Using Health Facility Assessment Data to Address Programmatic Questions

ILLUSTRATIVE EXAMPLES FOR PROGRAM MANAGERS

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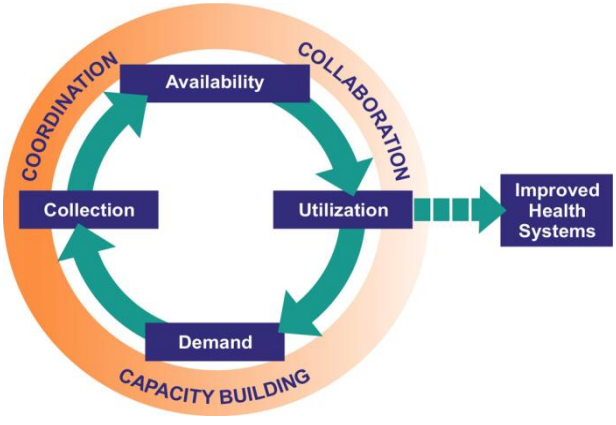
Using Health Facility Assessment Data

Health care providers, program managers, and policy-makers are required to make decisions that hold consequences for the health outcomes of individuals, communities and countries. Ideally, these health professionals demand and use data to inform their decisions and actions. In practice however, decisions are often made without consulting data. Poor data availability and quality, as well as the lack of data in the appropriate metrics, are often cited as major barriers to information use. But even when quality information is available, it is frequently not used in the decision-making process. In the absence of using data to make decisions, decisions are based on anecdotes and gut feelings. In these situations, the health system fails to respond to the priority needs of the populations it serves.

Why Are Health Facility Assessment Data Important?—Health facility assessment (HFA) data tell the story of what is going on within health facilities. They are historically underutilized yet are high quality sources of information that can be helpful in making data-informed decisions to improve health programs. This paper illustrates how data can be applied to answer questions currently facing many program managers.

Encouraging data-informed decision making promotes decisions that are objective, targeted and transparent. Data-informed decision making helps to ensure that programs monitor progress toward their objectives and meet their health goals. In times of high disease burden, a growing population and finite resources, decision makers need reliable data to ensure that they are providing the most efficient and effective services to the communities they serve. Towards this goal, this paper illustrates how health facility assessment (HFA) data can be applied to answer questions currently facing many health program managers. The MEASURE Evaluation data demand and use (DDU) conceptual framework (Figure 1) is used as an organizing construct, which depicts data demand and use as a cycle that connects data demand, data collection/analysis, and information availability to data use.

Figure 1 The DDU Conceptual Framework



This cycle, elaborated by the construct, is supported by collaboration, coordination, and capacity building. There is a clear and consistent link between the use of health information and

the commitment to improving the quality and availability of data. Increased information use generates greater demand for data which, in turn, spurs future information use and continued demand.

The examples addressed in this paper highlight the application of data from HFAs. We will describe how to extract HFA data from published reports to answer the example questions as well as the process for using the data in the decision making process.

THE IMPORTANCE OF HFA DATA

HFA data are historically underutilized yet are high quality data sources that can be helpful in making data-informed decisions. Most standard HFAs present a picture of the services and service quality that exists in health facilities. They tell what is actually happening at the level of service delivery (input, process, costs, output, and quality) and expose the contextual issues that may hinder or facilitate quality health service provision. Such information is needed for monitoring and improving facility-level performance and service quality.

As defined in *Profiles of Health Facility Assessment Methods*,[1] health systems are comprised of networks of health facilities, i.e., formal service delivery points. Indicators that focus on the individual facilities (or service delivery points) are needed to show how inputs to a health system are reflected in the type, quantity, and quality of services actually available to a population. Such indicators produce information essential for needs assessments and planning investments in a health system, as well as for assessing the impact of health services on health outcomes. Health facility assessment is a key technique of generating information for these indicators. The key areas of information provided by HFA are the following:

