFA mehods, available from www.ihfan.org.

## Session 6 (Day 2): Country Presentations on Instruments Used in HFA

Limited utilization of information is a common concern in many countries. In this session, a country team typically presents examples of HFA data and results to demonstrate reading and interpretation of data. Each presentation should emphasize scope and limitations of data (e.g., general vs. in-depth, and sample-based vs. census), other important collateral information, such as knowledge of program context, and how this informs the interpretation of findings.

The purpose of the following country presentations are to show selected results of the study, share strengths and limitation in each methodology from country experiences, and show how the data can be utilized.

**Service Availability Mapping (Tanzania) —** This part of the session is based on a presentation at the Entebbe workshop by Josibert Rubona, Tanzania Ministry of Health. A Tanzania Service Availability Mapping Survey (SAM) was conducted in Tanzania between 2005 and 2007. The Tanzania SAM can be divided into the following three components: national survey of all districts; facility census of all facilities in Dar es Salaam, Zanzibar, and the district of Kibaha in Coast region; and facility census and assessment of service availability for HIV/AIDS prevention in Mwanza region (Prevention)-SAM.

Following is the outline of the presentation.

- background
- SAM objectives
- methodology
- selected results for district survey
- selected results for facility census
- SAM strength and limitations

Utilization of SAM results, SAM data collection, data entry, and data analysis can be explained using the illustration in Figure B5.

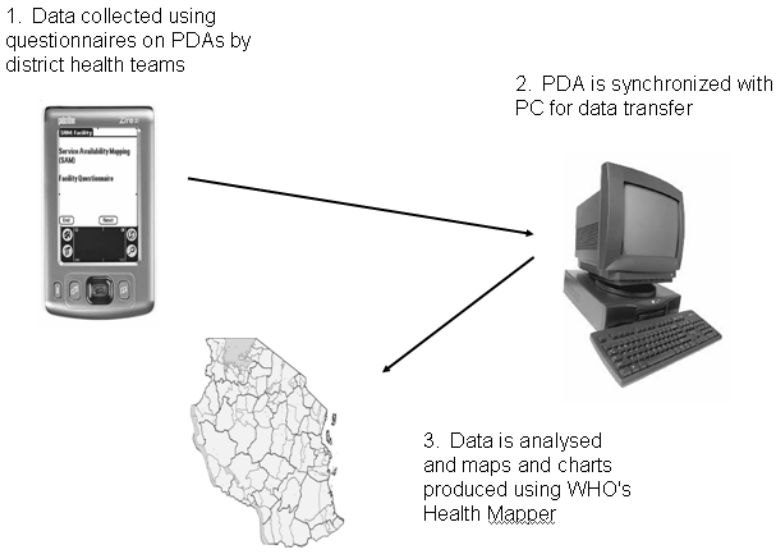



Figure B5. SAM methodology illustration.

In order to facilitate the understanding of the participants, the presentation must include illustrative results (e.g. graphs, maps) of data analysis. Examples of SAM results are presented in Figures B6 and B7.

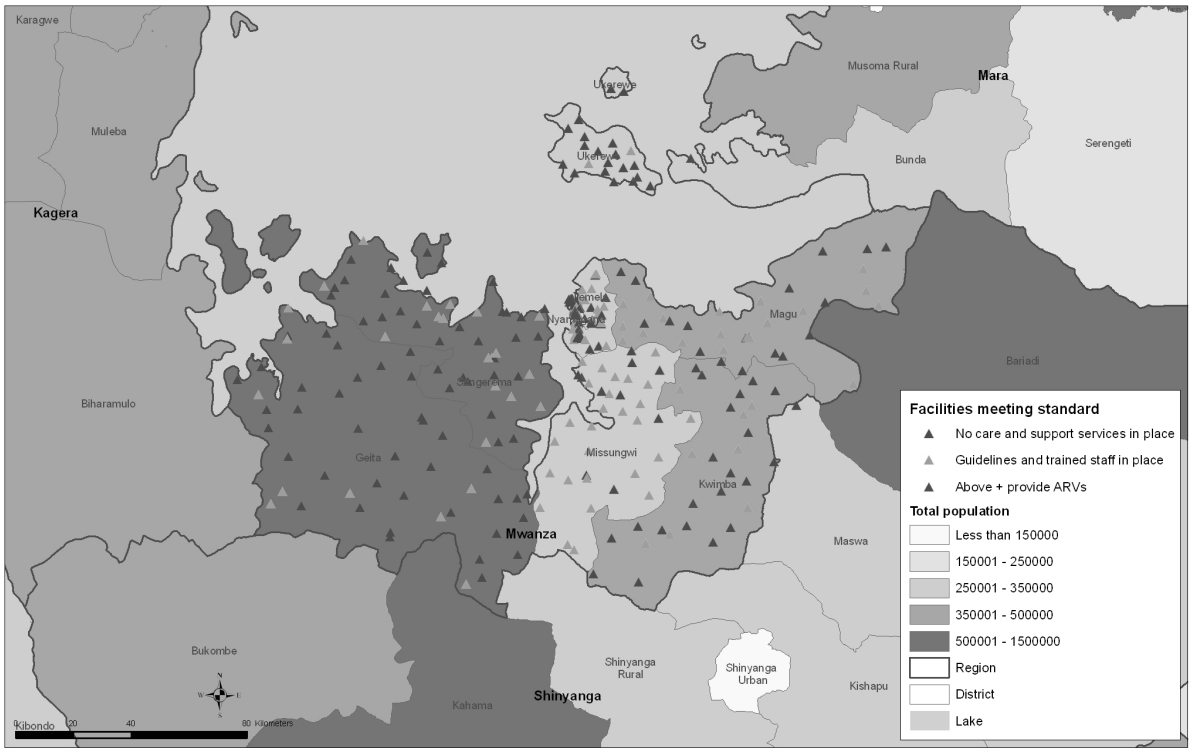



Figure B6. Selected results of SAM Tanzania, a map of health faciliites and availability of antiretroviral therapy, Mwanza region.

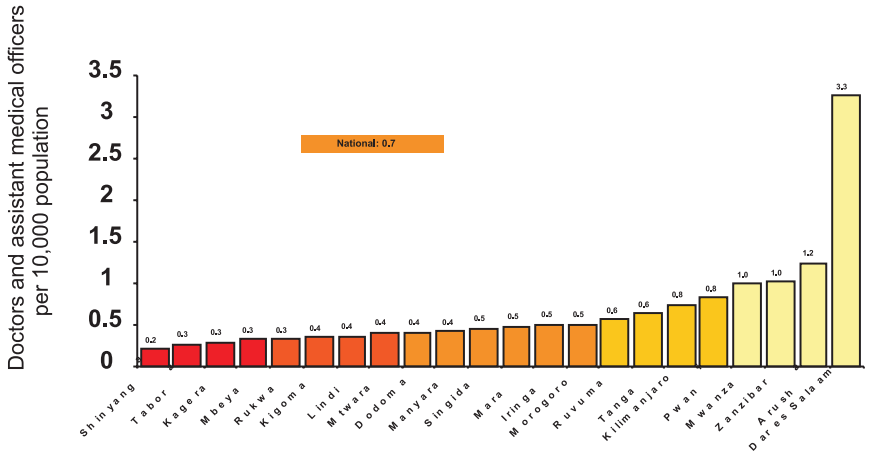



Figure B7. Selected results of SAM Tanzania, doctors and assistant medical officers per 10,000 population by region.

The implementation of a HFA survey requires significant human and financial resources. The HFA data should be used by key stakeholders to effectively inform policy and programmatic decision making. Learning other country's experiences of the use of HFA results will facilitate further discussion and planning of data use among the participants. In case of Tanzania SAM, the followings are the utilization examples of the SAM data:

- update of Tanzania health policy
- development of Health Sector Strategic Plan III (2009 -2013)
- plan for strengthening Primary Health Care (PHC)
- some indicators have been included in Health Sector Performance Profile Report

**Service Provision Assessment —** Service Provision Assessment (SPA) surveys have been conducted in many countries. This outline is based on a presentation at the Entebbe workshop developed by Paul Ametepi and Alfredo Fort covering selected illustrative results of SPAs in Zambia, Tanzania, Kenya, and Egypt. The presentation showed various aspects of SPAs, including service availability, infrastructure, client comfort, amenities such as regular electricity or water, infection control and waste disposal, observation of consultations, client exit interviews, and provider interviews.

The outline of such a presentation could be as follows:

- M&E conceptual framework
- country profiles
- illustrative results of SPA surveys
- use of SPA

In order to facilitate the understanding of the participants, the presentation must include illustrative results (e.g., graphs, maps) of data analysis. Examples of SPA results are shown in Figures B8 and B9.

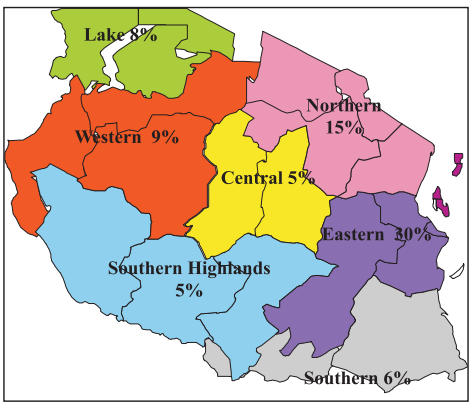



Figure B8. Selected results of an SPA, basic client comfort amenities, electricity and water, by zone, in Tanzania (N=611).

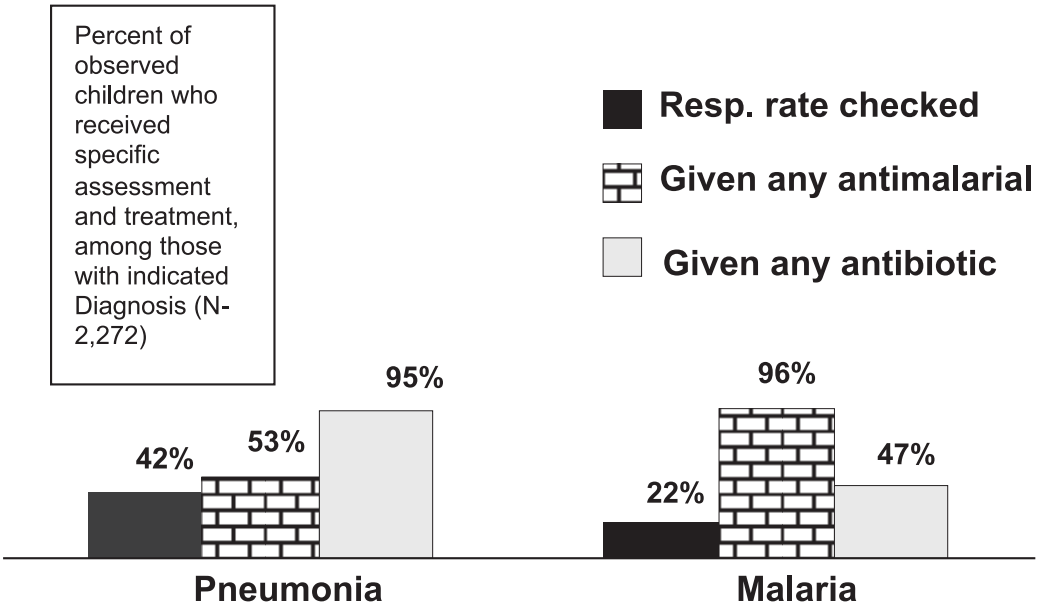



Figure B9. Selected results of SPA assessment and treatment of children with indicated diagnoses, Tanzania, 2006.

Leaning other country's experiences of the use of HFA results will facilitate the further discussion and planning of data use among the participants. In the case of SPA, the following were shared during the Entebbe workshop as utilization of the SPA data in various countries:

- extensive dissemination at zonal and regional levels (Kenya, Tanzania)
- informed national strategic plan (Kenya)
- further analysis of data with journal articles (Kenya)
- study on effect of health care services on IUD use in Egypt, published in a journal
- request from a Johns Hopkins University School of Medicine center for data sets for further analysis

**Further Analysis of Kenya SPA —** This presentation from the 2008 Entebbe workshop was developed by Paul Kizito. Secondary analysis was conducted using data from a Kenya Service Provision Assessment (KSPA). The purposes of the secondary analysis were to increase use of KSPA findings to inform policy and programs, to increase skills of Kenyan researchers for using the KSPA data set, to try to explain current trends in fertility and mortality, and to involve stakeholders in the analysis and use of information. This presentation was intended to share selected results of SPA to facilitate the understanding of the participants on data analysis and data use.

Following is the outline of the presentation:

- background
- objectives of the SPA data analysis
- KSPA further analysis
- examples of analysis
- use of SPA – policy and program implications

The following is a KSPA data analysis example. In this example, the analysis is examining the quality of Youth Friendly Service offered at health facilities in Kenya. The units of analysis are health care facilities and clients (observation and exit interview of STI consultations). The independent variables are quality of services provided; and counseling, examination/treatment, and referrals.

The results of the analysis are as follows:

- About 27% of adults are likely to be offered an HIV/AIDS tests, versus 5.3% of youth.
- Attendance of STI clinics was 83.4% adults, compared to 16.6% of youth.
- Of female clientele visiting STI clinics, adults comprised 75.3 % and youth 24.7%.

From the above results, the following policy and program implication can be interpreted:

- Barriers exist in serving youth.
- Programs need to encourage health providers to talk to the youth freely .
- More efforts are needed to disseminate these findings to the health providers.

**Health Facility Census in Zambia —** This presentation in the Entebbe workshop was made by Rutendo Chitembure and Virginia Simushi of the Zambia Ministry of Health, and Priscilla Likwasi of Japan International Cooperation Agency (JICA). With support from JICA, the ministry conducted a census of all public and private not-for-profit health facilities in Zambia. The census was conducted in two phases, in 2005 and 2006.

Following is an outline of the presentation:

- background objectives of the census
- data collection method
- primary data collectors
- source of transport for data collection
- scope and limitation of data collected
- how to interpret the data in real program content
- how to present the data to different audiences

- how the data have been and can be used
- data availability and country contact
- conclusion

Various types of analyses can be undertaken using the HFC data. For example, population density can be analyzed with the location of facilities to determine physical accessibility and utilization of the facility. The location of health facilities, in connection with land marks such as district and provincial boundaries, roads, and rivers can be used to analyze physical accessibility and utilization of the facility. In Zambia, programs and project requirements for basic and key health interventions, such as availability of human resources, availability and conditions of delivery, VCT, laboratory, surgical, X-ray, etc. facilities data, were used to analyze needs and availability of respective services at the facility.

In order to facilitate the understanding of the participants, the presentation must include illustrative results (e.g., graphs, maps) of data analysis. Examples of HFC results for this presentation are shows in Figures B10 and B11.

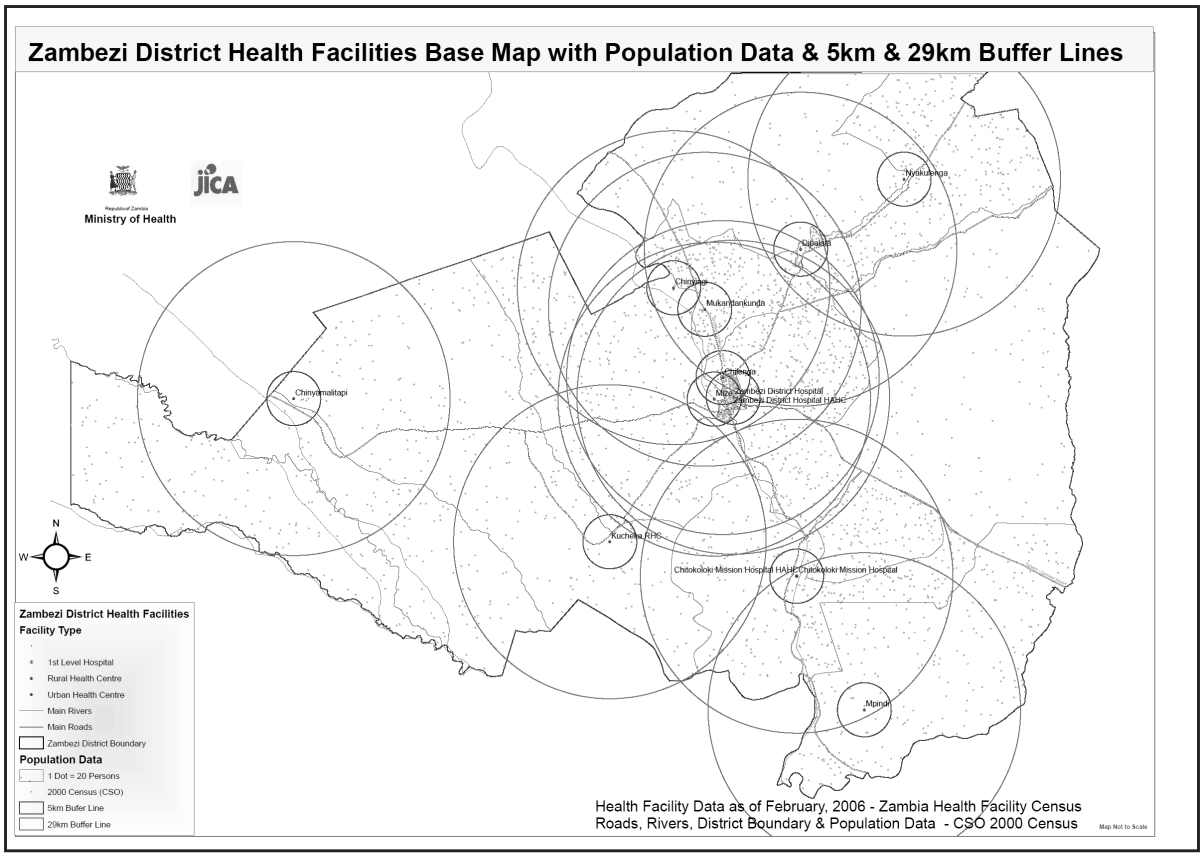



Figure B10. Selected results of HFC Zambia.

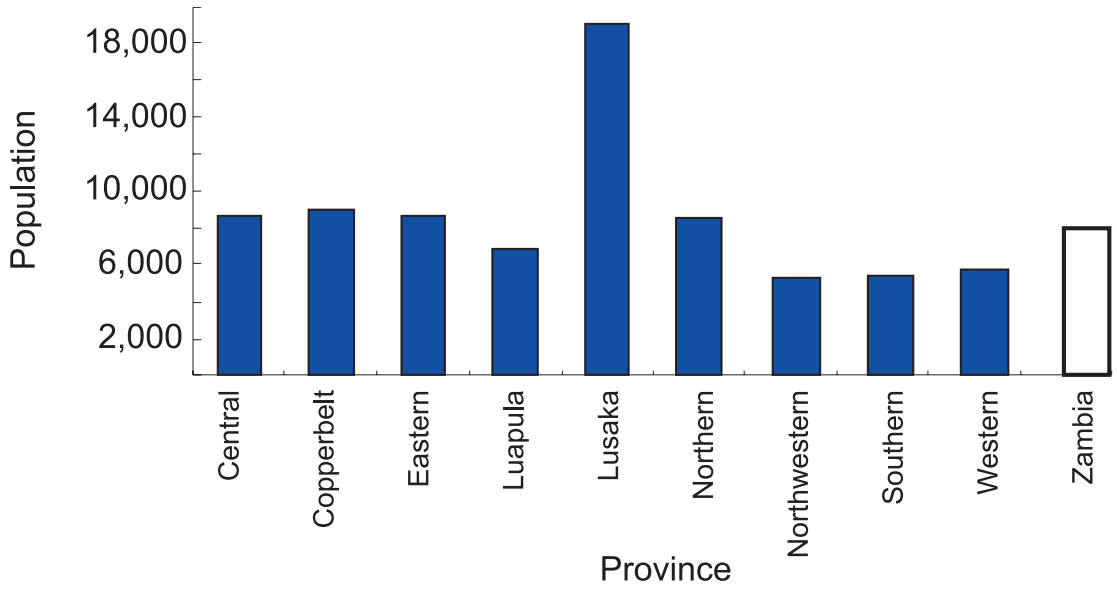



Figure B11. Selected results of HFC Zambia, population per facility by province.

It is always good to share the example of use of data. In Zambia, the HFC data have been linked to the ministry's identified basic requirements for a facility to deliver the basic health care package. The data have been intensively used to analyze the situation of facilities, and identify and prioritize health capital investments at districts and levels two and three (tertiary) hospitals, and to estimate the cost for the implementation of the capital investment.

**Rapid Health Facility Assessment —** This Entebbe presentation was developed by James G. Ricca and Joseph Valadez. Rapid Service Provision Assessment was originally designed for use by NGOs implementing child health interventions, particularly those within the Child Survival and Health Grants Program. The Rapid Health Facility Assessment (R-HFA) is suitable for use by district health management teams. It is a relatively rapid instrument for measuring a small set of key indicators to give a "balanced scorecard" for maternal, newborn, and child health services at the primary health care level, including an optional module for use with community health workers for community outreach services. The health facility scorecard includes health worker performance and service readiness. It identifies key bottlenecks to quality service delivery.

Following is an outline of the presentation:

- description of R-HFA (characteristics, summary logistics, initial data analysis, core indicators, and optional indicators)
- basic analysis and reporting of R-HFA information (analysis on utilization, geographic access, and quality of care; data use and dissemination)
- use of R-HFA information for making decisions for improvement of access and quality (priority setting, examples of data use, methods for follow-up)

The R-HFA survey tool includes data entry sheets with automatic construction of disaggregated frequency tables and bar charts for 12 key indicators. Figue B12 provides an example.

