Rapid Health Facility Assessment (R-HFA):

What is it? Should I use it?

Jim Ricca, Child Survival Technical Support Project, Macro International
Bolaji Fapohunda, MEASURE Evaluation

R-HFA Introduction: Learning Objectives

- Describe why and how the R-HFA tool was developed
- Describe the kind of information that the R-HFA generates
- Describe the steps necessary to prepare for and implement the R-HFA

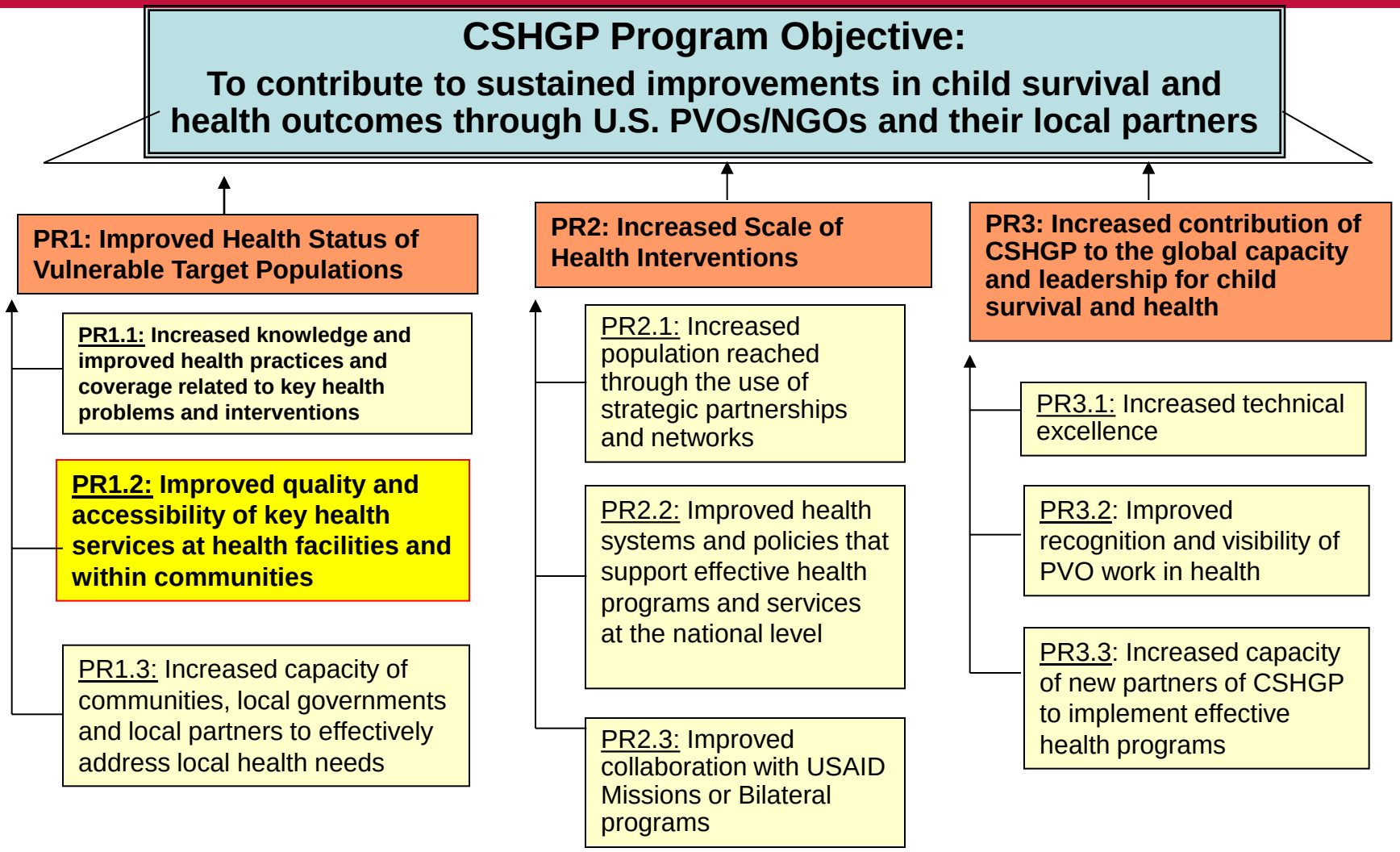
  (partnership development, choosing units for assessment, logistics planning)

In general, what is an HFA?