- Availability, location, and condition of infrastructure (health care facilities, beds, basic medical equipment) for providing a given service. Examples of surveys providing these types of information include the Service Availability Mapping (SAM), the Service Provision Assessment (SPA), the Service Availability and Readiness Assessment (SARA) and the health Facility Census (HFC). These and other HFA approaches and tools are briefly discussed elsewhere in this document.
- Location of health service delivery points, including health facilities and outreach points by ownership, public/private (e.g., SAM, SPA, HFC).
- Range of health services provided (maternal and child health, STI, HIV/AIDS, TB, Malaria), and availability of systems and resources to support quality services (e.g., SAM, SPA, SARA, HFC, Facility Audit of Service Quality [FASQ]).
- Types of integration or linkages between services (e.g., Assessing Integration Methodology [AIM]).
- Health facilities readiness to provide services and/or improve integration and linkages among services (e.g., SARA, SPA, AIM).
- Information on staff qualifications, training, operating hours, and supervision (e.g., SPA, Human Resource for Health Surveys, SARA, FASQ).
- Community linkages and selected administrative and quality control procedures (e.g., FASQ, SPA, SAM, HFC).

[1] International Health Facility Assessment Network (IHFAN). 2008. *Profiles of Health Facility Assessment Methods* [tr-06-36]. Chapel Hill, NC: MEASURE Evaluation, University of North Carolina. [http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/hfa-methods, accessed on 1/8/2012]

- Adherence to standards of practice and infection control, such as injection safety and medical waste management practices (e.g., SPA, FASQ, other program-based HFA tools such as the Making Medical Injection Safer Evaluation tool).
- Patient satisfaction by type, number, quality of services received, collected through observation of client-provider interactions, and client interviews (e.g., SPA, R-HFA, SAM, FASQ, AIM).

HEALTH FACILITY ASSESSMENT VERSUS ROUTINE FACILITY DATA

Routine facility data are data that are generated via patient encounters with health care providers. Since they are collected during the course of service provision, they are invaluable sources of data for program monitoring and improvement at all levels of the system. In well-functioning systems, routine data are the most authoritative, current, and complete sources of facility information. But weak systems are beset with problems of data accuracy, timeliness of data collected, inconsistent data collection and reporting tools, and poor coverage. In strong and weak systems alike, the omission of the private sector renders the routine information systems incomplete and fragmented. In these contexts, an HFA provides an important resource for understanding the health service delivery context.

USES OF HEALTH FACILITY ASSESSMENT DATA

Data obtained from health facility assessments are useful as a stand-alone analysis of health system's strength and gaps. They also play a vital role when combined with population-level data. Health facility surveys and census data can also help elaborate health-seeking behavior (e.g., utilization of services) and clarify the impact of service utilization on population-level outcome measures. Specifically, health facility assessment data are useful for the following:

- Monitoring and evaluating (M&E) health service level changes (for example, infrastructure, staffing, service quality), at the national, sub-national, and community levels. M&E data facilitate the planning of service quality improvements at these levels.
- Assessing facilities and services for strengths, weaknesses, and adherence to standards.
- Producing integrated service profiles covering all health facilities operating in a district, government and private sector.
- Obtaining data for digital mapping useable for tracking service availability, gaps in coverage, and inequities in access.
- Validating routine service statistics and self reports on facility infrastructure, resources, and service provision status collected from patient ecounters.
- Assessing patient satisfaction with facility-based services.
- Elaborating health worker knowledge of standards of practice, types of services provided, types of patient seen, and satisfaction with the current practice.
- Contributing to the understanding of overall improvements in health; HFA tells the implications of service availability and their provision at the desired levels of quality and quantity for longer term health outcomes.

UTILIZING HFA DATA TO ADDRESS PROGRAMMATIC QUESTIONS

Many different types of individuals will find HFA data useful to their decision-making process. The following examples target ministry of health (MOH) program managers and district health management teams (DHMTs). Program managers need a great deal of information in order

to oversee health facilities effectively. They make day-to-day decisions that are critical for the running of health service delivery. Their ability to inform these decisions with data is vital to the health system.

Several questions of interest to this target audience are listed below. The questions are relevant to health facilities regardless of their size, level within the health system or the types of services offered. The illustrative questions include:

- What types of services are provided at different health facilities and do they conform to the standard service norms or recommendations?
- Do the health facilities have the relevant infrastructure to support quality service delivery?
- How many health facilities in the geographic area have appropriate infrastructure to deliver services?
- How many facilities report stock-outs of the relevant drugs in the last six months?
- Do the health facilities have the competent staff to provide services?
- What infection prevention and control practices are in place in the health facilities?