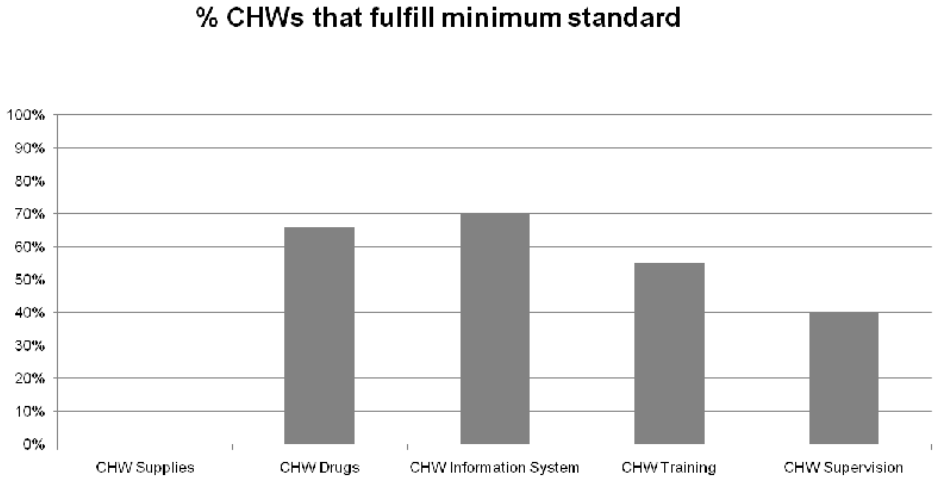



Figure B12. Results of an R-HFA showing percentage of community health workers who meet minimum standards.

The results of the R-HFA will assist in setting priorities for improvement. For example, based on the results of the R-HFA, decision-makers can prioritize the purchase of a particular drugs or supplies. The results can also be used to make training plans to address gaps in the performance of health workers.

## Session 7 (Day 2): Practical Exercise — Analyzing, Translating, and Using HFA Data

**Small Group Session —** Session 7 involves working in small groups, followed by a plenary session. The purpose of the small group work is to enable the participants to read, interpret, and understand HFA tables, and have increased knowledge and use of HFA results; and to interpret findings in HFA reports in the context of background characteristics, national expectations and international standards.

In the Entebee workshop, the 2006 Tanzania Service Provision Assessment (TSPA) report was used as an example. Based on small group sessions organized by Nancy Fronczak, participants were divided into the following groups with designated specific interests, and went through a series of exercises to ensure they could read tables, identify important findings, and then discuss

how to use these findings in future work.

Group 1. Facility-Level Infrastructure, Resources and Structures

Group 2. Child Health Services

Group 3. Family Planning Services

Group 4. Maternal Health Services

Group 5. Reproductive Tract and Sexually Transmitted Infections, Tuberculosis, and Malaria

Group 6. HIV/AIDS

Participants went through a series of real-life examples from the TSPA to be used for improving health systems or monitoring programs. Using the report's tables, participants learned the types of data that apply to specific policy/program issues, how data can be translated into information, and how the information is utilized to address the specific policy/program situation.

**Plenary Discussion —** After the small group discussions, the participants discussed the findings from the small groups. The purposes of this plenary session were to enable the participants to interpret and use HFA data for research and policy-making; and to determine priorities in contexts of low resources and multiple deficiencies. The facilitators highlighted best practices in interpreting and using the data, as well as encouraged participants to think of specific criteria to be used in selecting priority interventions. (See pages 23-24 for examples of two topics discussed during the plenary session.)

## Session 8 (Day 3): Overview of Data Demand and Information Use Strategies and Tools

DDIU is a strategy to identify opportunities for and constrains to effective and strategic data collection, analysis, availability, and use. To support evidence-based decision-making, MEASURE Evaluation has developed a conceptual framework (Figure B13) and set of tools to aid policy-makers and stakeholders in implementing DDIU strategies. This session presents the conceptual framework of DDIU and introduces the DDIU strategies and tools that can help facilitate use of information for decision-making.

After this presentation by Teresa Harrison in the Entebbe workshop, participants were asked to provide examples of the decisions they make, the barriers they have faced to using data and the solutions that could have been used to address the constraints. This is to increase awareness of the types of decisions people make, stimulate thinking about barriers that they face to using information for decision-making, and encourage problem solving to address the barriers.

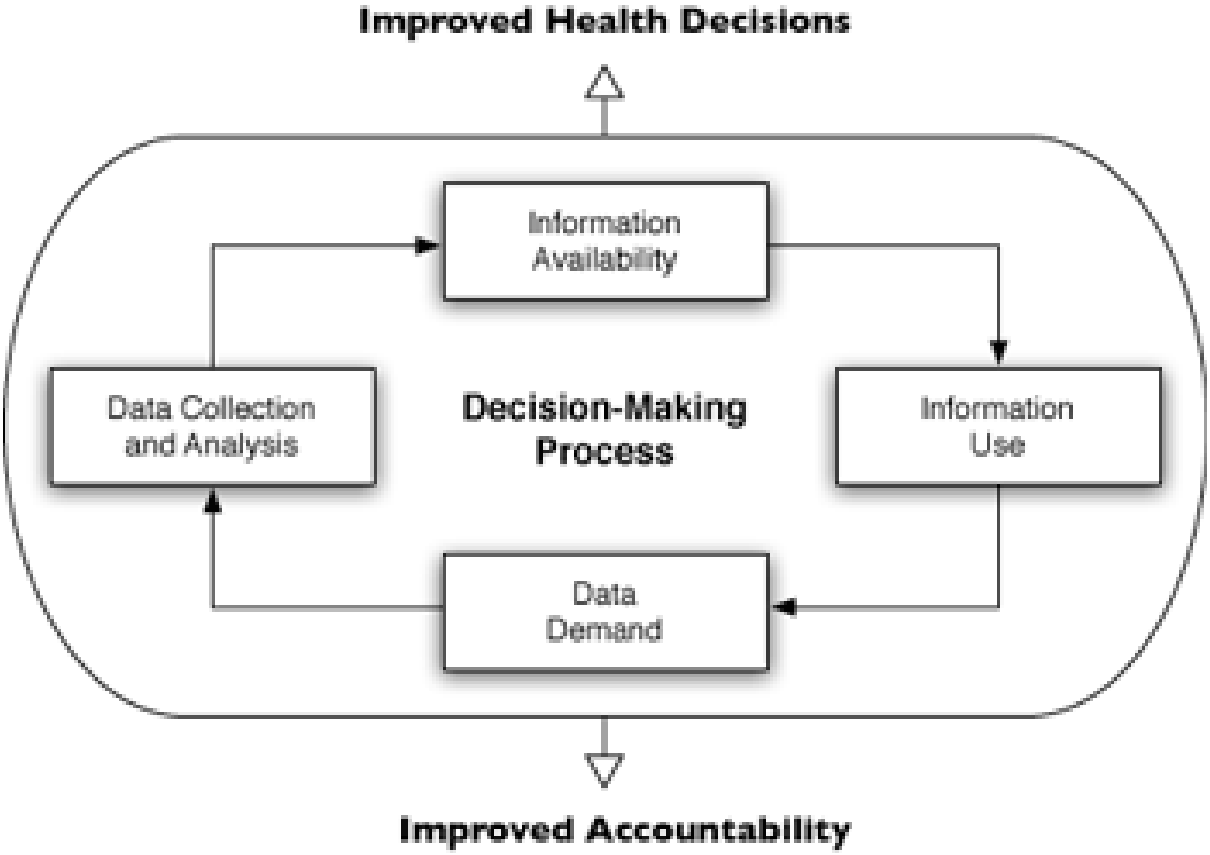



Figure B13. The DDIU conceptual framework.

Source: Foreit K, Moreland S, LaFond A. *Data Demand and Information Use in the Health Sector A Conceptual Framework.* Chapel Hill, NC: MEASURE Evaluation; 2006; 3.

## Session 9 (Day 3): Information Packaging for Diverse Audiences

The purpose of this session is to facilitate better information presentation to enhance use of data for decision-making. Before coming to the meeting, participants should give some thought to examples in their own experience where data presentation had an impact (positive or negative) on decision-making in health. Examples could include decisions taken at district or national levels. Participants should say why, in their view, the data dissemination successfully affected decision-making. Alternatively, they may prefer to use examples where decisions were not affected despite the availability of data that should have had an influence.

Led by Carla AbouZahr at the Entebbe workshop, participants further discussed the main audiences for HFA results, approaches for communicating with different audiences, and advantage and disadvantage of each approach in terms of influencing policy decisions.

## Session 10 (Day 3): Articulating Regional/Country Plans

In this session, participants break up by country to brainstorm on needs and opportunities for the use of HFA in their own countries. Suggested discussion points are described on page 28.

Participants in Entebbe outlined plans for strengthening the pillars of HFA and information use in countries, which could include stepping down HFA training at the country level, and any resources that the countries may require for this follow-up. After the group work, participants made presentation, followed by interactive discussion on presented topic.

## Workshop Posters

It is good to have key summary points of each HFA survey method in a poster format and to place the posters on the wall of the workshop venue, as it is not possible to cover all poster content during a presentation. Each poster should include the objectives, methods, and results of the survey. Following is an examle of recommended guidelines for a poster's content based upon guidance given to MEASURE Evaluation staff presenting posters during a 2009 symposium:

> *Title:* A short and catchy main title (maximum of 16 characters, including spaces) and a subtitle (maximum of 74 characters, including spaces) are suggested. The title should speak to the broad audience expected, and avoid acronyms and highly technical terms. For example, "Business as Unusual: Changing the Paradigm of Health Facility Data Demand and Information Use."
>
> *General Statement:* Include a general statement (maximum 188 characters) that describes what you are trying to say with this poster. Lead in text is included so that the general statement can stand alone (e.g., "Profile of HFA Methods: The Profile of HFA Methods is…").
>
> *Body:* The body of the poster may include up to four headings/sections (e.g., "Objectives," "Methods," "Results," and "Conclusions"). Make headings very short. It is suggested that the first two sections be limited to 300 words each, and Results and Conclusions be limited to 630 words each.

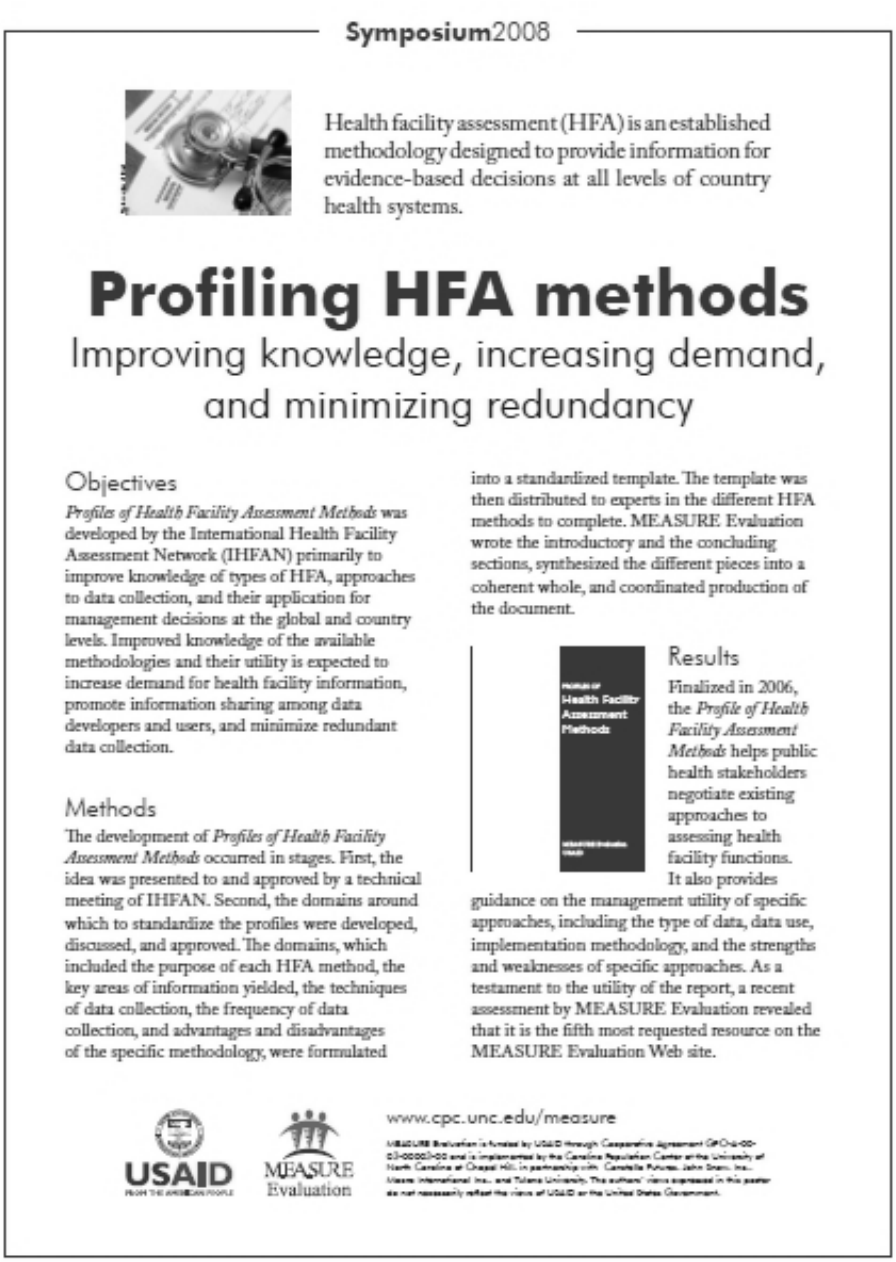
Following are examples of the Entebbe workshop posters.

**Profiling HFA Methods Poster —** Developed by Bolaji Fapohunda, this poster is shown in Figure B14. The poster was developed to improve knowledge of types of HFA, approaches to data collection, and their application for management decisions at the global and country levels. Improved knowledge of the available methodologies and their utility is expected to increase demand for health facility information, promote information sharing among data developers and users, and minimize redundant data collection.

First, the idea was presented to and approved by a technical meeting of IHFAN. Domains around which to standardize the profiles were developed, discussed, and approved. Finally,

the domains (i.e., the purpose of each HFA method, the key areas of information yielded, the techniques of data collection, the frequency of data collection, and advantages and disadvantages of the specific methodology) were formulated into a standardized template. The template was then distributed to experts in the different HFA methods to complete.

Finalized in 2006, the "Profiling HFA methods" poster helps public health stakeholders negotiate existing approaches to assessing health facility functions. It also provides guidance on the management utility of specific approaches, including the type of data, data use, implementation methodology, and the strengths and weaknesses of specific approaches.



Symposium2008

Health facility assessment (HFA) is an established methodology designed to provide information for evidence-based decisions at all levels of country health systems.

# Profiling HFA methods

## Improving knowledge, increasing demand, and minimizing redundancy

### Objectives

*Profiles of Health Facility Assessment Methods* was developed by the International Health Facility Assessment Network (IHFAN) primarily to improve knowledge of types of HFA, approaches to data collection, and their application for management decisions at the global and country levels. Improved knowledge of the available methodologies and their utility is expected to increase demand for health facility information, promote information sharing among data developers and users, and minimize redundant data collection.

### Methods

The development of *Profiles of Health Facility Assessment Methods* occurred in stages. First, the idea was presented to and approved by a technical meeting of IHFAN. Second, the domains around which to standardize the profiles were developed, discussed, and approved. The domains, which included the purpose of each HFA method, the key areas of information yielded, the techniques of data collection, the frequency of data collection, and advantages and disadvantages of the specific methodology, were formulated into a standardized template. The template was then distributed to experts in the different HFA methods to complete. MEASURE Evaluation wrote the introductory and the concluding sections, synthesized the different pieces into a coherent whole, and coordinated production of the document.



### Results

Finalized in 2006, the *Profile of Health Facility Assessment Methods* helps public health stakeholders negotiate existing approaches to assessing health facility functions. It also provides guidance on the management utility of specific approaches, including the type of data, data use, implementation methodology, and the strengths and weaknesses of specific approaches. As a testament to the utility of the report, a recent assessment by MEASURE Evaluation revealed that it is the fifth most requested resource on the MEASURE Evaluation Web site.

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MEASURE Evaluation

www.cpc.unc.edu/measure

Figure B14. Example of a workshop poster.

**Service Availability Mapping —** These illustrations developed by Wanjala Pepela of Kenya are intended to provide timely health service information on the distribution, availability, and coverage of PH interventions and resources at the national, district and facility levels; provide national planners and decision-makers with information on the distribution of services within the country, particularly at the district level; assess the feasibility of using SAM as a planning and monitoring tool at the district level; assess equitable and appropriate distribution of services and resources; and create thematic maps, graphs and reports to support public health programs.

The SAM methodology illustration is shown in Figure B15, with the following text: 1. Questionnaire programmed on Palm Pilot; 2. Data collection with handheld unit; 3. Palm synchronized with PC for data transfer; and 4. Data analysis and production of maps with HealthMapper. The SAM poster includes the graphic representations of the results such as graphs of charts, pictures, and maps (e.g. map of hospitals), shown in Figure B16.

This is a nice way of facilitating a better understanding of SAM. Carefully consider the size of the poster, which limits how much information may be presented before dthe material is too difficult to read.

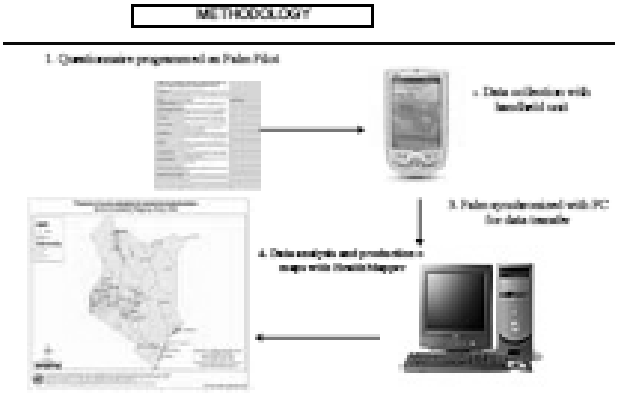



Figure B15. Portion of SAM methodology poster.

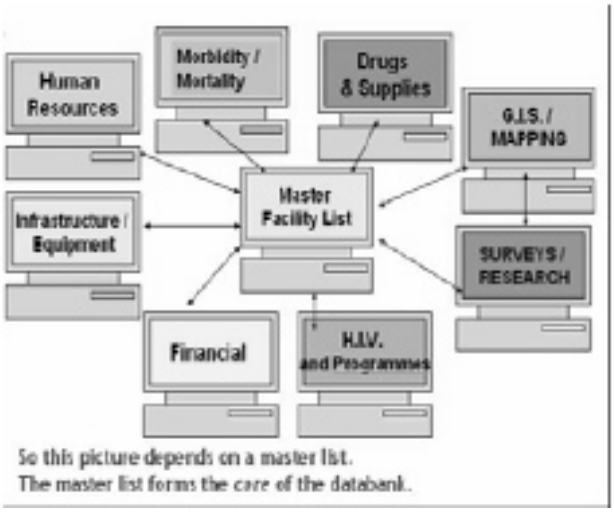
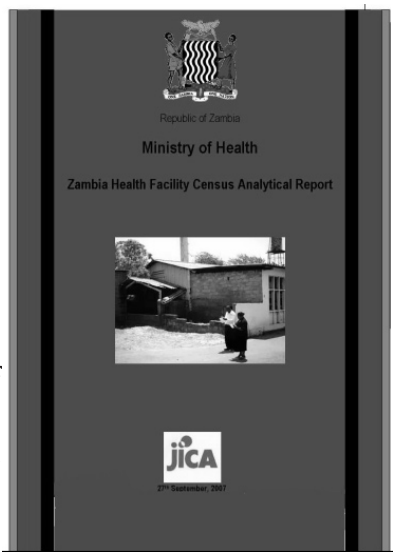



Figure B16. Graphic repesentations from SAM poster.

## Workshop Reports and Tools

Following are descriptions of other tools that were useful in the Entebbe workshop.

**Zambia Health Facility Census Analytical Report —** This report was prepared by the Zambia Ministry of Health and JICA (Figure B17 shows the report's cover). The objective of the HFC was to establish a database on the country's health facilities in terms of geographic location, medical equipment, infrastructure, services delivered, and human resources. Such knowledge would assist stakeholders in identifying facilities which do not meet national criteria for providing key health services.




Data were collected through a survey of all public health facilities in the country through physical assessment of infrastructure, inventory of medical equipment, interviews with health service providers, and the use of GPS equipment. The key information areas provided included: availability and condition of infrastructure, availability and condition of medical equipment, availability of health services, headcounts of health workers, and location of health service delivery points.

Figure B17. Cover of Zambia report.

The HFC method has also been used in Malawi. Based on HFC data, situation analysis reports and a health facility atlas were produced. The atlas shows the location of the health facility relative to population density and basic landmarks such as district boundaries, roads, and rivers. It is a useful tool for health planners to understand the relationship between population density and health facilities and identify the areas where new facilities or rehabilitation/upgrade of facilities is needed. Furthermore, in both countries, health planners used the HFC data to prioritize future investment in the health sector and developed capital investment plans to improve availability of health care services. To make the best use of scarce resources, health planners and policy-makers must have access to accurate and key health systems statistics. The HFC is an appropriate tool for providing this information.

**The Signature Domain —** This is a tool designed for identifying health facilities uniquely, described in a paper available at http://www.cpc.unc.edu/measure/publications/pdf/wp-07-91.pdf.