A Health Facility Assessment consists of qualitative and quantitative data collection about the health system and its services that —

- Examines what health services/supplies are available, their accessibility, quality, and current use pattern
- Uses a systems orientation to identify gaps and strengths in the health system
- Can cover different types of service provision, e.g., formal, informal, private, and public sector services
- Requires a package of tools to cover the different components of assessment of services
- Should be participatory to maximize ownership and capacity building of project and District Health staff

R-HFA: Why was it developed (1)?



R-HFA: Why was it developed (2)?

CSHGP's interest:

Develop or choose standard indicator(s) of **health service quality and access** that can be used to assess CSHGP project results in a comparable manner

Considerations from point of view of projects:

- Utility: Data should be useful primarily for project managers and local partners (especially DHMTs)
- Feasibility: Should increase data collection burden as little as possible (i.e., be rapid and only collect minimum info)
- Familiarity: Should be based on existing tools as much as possible, especially those already being used by grantees

CSHGP grantee quality / access activities

Examples of grantee activities to improve QUALITY

- Ensure supply of essential medicines
- Improve facility patient flow
- Improve case management
- Improve culturally sensitive treatment of patients
- Improve counseling skills

Examples of grantee activities to improve ACCESS

- Establish community insurance schemes
- Increase outreach activities
- Establish or revitalize CHW systems
- Improve referrals from communities to health facilities
- Establish community emergency transportation systems

Why have core indicators for an HFA?

- **Focus** data collection, emphasizing the value of a few basic, essential pieces of information (but leave **flexibility** to gather additional project-specific information)

- Increase **validity and reliability** of information gathered for a small set of indicators, just as the Rapid CATCH does for community surveys

- Increase **comparability** between project data and other existing data (e.g. Routine MOH Health Information System, WHO analyses, national HFAs funded by bilateral donors) to improve planning and priority setting

- Increase **comparability** across the CSHGP portfolio for improved ability to advocate for the program, demonstrating increases in access to and quality of services through project actions

What were PVOs already doing in to assess services in before development of the R-HFA (2005)?

Project	Assess Community Level Health Providers (i.e., CHWs, TBAs)?	Assess First Level Facilities?	Assess Private Providers?	Assess Referral Level Facilities?
ACTS Georgia	x	x		x
ARC Cambodia	x	x	x	
CPI India	x	x	x	
CRWRC Bangladesh	x			
CWI Bangladesh		x	x	
HHF Haiti	x	x		
HKI Niger	x	x	x	
MC Tajikistan		x		
PLAN Kenya	x	x	x	
SC Mali	x	x		
WRC Mozambique	x	x		

What domains were PVOs already assessing in terms of access and quality?

Project	Access	Inputs		Process			Performance
	Geo Access/ Community Orientation	Availability of Essential Supplies	Advocacy and Policy	HW Training	HW Perfor-mance	HW Super-vision	Client Satisfaction
ACTS Georgia		x		x	x		
ARC Cambodia							
CPI India	x	x		x	x	x	
CRWRC Bangladesh	x						
CWI Bangladesh			x			x	
HHF Haiti	x				x		
HKI Niger			x		x		
MC Tajikistan					x		
PLAN Kenya		x			x		
SC Mali						x	
WRC Mozambique	x	x		x			