To illustrate the application of HFA data to a specific decision-making context, we have selected two questions from this list to elaborate in this paper. We show how these questions can be answered using HFA from an SPA survey conducted in Kenya in 2004 and a health facility assessment survey conducted in Nigeria by the Making Medical Injection Safer (MMIS) project.

Question 1—Do the health facilities have the relevant infrastructure to support quality service delivery?

A—Data Elements

Health facility infrastructure readiness can be measured in two ways. The first is using a one-item indicator, such as the existence of a counseling room or a consultation table. The second is using a multi-item measure, in which a host of items of infrastructure, such as the existence of counseling room, consultation table, toilet facilities, beds, operating tables, are considered at a time. We recommend the multi-item approach because this is a more robust measure. Health facility infrastructural readiness is a composite of many items of infrastructure (see below), which makes the health facility as operational as possible. IHFAN's composite measure of health facility infrastructural status is a good methodology for addressing multiple items when assessing health facility infrastructure readiness. Per this methodology,[2] the criteria to be met for basic infrastructure are:

- power (e.g., connectivity to a grid and/or functional generator) in the health facility
- improved running water source close to the health facilities
- toilets in the health facility
- availability of room with auditory and visual privacy for patient consultation
- emergency transportation present and functional
- emergency communication equipment present and functional
- overnight beds present

[2] Fapohunda B, Fronczak N, Noriega-Minichiello S, Spencer J. 2007. *Guidance for Selecting and Using Core Indicators for Cross Country Comparisons of HF Readiness to Provide Services*. [wp-07-97]. Chapel Hill, NC: MEASURE Evaluation.

B—Data Sources

When assessing health facility infrastructure readiness, the facility's routine health information system (RHIS) should be consulted as the primary source of data if the system includes an infrastructure and equipment audit. In well-functioning systems, RHIS is the most authoritative, current, and complete source of information. But in systems in which RHIS data collection does not include an infrastructure and equipment audit, or the audit is of poor quality, HFAs should be the primary data source. In cases where the RHIS is of good quality the use of HFA data should still be considered. Data triangulation is always a good practice and the use of both data sources can verify findings.

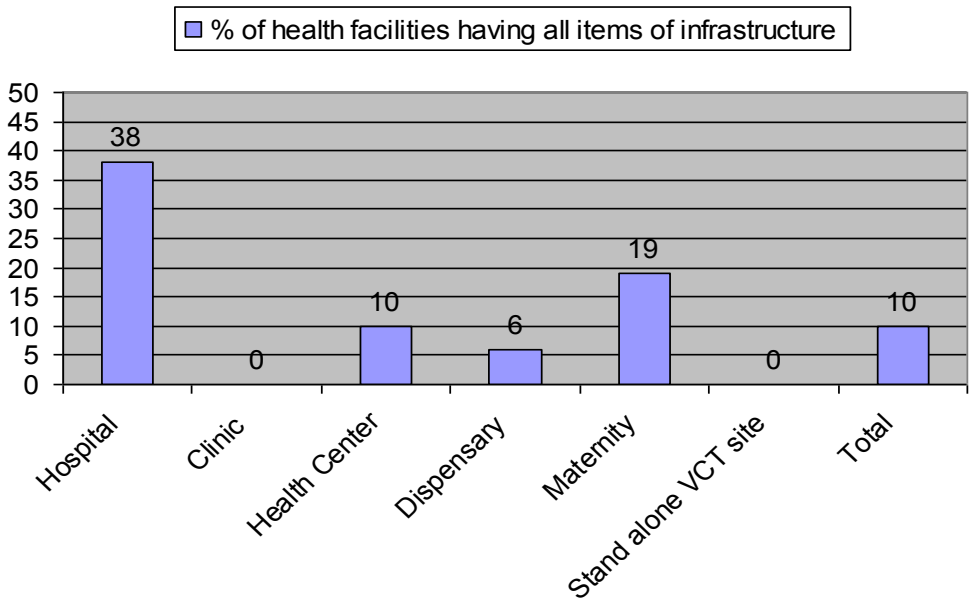
The data summarized in Table 1 and Figure 2 were obtained from published reports of the SPA survey conducted in Kenya in 2004. SPAs conventionally gather data on all seven dimensions of health facility infrastructural readiness measure enumerated above. Developed by MEASURE DHS for national level monitoring of health systems, the SPA is a standard HFA that provides objective and quantifiable information on the status of health services, as measured through resources, systems, and some observed practices. In most countries, published reports on standard HFA can be obtained from the country's bureau of statistics or from the divisional monitoring and evaluation (M&E) offices at the MOH. Published HFA reports such as these are a good starting point for identifying data to inform decisions. When the relevant data are unavailable in published reports or additional information is needed, the MOH or DHMT can arrange with the country's national statistics bureau or the relevant data producers to have the desired statistics computed for them. The names and addresses of the relevant data producers are presented along with the summaries of the leading HFAs in a section below. Alternatively, if they have the capacity in-house, the MOH or the DHMT may choose to compute the relevant statistics from the primary data using their own staff.