When analyzing multiple health facility surveys, it can be difficult to do cross survey comparisons of health facilities are not uniquely identified. The signature domain provides a set of elements that can permit health facilities to be identified across different surveys. Imagine that a national government conducts a country-wide health facility survey. Years later, another survey is conducted in the same country, this time by a donor agency. Comparing data from the two surveys could be difficult if individual facilities were not identified or if no geographic

identifiers were included in both data sets. The signature domain is part of the standardized indicators developed by IHFAN and is a tool that can make cross-survey comparisons easier. Collecting as many of the following elements of the Signature Domain as possible during the survey can provide enough data to identify a health facility uniquely:

- date of survey
- health facility country registry code
- health facility survey ID
- health facility name
- GPS coordinates
- administrative unit where facility is located
- health facility contact information (postal address, main telephone number, main fax number, main e-mail address, name of director, director's telephone number)

It may not be possible to collect every element of the signature domain, but the more elements that are collected, the greater the possibility of identifying the facility.

The advantages of the signature domain are multiple. Not only does this system provide a list of simple-to-collect elements that can be useful in health facility identification, it provides a standardized format for collecting the elements. When different health facility surveys collect the same elements, it becomes much more likely that data from different surveys can be compared.

**Assessing Integration Methodology —** The assessing Integration Methodology (AIM) was developed by the Population Council to respond to a growing interest in integration and linking of family planning services, either with other reproductive health services or with related family planning services. Descriptions provided in a poster developed by Ian Askew of the Population Council for the Entebbe workshop (entitled "Aiming for Integration? Assessing the Nature and Extent of Linkages between Reproductive Health Services") indicates that AIM provides information to guide decision-makers in determining the feasibility, quality, and effectiveness of particular service combinations. The approach elaborates a specific type of service delivery that hinges on the provision of services, e.g. HIV counseling, post-abortion care, etc. (see Figure B18) and enables reproductive health programs to determine the feasibility of effectiveness of efforts to link or integrate services. AIM data have been utilized to:

- diagnose whether it is feasible and acceptable for a program to provide integrated or linked services
- identify barriers to providing services jointly
- pilot-test innovative approaches to integrating services
- evaluate the effect of integration on quality of care received
- compare the cost-effectiveness of alternative models for integrating services

Countries where AIM has been conducted are presented in the map in Figure B19.

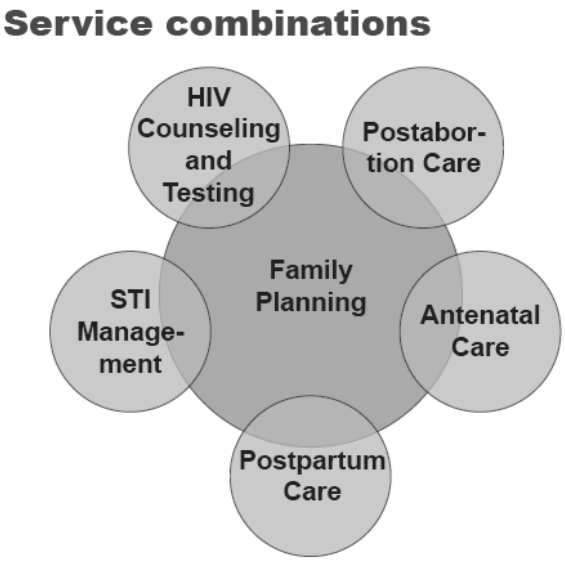



Figure B18. Overlapping services.

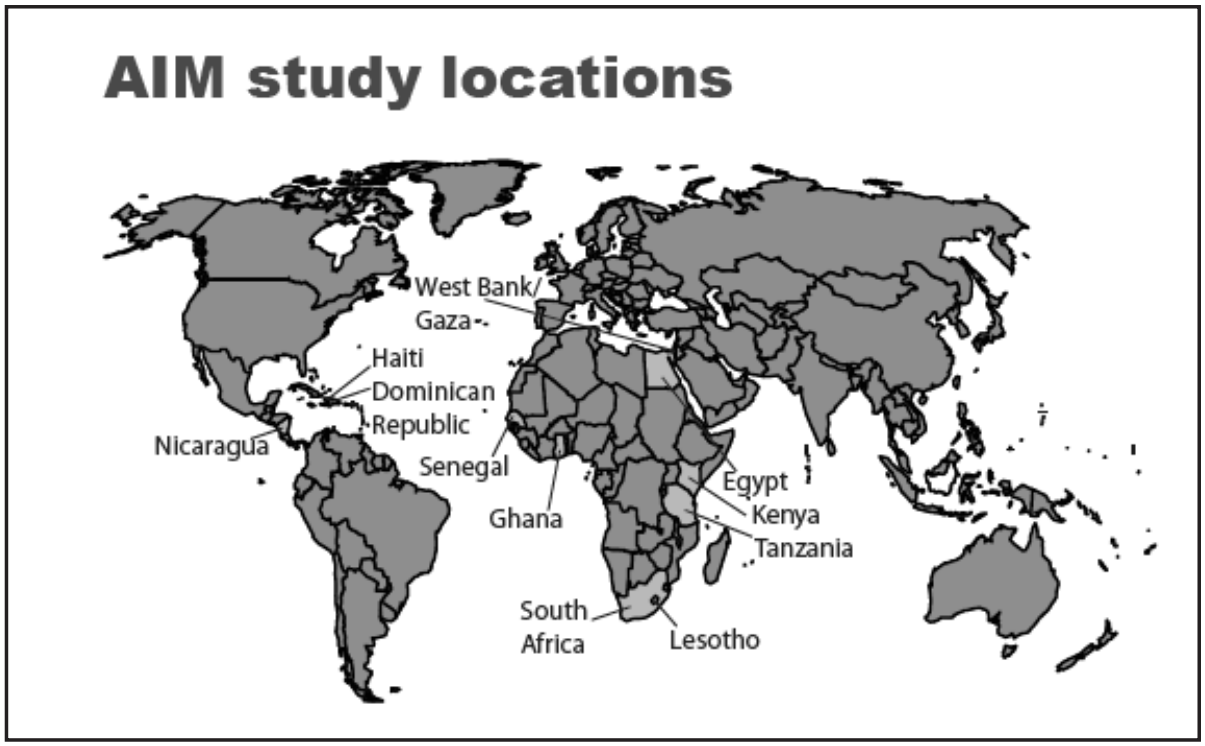



Figure B19. World map of where AIM has been used.

# Appendix C. Annotated Bibliography of HFA Resources and Papers

This bibliography provides rich materials that writers can draw on in completing materials for the various sessions discussed above. This listing is adapted from IHFAN's *Health Facility Assessment Relevant Resources/Supporting Documents and Mapping Resources Annotated Bibliography* available at MEASURE Evaluation's Web site at http://www.cpc.unc.edu/measure/publications/pdf/wp-08-107.pdf.

## Introduction

Health facility assessment (HFA) surveys provide valuable information for evidence-based policy-making as well as planning, monitoring, and evaluating programs. Such surveys include the Service Provision Assessment (SPA), Macro International; the Facility Audit of Service Quality (FASQ), MEASURE Evaluation; the Service Availability Mapping (SAM), World Health Organization (WHO); Human Resource for Health (HRH) survey, Abt Associates; and the Health Facility Census (HFC), Japan International Cooperation Agency (JICA).

Many HFA surveys have been conducted around the world, and various resources such as tools, reports, and, in some cases, microdata, are accessible by the public. Such resources, however, are not stored in one place but are scattered in various locations — some are on the Internet, others are kept by the implementing agency or country. In order to obtain those resources, countries, donors, and researchers who are interested in conducting an HFA survey or analysing the data need to conduct an intensive search for relevant resources and information.

This annotated bibliography is the first effort to compile relevant resources and supporting documents of HFA surveys for dissemination through print media. It cites over 80 relevant documents, including data collection instruments such as questionnaires and manuals, analytical reports, technical and survey reports, and articles that cited data from major HFA surveys. For most of these, abstracts are presented. The document also includes relevant resources on mapping HFA survey data using geographic information systems (GIS), ranging from databases and data repositories to Web sites that provide GIS application tools. Where available, each item contains details of its availability from the original source and other contact information that may enable readers to obtain original documents.

This annotated bibliography is a work-in-progress. New information will be added as we discover them and based on readers' inputs. We encourage our readers to provide us with additional resources to enhance the comprehensiveness and utility of the bibliography.

## Overall Health Facility Assessment

Authors: Fapohunda, B., Fronczak, N., and Hozumi, D.

Year: 2008

Title: Synopsis of Health Facility Assessments Methods (Microsoft PowerPoint presentation)

Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract: The presentation explains the difference between population-based assessment and facility-based assessment in terms of the key questions answered by the two types of assessment; introduces major HFAs (SPA, SAM, R-HFA, HFC-JICA, HRH-Abt) that have been already used around the world and other key tools of data collection; and addresses the methodological and cross-cutting implementation issues associated with HFA.Available from the International Health Facility Assessment Network (IHFAN) secretariat

(Tel: +1-703-528-7474 / Fax: + 1-703-528-7480, Email: bfapohunda@jsi.com)

Author: Fapohunda, B., and Hozumi, D.

Year: 2006

Title: Approaches to Health Facility Data Collection and Mapping. (Microsoft PowerPoint presentation)

Source: Chapel Hill, North Carolina: MEASURE Evaluation

Abstract: This presentation describes the role of health facility mapping in strengthening health service delivery and key approaches to HF mapping and addresses the advantages and disadvantages of specific approaches.

Available at http://www.ccih.org/conferences/presentations/2006/Data_Collection_Mapping_Fapohunda_CCIH2006.ppt

Author: Fapohunda, B., and Minichiello, S.N.

Year: 2008

Title: Overview: Introduction to Health Facility Assessments (Microsoft PowerPoint presentation)

Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract: The presentation covers the overview information on the HFA. The topics in the presentation include 1) types of data that are generated using HFA, 2) main sources of health facility information, 3) implementation issues, 4) HFA and the health system, 5) how HFA fits into a country's health information system, 6) benefits of using multiple sources of data, and 7) definition of HFA.

Available from the International Health Facility Assessment Network (IHFAN) secretariat (Tel: +1-703-528-7474 / Fax: + 1-703-528-7480, Email: bfapohunda@jsi.com).

Author: Fronczak, N., and Fapohunda, B.

Year: 2008

Title: Core Indicators of HF Readiness to Provide Services: What, Why, How (Microsoft PowerPoint presentation)

Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract: In response to users' requests for a set or core indicators for cross country comparisons of HFA, the IHFAN drafted a set of minimum core indicators that can be collected with any HFA approach. This presentation introduces the definitions of these indicators and examples of analysis based on data.

Available from the International Health Facility Assessment Network (IHFAN) secretariat (Tel: +1-703-528-7474 / Fax: + 1-703-528-7480, Email: bfapohunda@jsi.com)

Author: Fronczak, N., Fapohunda, B., Buckner, B., and Shenck-Yglesias, C.

Year: 2007

Title: Using Health Facility Profiles as a Monitoring Tool: An Example Based on Data from Three African Countries

Source: Chapel Hill, North Carolina, USA: MEASURE Evaluation. (MEASURE Evaluation Working Paper Series, wp-07-101)

Abstract: Substantial investments have been and continue to be made to improve health services in countries with weak health systems. However, useful information on the status of services and the overall health systems within which they operate is rarely available. Sound decisions about where to invest resources to improve health services require knowledge of the existing health infrastructure, the services currently offered, the systems needed to support the services, and the availability of equipment and consumable supplies. As a first step towards improving access to this information, the IHFAN has compiled a recommended set of core indicators that measure the presence or absence of minimal, basic standards for facility-based health based services. In this paper, Service Provision Assessment data from three countries (Ghana, Kenya, and Tanzania) were used to calculate the core indicators and to develop a profile of the health facilities in these countries.

Authors found that facilities in Ghana were the least likely to have an emergency communication system (33%) and facilities in Tanzania were the least likely to have an emergency transportation system (10 %). The proposition of all facilities with overnight or impatient beds ranged from 80% in Ghana to 42 % in Kenya. Low availability of sterilization equipment in facilities below hospital level was revealed across the three countries. The proportion with functioning sterilization equipment was highest across all facilities in Kenya (30%), while in Ghana and Tanzania, less than one in five facilities had functioning sterilization equipment. Regarding

the availability of varieties of services, 38 percent of hospitals offered all maternal and child health services and reproductive health services in Tanzania, while only 2 percent in Ghana and 7 percent in Kenya. The results of the analysis show substantial room for improvement of infrastructure, equipment and supplies for providing minimum quality of client services.

Available at http://www.cpc.unc.edu/measure/publications/pdf/wp-07-101.pdf.

Author: Gupta, N., and Dal Poz, M.R.

Year: 2008

Title: Monitoring Health Workforce Skills Mix and Productivity to Support Decision Making for Health Policy and Planning: Insights from Survey Data in Six Low- and Middle-Income Countries (Powerpoint presentation)

Source: Berkeley, California, USABerkeley Conference on the Global Health Workforce

Abstract: The conference highlights recent research advances that address the lack of evidence in shaping health workforce public and health care industry policy, both within countries and across regions. This Powerpoint presents the results of the assessment of human resource for health in 6 lower and lower-middle income countries across 3 regions. The authors discuss the strength and weakness of using the standardized survey instruments for HRH and share lessons learned from their experiences.

Available at

http://www.gchepr.org/events/2008_gchepr_conf/media/PPT/Panel3_Neeru_Gupta.ppt

Author: Health Facility Assessment Technical Working Group

Year: 2007

Title: Guidance for Selecting and Using Core Indicators for Cross-Country Comparisons of Health Facility Readiness to Provide Services

Source: Chapel Hill, North Carolina, USA: MEASURE Evaluation. (MEASURE Evaluation Working Paper Series, wp-07-97-en)

Abstract: Health information systems depend on health facility surveys for data. International and program-based approaches using health facility data include the Service Provision Assessment (SPA), Macro International; the Facility Audit of Service Quality (FASQ), MEASURE Evaluation; the Service Availability Mapping (SAM) census, World Health Organization; and the Health Facility Censuses (HFC) with a focus on infrastructure, Japan International Cooperation Agency. Several rounds of data from these sources are available for selected countries. A key gap in facility-based information is that definitions of indicators and

data elements differ from approach to approach. The recommended core indicators in this document were selected based on existing tools and data. The indicators assess health systems' functionality rather than the health status of the targeted population.

Author: Health Facility Assessment Technical Working Group

Year: 2007

Title: The Signature Domain and Geographic Coordinates: A Standardized Approach for Uniquely Identifying a Health Facility

Source: Chapel Hill, North Carolina, USA: MEASURE Evaluation. (wp-07-91)

Abstract: With any facility survey, the ability to identify a facility uniquely is vital to being able to use and analyse the data properly. This is especially true when making comparisons across surveys or years. This document proposes the creation of a "signature domain" to ensure each facility can be uniquely identified. The elements in the signature domain include: date of the survey, health facility country registry code, health facility survey identification, health facility name, health facility contact information, facility's geographic administrative unit, and Global Positioning System (GPS) coordinates. The document provides an overview of the elements of the signature domain so that those elements can be included in health facility survey instruments. It also provides a standardised approach for GPS coordinates data collection.

Available at http://www.cpc.unc.edu/measure/publications/pdf/wp-07-91.pdf.

Author: Health Metrics Network (HMN)/World Health Organization (WHO)

Year: 2008

Title: Framework and Standards for Country Health Information Systems (second edition)

Source: Geneva, Switzerland: World Health Organization

Abstract: The framework serves two broad purposes. At a country level, it can focus investment and technical assistance for health information system (HIS) development in a standardized way. It thus serves as a basis for baseline HIS assessment. As part of this, a roadmap is described for strengthening health information systems, and putting in place ongoing monitoring and evaluation. Second, the framework permits access to – and better use of – improved health information at the country and global levels. The framework is not intended to replace existing guidelines that provide detailed information on health information system elements. Instead, it seeks to identify appropriate and existing standards and to promote them. This dynamic approach is expected to evolve over time as it incorporates new developments, country experiences, and partner inputs. This second edition has been informed by a wealth of input on different aspects of health information systems obtained through consultative meetings and

country visits. Its adaptation is intended to be iterative as HMN progresses and country health information systems mature. It is intended that the HMN framework will be instrumental in forging consensus around the vision, standards, and processes required of a health information system.

Available at http://www.who.int/healthmetrics/documents/hmn_framework200803.pdf.

Author: Heard, N., and Spencer, J.

Year: 2008

Title: Signature Domain and Geographic Coordinates: Uniquely Identifying a Facility (Microsoft PowerPoint presentation)

Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract:. A standardized approach for uniquely identifying health facilities includes geographic coordinates (obtained using GPS receivers), facility name, date of survey, health facility country registry code, health survey ID, and health facility contact information. This presentation demonstrates the rationale for and use of signature domain and how the approach fits within HFA.Available from the International Health Facility Assessment Network (IHFAN) secretariat (Tel: +1-703-528-7474 / Fax: + 1-703-528-7480, Email: bfapohunda@jsi.com)

Author: Hozumi, D., Fronczak, N., Minichiello, N.S., Buckner, B., and Fapohunda, B.

Year: 2006

Title: Profiles of Health Facility Assessment Methods (TR-06-36)

Source: Chapel Hill, North Carolina, USA: MEASURE Evaluation.

Abstract: This document profiles four instruments used for health facility assessment, and specifies their management utility. The instruments included in this document are Service Provision Assessment, Facility Audit of Service Quality, Health Facility Census, and Service Availability Mapping.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-06-36.pdf.

Author: International Health Facility Assessment Network.

Year: 2008

Title: Flowchart of Steps of Conduct a Health Facility Assessment (MS-08-28)

Source: Chapel Hill, North Carolina, USA: MEASURE Evaluation.

Abstract: The flow chart is a step-by-step guide, in visual form, of key stages in the preparation and conduct of a health facility assessment (HFA). It has two parts, the first being a short presentation of the actual stages, the people involved in them, any documentation available for more details, and any special considerations. The second part is a narrative description of issues related to each stage, and information to help the reader understand how each stage is connected to the preceding and subsequent stages.

Available at www.cpc.unc.edu/measure/publications/pdf/ms-08-28.pdf.

Author: KizitoYear: 2008

Title: Further Analysis of 2004 Kenya Service Provision Assessment (Microsoft PowerPoint presentation)

Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract: In Kenya, the secondary analysis was conducted using the data from the Kenya Service Provision Assessment (KSPA). The purposes of the analysis were to increase use of KSPA findings to inform policy and programs, to increase skills of Kenyan researchers for using the KSPA dataset, to try to explain current trends in fertility and mortality, and to involve stakeholders in the analysis and use of information. This presentation shows examples of the analysis of data generated by the SPA.

Available from the International Health Facility Assessment Network (IHFAN) secretariat (Tel: +1-703-528-7474 / Fax: + 1-703-528-7480, Email: bfapohunda@jsi.com).

Author: Likwasi, P., Simushi, V., and Chitembure, R.

Year: 2008

Title: Zambia Health Facility Census Presentation (Microsoft PowerPoint presentation)

Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract: This presentation introduces the data collected, methodology, scope and limitation of data, and how to use the data in a real context. Examples of data analysis including the maps generated from the HFC data are also shown in the presentation.

Available from the International Health Facility Assessment Network (IHFAN) secretariat (Tel: +1-703-528-7474 / Fax: + 1-703-528-7480, Email: bfapohunda@jsi.com).

Author: Lindelöw, M., and Wagstaff, A.

Year: 2003

Title: Health Facility Surveys: An Introduction (Policy Research Working Paper 2953)

Source: Washington, USA: World Bank

Abstract: Health facility surveys come in various dimensions. One dimension in which they vary is motivation. Some seek to understand better provider behavior and performance. Still others seek to understand the interrelationships among providers, while yet others seek to shed light on the linkages between government and providers. Health facility surveys also differ in the data they collect, in part due to the different motivations. Surveys also vary in the way they collect data — some relying on direct observation, some on record review, and some on interview. Some quality data are collected from clinical vignettes. Facility data have been put to a variety of uses, including planning and budgeting; monitoring, evaluation, and promoting accountability; and research. Lindelöw and Wag review some of the literature under each heading and offer some conclusions regarding the current state of health facility surveys.

Available at http://econ.worldbank.org.

Author: Lindelow, M., and Wagstaff, A.

Year: 2008

Title: Assessment of health facility performance: an introduction to data and measurement issues.

Source: In Amin S, Das J, Goldstein M. (Eds.) Are you being served? New tools for measuring service delivery (pp. 19-66). Washington, DC, USA: The World Bank

Abstract: This booklet provides an overview of a range of tools for measuring public service delivery (in health and education) and offers lessons on the opportunities and constraints practitioners face in measuring performance. The authors investigate country cases using data from a range of sources in a variety of contexts. Their experiences yield important insights on how to avoid pitfalls, what practices to improve, and how to learn the most from the data at hand. Taken together, those lessons represent an important step in strengthening accountability and governance so as to enhance service delivery. Empirical investigations of the relationship between particular characteristics of the public provisioning of goods and services at the local level and the characteristics of the localities receiving these goods and services may help us understand the impact of policy and learn to design more effective public interventions. Monitoring data are an integral part of the process of learning about the performance of any social program. Many impact evaluations of social programs assume that the interventions occur at specified launch dates and produce equal and constant changes in conditions among eligible beneficiary groups.

Part One of the booklet provides an overview on the assessment of public service delivery in health and education. The second chapter in Part One, Assessment of health facility performance: an introduction to data and measurement issues, discusses the assessment of health facility. In the first section, the authors examine the motivation for various health facility surveys. Such motivation, according to the authors, include the desire 1) to understand the link among providers and household health seeking behavior, and health outcomes among household, 2) to measure and understand the provider performance, 3) to analyze cost, quality, and efficiency, 4) to have insights on service providers, and 5) to examine linkages among service providers. In the second section, the authors provide details on the types of data that have been collected in the surveys and discuss some measurement issues. The following section outlines the uses of facility data for monitoring and evaluation and research purposes. In conclusion, the authors discuss the lessons learned from past experiences with health facility surveys and emerging themes for the future. This chapter also includes an annex that summarizes key information about selected health facility survey programs.