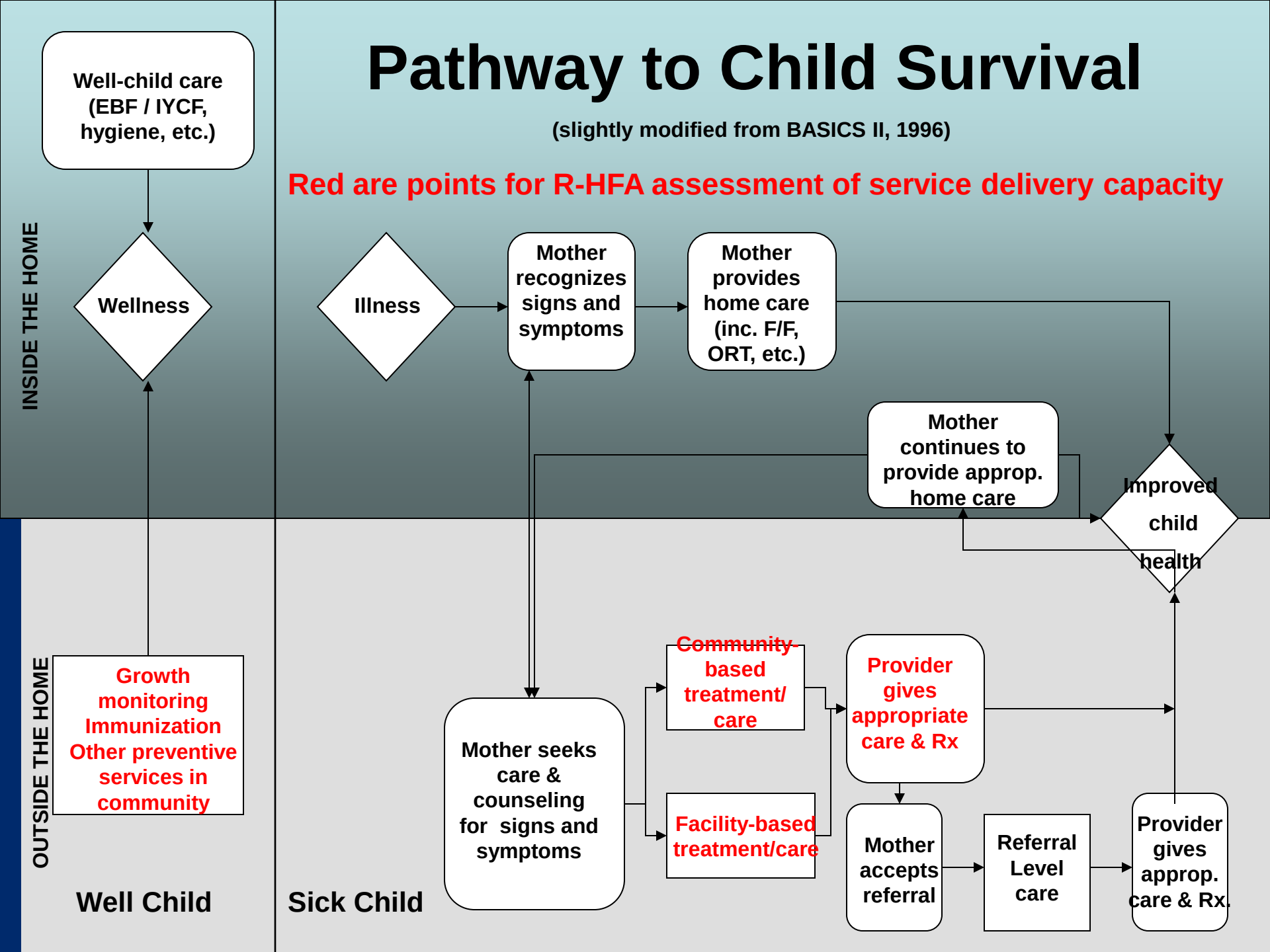
What tools were PVOs already using?