Table 1 Percent (%) of Health Facilities with the Specific Item of Infrastructure, Kenya SPA 2004[3]

Type of Facility	Items of Infrastructure								
	Regular Electricity or Generator	On-site Improved Water Sources	Private Room	Client Toilet	Emergency Commu-nication	Emer-gency Trans-portation	Over-night Beds	All Items	Total Number of Facilities by type
Hospital	89	62	100	100	97	69	97	38	29
Clinic	50	63	88	100	88	13	14	0	8
Health Center	50	44	100	100	79	17	64	10	125
Dispensary	37	44	96	96	65	16	21	6	248
Maternity	75	65	100	100	90	30	100	19	20
Stand-Alone Voluntary Counseling and Testing	80	67	90	100	90	10	10	0	10
All Facilities	47	47	97	97	73	20	42	10	440

[3] Fronczak N, Fapohunda B, Bates B, Schenck-Yglesias C. 2007. *Using Health Facility Profiles as a Monitoring Tool: An Example based on Data from three African Countries* [wp-07-101]. Chapel Hill, NC: MEASURE Evaluation.

Figure 2 Percent of Health Facilities with All Items of Infrastructure, Kenya SPA 2004



C—Understanding Data

A common barrier to using data in decision making is the limited capacity of data users to interpret data in the context of program improvement. Program managers and policy-makers, the end data users, are seldom involved in the research and data collection process, thus limiting their understanding of how the data were collected, the questions the study addressed, and the limitations of the data. To overcome this, it is helpful to provide an interpretation of data above and to illustrate how these data are translated to information for decision making.

The information in Table 1 and Figure 2 shows the health facilities that have the specific/all items of infrastructure. Overall, only 10% of all health facilities, irrespective of facility type, have the relevant items of infrastructure in place. Of note is that none of the health facilities classified as clinics or stand-alone voluntary counseling and testing (VCT) sites meet these criteria. Facilities classified as hospitals appear better-positioned than most; 38% of facilities in this category have all the items of infrastructure in place. However, even this 38% falls short of expectations. In a well-performing system, all health facilities should have each of the assessed items in place.

D—Using Data in the Decision-Making Process

Program managers can use this information to support advocacy efforts for better health care infrastructure. Figure 1 shows that only 10% of the health facilities in Kenya had all assessed items of infrastructure. This signifies a major weakness in the health care system that requires attention. These data are the key for raising the profile of poor infrastructural readiness.

In insufficiently resourced countries where health programs are commonly confronted with multiple service delivery problems, these data can also be used to prioritize specific programmatic areas for improvement or to identify gaps in service readiness by health facility type. The data show that health facilities perform better on some items than others. For instance, almost all the health facilities surveyed have a private examination room (97%) and

toilet facilities for clients (97%). Very few have emergency transportation (20%), overnight beds (42%), electricity (47%) or on-site improved water sources (47%). The finding that close to two-thirds of the health facilities with the required infrastructure are hospitals or maternity centers indicates that primary health care centers are ill equipped to provide services. When this finding is combined with the information that primary health care centers in Kenya serve approximately 90% of the target population, a powerful case is built for taking action to influence policy towards improving the primary health care infrastructure.