Part Two introduces the examples of the use of administrative data and discusses how to use the administrative data to measure public services and issues in interpreting them. Part Three discusses the challenges of using data from Public Expenditure Tracking Surveys based on experiences of Mozambique, Chad, and Papua New Guinea. Part Four introduces cases of various facility surveys including research in the post-disaster environment, school survey in Ukraine, qualitative research on health workers in Ethiopia and Rwanda, and the research using vignettes to measure quality of health care. Part Five presents lessons from combined household and facility surveys such as client satisfaction and perceived quality of care in Uganda, Indonesia Family Life Survey (IFLS), and Living Standards Measurement Study (LSMS).

Available at < http://go.worldbank.org/F6KIIC0700 >

Author: Murray, C.J.L., and Evans, D.B. (Eds.)

Year: 2003

Title: Health Systems Performance Assessment — Debates, Methods, and Empiricism

Source: Geneva, Switzerland: World Health Organization

Abstract: This book is intended to strengthen the foundations for evidence-based policies aimed at health systems development. This has included work to develop a common conceptual framework for health systems performance assessment, to encourage the development of tools to measure its components, and to collaborate with countries in applying these tools to measure and then to improve health systems performance. It began with the enunciation of a framework that specified a parsimonious set of key goals to which health systems contribute, and the first set of figures on goal attainment and health system efficiency in countries that were Members of the Organization was published in The World Health Report 2000.

This book provides a uniquely comprehensive exploration of many different facets of health

systems performance assessment. It is relevant for researchers, students, and decision-makers seeking a more detailed understanding of concepts, methods, and the latest empirical findings. While most authors in this volume take a global perspective, the findings have important implications for the development of national performance frameworks and the creation of a culture of accountability.

Available at http://www.who.int/publications/2003/hspa/en/.

Author: Ricca, J., and Valadez, J.

Year: 2008

Title: Rapid Health Facility Assessment (R-HFA): Collecting and Using Data for Improvement of Access to and Quality of Primary Health Care Services(Microsoft PowerPoint presentation) Source: Entebbe, Uganda: East African Community/IHFAN Regional Workshop on Pillars of HFA and Information Use

Abstract: The presentation describes basic analysis and reporting of R-HFA information in conjunction with the core indicators and the use of R-HFA information for making decisions for improvement of access and quality of primary health care services at district level.

Author: Turner, A.G., Angeles, G., Tsui, A.O., Wilkinson, M., and Magnani, R.

Year: 2001

Title: Sampling Manual for Facility Surveys for Population, Maternal Health, Child Health and STD Programs in Developing Countries

Source: Chapel Hill, North Carolina, USA: MEASURE Evaluation (MS-01-03)

Abstract: The manual presents a sampling methodology that can generate estimates of health facilities and their characteristics, and, when desired, tie the characteristics of the sampled facilities to those of the serviced population in a meaningful way. Two sampling designs are proposed and recommended in this manual. The first is for a stand-alone health facility survey, and the second is for a health facility survey linked to a household survey. The design for the latter requires adopting the same sample areas used to generate household data collected in surveys such as Demographic and Health Surveys or the Reproductive Health Surveys. Both recommended sampling designs provide unbiased estimates of facilities and their characteristics; the linked sampling design, however, provides additional information on the health service environment for resident populations in the household survey sample areas.

Available at http://www.cpc.unc.edu/measure/publications/pdf/ms-01-03.pdf.

Author: World Health Organization (WHO)

Year: 2000

Title: The World Health Report, 2000 — Health Systems: Improving Performance

Source: Geneva, Switzerland: World Health Organization

Abstract: This report examines and compares aspects of health systems around the world. It provides conceptual insights into the complex factors that explain how health systems perform, and offers practical advice on how to assess performance and achieve improvements with available resources.

It uses five indicators: overall level of population health; health inequalities (or disparities) within the population; overall level of health system responsiveness (a combination of patient satisfaction and how well the system acts); distribution of responsiveness within the population (how well people of varying economic status find that they are served by the health system); and the distribution of the health system financial burden within the population (who pays the costs). For each one, WHO has used existing sources or newly generated data to calculate measures of attainment for the countries where information could be obtained.

Available at http://www.who.int/whr/2000/en/whr00_en.pdf.

Author: World Health Organization (WHO)

Year: 2007

Title: Everybody's Business. Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action

Source: Geneva, Switzerland: World Health Organization

Abstract: The primary aim of this framework is to clarify and strengthen WHO's role in health systems in a changing world. There is continuity in the values that underpin it from its constitution, the Alma Ata Declaration of Health For All, and the principles of Primary Health Care. Consultations over the last year have emphasized the importance of WHO's institutional role in relationship to health systems. The General Programme of Work (2006-2015) and Medium-term Strategic Plan (2008-2013) focus on what needs to be done. While reaffirming the technical agenda, this framework concentrates more on how the WHO secretariat can provide more effective support to Member States and partners in this domain.

Available at http://www.searo.who.int/LinkFiles/Health_Systems_EverybodyBusinessHSS.pdf.

Author: World Health Organization

Year: 2008

Title: Assessment of human resources for heath: survey instruments and guide for administration

Source: Geneva, Switzerland: Evidence and Information for Policy, Department of Health Service Provision, World Health Organization

Abstract: This survey instrument was developed by WHO for collecting quantitative and qualitative information for assessing the human resources for health situation in a country. It is intended to be used for data collection at the national and institutional levels, as well as from individual health care providers. Four questionnaires are included in the tool, focusing on the following areas: regulation of health occupations, training institutions, health care facilities and health care providers. The tool was field-tested in 2002-2004 in six countries: Chad, Côte d'Ivoire, Jamaica, Mozambique, Sri Lanka and Zimbabwe.

Available at http://www.who.int/hrh/tools/hrh_assessment_guide.pdf

## Service Provision Assessment (SPA)

Author: Barden-O'Fallon, J., Angeles, G., and Tsui, A.

Year: 2006

Title: Imbalances in the health labor force: an assessment using data from three national health facility surveys

Source: Health Policy and Planning, 21(2):80-90

Abstract: This study used health facility survey data to examine characteristics of the primary health care labor force in Nicaragua, Tanzania, and Bangladesh. The characteristics examined are those that are likely to affect service provision, including urban/rural distribution, demographic characteristics, and experience and in-service training, for three types of providers (physicians, nurses, and auxiliary nurses). The Nicaragua data come from the 2001 Encuesta de Establecimientos de Salud, carried out by the Nicaraguan Ministry of Health in conjunction with the MEASURE Evaluation project. The Tanzania data came from the 1999 Tanzania Reproductive and Child Health Facility Survey, conducted by the Tanzanian National Bureau of Statistics and MEASURE Evaluation. The Bangladesh data came from the 1999-2000 Bangladesh Service Provision Assessment Survey, conducted by the National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, as part of the 1999-2000 Bangladesh Demographic and Health Survey.

Available on-line at http://heapol.oxfordjournals.org/cgi/content/full/21/2/80.

Author: Egypt Ministry of Health and Population; El-Zanaty Associates Cairo, Egypt; and ORC Macro

Year: 2003

Title: Egypt Service Provision Assessment Survey 2002

Source: Calverton, MD, USA: Ministry of Health and Population, El-Zanaty Associates, and ORC Macro

Abstract: The Egypt Service Provision Assessment (ESPA) was conducted in 2002. Through a representative sample of nongovernmental and public facilities, information was collected to provide a picture of the strengths and weaknesses of the service delivery environment for each assessed service. The primary objectives of ESPA were to describe the preparedness of government and nongovernment health facilities in Egypt to provide quality child, maternal, and reproductive health services; describe the preparedness of government and nongovernment health facilities in Egypt to provide quality services for specific infectious diseases (STIs, HIV/AIDS, and tuberculosis); identify gaps in the support services, resources, or the processes used in providing client services that may impact the ability of facilities to provide quality services; describe the processes used in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed; provide comparisons on findings between regions in Egypt and, at a national level, between different types of facilities, as well as those operated by different authorities (i.e. governmental or nongovernmental); and to describe the extent to which clients understand what they must do to follow up on the service received so that the best health outcome is achieved.

Available at http://www.measuredhs.com/pubs/pdf/SPA5/00FrontMatter.pdf.

Author: Egypt Ministry of Health and Population; El-Zanaty Associates Cairo, Egypt; and ORC Macro

Year: 2005

Title: Egypt: MCH SPA, 2004 – Final Report

Source: Calverton, MD, USA: Ministry of Health and Population, and ORC Macro

Abstract: The 2004 Egypt Service Provision Assessment (ESPA 2004) was conducted in a representative sample of 659 health facilities throughout Egypt. At the request of the U.S. Agency for International Development (USAID) and the Ministry of Health and Population (MOHP), seven governorates (Cairo, Alexandria, Fayoum, Beni Suef, Menya, Qena, and Aswan) that are part of a USAID-supported pilot project were over-sampled to provide key indicators for these areas. The survey covered general, district, and integrated hospitals (referred to in the report as "general service hospitals"), fever hospitals, maternal and child health/urban health units (MCH/urban HUs), rural health units (rural HUs), mobile units,

health offices, and nongovernmental organization (NGO) facilities. The ESPA 2004 used interviews with health service providers and clients, as well as observations of provider-client consultations, to obtain information on the capacity of facilities to provide quality services and the existence of functioning systems to support quality services. The areas addressed were the overall facility infrastructure and resources; specific child health, family planning, and maternal health services; and services for specific infectious illnesses — reproductive tract and sexually transmitted infections (RTI/STIs) and tuberculosis. The objective was to assess the strengths and weaknesses of the infrastructure and systems supporting these services, as well as to assess the adherence to standards in the delivery of curative care for children, family planning, antenatal care (ANC), and consultations for RTI/STIs.

Available at http://www.measuredhs.com/pubs/pdf/SPA7/00FrontMatter00.pdf.

Author: Ghana Statistical Service, Health Research Unit, Ministry of Health, and ORC Macro

Year: 2003

Title: Ghana Service Provision Assessment Survey 2002

Source: Calverton, MD, USA: Ghana Statistical Service and ORC Macro

Abstract: This is a country report of the MCH SPA conducted in Ghana in 2002. From a representative sample of public and nongovernment facilities, information was collected to provide a picture of the strengths and weaknesses of the service delivery environment for each assessed service. The objectives of the 2002 Ghana SPA (GSPA) survey were to describe the preparedness of government and nongovernment health facilities to provide quality child and reproductive health services; to describe the preparedness of government and nongovernment health facilities to provide quality services for sexually transmitted infections (STIs), including HIV/AIDS; to identify gaps in the support services, resources, or the processes used in providing client services that may affect the ability of facilities to provide quality services; to describe the processes used in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed to provide comparisons on findings between regions and, at a national level, between different types of facilities as well as those operated by different authorities; and to describe the extent to which clients understand what they must do to follow up on the service received so that the best health outcome is achieved.

Available at http://www.measuredhs.com/pubs/pdf/SPA6/00FrontMatter.pdf.

Author: Girosi, F., Olmsted, S.S., Keeler, E., Hay Burgess, D.C, Lim, YW., Aledort, J.E., Rafael, M.E., Ricci, KA., Boer R, Hilborne, L., Derose, K.P., Shea, M.V., Beighley, C.M., Dahl, CA., and Wasserman, J.

Year: 2006

Title: Developing and interpreting models to improve diagnostics in developing countries

Source: Nature, 444:3-8

Abstract: The introduction of new diagnostic tools can help to reduce the large burden of disease in the developing world. New tests that can accurately discriminate between patients who do and do not need treatment will reduce mortality, morbidity, and the waste of scarce resources. Although high-performance tests are desirable, those that are more accurate usually require greater levels of infrastructure and are therefore accessible to fewer people. In this article, the authors outline an approach for estimating the health benefits of new diagnostic tools, and examining the trade-offs between accuracy and infrastructure requirements. The questionnaire used in this study was partially based on the Service Provision Assessment (SPA) surveys performed by ORC Macro, as part of the MEASURE DHS project. The questionnaire also draws on the draft WHO Service Availability Mapping (SAM) reports. The authors also cite the SPA and SAM reports as references. The results of the analysis indicated that a large portion of the population in each of the regions modeled has access to some form of health-care setting. However, in some cases, the capabilities of these settings are limited in terms of both infrastructure and level of staff training. The authors suggested that a method for improving health outcomes that could be approached in parallel to improving diagnostic tests would be enhancing the infrastructure and staffing available at these health-care settings

Available on line http://www.bvsde.paho.org/bvsacd/cd59/developing.pdf.

Author: Guyana Ministry of Health, Guyana Responsible Parenthood Association, and ORC Macro

Year: 2005

Title: Guyana: HIV SPA, 2004 — Final Report

Source: Calverton, MD, USA: Guyana Ministry of Health, Guyana Responsible Parenthood Association, and ORC Macro

Abstract: Guyana is located in the northwestern shoulder of South America and has a population of 751,223, according to the 2002 Guyana Population and Housing Census. The country covers about 215,000 square kilometers and is divided into 10 administrative regions. Regions along the coastal line are densely populated and include Guyana's major cities. Guyana is one of the poorest countries in the Caribbean and in the world, ranking 104 in the 2004 Human Development Index Report. According to the 1999 Guyana Survey of Living Conditions, 36 percent of the population was living in absolute poverty (below U.S. $1.40 per day), 78 percent of whom were living in rural interior areas. Guyana is the only English-speaking country on the mainland of South America. The 2002 Population and Housing Census shows that from 1980 to 1990, the negative growth rate of the Guyanese population was reversed, but emigration

remains a significant factor in the Guyana demographic profile. Guyana is still in an expansive phase of demographic transition, but there are signs of an aging population. There has been a decline in the proportion of the population age 0-4 and 5-9 years (indicating fertility decline, and/or migration of young children or high child mortality), and the population 65 years of age and over has risen from 3.9 percent in 1980 to 4.3 percent in 2002. Approximately 36 percent of the population is under age 15 and about 7 percent is over 60. The estimated rate of population growth for 2004 was 0.61 percent and the total fertility rate was estimated at 2.1 percent.

Available at http://www.measuredhs.com/pubs/pdf/SPA10/SPA10.pdf.

Author: Hong, R., Montana, L., and Mishra, V.

Year: 2006

Title: Family planning services quality as a determinant of use of IUD in Egypt

Source: BMC Health Services Research 6(79)

Abstract: The authors used data from the 2003 Egypt Interim Demographic and Health Survey (EIDHS) and the 2002 Egypt Service Provision Assessment (ESPA) survey to examine the relationship between quality of family planning services and use of intrauterine devices (IUD) in Egypt. The study linked the geographic information to data from a population-based survey with an independently sampled health facility survey. Using geographic information system (GIS) methods, individual women were linked to a facility located within 10 km of their community. A facility-level index was constructed to reflect the quality of family planning services. Four dimensions of quality of care were examined — counseling, examination room, supply of contraceptive methods, and management. The study found that IUD use among women who obtained their method from public sources was significantly positively associated with quality of family planning services (RRR = 1.36, $p < 0.01$), independent of distance to the facility, facility type, age, number of living children, education level, household wealth status, and residence. Quality of services related to counseling and examination room had strong positive effects on use of IUD (RRR = 1.61 for counseling and RRR = 1.46 for examination room). Obtaining IUD from a private source or using other contraceptive methods was not associated with quality of services. The authors concluded that service quality is an important determinant of use of clinical contraceptive methods in Egypt and suggested that improving quality of family planning services may help further increase use of clinical contraceptive methods and reduce fertility.

Available on-line at http://www.biomedcentral.com/content/pdf/1472-6963-6-79.pdf.

Author: Kenya Ministry of Health, Kenya National Council for Population and Development, and ORC Macro

Year: 2000

Title: Kenya Service Provision Assessment Survey 1999

Source: Calverton, MD, USA: Ministry of Health, National Council for Population and Development, and ORC Macro

Abstract: The 1999 Kenya Service Provision Assessment Survey (KSPA) was conducted in a representative sample of 388 health facilities throughout the country. The survey covered all levels of facilities from dispensaries to hospitals and included both governmental and private facilities. The KSPA used interviews with health workers and clients as well as observations of provider-client consultations to obtain information on the functioning and quality of the services provided at these facilities in four key areas: family planning, sexually transmitted diseases and HIV/AIDS, child health, and maternity care. The objective was to assess the strengths and weaknesses of the delivery of these health services and to provide recommendations as to how to improve the provision of services in the future.

Available at http://www.measuredhs.com/pubs/pdf/SPA1/00FrontMatter.pdf.

Author: Kenya National Coordinating Agency for Population and Development, Kenya Ministry of Health, Kenya Central Bureau of Statistics, and ORC Macro

Year: 2005

Title: Kenya: HIV/MCH SPA, 2004 — Final Report

Source: Nairobi, Kenya: National Coordinating Agency for Population and Development, Ministry of Health, Central Bureau of Statistics, and ORC Macro

Abstract: The Kenya Service Provision Assessment of 2004 (KSPA 2004) survey is a follow-up of the Service Provision Assessment conducted in Kenya in 1999. The KSPA provides the government with information necessary to monitor trends in facility performance. This information can be used to assess strengths and weaknesses of current strategies to improve maternal, child, and reproductive health, as well as services for sexually transmitted infections (STIs) and HIV/AIDS. The survey was designed to extract information about the general performance of facilities that offer maternal, child, and reproductive health services, as well as services for specific infectious diseases (STIs, HIV/AIDS, and tuberculosis). The KSPA 2004 survey instruments are based on the KSPA 1999 instruments, but were designed to collect more comprehensive information. In addition, the KSPA 2004 added a complete module on HIV/AIDS. In effect, the KSPA 2004 is a combination of the maternal and child health (MCH) SPA, which has been conducted in several countries, and the more specialised HIV/AIDS SPA. Information to provide a picture of the strengths and weaknesses of the service

delivery environment for each assessed service was collected from a representative sample of facilities managed by the public sector, the private sector, faith-based organisations (FBOs) and nongovernmental organizations (NGOs) from all eight provinces of the country. The KSPA 2004 provides national- and provincial-level representative information for all types of facilities. Findings can supplement household-based health information from the Kenya Demographic and Health Survey (KDHS) conducted in 2003, which provides information on health, fertility, nuptiality and utilisation of services by the overall population.

Available at http://www.measuredhs.com/pubs/pdf/SPA8/00FrontMatter.pdf.

Author: Kombe, G., Steffen, M., Holdaway, A., Srinath, K.P., Butera, D., Diarra, S., Kadjo, D., Landry, M., Seka, F., Kraffa, B., Laurence, E.A., Tuho, M.Z., Soumahoro, O., and Boka, A.

Year: 2008

Title: Cote d'Ivoire: Service Provision Assessment 2008

Source: Bethesda, MD, USA: Health Systems 20/20 project, and Abt Associates Inc.

Abstract: The purpose of the SPA in Côte d'Ivoire was to assess HIV/AIDS-related service provision capacity in the public and private health sectors. A total of 300 randomly selected public and private health facilities throughout the country were surveyed to assess the current levels of HIV/AIDS service provision. HIV/AIDS services examined include ART, CT, PMTCT, TB, PEP, and care and support services (CSS) at all levels of the health care system. In addition, the survey examined the availability of equipment, drugs and supplies, national protocols, record keeping, and waste disposal methods. Based on the findings of the SPA, the report proposes several recommendations for strengthening HIV/AIDS service provision in both the public and private sectors.

Available at http://www.healthsystems2020.org.

Author: MEASURE Evaluation

Year: 2002

Title: Training Manual for Conducting the Service Provision Assessment (MS-02-09)

Source: Chapel Hill, NC, USA: MEASURE Evaluation

Abstract: This training manual is designed for the data collectors of SPA. The document includes the overall data collection procedures, planning the SPA fieldwork, organization of activities during facility visit, and tips for conducting interview and observations. It also includes explanation on how to read the questionnaires, how to correct mistakes and how to ensure quality of data.

Available at http://www.cpc.unc.edu/measure/publications/pdf/ms-02-09-tool06-training_manual.pdf.

Author: MEASURE DHS

Year: 2005

Title: Overview of the service provision survey

Source: Calverton, MD, USA: ORC Macro

Abstract: This is a two-page summary brochure of SPA. It explains the scope, coverage, indicators of SPA and provides example of Ghana SPA.

Available at http://www.measuredhs.com/pdfs/SPA%20brochure%203-21-updated.pdf.

Author: MEASURE DHS

Year: 2008

Title: SPA Tools (Audits: SPA Q1, Observation Protocol and Exit Interview Questionnaire: SPAQ2, Health Worker/Provider Interview:SPAQ3)

Source: Calverton, MD, USA: ORC Macro

Abstract: The Service Provision Assessment (SPA) is a national health facility survey designed to collect information on the functioning of maternal, child and reproductive health (family planning and STD/HIV) services. The survey provides information on the availability and quality of health services and identifies gaps in services provision. Survey instruments are designed in modular format so that services may be assessed individually if required. SPA consists of four principal data collection instruments — a facility inventory, a provider interview, a client observation, and a client exit interview. All the instruments are designed to assess whether facilities meet internationally accepted standards and indicators. The facility inventory and provider interview collect information on the facility infrastructure; the availability of equipment, supplies, medicines, staff, protocols, client teaching materials and health information records; staff training and supervision. They also collect information about the availability and functioning of facility support system services including management committees, quality assurance programs, pharmacy logistics, equipment maintenance, infection control practices, and various monitoring systems. The observation and client exit interview tools are to assess whether the services are delivered to internationally recognized and local standards.