Project	BASICS HFA	WHO HFA	DHS SPA	COPE	PDQ	Other Tool(s)
ACTS Georgia	x					
ARC Cambodia						x
CPI India	x					x
CRWRC Bangladesh		x				
CWI Bangladesh						x
HHF Haiti						x
HKI Niger						x
MC Tajikistan	x					
PLAN Kenya	x					
SC Mali					x	x
WRC Mozambique						

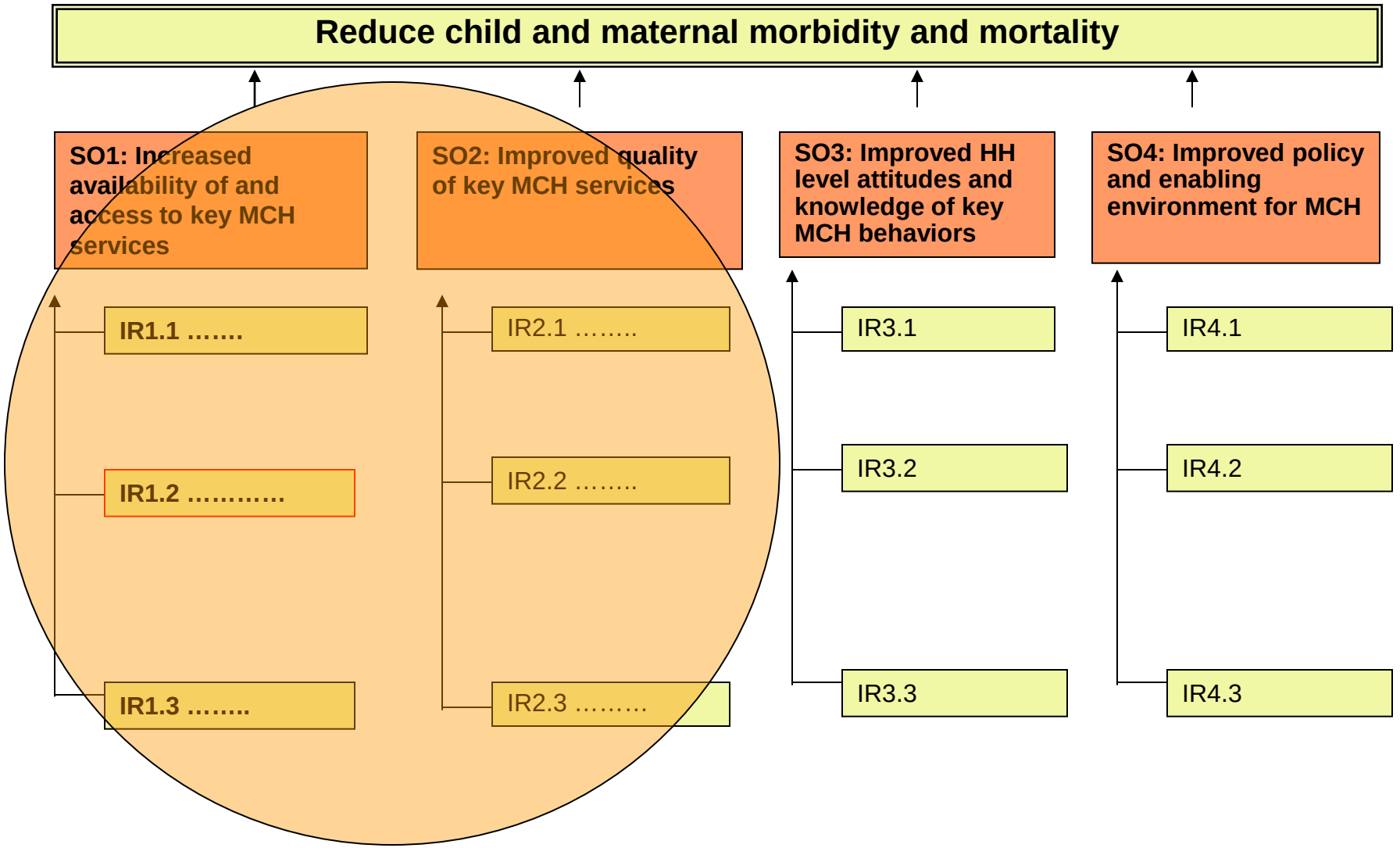
Pathway to Child Survival

(slightly modified from BASICS II, 1996)