Question 2—What infection prevention and control practices are in place in the health facilities?

In illustrating this example, we draw specifically from the health facility assessment survey conducted in Nigeria by the MMIS project. From 2004 to 2009, the project was funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) and implemented by John Snow, Inc. (JSI). The goal was to promote safer injection and environmentally acceptable and appropriate waste management practices. In 2004, the project was piloted in four local government areas (LGAs) in two states and the Federal Capital Territory (FCT). By 2009 the project had expanded and was being implemented in five states and the FCT.

A—Data Elements

The MMIS project measured infection prevention and control with the following data elements:

- injection providers received relevant training
- waste handlers received relevant training
- injection providers received hepatitis B vaccinations
- waste handlers received hepatitis B vaccinations
- waste handlers are provided with personal protective equipment
- infectious non-sharps waste (including biological waste) is disposed of properly following patient procedures
- medical waste is segregated into different containers for use with sharps, infectious waste, and non-infectious waste
- providers practice good hand hygiene with soap and running water before beginning an injection session
- providers remove needles from multi-dose vials between injections
- providers use protective barriers when breaking an ampoule
- most recent injection given with new unopened syringe

B—Data Sources

The data presented in Table 2 are from MMIS baseline and follow up surveys conducted in 2005 and 2008.[4] The assessment explored different components of injection safety including supplies, equipment and material management, communication, infection prevention and control, and waste management.

[4] Akpan T, Bhat Shanadi Deepa, Noel M; Sowande A, Van Roekel K, Collins E. 2009. *Evaluation of Injection Safety and Health Care Waste Management in Nigeria*: 2009 Final Report, March edition. MMIS for the Office of the Global AIDS Coordinator (OGAC) and USAID.

Table 2 **Percentage (%) and Number of Facilities with Specific Measures of Infection Prevention and Control, MMIS Project Surveys, 2005 and 2008**[5]

Measures of Infection Prevention and Control	Percent of Facilities in which Specific Items Were Reported/Observed in Project Area			
	2005	N	2008	N
Injection providers received relevant training	33%	237	72%	284
Waste handlers received relevant training	14%	97	55%	101
Injection providers received hepatitis B vaccinations	52%	237	70%	284
Waste handlers received hepatitis B vaccinations	37%	97	39%	96
Waste handlers are provided with NO personal protective equipment	51%	97	23%	101
Infectious non-sharps waste (including biological waste) is disposed of properly following patient procedures	–	–	–	–
Medical waste is segregated into different containers for used sharps, infectious waste, and non-infectious waste	11%	551	25%	984*
Providers practice good hand hygiene with soap and running water before beginning an injection session	12%	551	25%	984*
Providers removes needles from multi-dose vials between injections	63%	117	86%	356*
Providers used protective barriers when breaking an ampoule	52%	33	57%	390*
Most recent injection given with new unopened syringe	94%	514	99%	1,023

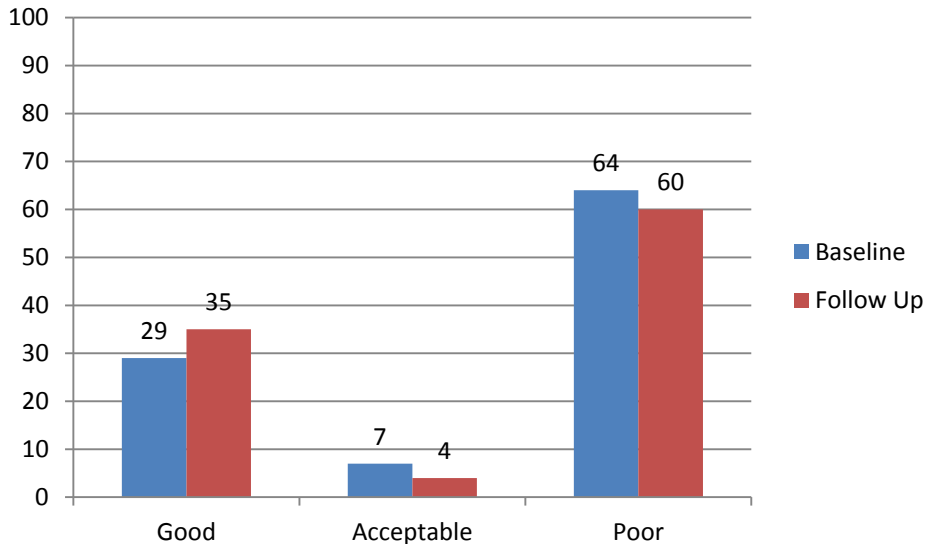
– Data are not available in the published reports
** N is equal to number of injections observed*