Available at http://www.measuredhs.com/pubs/search/search_results.cfm?Type=37&srchTp=type&newSrch=1

Author: Rwanda Ministry of Health, Rwanda National Population Office, and ORC Macro

Year: 2003

Title: Rwanda Service Provision Assessment Survey 2001

Source: Calverton, MD, USA: Ministry of Health, National Population Office, and ORC Macro

Abstract: The 2001 Rwanda Service Provision Assessment (RSPA) was conducted in a representative sample of 223 health facilities throughout Rwanda. The survey covered hospitals and health centers, and included both governmental (public) and nongovernmental health facilities that receive government support. The RSPA used interviews with health service providers and clients and observations of provider client consultations to obtain information on the capacity of facilities to provide quality services, and the existence of functioning systems to support quality services. It was undertaken to provide a picture of how the health facilities function and of the quality of the reproductive and child health services available. Service areas assessed were child health, family planning, maternal health, and services for sexually transmitted infections (STIs), including HIV/AIDS. The goal of the RSPA was to describe facility-based health services and to recommend improvements to service delivery.

Available at http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=212&ctry_id=35&SrvyTp=type

Author: Saha, T.

Year: 2002

Title: Bangladesh Service Provision Assessment Survey 1999-2000

Source: Calverton, MD, USA: National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ORC Macro

Abstract: This is a country report of the MCH SPA conducted in Bangladesh in 1998. Survey collected information on the provision of reproductive and child health services in Bangladesh. The Bangladesh Service Provision Assessment (BSPA) was carried out in conjunction with the 1999-2000 Bangladesh Demographic and Health Survey (BDHS), covering 341 clusters. The main objective of the BSPA was to assess the strengths and weaknesses of reproductive and child health service provision including 1) family planning and contraceptive options, 2) maternity and delivery care, and 3) treatment of childhood disease. The BSPA reveals that health services are widely available in the country, but quality of services and medications are often lacking. The BSPA collected information on the provision of reproductive and child health services in Bangladesh in conjunction with the BDHS. A modified SPA instrument from the MEASURE DHS+ program was used in the survey. It included questions on service provision and interviewed both service providers and field- workers. The survey provides information to program managers on the extent to which facilities have the equipment supplies and staff to deliver high quality services.

Available at http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=136&ctry_id=1&SrvyTp=type

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: Antigua and Barbuda, Caribbean Region, HIV/AIDS Service Provision Assessment 2006 (TR-07-50)

Source: Calverton, MD, USA: St. George's University, Grenada; AID Inc., Barbados; Macro International; and MEASURE Evaluation

Abstract: This is a country report of the HIV SPA conducted in Antigua and Barbuda in 2006. Focusing on the formal public health sector in Antigua and Barbuda, the HSPA findings provide information on both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-50.pdf.

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: Barbados, Caribbean Region, HIV/AIDS Service Provision Assessment 2005 (TR-07-45)

Source:Calverton, MD, USA: St. Georges University, Grenada; AID Inc., Barbados; Macro International; and MEASURE Evaluation

Abstract: This is a country report of the HIV SPA conducted in Barbados in 2005. Focusing on the formal public health sector in Barbados, the HSPA findings provide information on both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-45.pdf.

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: Dominica, Caribbean Region, HIV/AIDS Service Provision Assessment 2005 (TR-07-48)

Source: Calverton, MD, USA: St. George's University, Grenada; AID Inc., Barbados; Macro International; MEASURE Evaluation project

Abstract: This is a country report of the HIV SPA conducted in Dominica in 2005. Focusing on the formal public health sector in Dominica, the HSPA findings provide information on

both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-48.pdf.

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: St. Lucia, Caribbean Region, HIV/AIDS Service Provision Assessment 2005 (TR-07-47)

Source: Calverton, MD, USA: St. George's University, Grenada; AID Inc., Barbados; Macro International; MEASURE Evaluation

Abstract: This is a country report of the HIV SPA conducted in St. Lucia in 2005. Focusing on the formal public health sector in St. Lucia, the HSPA findings provide information on both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-47.pdf.

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: St. Vincent and Grenadines, Caribbean Region, HIV/AIDS Service Provision Assessment 2005 (TR-07-46)

Source: Calverton, MD, USA: St. George's University, Grenada; AID Inc., Barbados; Macro International; MEASURE Evaluation

Abstract: This is a country report of the HIV SPA conducted in St. Vincent and Grenadines in 2005. Focusing on the formal public health sector in St. Vincent and Grenadines, the HSPA findings provide information on both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-46.pdf.

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: Surinam, Caribbean Region, HIV/AIDS Service Provision Assessment 2006 (TR-07-53)

Source: Calverton, MD, USA: St. George's University, Grenada; AID Inc., Barbados; Macro International; MEASURE Evaluation

Abstract: This is a country report of the HIV SPA conducted in Surinam in 2006. Focusing on the formal public health sector in Surinam, the HSPA findings provide information on both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-53.pdf.

Author: St. George's University, Grenada; AID Inc., Barbados; Macro International

Year: 2007

Title: Trinidad and Tobago, Caribbean Region, HIV/AIDS Service Provision Assessment 2005 (TR-07-49B)

Source: Calverton, MD, USA: St. George's University, Grenada; AID Inc., Barbados; Macro International; MEASURE Evaluation

Abstract: This is a country report of the HIV SPA conducted in Trinidad and Tobago in 2006. Focusing on the formal public health sector in Trinidad and Tobago, the HSPA findings provide information on both basic and advanced level HIV and AIDS services and the availability of record keeping systems for monitoring HIV and AIDS care and support.

Available at http://www.cpc.unc.edu/measure/publications/pdf/tr-07-49B.pdf.

Author: Tanzania National Bureau of Statistics and Macro International Inc.

Year: 2007

Title: Tanzania: HIV/MCH SPA, 2006 – Final Report

Source: Dar es Salaam, Tanzania: National Bureau of Statistics and Macro International Inc.

Abstract: The 2006 Tanzania Service Provision Assessment (TSPA 2006) survey collected data from a representative sample of 611 health facilities throughout Tanzania. The survey covered all levels of facilities, from dispensaries to hospitals, and sampled facilities operated by different managing authorities, including government, private for-profit, parastatal, and faith-based organisations. TSPA personnel collected information from facility inventories, interviews with health service providers, observations of client-provider consultations, and exit interviews with clients in order to assess the capacity of facilities to provide good quality services and the existence of functioning systems to support these services. The survey addressed overall facility infrastructure and resources as well as services for child health, family planning, maternal health, and specific infectious diseases, including sexually transmitted infections (STIs), tuberculosis

(TB), malaria, and HIV/AIDS. One of the objectives of the survey was to assess the strengths and weaknesses of the infrastructure and systems supporting these services. The survey also sought to assess the adherence to standards in the delivery of curative care for sick children and adult STIs, family planning, and antenatal care (ANC).

Available at http://www.measuredhs.com/pubs/pdf/SPA12/SPA12.pdf.

Author: Waithaka, M., and Bessinger, R.

Year: 2001

Title: Sexual Behavior and Condom Use in the Context of HIV Prevention in Kenya (SR-01-07)

Source: Chapel Hill, NC, USA: Population Services International and MEASURE Evaluation

Abstract: This report presents an analysis of data on sexual behavior, condom knowledge, and condom use from the 1998 Kenya Demographic and Health Survey (KDHS). These results are supplemented with data from the Ministry of Health and PSI's social marketing program on the number of condoms distributed annually and with data on condom promotion and availability at health facilities from the 1999 Kenya Service Provision Assessment. The study found that there are large gender differences in the practice of high-risk sexual behavior with three times as many men as women practicing risky sex. A much greater percentage of men than women have multiple sexual partners, participate in payment for sex, or have had an STD in the past 12 months. Differences in risk among married men and women are particularly important as married women are often at risk for HIV infection based on their husbands' sexual practices rather than their own. While only a small percentage of married women are classified as having risky sexual practices, almost one in four married men fall into this category. While extramarital sex is relatively common among men, less than one-half of married men used a condom with other sexual partners than their wives.

Available on-line at http://www.cpc.unc.edu/measure/publications/pdf/sr-01-07.pdf.

Author: White, J.S., and Speizer, I.S.

Year: 2007

Title: Can family planning outreach bridge the urban-rural divide in Zambia?

Source: BMC Health Services Research 7:143

Abstract: This paper assesses family planning outreach as a tool to narrow the urban-rural gaps in accessing family planning services in Zambia. The authors used the Zambia Demographic and Health Survey (DHS) data, collected between 2001 and 2002. The Zambia SPA Country Report (2006) is referenced in this article to indicate the percentage of facilities that offer

VCT and PMTCT of HIVAIDS service in urban and rural areas. The authors found that the differences in modern contraceptive use between urban and rural areas persist (OR: 1.56, 95 percent CI: 1.24–1.96) even after adjusting for a number of demographic, socioeconomic, cognitive, and attitudinal factors. Household visits by a community health worker significantly increased the likelihood of modern contraceptive use among rural women (OR: 1.83; 95 percent CI: 1.29–2.58). If all rural women received at least one outreach visit per year, the prevalence rate for modern contraceptive methods would be expected to increase for this group by 5.9 percentage points, a marked increase but less than one-quarter of the total urban-rural differential. Based on these findings, the authors concluded that outreach in the form of health worker visits can improve access to family planning services, but it does not eliminate barriers to access or address continued high-fertility desires in Zambia.

Available at http://www.biomedcentral.com/content/pdf/1472-6963-7-143.pdf.

Author: Zambia Ministry of Health, Central Statistical Office, Zambia;, and ORC Macro

Year: 2006

Title: Zambia: HIV SPA, 2005 – Final Report.

Source: Calverton, MD, USA: Zambia Ministry of Health, Central Statistical Office, and ORC Macro

Abstract: Zambia is a landlocked country located in southern Africa. The country is bordered by Angola in the west; Botswana and Zimbabwe in the south; the Democratic Republic of Congo and Tanzania in the north; Malawi and Mozambique in the east; and Namibia in the southwest. Zambia covers an area of 752,612 square kilometers, which is divided into nine provinces and 72 districts. Zambia has an estimated population of about 11 million people and is one of the most urbanized countries in sub-Saharan Africa, with approximately 40 percent of its population living in urban areas, mostly in Lusaka and Copperbelt provinces. Zambia has a mixed economy consisting of an urban modern sector and a rural agricultural sector. Zambia inherited a strong mining-based economy after independence in 1964, which deteriorated in the mid-1970s following a sharp decline in copper prices, compounded by the global oil crisis. The country's attempt to diversify its economy to minimize dependency on copper exports did not achieve the desired results. The Structural Adjustment Programmes (SAP) implemented in the 1980s failed to substantially revitalize the country's economy. Zambia is one of the poorest countries in Africa and the world, ranking 166 out of 177 in the Human Development Index, according to the 2005 Human Development Report. According to the Human Development Report, 64 percent of the population is living in absolute poverty (less than US $1 per day), and 73 percent is living under the national poverty line.

Available at http://www.measuredhs.com/pubs/pdf/SPA11/SPA11.pdf.

## Service Availability Mapping (SAM)

Author: Chamla, D.D., Olu, O., Wanyana, J., Natseri, J., Mukooyo, E., Okware, S., Alisalad, A., and George, M.

Year: 2007

Title: Geographical information system and access to HIV testing, treatment and prevention of mother-to-child transmission in conflict affected northern Uganda

Source: Conflict and Health 1:12

Abstract: This paper attempts to use geographical information system (GIS) as a tool to determine access to and gaps in providing HIV voluntary counseling and testing (VCT), antiretroviral treatment (ART), and prevention of mother-to-child transmission (PMTCT) services in conflict affected northern Uganda. The authors conducted Service Availability Mapping (SAM) of health facilities located inside and outside the internal displaced persons (IDP) camps in three districts. The SAM consisted of a survey methodology whereby structured camp and health facility questionnaires were used to collect data in the field, and global positioning system (GPS) instruments to collect the coordinates of the camps and health facilities. These GPS readings were then uploaded to and processed by the GIS software to generate the maps.

The study found that there were 167 health facilities located inside and outside 132 IDP camps with VCT, PMTCT, and ART services provided in 32 (19.2%), 15 (9%), and 10 (6%) facilities, respectively. There was uneven availability and utilization of services and resources among districts, camps, and health facilities. Inadequate staff and stock-out of essential commodities were found in lower health facility levels. Provision of VCT was 100% of the HSSP II target at health centers IV and hospitals but 28% at HC III. For PMTCT and ART, only 42.9% and 20% of the respective targets were reached at the health centers IV. The authors concluded that access to VCT, PMTCT and ART services was geographically limited due to inadequacy and heterogeneous dispersion of these services among districts and camps. GIS mapping can be effective in identifying service delivery gaps and presenting complex data into simplistic results hence can be recommended in need assessments in conflict settings.

Available on-line at http://www.conflictandhealth.com/content/pdf/1752-1505-1-12.pdf.

Author: Institute of Public Health of Albania, WHO, and SouthEastern Europe Network.

Year: 2005

Title: Service Availability Mapping Albania

Source: Geneva, Switzerland: World Health Organization

Abstract The SAM Albania was conducted to 1) provide national planners and decision-makers

with up-to-date information on the distribution of services within the country with a focus on the district level; 2) provide a snapshot of service availability for key interventions such as HIV/AIDS counseling and testing, maternal and child health, TB and other services national level; 3) provide information on the availability of services at private facilities, although it is likely that these facilities are under-reported; and 4) take SAM to the facility level, so that the district can be enabled to plan and monitor. The district questionnaire was applied in 36 districts, and the facility questionnaire was applied in all the facilities of the 12 districts, which were selected based on the 12 prefectures (counties) of Albania.

Available at http://www.who.int/healthinfo/systems/samreportalbania.pdf.

Author: Kenya Ministry of Health and WHO

Year: 2007

Title: Service Availability Mapping Kenya

Source: Geneva, Switzerland: World Health Organization

Abstract: The SAM Kenya was conducted to provide baseline data for the scale-up of key HIV/AIDS-related services such as antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT) of HIV, and HIV voluntary counselling and testing. The district-level questionnaire was applied in all 72 districts, while the facility-level questionnaire was carried out in three major urban centers in Nairobi, Mombassa, and Nakuru, as well as in three districts (Thika, Kilifi and Kisumu).

Available at http://www.who.int/healthinfo/systems/samreportkenya.pdf.

Author: Kintu, P., Nanyunja, M., Nzabanita, A., and Magoola, R.

Year: 2005

Title: Development of HMIS in poor countries: Uganda as a case study

Source: Health Policy and Development Journal 3(1):46-53

Abstract: The authors reviewed the implementation of a health management information system (HMIS) in Uganda. In the article, the information on the availability of computers as well as Internet was cited from the WHO SAM Uganda country report. They concluded that the main challenges are in-patient data collection and processing, regular availability of HMIS tools, data utilization, and electronic data management.

Available at https://tspace.library.utoronto.ca/bitstream/1807/6076/1/hp05008.pdf.

Author: Rwanda Ministry of Health, WHO, and UNAIDS

Year: 2007

Title: Service Availability Mapping Rwanda 2005

Source: Geneva, Switzerland: World Health Organization

Abstract The SAM Rwanda was conducted to 1) provide national planners and decision-makers with information on the distribution of services within the country, with a focus on the district level; 2) provide baseline monitoring information for the scale-up in the provision of key HIV/AIDS-related services such as antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT) of HIV and voluntary counseling and testing of those with HIV/AIDS SAM in Rwanda was implemented in two phases; and 3) assess whether a district-level SAM, in which all health facilities are visited, can become a useful and feasible planning and monitoring tool at the district level. The Rwanda SAM covered all 40 health offices and 436 health facilities, representing all public health and government-supported facilities. Private facilities were included for Kigali.

Available at http://www.who.int/healthinfo/systems/samreportrwanda.pdf.

Author: Tanzania Ministry of Health and Social Welfare, and WHO

Year: 2007

Title: Tanzania Service Availability Mapping 2005-06

Source: Geneva, Switzerland: World Health Organization

Abstract: The SAM Tanzania was conducted to complement existing information on health services and provide the United Republic of Tanzania with information on the distribution of facilities, human resources, and basic health services. The SAM included a national survey of all districts in the United Republic of Tanzania, a SAM of facilities in all districts of Dar es Salaam and Mwanza regions, Zanzibar, and the district of Kibaha in Pwani; and an HIV prevention-focused SAM of schools, workplaces, and priority prevention areas in Mwanza region.

Available at http://www.who.int/healthinfo/systems/SAM_CountryReport_Tanzania.pdf.

Author: Uganda Ministry of Health and WHO

Year: 2005

Title: Service Availability Mapping Uganda

Source: Geneva, Switzerland: World Health Organization

Abstract: The SAM Uganda was conducted to collect information on the availability and distribution of key health services by interviewing the district director of health services and his/her team and to provide baseline monitoring information for the scale-up of the provision of key HIV/AIDS-related services such as ART, PMTCT of HIV, and counseling and HIV testing.

The district SAM covered all districts and facility SAM covered facilities in Jinja, Kiboga and Mbarara districts.

Available at http://www.who.int/healthinfo/systems/samreportuganda.pdf.

Author: World Health Organization

Year: ND

Title: Improving Service Availability Mapping: Data Use and Dissemination

Source: Geneva, Switzerland: World Health Organization

Abstract: Clear strategies for the use and dissemination of data are necessary to realize their full value, including the efforts that have gone into their collection. This paper summarizes the results obtained from a number of surveys as well as a series of interviews with decision makers at the global, regional, national, and subnational or district level conducted to identify the needs of potential data users.

Available at http://www.who.int/healthinfo/systems/samintro/en/index.html.

Author: World Health Organization

Year: ND

Title: Service Availability Mapping Facility Questionnaire

Source: Geneva, Switzerland: World Health Organization

Abstract: Service Availability Mapping (SAM) is a tool to collect and present basic information on health services: health infrastructure, human resources and services offered. Its main application is at the subnational or district level, where district health management teams can use the results of the SAM in conjunction with WHO's HealthMapper application, developed by the Public Health Mapping and GIS program, to map and monitor health services. SAM is made up of a survey methodology, remote field data collection devices, and WHO's HealthMapper application. The facility SAM requires a visit to a health facility and an interview of the health workers, using a brief questionnaire. This questionnaire could be administered during a regular supervisory visit. Data are collected on availability of the health equipment, staffing, drugs and commodities, and the services offered. A six-monthly cycle of

data collection is recommended.

Available at. http://www.who.int/healthinfo/systems/sam_fac_quest_en.pdf.

Author: World Health Organization

Year: ND

Title: Service Availability Mapping Overview Presentation. (Microsoft PowerPoint presentation)

Source: Geneva, Switzerland: World Health Organization

Abstract: This presentation provides the background and overview of the SAM. The content includes the objectives, implementation process, SAM tool, application, data use, findings and future vision, and implementation plans.

Available at http://www.who.int/healthinfo/sam_overview.ppt.

Author: World Health Organization

Year: 2006

Title: Service Availability Mapping — Trainers Guide (Draft 2)

Source: Geneva, Switzerland: World Health Organization

Abstract: This guide has been developed as a training aid for focal points at regional and country level for training national teams in the implementation of SAM. The guide aims specifically to provide an overall background and understanding of what SAM is, and provides guidelines and checklists for planning and conducting a SAM survey in a specific country. It also provides step by step guidance on using survey tools and instruments, including personal digital assistants (PDAs) and forms, global positioning systems (GPS), and the HealthMapper application. This document was prepared for the Training of Trainers Workshop, an orientation workshop of SAM, held in Bangkok in 2006.

Available at http://www.searo.who.int/LinkFiles/2006_Trainers_Guide.pdf.

Author: Zambia Ministry of Health and World Health Organization

Year: 2006

Title: Service Availability Mapping Zambia

Source: Geneva, Switzerland: World Health Organization

Abstract: The SAM Zambia was conducted to 1) provide national planners and decision-makers with information on the distribution of services within the country, with a focus on the district level; 2) provide baseline monitoring information for increasing the provision of key services such as antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT) of HIV, and voluntary counseling and testing of HIV/AIDS; and 3) assess whether the facility SAM can become a useful and feasible planning and monitoring tool at the district level. The SAM covered all 72 district health offices and selected health facilities in Kabwe and Kafue districts.

Available at http://www.searo.who.int/LinkFiles/2006_SAM3_2.pdf.

## Rapid Health Facility Assessment Tool (R-SPA)

Title: Rapid Health Facility Assessment Tools Child Survival Technical Support+ (CSTS+) Web site

Year: 2007

Source: http://www.childsurvival.com

Abstract: This Web page has a link to the information and tools to conduct the Rapid Health Facility Assessment. Following documents are accessible at this Web site.

R-HFA survey forms: These are the R-HFA survey forms in five modules (clinical observation, exit interview, health facility checklist, health worker interview, and community health worker form). All the questions needed to construct all core and optional indicators are included.

R-HFA introductory presentation: This presentation explains the development of the tool, what it measures, a brief description of the training and implementation of the R-HFA.

R-HFA data entry and analysis program: Data from the assessments can be entered in these Microsoft Excel sheets. The program automatically calculates tables for use in your report and calculates all the core and optional indicators, giving the "balanced score card" for child health and for maternal-neonatal health for facilities and community health workers.

R-HFA data entry and analysis example: This gives sample data (not actual project data) in the data entry and analysis program to give an idea of the output produced.

R-HFA data analysis presentation: This presentation describes the data analysis and dissemination plan for use of R-HFA data.

R-HFA report example – Rwanda 2007: This is a sample report from R-HFA version 1.0 (child health only). It shows how the data can be presented in disaggregated tabular format as well as in the form of the indicators.

R-HFA short tool description: This is a brief two-page description of the tool to give to interested stakeholders.

R-HFA manual: This is a brief manual describing how to implement the survey. There is an annex with a 3-4 day training agenda for surveyors.

R-HFA – IHFAN instructions on use of GPS: gives instructions for how to collect geographic positioning system information on health facilities. Instructions are provided by the International Health Facility Assessment Network (IHFAN). (Also available at http://www.cpc.unc.edu/measure/publications/pdf/wp-07-91.pdf.)

## Logistics Indicators Assessment Tool (LIAT)

Author: Amenyah, J., Chovitz, B., Hasselberg, E., Karim, A., Mmari, D., Nyinondi, S., and Rosche, T.

Year: 2005

Title: Tanzania: Integrated Logistics System Pilot-Test Evaluation: Using the Logistics Indicator Assessment Tool

Source: Arlington, VA, USA: DELIVER/John Snow, Inc.

Abstract: The Tanzania Ministry of Health, in response to decentralization, was in the process of transferring responsibility for drug management from the central level, primarily through the kit system, to districts. A new system for drug ordering, called the Integrated Logistics System (ILS), was pilot tested in Dodoma and Iringa regions from April 2005 to September 2005. In October 2005, the Pharmaceuticals and Supplies Unit of the Ministry of Health, which is responsible for implementing the ILS, conducted an evaluation of the ILS using the JSI/DELIVER Logistics Indicator Assessment Tool (LIAT). The results show that the ILS is performing as expected and meets the needs of most facilities. Health care workers overwhelmingly prefer it to the previous system. Stockout rates are about the same or a little better than under the previous system, which is an accomplishment given that the transfer of responsibility to districts has taken place. Proposed recommendations are improvements to the ILS that can be applied as it is rolled out to additional regions. No major changes are proposed.

Available at http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/TZ_InteLogiSystPilo.pdf.

Author: Bossert, T.J. Bowser, D.M., and Amenyah, J.K.

Year: 2007

Title: Is decentralization good for logistics systems? evidence on essential medicine logistics in Ghana and Guatemala

Source: Health Policy and Planning 22(2):73-82

Abstract: The authors developed a data collection instrument based on the LIAT for this study. This paper sets out a framework and methodology of a pioneering exploratory study that examines the experiences of decentralization in two countries, Guatemala and Ghana, and presents suggestive results of how decentralization affected the performance of their logistics systems. The study found that less choice (i.e. more centralized) was associated with better performance for two key functions (inventory control and information systems), while more choice (i.e. more decentralized) over planning and budgeting was associated with better performance. The authors concluded that logistics systems can be effectively decentralized for some functions while others should remain centralized.

Available at http://heapol.oxfordjournals.org/cgi/content/full/22/2/73#RNT1.

Author: Bossert, T.J., Bowser, D.M., Amenyah, J.K., and Copeland, B.

Year: 2004

Title: Ghana: Decentralization and Health Logistics Systems

Source: Arlington, VA, USA: John Snow, Inc./DELIVER

Abstract: Health sector reform in Ghana took place from 1998 to 2002, and it continued under another five-year medium-term health strategy for 2002-2006. To implement these reform packages, a number of health reform initiatives were put in place, one of which was decentralization of administration within the sector and the integration of supply systems to improve management efficiency. This country study assessed the impact of decentralization on the performance of health logistics systems and examined pre-defined functions within the health logistics system in order to measure the changes in performance indicators related to changes introduced by decentralization and integration. In order to assess the performance of the logistic system, the study team modified an existing LIAT and used it as a data collection tool.

Available at http://deliver.jsi.com/dlvr_content/resources/allpubs/policypapers/GH_DeceHealLogi.pdf.

Author: Bossert, T.J., Bowser, D.M., Amenyah, J.K., and Copeland, B.

Year: 2003

Title: Guatemala: Decentralization and Integration in the Health Logistics System

Source: Arlington, VA, USA: John Snow, Inc./DELIVER

Abstract: Decentralization has been one of the most far-reaching interventions in the health sector reform packages. Sectoral reform in Guatemala began in 1996 with the Health Services Improvement Program (HSIP), implemented by the Ministry of Health and Social Welfare.

Among the goals of the reform were to expand health coverage with an emphasis on populations that lack access, increase the level of public expenditure, redirect resources based on efficiency and equity criteria, and generate an organized social response for mobilization and control of public resources. Another key objective was the development of a new health care model based on decentralization, provision of a basic services package, and community participation. Using the decision-space model, functions within the health logistics system were analyzed to measure the changes in performance indicators related to changes introduced by decentralization. The study's indicators for high decision space were related to better performance indicators for budgeting, needs quantification, procurement, and assignment of personnel to logistics tasks. These are major functions in a logistics system and, for effectiveness, it is important to be able to make adjustments to local conditions. Conversely, the findings also suggest that some functions may perform better if they remain more centralized.

Available at http://deliver.jsi.com/dlvr_content/resources/allpubs/policypapers/GT_DeceInteHeal.pdf.

Author: Bunde, E., Ronnow, E., and Kimondo, G.

Year: 2007

Title: Kenya: Stock Status and Logistics System Assessment 2006

Source: Arlington, VA, USA: DELIVER/John Snow, Inc.

Abstract: This document presents the results of the LIAT conducted in 2006 in Kenya to take stock of the performance of the logistic systems and to provide stock status information for key public health commodities. Results of the assessment revealed that nearly all systems were implemented as designed, but strengths and weaknesses continue to exist. The widespread availability of key commodities for each program was found throughout the logistic systems. In addition, both commodity availability and logistics management practices in the ARV program were performing well.

Available at http://deliver.jsi.com/dhome.

Author: Chimnani, J., Chirwa, V., and Ronnow, E.

Year: 2006

Title: Malawi Logistics System and Stock Status Report 2006: Comparison of 2004 and 2006 Assessment Results

Source: Arlington, VA, USA: DELIVER/John Snow, Inc.

Abstract: In March 2006, DELIVER conducted a nationally representative survey on the availability of selected health commodities at MoH and NGO facilities throughout Malawi

to assist the MoH and its partners to monitor the effectiveness and efficiency of the health commodity logistics system and to make adjustments as necessary. The LIAT, which was tailored in Malawi in 2004, was used again in 2006 with minor adaptations to address current assessment needs. This document presents the comparative analysis between 2004 and 2006 to determine any change in the health commodity logistics system over the last two years.

Available at http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/MW_MalaLogiSystStoc.pdf.

Author: Dana, A., Bieze, B., Felling, B., and Chandani, Y.

Year: 2006

Title: Assessing Supply Chains for HIV/AIDS Commodities

Source: Arlington, VA, USA: John Snow, Inc./DELIVER

Abstract: This paper serves as a technical resource for assessing supply chain management systems for HIV/AIDS programs in the context of system design, implementation, and monitoring and evaluation. While many tools and indicators for the various types of assessments will remain relatively standardized across commodity groups, including forecasting and monitoring and evaluation for the purposes of system design, a number of key differences exist for HIV/AIDS commodities, notably in the types of assessments, the special considerations during the process, and the frequency and follow up of assessments. This paper serves as a guide for relevant stakeholders to understand the various types of assessments that are undertaken to measure or monitor system performance, the purpose behind the different assessments, and the tools that are appropriate and valuable to use in the different circumstances. LIAT (or a slight modification of LIAT) is recommended as one of the appropriate tools for supply chain of HIV/AIDS commodities.

Available at http://scms.pfscm.org/portal/pls/portal/!PORTAL.wwpob_page.show?_docname=678001.PDF.

Author: John Snow, Inc./DELIVER

Year: 2005

Title: Logistics Indicators Assessment Tool

Source: Arlington, VA, USA: John Snow, Inc./DELIVER

Abstract: This document contains various tools (user's guide, interviewer's guide, questionnaire, and description of indicators) to undertake the Logistics Indicators Assessment Tool (LIAT). LIAT is a quantitative data collection instrument developed by DELIVER and is used to conduct a facility-based survey to assess health commodity logistics system performance and

commodity availability at health facilities. LIAT can be used to monitor the performance of certain processes involved in the logistics management of health commodities over time, to evaluate certain outcomes of logistics interventions, to provide ongoing supervision and performance monitoring, and to monitor commodity availability. The data collected using the LIAT can be used to calculate the following core logistics indicators: accuracy of logistics data for inventory management; percentage of facilities that receive the quantity of products ordered; percentage of facilities that maintain acceptable storage conditions; percentage of facilities whose stock levels ensure near-term product availability (stock status); percentage of facilities that experienced a stockout at any point during a given period or at the time of the visit. The DELIVER project also developed a set of core indicators and assessment tools (LIAT and LSAT) to monitor and evaluate logistics system performance and program outcomes. The five indicators, which can be measured using data collected from LIAT, are described in this document. These indicators are accuracy of logistics data for inventory management, percentage of facilities that receive the quantity of products ordered, percentage of facilities that maintain acceptable storage conditions, percentage of facilities that experienced a stockout at any point during a given period or at the time of the visit, and percentage of facilities whose stock levels ensure near-term product availability.

Available at http://pdf.usaid.gov/pdf_docs/PNADE735.pdf.

Author: John Snow, Inc./DELIVER

Year: 2005

Title: Guidelines for Managing the HIV/AIDS Supply Chain

Source: Arlington, VA, USA: John Snow, Inc./DELIVER

Abstract: This document includes a set of references for managers working to ensure a continuous supply of quality HIV/AIDS commodities to programs. It highlights lessons learned from JSI and DELIVER advisors' experience designing, implementing, and improving HIV/AIDS supply chains in resource poor settings. The recommendations and tools presented in this document have been developed specifically for programs where supply chain implementation is occurring within the context described above. LIAT (or a slight modification of LIAT) is recommended as one of the appropriate tools for data collection.

Available at http://pdf.usaid.gov/pdf_docs/PNADF424.pdf.

Author: McLaughlin, C., Ronnow, E., Shea, E., Edah, P., and Bruce, E.

Year: 2006

Title: Ghana: Quantitative and Qualitative Logistics System Assessment (LIAT and LSAT) Report 2006

Source: Arlington, VA, USA: DELIVER

Abstract: A Logistics System Assessment and Stock Status Survey was conducted to provide information to the MoH, USAID/Ghana, and other stakeholders in Ghana on the availability of health commodities and logistics information at the central, regional, district, and health facility levels. This comprehensive assessment of the logistics system consisted of both quantitative and qualitative data collection using two separate data collection tools: the LIAT and the Logistics System Assessment Tool (LSAT), respectively. This document summarizes the results of the survey.

Available at http://deliver.jsi.com/dhome.

Author: Nyenwa, J., Alt, D., Karim, A., Kufa, T., Mboyane, J., Ouedraogo, Y., and Simoyi, T.

Year: 2005

Title: Zimbabwe HIV and AIDS Logistics System Assessment

Source: Arlington, Virginia, USA: John Snow, Inc./DELIVER

Abstract: In July and August 2005, the Ministry of Health and Child Welfare, with technical assistance from the USAID-funded JSI/DELIVER project, conducted an assessment of the performance of the logistics management and supply chain systems for selected commodities used by HIV and AIDS programs in Zimbabwe. The survey's overall objective was to assess how the logistics systems managed selected HIV and AIDS commodities at public health institutions. This report presents the findings of the assessment as well as the short- and long-term recommendations to improve the HIV/AIDS logistics systems in Zimbabwe. The study revealed high stockout rates for some antiretroviral drugs, cotrimoxazole, and rapid HIV test kits. There is no effective logistics management system in place for these commodities. Proposed recommendations include improving supervision, increasing the resource capacity for the AIDS and TB Unit, strengthening the coordination of multiple HIV and AIDS supply chains, and integrating components of the essential drugs and HIV/AIDS logistics management systems.

Available at http://www.synergyaids.com/documents/ZIMBABWE-HIV-AIDS-LIAT1.pdf.

## Human Resources for Health (HRH) Survey

Author: Butera, D., Fieno, J.V., Diarra, S., Kombe, G., Decker, C., and Oulai, S.

Year: 2005

Title: Assessment of Human Resource Requirements to Deliver the President's Emergency Plan for AIDS Relief and Other Basic Health Services in Côte d'Ivoire

Source: Bethesda, MD, USA:The Partners for Health Reformplus Project, Abt Associates Inc.

Abstract: The purpose of this survey is to quantify the human resources currently available and that are required to achieve the HIV/AIDS service targets of the government and its partners, including the Global Fund to Fight Malaria, AIDS, and Tuberculosis; the U.S. President's Emergency Plan for AIDS Relief; the World Bank's Multi-Country HIV/AIDS Program for Africa; and WHO's "3 by 5" initiative. The assessment shows that meeting targets will require substantial human resources mobilization. The authors recommend Côte d'Ivoire to support the development of a long-term human resources plan and database, and make better use of its trained health professionals. They also suggest that an assessment of human resources in the private sector be conducted to provide a comprehensive picture of the entire health sector.

Available at http://www.abtassociates.com/reports/PHRplus_cotedivoire_Tech072_fin.pdf.

Author: Chankova, S., Kombe, G., Muchiri, S., Decker, C., Kimani, G., and Pielemeier, N.

Year: 2006

Title: Rising to the Challenges of Human Resources for Health in Kenya: Developing Empirical Evidence for Policy Making

Source: Bethesda, MD, USA: The Partners for Health Reformplus Project, Abt Associates Inc.

Abstract: This report presents a comprehensive analysis of the human resources for health (HRH) currently available and required to reach the targets set by the U.S. President's Emergency Plan for AIDS Relief and the Millennium Development Goals (MDGs) in both the public sector and the faith-based organizations (FBOs) in Kenya. A stratified convenience sample of health facilities at all levels of care (primary, secondary, tertiary) in each of eight provinces was selected for the assessment, and detailed information on human resources and provision of services related to HIV/AIDS, tuberculosis (TB), malaria, maternal health, and child health was collected. The data from the study confirmed the commonly held perception that HRH poses a major challenge to scale up HIV/AIDS and other basic health services. The authors also found that the geographical distribution of skilled HRH in Kenya is heavily skewed towards urban areas.

Available at http://www.healthsystems2020.org/content/resource/detail/1654/.

Author: Chankova, S., Nguyen, H., Chipanta, D., Kombe, G., Onoja, A., and Ogungbemi, K.

Year: 2006

Title: A Situation Assessment of Human Resources in the Public Health Sector in Nigeria

Source: Bethesda, MD, USA: The Partners for Health Reformplus Project, Abt Associates Inc.

Abstract: This document reports the results of the assessment which measured the size, skills

mix, distribution, and growth rate of HRH in the public health sector in Nigeria. The assessment also quantifies the increase in HRH requirements in the public health sector necessary for reaching key U.S. President's Emergency Plan for AIDS Relief targets and the Millennium Development Goals. The findings are based on a survey conducted in April and May, 2006, in 290 public health facilities representing all levels of care (primary, secondary, and tertiary). The study found that rural areas in particular appear much more disadvantaged compared to the urban areas in terms of availability of health personnel: on average, an urban resident has access to nearly three times more doctors and two times more nurses/midwives, compared to a rural resident. The study data enabled the authors to estimate the total number of doctors, nurses, midwives, lab and pharmacy staff, and community health workers currently employed in the public sector. The distribution of health workers by level of care, and HRH availability in rural and urban areas were also quantified. The authors determined the staff attrition rates, measuring the number of those leaving the public sector as percent of total staff among all staff categories. The annual growth in HRH in the public sector from new graduates was also measured.

Available at http://www.healthsystems2020.org/content/resource/detail/1704/.

Author: Kombe, G., Galaty, D., Gadhia, R., and Decker, C.

Year: 2004

Title: The Human and Financial Resource Requirements for Scaling Up HIV/AIDS Services in Ethiopia

Source: Bethesda, MD, USA: The Partners for Health Reformplus Project, Abt Associates Inc.

Abstract: Ethiopia is currently one of the countries most seriously affected by HIV/AIDS, with the sixth highest number of infections in the world. To combat this epidemic, the government of Ethiopia has launched a national HIV/AIDS program focused on decreasing the vulnerability of individuals and communities to the disease, providing care and support for people living with HIV/AIDS, and reducing the adverse socioeconomic consequences of the epidemic. As the country scales up HIV/AIDS services, increased attention is focused on identifying constraints to program expansion. One of the most important constraints is that of human resources, though this issue has received little attention nationally. The HRH survey in Ethiopia took place in 2004. The aim of this assessment was to estimate the financial and human resources requirements for the expanding HIV/AIDS services in the country. Towards this aim, the authors estimated (a) the available human resources required to reach the targets of major HIV/AIDS initiatives such as PEPFAR, the Global Fund, and the WHO "3 by 5" initiative, and (b) the financial costs of providing highly active antiretroviral therapy, prevention of mother-to-child transmission, and voluntary counseling and testing services. The findings of the assessment highlight four key issues. First, there is already a clear shortage of human resources for health. The current doctor-to-patient and nurse-to-patient ratios are inadequate for the provision of basic health care — in fact, the doctor-to-patient ratio of 1:34,000 is

less than a third of the WHO-mandated minimum of 1:10,000 for the provision of quality health care. Given this existing shortage of key human resources, the health care system is already strained and may not be well positioned to respond to the rapid scale-up of HIV/AIDS services. Of 77 HIV/AIDS staff observed during the assessment, only six (8 percent) work exclusively on HIV/AIDS services, raising concern over the number of trained staff dedicated to provide HIV/AIDS services.

Available at http://www.healthsystems2020.org/content/resource/detail/1521/.

Author: Kombe, G., Galaty, D., Mtonga, V., and Banda, P.

Year: 2004

Title: Human Resource Crisis in Zambia's Health System: A Call for Urgent Action

Source: Bethesda, MD, USA: The Partners for Health Reformplus Project, Abt Associates Inc.

Abstract: Human resources are the cornerstone of a health system. Without a strong and skilled health workforce, the Zambian public sector health system cannot deliver adequate and appropriate care to its population. Over the past few years, the human resources situation in the Zambia public sector has reached a point of severe crisis and inability to provide basic health services. The authors present three main findings in the report. First, attrition rates for all health staff have increased dramatically compared to historical trends. Second, looking only at national human resources figures may obscure important trends within the country. Third, many facilities will soon start experiencing severe constraints in expanding their HIV/AIDS services. Such findings will assist policy makers to make decisions on how to handle the human resource crisis during this critical HIV/AIDS scale-up.

Available at http://www.healthsystems2020.org/content/resource/detail/1535/.

Author: Kombe, G., Rosensweig, F., and Taye, A.

Year: 2008

Title: Data Collection Training For HRH Assessment: Participant's Manual

Source: Bethesda, Maryland, USA: Health Systems 20/20 project, Abt Associates Inc.

Abstract: In all discussions of health service performance, the impact of the workforce is generally seen to be of paramount importance. Periodic Human Resources for Health (HRH) assessments facilitate workforce strengthening and management, thus allowing health supply to meet ever-increasing health demand. The participant's manual contains technical materials that are presented in the workshop as well as corresponding rationales for every step of the HRH assessment and processes.

Available at http://www.healthsystems2020.org/content/resource/detail/1938/.

Author: Kombe, G., Rosensweig, F., and Taye, A.

Year: 2008

Title: Data Collection Training for HRH Assessment Trainer's Guide

Source: Bethesda, MD, USA: Health Systems 20/20 project, Abt Associates Inc.

Abstract: In all discussions of health service performance, the impact of the workforce is generally seen to be of paramount importance. Periodic Human Resources for Health (HRH) assessments facilitate workforce strengthening and management, thus allowing health supply to meet ever increasing health demand. The trainer's manual contains a suggested workshop design for use by individuals and organizations planning HRH assessments. These materials can be used to train supervisors and data collectors to conduct an HRH assessment. It is intended to be used in conjunction with the participant manual.

Available at http://www.healthsystems2020.org/content/resource/detail/1939/.

Author: Lee, W.C., Kombe, G., Diarra, S.D., Butera, D., Holdaway, A., Bishop, A., Boci, K., and Souahoro, O.

Year: 2006

Title: Human Resources for Health in the Private Sector: Understanding the Capacity, Motivation and Skills Mix in Cote d'Ivoire

Source: Bethesda, MD, USA: Private Sector Partnerships-One Project, Abt Associates Inc.

Abstract: Cote d'Ivore has a diverse mix of private health care providers, ranging from traditional to modern practitioners. As in many sub-Saharan African countries, private providers in Cote d'Ivore can be classified by their for-profit or non-profit commercial orientation and by their type of ownership (for example, individual/group-owned practices and mission/charitable clinics). This assessment measures the size, skills mix, distribution, and growth rate of health care workers in the private sector. The findings are based on a comprehensive survey of 279 private health facilities representing all types of modern facilities. The report addresses four interrelated issues. First, it estimates total number of doctors, nurses, midwives, and laboratory and pharmacy staff currently employed in the private sector. Second, it presents the distribution of health facilities and availability of health services by region. Third, it estimates the number of health care workers entering and leaving the sector; and finally, it measures the average number of new graduates coming out training institutions per year.

Available at http://www.abtassociates.com/reports/PHRplus_cotedivoire_Tech072_fin.pdf.

## Health Facility Census (HFC)

Author: Heard, N.J., Larsen, U., and Hozumi, D.

Year: 2005

Title: Investigating access to reproductive health services using GIS: proximity to services and the use of modern contraceptives in Malawi

Source: African Journal of Reproductive Health 9(1):166

Abstract: This paper attempts to identify whether access to reproductive health services partly explains use of modern contraception in Malawi. A geographic information system (GIS) was employed to integrate health facility data from the Malawi health facilities inventory and global positioning data from the 2000 Malawi Demographic and Health Survey. The authors attempted to find a plausible causal pathway by using distance to health services as a proxy variable for access to services. The authors conducted a multivariate logistic regression analysis, and concluded that, after controlling for background variables traditionally associated with use of modern contraception, access could not be shown to explain use of modern contraception in Malawi.

Available at http://www.bioline.org.br/request?rh04037.