C—Understanding Data

The project demonstrated significant improvements in all assessed criteria from 2005 to 2008 (Table 2). For instance, the number of facilities in which health workers received the relevant training more than doubled for injection providers. Among waste handlers, the number almost quadrupled between 2005 and 2008. The number of facilities in which waste handlers had no protective coverings declined by 55 percentage points between the two time periods. These data provide the evidence base for program managers to promote and expand services. Results presented in Table 2 are corroborated by the information in Figure 3.

[5] Akpan T, Bhat Shanadi Deepa, Noel M; Sowande A, Van Roekel K, Collins E. 2009. *Evaluation of Injection Safety and Health Care Waste Management in Nigeria*: 2009 Final Report, March edition. MMIS for the Office of the Global AIDS Coordinator (OGAC) and USAID.

Figure 3 **Overall Satisfaction of Clients with Infection Control Practices: Percent of Health Workers Reporting Specific Results**



In Figure 3, the project uses a categorical indicator, constructed to provide a measure of the overall satisfaction of clients with infection control programs in the project area. Satisfaction is assessed from the point of view of the waste management staff in the health facilities. This measure has three categories: good, acceptable, and poor.[6] The information presented in Figure 3 reports findings in these three areas per the waste management's staff's self-report. The project recorded considerable improvements over the baseline in all assessed criteria of infection control. This summary is effective for providing a bird's eye view of how program managers perceive program accomplishments. For instance, the figure shows improvements over the baseline in the number of waste management staff characterizing the infection control practices as good and declines in those characterizing the waste management system as acceptable or poor. These changes are in the expected direction. While Figure 3 suggests that more work is needed to increase good practices, the consistency and strength of evidences presented in Table 2 and Figure 3 provide some rationale for scaling up the intervention.

D—Using Data in the Decision-Making Process

Program managers can use the information in Table 2 and Figure 3 to support advocacy efforts for interventions to improve infection control and waste management. The findings from Table 2 show that the percentage increase from baseline survey (2005) to the follow-up survey (2008) is more than 20% in all of the measure dimensions and in four, the number more than doubled. Figure 3 shows that individuals rating the overall infection control practices as good also increased by over 20% between the two time periods. A program manager can cite these data to advocate to government or donors for more visibility and/or resources for infection control and good medical waste management. Second, the data can guide the process of identifying specific elements of the systems that either needs to be strengthened/improved or maintained. Consider the provision of injections with new and unopened syringes as represented by item eleven in

[6] Waste disposal definitions: Good = high or medium-temperature incineration, dumping into a latrine or other protected pit, burying underground, and/or transportation off-site for processing. Acceptable = using ;ow-temperature incineration. Poor = open-air burning on the ground or in a hole or enclosure, burial alone, and/or dumping into an unsupervised open area, latrine or other open locations.

Table 2. About 94% of facilities were complying with this dimension at baseline. Additional efforts did not lead to any major improvement in this dimension in 2008. Program managers will therefore need to develop new strategies to elevate this indicator to 100%.

CONCLUSION

HFA data are historically underutilized yet are high quality data sources that can be helpful in making data-informed decisions. The lack of an example of how HFA data can be used in addressing programmatic questions is a key reason for the low use of HFA data. This document provides two examples of the utility of HFA data to program assessment, diagnosis, and improvement as well as a catalogue of the types of HFA data and data collection tools available. The problems program managers may have to deal with in specific contexts may not be the exact replicas of the ones illustrated, but program managers will be able to apply the insights offered by these examples to their own contexts.