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2005

Title: Health Facility Census Questionnaire (Level 1 and Below Health Facilities)

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract: This is a set of questionnaires for the HFC developed in Zambia. The objective of the HFC is to establish a database on the country's health facilities in terms of geographic location, medical equipment, infrastructure, services delivered, and human resources. Such knowledge would assist stakeholders in identifying facilities which do not meet national criteria for providing key health services. The questionnaires were designed to capture information on the condition of infrastructure (including utility), availability of medical equipment, availability of health care services, and human resource (head count) in the level 1 and below public health facilities in Zambia. If the HFC is conducted in other countries, these questionnaires should be adapted to the country's specific context.

Available from the Ministry of Health, Zambia (telephone 260-1-253040-45, fax 260-1-253344/253026, e-mail m&e@moh.gov.zm ).

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2005

Title: Health Facility Census Manual

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract: This is a manual to be attached to the utility and infrastructure HFC questionnaire for all levels of facilities. The manual was developed to assist the data collector in undertaking the assessment of the condition of the building, room, water source, and power source using the standardized criteria. It also provides instruction on how to fill in the infrastructure and utility questionnaires.

Available from the Ministry of Health, Zambia (telephone 260-1-253040-45, fax 260-1-253344/253026, e-mail m&e@moh.gov.zm ).

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2006

Title: Health Facility Census Questionnaire (Level 2 and 3 Hospitals)

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract: This is a set of questionnaires for the HFC developed in Zambia. The objective of the HFC is to establish a database on the country's health facilities in terms of geographic location, medical equipment, infrastructure, services delivered, and human resources. Such knowledge would assist stakeholders in identifying facilities which do not meet national criteria for providing key health services. These questionnaires were designed to capture information on the condition of infrastructure (including utility), availability of medical equipment, availability of health care services, and human resource (head count) in the level 2 and level 3 hospitals in Zambia. If the HFC is conducted in other countries, these questionnaires should be adapted to the country's specific context.

Available from the Ministry of Health, Zambia (telephone 260-1-253040-45, fax 260-1-253344/253026, e-mail m&e@moh.gov.zm ).

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2008

Title: Health Facility Atlas

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract: The atlas was produced as one of the direct outputs of the HFA. The atlas includes the national, provincial, and district maps showing the location of health facilities. The map also presents the type of the health facility and name of the facility for easy reference. In addition, the map shows the location of the district boundaries, main roads, rivers, national park, lake, and swamps as landmarks. It is a useful tool for health planners to understand the relationship between population density and health facilities and identify the areas where new facilities or rehabilitation/upgrade of facilities is needed.

Available from the Ministry of Health, Zambia (telephone 260-1-253040-45, fax 260-1-253344/253026, e-mail m&e@moh.gov.zm ).

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2008

Title: Health Facility Census Data Analysis Report

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract: The Zambia Health Facility Census (HFC) was conducted by the Ministry of Health of Zambia, in technical and financial collaboration with Japan International Cooperation Agency (JICA). The main objective of the HFC was to provide evidence for policy, planning, and development of health services in Zambia. Following data were collected: location and other general information (i.e. ownership, type, etc); availability and status of medical equipment; infrastructure; service availability; and headcounts of human resources of health facilities in the country. The data collection targeting level 1 and below health facilities took place between February and July, 2005. The data collection targeting level 2 and 3 hospitals was undertaken from June to September, 2006. There are 1,419 health facilities in the current HFC database, out of which 84.3% belong to Ministry of Health, 8.0% belong to Churches Health Association of Zambia (CHAZ), and 5.6% are privately owned. When segregating the data by the type of facility, 67.4% of facilities were rural health centers (RHC), 15.6% were urban health centers (UHC), 7.5% was health posts, 5.0% were level 1 hospitals, 2.8% were hospital affiliated health centers (HAHC), 1.3% were level 2 hospitals, and 0.4% were level 3 hospitals. One of the notable findings was the relationship between delivery service and trained personnel. For safe delivery, it is necessary for the delivery to be assisted by trained personnel such as a medical doctor or midwife, and trained personnel should be available for 24 hours a day. However, the HFC data show that out of 1,108 health facilities that offer delivery service, only 45.4% responded that they had a doctor or a midwife on-site or on-call for 24 hours each day. Especially in Luapula and Western Provinces, even though the percentage of facilities that offered delivery service was high, the availability of doctor or midwife 24 hours a day on-site or on-call was very low, at 20.5% and 24.4% in Luapula and Western, respectively.

Available from the Ministry of Health, Zambia (telephone 260-1-253040-45, fax 260-1-253344/253026, e-mail m&e@moh.gov.zm ).

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2008

Title: Health Facility Census Database.

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract:The Zambian HFC database is in Microsoft Access format to enable the users to import any major statistical software, such as STATA and SPSS. Selected data (i.e., selected services, infrastructure, and medical equipment) are also be soon available online.

Author: Zambia Ministry of Health and Japan International Cooperation Agency

Year: 2008

Title: Health Facility Census Technical Report (Final Draft)

Source: Lusaka, Zambia: Zambia Ministry of Health and Japan International Cooperation Agency

Abstract: This is a technical report of the Zambia HFC and Health Capital Investment Plan Supporting Project (HCIP). The document contains the description of the survey methodology, data items, and data collection methods for undertaking the HFC. Each step of the capacity development workshop for capital investment planning is also explained in this report. During the capacity building workshop, district health officers in a participatory process interactively analyse various data sources (i.e. ZHFC data, health management information system data, and population data) to identify health facilities which do not meet the criteria to provide the basic health services, and discussed the types of capital investment required. Based on the results of this exercise, the evidence-based Health Capital Investment Plan was developed by the MoH.

Available from the Ministry of Health, Zambia (telephone 260-1-253040-45, fax 260-1-253344/253026, e-mail m&e@moh.gov.zm ).

## Evaluation of Long-Acting and Permanent Methods Services (ELMS) Suite

Author: Bradley, J., and Mursagulova, N.

Year: 2006

Title: Reproductive Health and Services in Azerbaijan, 2005: Results of a Baseline Survey in Five Districts (E&R Study #6)

Source: New York, USA: EngenderHealth/The ACQUIRE Project

Abstract: The baseline study was conducted by the ACQUIRE Project in five districts in Azerbaijan to 1) identify problems and barriers to services specific for each district, 2) provide data that could assist with project implementation, and 3) allow determination of benchmarks and targets to measure success. The project started with a baseline assessment of facilities, providers, and community members in the five core districts. The objectives of the assessment were to evaluate factors contributing to the current use of family planning services, including: the supply of these services in the public and private sectors, the demand for family planning, and the population's knowledge of, attitudes toward, and practice of pregnancy prevention. Data collection took place between March and June, 2005. The survey tools used for this study were 1) audit of sample pf public health facilities in the area of infrastructure, equipment, and PF supplies and services; 2) structured interviews with health care providers; and 3) audit and interview with pharmacist for contraceptive provision.

Available at http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/Azer-baseline-report-final.pdf.

Author: EngenderHealth

Year: 2004

Title: The ACQUIRE Project Health Facility Survey Tools

Source: New York, NY, NC, USA: EngenderHealth

Abstract: The ACQUIRE Project's Evaluation of Long Acting and Permanent Methods Services (ELMS) suite is an adaptation of MEASURE Evaluation's Facility Audit of Service Quality (FASQ). ELMS includes general family planning information, with a focus on gathering information on long-acting and permanent methods, and uses multiple methods and respondents to provide triangulation of assessment of facility-based provision of family planning and other reproductive health services. Triangulation in ELMS facilitates the collection of actionable data that are responsive to the needs of key stakeholders.

More information is available at http://www.acquireproject.org, or by e-mail at hsearing@engenderhealth.org or njohri@engenderhealth.org.

Author: Goldberg, R., Durán, R., Mielke, E., Monterrey, J., Searing, H., and Viscarra, M.

Year: 2006

Title: Bolivia Baseline Survey, 2005: Technical Report

Source: New York, NY, USA: The ACQUIRE Project/EngenderHealth

Abstract: This baseline survey was conducted by the ACQUIRE Project in 2005 in Bolivia. The objective is to measure the extent to which ACQUIRE program activities in Bolivia have affected the availability and quality of services at the facilities it supports. This study encompasses the technical areas of family planning (including its integration into other reproductive health services), maternal health, and related care. The cross-cutting areas of reproductive health services for men, male involvement (i.e., "men as partners" or MAP), intercultural issues, quality, counseling, and infection prevention were also addressed in the study tools. The baseline fieldwork was conducted between June and August, 2005, at 234 health facilities, including public-sector primary-level health centers, secondary-level network hospitals, and tertiary-level referral hospitals, as well as various levels of sites operated by two NGO entities. The study found that the vast majority of facilities surveyed offer contraceptive methods. However, the study revealed significant gaps in the supply of short-acting and long-acting methods (male condoms, the pill, injectables, and IUDs), both on the day of the survey and in the six months preceding the survey. Providers surveyed at the health centers were less likely than providers at the higher-level facilities to report having an on-site supervisor; however, health center providers reported more frequent supervision by external supervisors.

Available at http://67.96.133.10/fileadmin/user_upload/ACQUIRE/Publications/Bolivia_English_final.pdf.

Author: Jain, A., Makawia, A., Searing, H., Schlecht, J., Pile, J.M., Lusiola G., Wickstrom, J., Ntabaye, M., Kanama, J., and Manongi, L.

Year: 2006

Title: Tanzania Baseline Survey Report 2004–2005: Technical Report (E&R Study #4)

Source: New York, NY, USA: EngenderHealth/The ACQUIRE Project

Abstract: This baseline study was conducted in 2004-2005 to measure the situation of reproductive health and family planning services in 10 regions of Tanzania where The ACQUIRE Project intends to focus its interventions. The survey used a random probability sample of hospitals, health centers, and dispensaries in the focus regions. The survey assessed facilities' capacity to provide family planning and related care; the extent to which providers received up-to-date training in related clinical procedures; and clients' experiences with and perceptions of the quality of care offered. The study found that fewer than two out of five facilities were prepared to provide any one of the long-acting and permanent family planning

methods. For example, 28% of hospitals were able to provide intrauterine contraceptive devices (IUCD), and 15% of hospitals were able to provide no-scalpel vasectomy (NSV) on the day of the visit. It also revealed that a high proportion of providers knew the duration of the effectiveness of long-acting methods, such as the IUCD (78%) and Norplant implants (75%). When asked by the interviewers, most clients reported that they were satisfied with the services provided at facilities (97%) and would recommend the services to family and friends (94%).

The baseline study provides information on the current state of facility-based reproductive health services in Tanzania. This information will enable the Tanzania national reproductive health/family planning program to develop appropriate interventions to address the issues identified.

Available at http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/Tanzania_Baseline_final.pdf.

Author: Mahboob-E-Alam, Searing, H., Jain, A., Ali, L., Goldberg, R.

Year: 2006

Title: Strengthening Delivery of Long-Acting and Permanent Family Planning Methods in Bangladesh. Baseline Survey Report 2004 (E&R Study #3)

Source: New York, NY, USA: EngenderHealth/The ACQUIRE Project

Abstract: This study was conducted by The ACQUIRE Project from April to July, 2004, in Bangladesh. The study data was to provide a primarily quantitative assessment of the status of family planning service delivery in 2004 (an endline study was planned for 2008). The objectives of the baseline and endline surveys are to assess the service provider's performance, health facility infrastructure and supplies (in terms of providing full range of family planning services), and the extent to which The ACQUIRE Project affected the quality of services, availability of service, and use of service. The four tools used in this survey include a facility audit, a client-provider observation, a client exit interview, and a provider interview. The sample includes 121 facilities in four districts. Site selection was based on levels of contraceptive use and logistics. The study found that, on the day of the survey, basic infrastructure was more often in place at Upazila Health Complex (UHC)/Mother and Child Welfare Center (MCWC) than at Family Welfare Center (FWC) facilities. All UHC/MCWC facilities had working electricity, compared with 40% of FWC facilities. On-site telephones were present and working at about one of every two UHC/MCWC facilities, but very rarely at FWC facilities. The majority of UHC/MCWC facilities had piped water, compared with about one-third of FWC facilities. Supplies and equipment were available universally for short-term methods, including condoms, the pill, and injectables, irrespective of location and facility type.

Available at http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/Bangladesh-baseline-final.pdf.

## Health Facility Survey (by WHO)

Author: Family and Community Health Cluster, Department of Child and Adolescent Health and Development, World Health Organization

Year: 2003

Title: Health Facility Survey. Tool to evaluate the quality of care delivered to sick children attending outpatients tacilities (using the Integrated Management of Childhood Illness clinical guidelines as best practices)

Source: Geneva, Switzerland: World Health Organization

Abstract: This manual presents a survey tool for evaluating the quality of care delivered to sick children at health care facilities. The tool is based on the clinical guidelines developed for the Integrated Management of Childhood Illness (IMCI) as the clinical standard against which health worker practices are compared. The survey is designed to assess the quality of care delivered to sick children attending outpatient health facilities; caregivers' understanding of home treatment and key messages after visiting these facilities; health system supports for quality care; and facility utilization by sick children. Survey forms, question-by-question explanations, training manual for survey staff, indicators for IMCI in the first level health facilities are included in the annexes.

Available at http://whqlibdoc.who.int/publications/2003/9241545860.pdf.

Author: Regional Office for the Eastern Mediterranean, Child and Adolescent Health Unit, World Health Organization

Year: 2003

Title: Health Facility Survey on the Quality of Outpatient Child Care Services. Survey Procedures and Question-by-Question Explanations. Adaptation for the survey in Sudan

Source: Cairo, Egypt: World Health Organization, Regional Office for the Eastern Mediterranean

Abstract: This document is designed to assist the implementers of the Health Facility Survey on the Quality of Outpatient Child Care (IMCI Health Facility Survey). It explains each step of the data collection procedure and provides explanation of each question. In the annexes, following data collection tools are included: 1) observation checklist for the sick child, 2) caretaker exit interview, 3) re-examination of child 2 month to 5 years, 4) facility equipment and supply checklist, and 5) observation sheet.

Available at http://www.emro.who.int/cah/pdf/IMCSurvey/SUD/SurveyProcedure03.pdf

Author: Regional Office for the Eastern Mediterranean, Child and Adolescent Health Department, World Health Organization and Egypt Ministry of Health and Population

Year: 2002

Title: IMCI Health Facility Survey, Egypt

Source: Cairo, Egypt: World Health Organization, Regional Office for the Eastern Mediterranean

Abstract: IMCI was introduced in Egypt in 1997 to integrate vertical child health care programs under the primary health care program. It has since expanded to cover some 600 health facilities in 10 governorates. The IMCI Health Facility Survey was planned to measure outcome indicators (quality of care) at IMCI health facilities. The study found that caretakers highly appreciated the child health care services provided. The management of sick children seen by providers trained in IMCI followed a systematic approach in most cases and drugs were used rationally. Key supportive elements of the health system were in place in the IMCI facilities visited. The report concluded that the IMCI strategy seems to act as a powerful channel to improve the quality of services. Better links should be established between IMCI and mother care.

Available at http://www.emro.who.int/cah/pdf/imcisurvey/egy/report02.pdf.

Author: Regional Office for the Eastern Mediterranean, Child and Adolescent Health Department, World Health Organization and Sudan Ministry of Health and Population

Year: 2004

Title: Health Facility Survey on Quality of Outpatient Child Health Services, IMCI Health Facility Survey, Sudan

Source: Cairo, Egypt: World Health Organization Regional Office for the Eastern Mediterranean

Abstract: Integrated Management of Childhood Illness (IMCI) was introduced in Sudan in 1996 as a strategy to address the most important causes of under-five mortality and morbidity using an integrated approach in line with the primary health care policy. It has since expanded to cover about 500 health facilities in 71 (30%) of 240 districts located in 10 states. The IMCI Health Facility Survey was planned to measure outcome indicators on quality of care at IMCI health facilities. The survey revealed that performance by providers not trained in IMCI was often rather poor, raising the issue about pre-service training and in-service supervision. For example, 74% of children were prescribed antibiotics unnecessarily, none of the caretakers of diarrhoea cases given ORS was advised on its preparation and administration, and often no advice on home care was given by providers not trained in IMCI. The survey enabled the collection of health facility data on child health service indicators, useful to monitor

progress towards the achievement of the Millennium Development Goals. The results on case management clearly show a better performance for tasks carried out by providers trained in IMCI than those untrained, evidence that IMCI training can improve quality of care.

Available at http://www.emro.who.int/cah/pdf/imcisurvey/sud/report03.pdf.

## Quick Investigation of Quality (QIQ)

Author: Bertrand, J. and Sullivan, T.

Year: 2000

Title: Quick Investigation of Quality (QIQ): Monitoring quality of care in clinic-based family planning programs

Source: MEASURE Evaluation Bulletin 1:1-3

Abstract: The Quick Investigation of Quality (QIQ) was developed in response to the need for a low-cost, practical tool to monitor quality of care routinely in clinic-based family planning programs. In this article, the authors described the three steps in the development of the QIQ tools: (1) selection of indicators, (2) development of protocol and data collection instruments, and (3) field testing. The selected 25 quality of indicators are included in this paper.

Available at http://pdf.usaid.gov/pdf_docs/PNACN334.pdf and http://www.cpc.unc.edu/measure/publications.

Author: Bessinger, R.E. and Katende, C.

Year: 2000

Title: The quality of family planning and antenatal care services in DISH and comparison districts in Uganda

Source: MEASURE Evaluation Bulletin 1:13-16

Abstract: A survey of the quality of care of family planning and antenatal care services was conducted in Uganda as part of the field test of the QIQ, in collaboration with the Delivery of Improved Services for Health (DISH) project. The project aimed to improve the quality, use, and sustainability of reproductive health services in 12 of Uganda's 45 districts. One objective of the survey was to compare the quality of care in DISH project and non-project districts for program evaluation and improvement. Some key findings include 1) a fairly adequate level of care in DISH and in comparison districts; 2) most family planning and antenatal clients were satisfied with the services received; 3) more new family planning clients received their preferred method in DISH districts than in comparison districts; 4) family planning and antenatal clients in DISH districts were more likely to have their problems addressed than in comparison districts; and 5) Integration of STD and HIV prevention activities into antenatal

visits occurred more frequently in DISH districts than in comparison districts.

Available at http://www.cpc.unc.edu/measure/publications.

Author: Gordillo, A. and Pinto, E.

Year: 2000

Title: Assessing the quality of care of NGO family planning services in Ecuador

Source: MEASURE Evaluation Bulletin 1:5-7

Abstract: A survey of the quality of care at NGO facilities in Ecuador was conducted as part of the QIQ field test. The two major NGOs in Ecuador, Asociacion Pro-bienestar de la Familia Ecuatoriana (APROFE) and Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF), operate a total of 43 health facilities in urban areas. A facility audit was performed at all 43 facilities. Two types of providers — doctors and obstetrices/nurses — were observed, and client exit interviews were conducted at each facility. The key findings suggest that it would be useful to: 1) review the counseling guidelines used at the facilities with the aim of better integrating the activities of clinical service provides and counselors in counseling new and follow-up clients; 2) encourage counselors and other health professions to provide information on HIV/AIDS to their clients during counseling sessions, given the growing spread of the epidemic in the country; 3) promote continuous education for clinical service providers in infection control and clinical procedures; 4) create a committee at each clinic to develop mechanisms to identify suggestions for making quality improvements and strategies to carry them out; and 5) maintain continuous monitoring of quality of care throughout the network of clinics.

Available at http://pdf.usaid.gov/pdf_docs/PNACN334.pdf and http://www.cpc.unc.edu/measure/publications.

Author: McCarrier, M., Moyo, I., and Williams, T.

Year: 2000

Title: Quick Investigation of Quality (QIQ) in SEATS-supported family planning clinics in Zimbabwe

Source: MEASURE Evaluation Bulletin 1:17-19

Abstract: Ensuring quality family planning services has been one of the main objectives of the Service Expansion and Technical Support (SEATS) project in Zimbabwe. All 39 facilities that received SEATS support were included in the QIQ study conducted in the next-to-last year of the project. Overall, the study revealed many areas in which quality is acceptably high; however, improvements are still needed in a number of areas. The findings of this field test will be a part

of a long-term and ongoing process for improving quality of care.

Available at http://pdf.usaid.gov/pdf_docs/PNACN334.pdf and http://www.cpc.unc.edu/measure/publications.

Author: Sullivan, T. and Bertrand, J. (Eds)

Year: 2000

Title: Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports (TR-00-05)

Source: Chapel Hill, NC, USA: MEASURE Evaluation

Abstract: The country reports from the QIQ field test have been compiled in an effort both to describe the results of the field test and to make recommendations for future applications based on the lessons learned. This compilation of reports includes an overview of the QIQ country reports from four countries (Ecuador, Turkey, Uganda, and Zimbabwe), methodological lessons learned, cost and practicality of the methodology, and recommendations for future applications.

Available at www.cpc.unc.edu/measure/publications/pdf/tr-00-05.pdf.

Author: Topcuoglu, E. and Curtis, S.

Year: 2000

Title: Quick Investigation of Quality (QIQ) provides data for family planning and reproductive health program monitoring in Turkey

Source: MEASURE Evaluation Bulletin 1:9-11

Abstract: The USAID/Turkey reproductive health program emphasizes the expansion of high quality family planning/reproductive health (FP/RH) services. To monitor the program's progress, a series of indicators had been selected, and a low-cost, rapid assessment tool was needed to collect the relevant data. The QIQ methodology was implemented in the USAID/Turkey focus province of Istanbul in October 1998. The Istanbul QIQ indicated that more than half of all public facilities of all types had the national FP guidelines and the FP pocket book. The survey also found that all private hospitals and 97% of the MCH/FP centers in the Istanbul QIQ either provided or prescribed at least three modern methods, as did over 80% of public hospitals. In contrast, only 41% of health centers provided or prescribed at least three modern methods. Regarding contraceptive storage, 83% of facilities had adequate contraceptive storage conditions, but only 21% of facilities met all of the four infection prevention standards. The results of the Istanbul QIQ have been used extensively to redefine program priorities and direct limited resources, and the QIQ methodology has become an integral part of the

USAID/Turkey performance monitoring plan. Following successful implementation of the survey in Istanbul, it has been used to provide baseline data for new programs in two other provinces in Turkey.

Available at http://pdf.usaid.gov/pdf_docs/PNACN334.pdf and www.cpc.unc.edu/measure/publications.

Author: MEASURE Evaluation project

Year: 2001

Title: Quick Investigation of Quality (QIQ). A User's Guide for Monitoring Quality of Care in Family Planning. (MS-01-02)

Source: Chapel Hill, NC, USA: MEASURE Evaluation project

Abstract: QIQ was created in response to the need for a low-cost, practical means to routinely measure quality of care (QC) in family planning services. Developed with support from the USAID Office of Population, the QIQ has benefited from the input of numerous cooperating agencies in identifying a "short list" of QC indicators, developing the set of instruments to measure them, and field-testing the instruments in four countries: Ecuador, Turkey, Uganda, and Zimbabwe. This guide is intended to make the QIQ methodology accessible to program managers, evaluation specialists, and others interested in monitoring quality of care in family planning programs. The experience of the field tests indicates that it is also adaptable to other areas of reproductive health. The guide contains an overview of the methodology used, sampling guidelines, tips for training field staff, copies of the actual instruments (with modifications based on the field test experience), and guidelines for field personnel in collecting the data. It also includes an approach to presenting the results: a concise summary in numeric and graphic form of the short list of 25 indicators appropriate for policy makers and program staff.

Available at www.cpc.unc.edu/measure/publications/pdf/ms-01-02.pdf.

## Assessment of Injection Safety

Author: Department of Vaccines and Biologicals, World Health Organization

Year: 2001

Title: Tool for the Assessment of Injection Safety

Source: Geneva, Switzerland: World Health Organization

Abstract: The first step towards evaluating the frequency of unsafe injection practices in countries is an injection safety assessment. In 2001, WHO, together with the Safe Injection Global Network (SIGN) and Basic Support for Institutionalizing Child Survival (BASICS) published a tool that provides a standard methodology for such assessments.The tool is

designed to determine how injections given in a health facility, a district, or a country depart from the national standard. The tool allows the users to 1) determine whether a facility where injections are given meets necessary requirements for staff competence, equipment, supplies, and waste disposal; 2) determine whether the critical steps of an infection administration are executed according to recommended best practices; 3) identify the unsafe practices that may lead to infections and that should be targeted by interventions to improve injection safety; and 4) estimate the proportion of health care facilities where injection practices are safe.

Available at http://who.int/vaccines-documents/DocsPDF01/www576.pdf.

Author: Fitzner, J., Aguilera, J.F., Yameogo, A., Duclos, P., and Hutin, Y.J.F.

Year: 2004

Title: Injection practices in Burkina Faso in 2000

Source: International Journal for Quality in Health Care 16:303-308

Abstract: Unsafe delivery and overuse of injections can result in the spread of hepatitis B virus, hepatitis C virus, and HIV. The aim of the present survey was to estimate the frequency of safe injection practices in Burkina Faso. Using the new standardized World Health Organization tool to assess injection practices, the authors selected 80 primary health facilities with a two-stage cluster sampling method, collected information using structured observations and provider interviews, and analyzed the data using Epi-Info software. The results show that in 50 facilities (96%; 95% confidence interval [CI] 85-99%) injections were given with a new, single-use syringe and needle. In 29 facilities (56%; 95% CI 36-74%), staff recapped needles using two hands. All 80 facilities visited had a stock in the community to provide new, single-use syringes and needles. In 61% (95% CI 54-79%) of facilities, staff reported needlestick injuries in the last 12 months. Used needles were discarded in open containers in 66 facilities (83%; 95% CI 55-96%) and observed in the surroundings of 46 facilities (57%; 95% CI 32-80%). The authors concluded that most of the health facilities in Burkina Faso were using sterile injection equipment. However, practices were still observed that could expose patients, health care workers, and communities to risks, and that required specific interventions.

Available at http://intqhc.oxfordjournals.org/cgi/content/full/16/4/303.

Author: Murhekar, M.V., Rao, R.C., Ghosal, S.R., and Sehgal, S.C.

Year: 2005

Title: Assessment of injection-related practices in a tribal community of Andaman and Nicobar Islands, India

Source: Public Health 119(7):655-658

Abstract: A survey to assess injection related practices was carried out among the Nicobarese, a mongoloid tribe of Andaman and Nicobar Islands, India. The survey was carried out using the rapid assessment and response guide of Safe Injection Global Network of the World Health Organization and included review of randomly selected prescriptions of patients attending outpatient clinic of district hospital, interview and observation of injection providers in the district hospital and sub-centres, and interview of the general population. The findings of the survey showed that 18.8% of prescriptions included at least one injection. The per capita injection rate was three per year. Majority of injections were administered with disposable syringe and needle and in hospital setting. All the injection providers were aware about possibility of HIV transmission through unsafe injections. However, the awareness among the general population was low. More than half of the individuals had a preference for injections. The results of the survey suggest that remedial measures, such as education of prescribers to reduce the number of injections to a bare minimum, maintaining regular supply of disposable injection equipment, provision of adequate sharps containers with safe disposal facilities, and community education be undertaken to avoid future spread of blood-borne pathogens.

Author: Vong, S., Perz, J.F., Sok, S., Som, S., Goldstein, S., Hutin, Y., and Tulloch, J.

Year: 2005

Title: Rapid assessment of injection practices in Cambodia, 2002

Source: BMC Public Health 5:56

Abstract: To estimate the magnitude and patterns of such practices, a rapid assessment of injection practices was conducted. The data collection forms were adapted from the WHO Safe Infection Assessment Guidelines. The survey covered a random sample of the general population in Takeo Province and convenience samples of prescribers and injection providers in Takeo Province and Phnom Penh city regarding injection related knowledge, attitudes, and practices. Injection providers were observed administering injections. The results of the survey show that among the general population sample (n = 500), the overall injection rate was 5.9 injections per person per year, with 40% of participants reporting receipt of one or more injections during the previous six months. Prescribers (n = 60) reported that 47% of the total prescriptions they wrote included a therapeutic injection or infusion. Among injection providers (n = 60), 58% recapped the syringe after use and 13% did not dispose of the used needle and syringe appropriately. Over half (53%) of the providers reported a needlestick injury during the previous 12 months. Ninety percent of prescribers and injection providers were aware HBV, HCV, and HIV were transmitted through unsafe injection practices. The survey results suggest that Cambodia has one of the world's highest rates of overall injection usage, despite general awareness of associated infection risks.

Available at http://www.biomedcentral.com/1471-2458/5/56/abstract.

## Hospital Assessment Tool by Making Medical Injections Safer (MMIS) Project

Author: Making Medical Injections Safer (MMIS) Monitoring & Evaluation Team

Year: 2006

Title: Health Facility Assessment Training Materials

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: This resource contains materials that are designed to provide a comprehensive three-day training of data collectors for use in health facility assessments. Materials include an agenda, presentations, and exercises for each section of the health facility assessment tool.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_WEBSITE_PGG/MMIS_HOMEPAGE_PG/MMIS_RESOURCES_TAB?p_url=MMIS_RESOURCES_TAB&p_render=SUBPAGE&p_pg=MMIS_RES_SURVEY_TOOLS_PG&p_key=.

Author: Making Medical Injections Safer project

Year: 2007

Title: Analysis Plan for Making Medical Injections Safer Health Facility Surveys.

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: This document guides the data analyst on how to analyze each question of the health facility assessment and how to include the results in the final report. This document is organized by each section of the health facility assessment tool.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_CONTENT_PGG/MMIS_RESOURCES_PG/MMIS_RES_SURVEY_TOOLS_PG/Analysis%20Plan%20for%20HFAs%20in%20general_April%202007.doc.

Author: Making Medical Injections Safer project.

Year: 2007

Title: MMIS Guidelines for Field Work.

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: This document provides specific guidelines on the entire data collection process

of the MMIS project Hospital Assessment Survey. The guidelines include instruction on gaining access to facilities, selections of facilities and procedure for replacements, selecting and interviewing respondents, obtaining informed consent, deciding which tool to use, and dealing with dangerous situations and emergencies.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_CONTENT_PGG/MMIS_RESOURCES_PG/MMIS_RES_SURVEY_TOOLS_PG/GUIDELINES%20FOR%20FIELD%20WORK_April%202007.doc.

Author: Making Medical Injections Safer project

Year: 2007

Title: MMIS Project Hospital and Lower Level Assessment Tool

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: The MMIS project Hospital Assessment Tool, adapted from a WHO tool, was developed by the MMIS project for use in assessing injection safety and waste management practices in project-area facilities. It contains questions on injection safety commodities and their management, injection administration practices by staff, waste handling and equipment, and patient experiences. The tool is used to provide data for calculating key indicators of injection safety. The hospital assessment tool and lower-level assessment tool have been combined into one tool with specific instructions for each type of facility. In addition, questions specifically relating to phlebotomy have been added for observation of phlebotomy procedures. Also, behavior change communication questions for the provider and patient have been added to evaluate effectiveness of project BCC materials.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_CONTENT_PGG/MMIS_RESOURCES_PG/MMIS_RES_SURVEY_TOOLS_PG/General%20MMIS%20hospital%20and%20lower%20level%20tool_April%202007.doc.

Author: Making Medical Injections Safer project

Year: 2007

Title: MMIS Supportive Supervision Checklist for Hospitals and Lower-Level Facilities

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: This tool is designed to provide data to assess the progress of the country in improving injection safety and waste management by focusing brief interviews and observations on key indicators. The tool includes a spreadsheet for summarizing the findings as well as the

questions.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_CONTENT_PGG/MMIS_RESOURCES_PG/MMIS_RES_SURVEY_TOOLS_PG/MMIS%20Supportive%20Supervision%20Checklist%20Dec%202007.xls.

Author: Making Medical Injections Safer project

Year: 2007

Title: Survey Preparation Guide for Country Directors

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: This document is a guide for the MMIS country teams for implementing the Health Facility Assessments. Guidance is given on what advance preparations are necessary in making the questionnaire, data analysis, and protocol country-specific sampling, getting local institutional review board and ministry of health approvals, hiring local consultants for the survey, planning the survey logistics, planning for the data entry and the survey report, training data collectors, and supervising the fieldwork teams.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_CONTENT_PGG/MMIS_RESOURCES_PG/MMIS_RES_SURVEY_TOOLS_PG/Survey%20preparation%20notes%20for%20CDs_April%202007.doc.

Author: Making Medical Injections Safer project

Year: 2007

Title: Wide Performance Indicators for MMIS Project

Source: Arlington, VA, USA: Making Medical Injections Safer (MMIS) project, John Snow, Inc.

Abstract: This table includes the indicators required for U.S. Agency for International Development and U.S. Centers for Disease Control and Prevention reporting as part of the standardized set of indicators developed by the U.S. President's Emergency Plan for AIDS Relief program partners implementing injection safety projects. MMIS project-specific indicators are used for cross-country comparison. The table gives the definition, data source and data collection method, and method of calculation for each indicator.

Available at http://portalprd1.jsi.com/portal/page/portal/MMIS_CONTENT_PGG/MMIS_RESOURCES_PG/MMIS_RES_SURVEY_TOOLS_PG/MMIS%20Indicator%20table_April%202007.doc.

## Other Facility Assessment Tools and Supporting Documents

Author: Population Council and Pubcomm Group, Inc.

Title: Computer-Based Tools to Improve Supervision, Monitoring, and Evaluation of Reproductive Health Programs

Source: New York, NY, USA: Population Council

Abstract: The Population Council and the Pubcomm Group, Inc. have developed simple, inexpensive, user-friendly computerized tool to assist supervisors in improving the quality of family planning, maternity care, and post-abortion care services. The programs are written (and are easily modifiable) in Microsoft Excel, and have been used to monitor provider knowledge, behavior, and capacity to provide reproductive health services. The tools are divided into several categories including family planning services, obstetric services, post-abortion care, and maternal and child health services.

The software is free and is available at http://www.popcouncil.org/rh/palmtops.html.

Author: MEASURE Evaluation

Title: Facility Audit of Service Quality

Abstract: The purpose of the Facility Audit of Service Quality (FASQ) is to facilitate local (e.g., project-level or district-level) and low-cost monitoring of availability and quality of facility-based reproductive and child health services at all government and private facilities, including private clinics. The key areas that FASQ provides information including 1) range of services offered, staffing and staff qualifications, operating hours, community linkages, selected administrative and quality control procedures; 2) facility infrastructure (i.e. electricity, water, telephone, lighting, vehicles, privacy/capacity, emergency, transportation, laboratory); 3) readiness to provide quality care in the areas of family planning; STI management, antenatal care, maternal/delivery care and post-abortion care, child health/welfare, and HIV prevention, treatment, and care; and 4) digital maps of facilities and services available.

More information is available in Profiles of Health Facility Assessment Method (2006, IHFAN/MEASURE Evaluation) at http://www.cpc.unc.edu/measure/publications/pdf/tr-06-36.pdf.

Author: Population Council

Title: Health Facility Assessment

Abstract: This assessment approach builds on the situation analysis methodology and provides a descriptive picture of the range of reproductive health services offered at health facilities and the resources used in their production. Program managers and policy-makers can use the data generated for diagnosis or needs assessment, and for monitoring and evaluation. This

methodology can also be used to test hypotheses when piloting interventions to improve service quality. The key areas covered by this approach are: 1) the availability of services, level of integration of services, infrastructure, equipment, supplies and commodities, management information system (MIS) and logistics systems; 2) provider attitudes, training, and behavior; and 3) client experiences, costs and service fees, and community perceptions of services and providers.

Available at http://www.popcouncil.org.

Author: Management Sciences for Health

Title: Integrated Health Facility Assessment Tool

Source: Cambridge, MA, USA: Management Sciences for Health

Abstract: This facility assessment tool is for planning the integration of health programs for infants and children at outpatient facilities. The assessment collects information on the case management of acute respiratory tract infections, diarrhea, malaria, measles, and malnutrition and on drug supply, equipment, supervision and training. It is designed to measure elements of Integrated Management of Childhood Illnesses (IMCI). District staff conduct all survey activities in three weeks and use data to help program planners and health workers design strategies and to monitor and evaluate progress toward integrated health worker practice.

Available at http://erc.msh.org/mainpage.cfm?file=2.45.htm&module=toolkit&language=English.

Author: Management Sciences for Health

Title: Inventory Management Assessment Tool (IMAT)

Source: Cambridge, MA, USA: Management Sciences for Health

Abstract: The Inventory Management Assessment Tool (IMAT) produces indicators to assess the effectiveness of record-keeping and stock management practices in a warehouse and provides suggestions for improvement. The tool guides users through the process of collecting data (based on the stock levels of a group of representative products over a 100 day period), calculating indicators, analyzing and interpreting the results, and identifying appropriate strategies for improvement. The IMAT can be conducted at a single warehouse, health facility, or other institution that manages stock. It can also be used at different levels of the health system to examine record-keeping and stock management practices throughout the country. Evaluators should plan for a half-day to implement the IMAT at each site.

Available at http://www.msh.org/resource-center/inventory-management-assessment-tool.cfm.

Author: Suh, S., Moreir, P., and Ly. M.

Year: 2007

Title: Improving quality of reproductive health care in Senegal through formative supervision: results from four districts

Source: Human Resources for Health 5:26.

Abstract: Management Sciences for Health (MSH) has implemented a program of formative supervision. This problem-solving approach collects data on quality of care, improves technical competence, and engages the community in improving reproductive health care. The IMAT tool developed by MSH was used in this program to assess the accuracy of stock registration and the effectiveness of drug supply management. The authors conducted a study to evaluate changes in service quality and community involvement after two rounds of supervision in 45 health facilities in four districts of Senegal. The authors used checklists to assess quality in four areas of service delivery — infrastructure, staff and services management, record-keeping, and technical competence. The authors concluded that formative supervision can improve the quality of reproductive health services, especially in areas where there is on-site skill building and refresher training.

Available at http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=2217524&blobtype=pdf.

Author: Reproductive Health Response in Conflict Consortium

Title: RHRC Monitoring and Evaluation Toolkit

Source: Reproductive Health Response in Conflict (RHRC) Consortium

Abstract: The RHRC Monitoring and Evaluation (M&E) Toolkit presents a decision-oriented model for program monitoring and evaluation. The toolkit is tailored specifically to the information and decision-making needs of managers of reproductive health programs serving refugees and other war-affected persons. One of many tools in the toolkit is the facility assessment protocol. This is designed to help users assess existing capacity of health facilities to meet the reproductive health needs of conflict-affected populations. This tool is meant to be used in conjunction with other tools, as this tool alone will not sufficiently determine what services are needed by a particular refugee population. Other tools in this kit address client record review, client exit interview, and training assessment.

Available at http://www.rhrc.org/resources/general%5Ffieldtools/toolkit/protocols.html.

## Mapping Resources

Author: MEASURE DHS

Title: GIS and Demographic and Health Surveys [fact sheet]

Source: Calverton, MD, USA: MEASURE DHS

Overview: This is a brochure on MEASURE DHS's work on GIS and DHS.

Available at www.measuredhs.com/pdfs/GIS-updated.pdf.

Author: MEASURE Evaluation

Title: Improving global M&E programs for orphans and vulnerable children (FS-07-19) [fact sheet]

Source: Chapel Hill, NC, USA: MEASURE Evaluation

Overview: This fact sheet is about global M&E of programs serving orphans and vulnerable children.

Available at http://www.cpc.unc.edu/measure/publications/pdf/fs-07-19.pdf.

Author: MEASURE Evaluation

Title: Using maps to better understand populations, programs, and health (FS-07-20) [fact sheet]

Source: Chapel Hill, NC, USA: MEASURE Evaluation

Overview: This fact sheet involves the use of maps in evaluating programs.

Available at http://www.cpc.unc.edu/measure/publications/pdf/fs-07-20.pdf.

Author: World Health Organization

Title: Global Health Atlas

Source: Geneva, Switzerland: World Health Organization

Overview: The World Health Organization's Global Health Atlas allows analysis and comparison of standardized data and statistics for infectious diseases at country, regional, and global levels. It also provides information on essential support services, such as the network of communicable diseases collaborating centers and the Global Outbreak Alert and Response Network, among others.

Available at http://www.hwo.int/globalatlas. Global Atlas of the Health Workforce is available at http://www.who.int/globalatlas/default.asp.

Author: Google

Title: Google Earth

Source: Mountain View, CA, USA: Google

Overview: Google Earth software allows you view satellite imagery, maps, terrain, and buildings via an Internet connection.

Available at http://earth.google.com.

Author: World Health Organization

Title: HealthMapper

Source: Geneva, Switzerland: World Health Organization

Overview: The HealthMapper is a surveillance and mapping application, developed by WHO, that aims to address critical surveillance information needs across infectious disease programs at national and global levels. The HealthMapper also packages a database of core baseline geographic, demographic and health information, including the location of communities, health care and education facilities, accessibility by road, access to safe water and demography. The system is currently in operation to support a range of infectious diseases in over 60 countries in all regions of WHO. Key infectious disease programs currently using the system include those addressing malaria, lymphatic filariasis elimination, buruli ulcer, guinea worm eradication, onchocerchiasis, and polio.

Available at http://www.who.int/health_mapping/tools/healthmapper/en/index.html.

Author: U.S. Agency for International Development

Title: HIVmapper

Source: Washington, DC, USA: U.S. Agency for International Development

Overview: The HIVmapper is an interactive GIS mapping tool that allows users to create maps quickly based on MEASURE DHS data found in the HIV/AIDS Survey Indicators Database Indicators Database. The indicators are primarily derived from the UNAIDS National AIDS Programmes: Guide to Monitoring and Evaluation.

Available at http://www.hivmapper.com/.

Author: U.S. President's Emergency Plan for AIDS Relief

Title: HIV Spatial Data Repository

Source: Washington, DC, USA: HIV Spatial Data Repository, U.S. President's Emergency Plan for AIDS Relief

Overview: The HIV Spatial Data Repository is a Web site especially designed for geographic information system (GIS) users interested in mapping HIV indicators. The site is one of the first to provide HIV data, primarily from developing countries, for GIS purposes. The HIV Spatial Data Repository features data from Demographic and Health Surveys (DHS) and from the U.S. Census Bureau. The repository provides geographically-linked HIV-related data for mapping in a GIS. Data are provided in a form that allows GIS users to integrate their own GIS data to produce new analyses and mapping of HIV data. In addition, the repository includes a gallery where GIS users can post maps they have created using data from the repository. On this interactive page, people can post maps they have created and comment on other HIV-related maps. The gallery is intended to be an online forum for collegial support and professional critiques.

Available at www.hivspatialdata.net.

Author: VanWey LK, Rindfuss RR, Gutmann MP, Entwisle B, and Balk DL.

Year: 2005

Title: Confidentiality and spatially explicit data: Concerns and challenges

Source: PNAS 102:43

Overview: Maps are indispensable for the display of results but also reveal information on the location of respondents and sampling clusters that can then be used in combination with shared data files to identify respondents. This paper presents four sometimes conflicting principles for the conduct of ethical and high-quality science using such data: protection of confidentiality, the social–spatial linkage, data sharing, and data preservation.

Available at http://www.pnas.org/cgi/reprint/0507804102v1.pdf.

## Appendix C Conclusion

This document is a compilation of relevant resources for the HFA surveys around the world. The types of health facility-based surveys included in this document ranged from the nationwide census to program-based or theme-specific surveys. We hope readers find this document useful in quickly identifying and reaching the needed information for research or program planning, monitoring and evaluation.

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