HFA Data Collection Tools and Data Availability

This section provides an overview of the types of HFAs and how to obtain more information about each.[7]

Service Provision Assessment

SPA was developed by MEASURE DHS and provides objective and quantifiable information on the status of health services, as measured through resources, systems, and some observed practices. The recommended frequency of implementation is once every three to five years. It is best used for national level monitoring of the health systems. SPA has been conducted in Caribbean countries, Egypt, Ghana, Guyana, Kenya, Zambia, Guatemala, Namibia, Uganda, Tanzania, and Rwanda. For more information and data, please visit: http://www.measuredhs.com/aboutsurveys/spa.

Health Facility Census

Developed by the Japanese International Cooperation Agency (JICA), the Health Facility Census (HFC) assesses the status of physical assets in the health sector and yield information useable for policy, planning and management of health systems development. Designed as a national level assessment of the functionality of health systems' assets, HFC is extensive and extremely robust, but relatively expensive. It is recommended once every five years but, in practice, it is implemented based on national objective, judgment, and availability of funds. HFC has been conducted in Malawi and Zambia. For data and resources, contact JICA, Human Development Department, 8th Floor, Shinjuku Mayad's Tower, 2-1-1 Yoyogi, Shibuya-ku, Tokyo 151-8558, Japan.

Service Availability Mapping

Developed by the World Health Organization (WHO), SAM is designed to support decision making by providing national and district planners with the skills and tools to routinely map service and resource availability. Designed as a district-owned system, SAM can be implemented as a stand-alone suite of tools or integrated into the routine health information system as a supervisory tool. As a monitoring tool, SAM is recommended every six months to one year. The frequency of implementation may be adjusted to suit program needs when utilized as a periodic evaluation tool. For a list of countries where SAM has been conducted and data, please visit http://www.who.int.

The Service Availability and Readiness Assessment

Service Availability and Readiness Assessment (SARA) is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system. SARA is designed as a systematic survey to generate reliable and regular information on a set of tracer indicators of service availability and readiness, such as the availability of key human and infrastructure resources, the availability of basic equipment, basic amenities, essential medicines, and diagnostic capacities; and on the readiness of health facilities to provide basic services, including

[7] The description presented is adapted from *Profiles of Health Facility Assessment*, developed by IHFAN. To read more, please visit http://www.ihfan.org.

family planning, child health services, basic and comprehensive emergency obstetric care, HIV, TB, malaria, and non-communicable diseases. The SAR A methodology was developed in 2011 through a joint WHO and USAID collaboration. To read more, please visit http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/index.html.

Health Facility-Based Survey of Human Resource for Health in HIV/AIDS, TB, Malaria and MCH Services

Developed by Abt Associates, Health Facility-Based Survey of Human Resource for Health in HIV/AIDS, TB, Malaria and MCH Services (HSHRS) is designed to provide situational analysis of the health workforce in health facilities. Data yielded by this approach are key for assessing health workforce profiles, stock, and flows, and for making projections for health workforce requirements for meeting PEPFAR and the United Nation's Millennium Development Goals in specific countries. The survey has been implemented in Nigeria, Cote d'lvoire, and Zambia. For information and data, please visit http://www.phrproject.com.

Rapid Health Facility Assessment

Rapid Health Facility Assessment (R-HFA) was developed by the Child Survival Technical Support Plus Project (CSTS+) in collaboration with MEASURE Evaluation and a panel of experts from US private voluntary organizations (PVOs) and USAID. R-HFA is a relatively rapid instrument for measuring a small set of key indicators to provide a "balanced scorecard" for maternal, newborn, and child health (MNCH) services at the primary health care level (including an optional module for use with community health workers for community outreach services). It identifies key bottlenecks to quality service delivery. The survey was originally designed for assessing quality of child health activities within the Child Survival and Health Grants Program (CSHGP), but in a few countries, it has been implemented in the context of the Malaria Booster Program. It is a perfect tool for service monitoring by DHMTs. R-HFA has been conducted in several countries, the most recent (i.e., conducted in last two years) being Bangladesh, Cambodia, Honduras, Nepal, Niger, Peru, Rwanda, Sudan, Uganda, and Zambia. To read more, please visit http://www.mchip.net/node/791.

The Facility Audit of Service Quality

FASQ is a relatively low-cost approach developed by MEASURE Evaluation for district-level monitoring on service availability and quality. Conducted annually, it provides information on the types of services, status and functionality of infrastructure, and equipment and quality of care. FASQ has been conducted in Bangladesh, Bolivia, Kenya, and Tanzania. For more information, please see http://www.cpc.unc.edu/measure/networks/ihfan.

ACQUIRE's Evaluation of Long Acting and Permanent Methods Services Suite

Developed by Engender Health's ACQUIRE project, the Evaluation of Long Acting and Permanent Methods Services (ELMS) Suite is an adaptation of MEASURE Evaluation's FASQ. ELMS assesses the presence or absence of basic resources in facilities providing long-acting and permanent family planning methods, including staffing, referral facilities, infection prevention, availability of clinical

and service delivery guidelines, job aids, communications materials, physical facilities, drugs, and basic equipment. The survey also assesses provider competence and knowledge of services/methods being provided, including qualification, training and adherence to standards. Clients' satisfaction with services is assessed using exit polls. This approach is recommended in program evaluation and can be conducted every three or four years following a baseline. For more information and data, please contact the ACQUIRE project at http://www.engenderhealth.org.

Assessing Integration Methodology

Developed by The Population Council, Assessing Integration Methodology (AIM) is used for the assessment of health service delivery in the context of integrated programs. AIM is suited to determining:

- types of integration or linkages between services
- readiness of health facilities and staff to improve integrated or linked services to clients
- number and types of services accepted by clients
- quality of care received by clients for each individual service
- costs to the program and service fees
- acceptability of integrated services to providers and clients' satisfaction with integrated services

AIM benefits from the experience gained by The Population Council in undertaking assessment of various combinations of integrated services in many countries, most within the USAID-funded Frontiers in Reproductive Health Program (FRONTIERS). AIM is rooted in situation analysis (SA), a methodology used for elaborating the range of programmatic factors that influence quality of care received by clients during facility-based family planning services.[8] AIM is not only suited to SA contexts but it may also be utilized to determine the changing patterns of service delivery, linkages in existing programs and synergies that are characteristic of service integration contexts. AIM has been conducted in several countries, including Bolivia, Dominican Republic, Egypt, Ghana, Haiti, India, Kenya, Lesotho, Nicaragua, South Africa, Tanzania, and Israel (West Bank/Gaza). For more information and data, please visit The Population Council at: http://www.popcouncil.org/publications/books/2008_AssessIntegratMethodAIM.asp.

The Logistics Indicators Assessment Tool

The Logistics Indicators Assessment Tool (LIAT) is a health facility-based survey developed by the DELIVER project. It is used mainly to assess health commodity logistics system performance and commodity availability at health facilities. LIAT is both an evaluation and a monitoring tool. The data collected using 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); and the percentage of facilities that experienced a stock-out at any point during a given period or at the time of the visit. Countries in which a facility survey using the LIAT have been conducted include Bangladesh, Bolivia, Democratic Republic of the Congo, Dominican Republic, El Salvador, Ethiopia, Ghana, Guatemala, Honduras, Kenya,

[8] Miller et al. 1997. *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook*. New York: The Population Council; Miller et al. (eds.) 1998. *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies*. New York: The Population Council.

Malawi, Mali, Nepal, Nicaragua, Nigeria, Paraguay, Philippines, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe. As of this report, another survey was forthcoming in Nigeria. For more information, survey reports or data, please visit: http://deliver.jsi.com/dhome/search?p_search_tok=liat.

International Health Assessment Network Survey Catalogue

In 2008, IHFAN began collating health facility surveys, censuses, and assessments that have been conducted across the globe. This activity is part of the IHFAN global initiative to strengthen facilities, coordinate data work worldwide, and mainstream and optimize the use of HFA data. As of 2012, the network had listed and profiled 99 surveys. These surveys, which are also contributed to the central catalogue maintained by the World Bank via the International Household Survey Network (IHSN) instrument, can be viewed from the IHFAN Web site. For more information and data, please visit http//www.ihfan.org. HFA catalogue is a valuable resource for program managers to determine which of the previously described surveys have been conducted in their countries.

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