Red are points for R-HFA assessment of service delivery capacity



CSHGP Project Results Framework



R-HFA: Key Characteristics

Based on Integrated HFA (BASICS II), SPA (DHS/Macro), FASQ (MEASURE-Evaluation), HFS (WHO), and International Health Facility Assessment Network (MEASURE-Evaluation, WHO, Macro, and others)

- **Maternal-Neonatal-Child Health** only
- **Assess primary health care service delivery points** (first level outpatient facilities and their outreach structures like CHWs) in one or several districts
- **Covers a range of domains** on access, inputs, processes, and performance to give a "balanced scorecard" for primary level health service provision
- **Simple and feasible**: Collect at baseline and final with subset of indicators that can be incorporated into ongoing monitoring and supervision, if desired
- **General and flexible** in order to be applicable in a variety of countries and contexts
- Gives **information that is comparable** to information collected nationally and internationally by others (includes DHS SPA & IHFAN core indicators)

R-HFA 2.0: What's new since last year

- Updates of R-HFA based on grantee feedback from last year
  - Calculation of some indicators adjusted
  - Developed data entry/analysis program in Excel that automatically generates disaggregated tables & summary indicator information for the HFA report
- In conjunction with Saving Newborn Lives, added MNC indicators (access, inputs, utilization)
- In conjunction with World Bank Malaria Booster Initiative
  - simplified instruction manual
  - simplified sampling scheme and analysis of observed clinical cases and exit interview
  - strengthened malaria questions and added optional indicators on ITN and ACT logistics
  - added a brief optional set of questions on laboratory services

R-HFA: Data collection instruments

Start with DHO interview:

Strengthen partnership; choose units to be assessed; calculate geographic access indicator

In HF themselves, apply five brief modules:

1. Observation of Clinical Care for Sick Child
2. Exit Interview of Caretaker of Sick Child
3. Health Facility Checklist & Supervisor Interview
4. Health Worker Interview
5. Community Health Worker Assessment

NOTE: The last module is an unusual component for HFAs but can give useful information for projects working on increasing access, especially through community case management

R-HFA: Core indicators

***IHFAN core indicator / **Child health component of IHFAN core indicator / ***SPA indicator**

Area	#	Domain	Indicator
Access	-	Geographic Access	% population with year-round access to MNC services
	1	Service availability	% HF in which MNC services are available (Child: sick child, immunizations, GMP; MNC: ANC services)
Inputs	2	Staffing*	% staff in HF who provide clinical services and are working on the day of the survey
	3	Infrastructure*	% essential infrastructure in HF to support MNC services available on the day of the survey
	4	Supplies**	% essential supplies in HF to support MNC services available on the day of the survey
	5	Drugs**	% first line medications for MNC services available in HF / CHW on the day of survey (HF: ORS, oral antibiotic for dysentery, oral antibiotic for pneumonia, first line anti-malarial, vitamin A / CHW: context-specific)
Processes	6	Information System**	% HF/CHW that maintain up-to-date and complete records of sick U5 children / ANC services AND show evidence of data use
	7	Training***	% HF/CHW where interviewed HW reports receiving in-service or pre-service education in MNC in last 12 months
	8	Supervision***	% HF/CHW that received external supervision at least once in the last 3 months (includes at least one: check records or reports, observe work, give feedback)

R-HFA: Core indicators (continued)

(Indicators #10-12 are for Child Health only)

^ BASICS Integrated HFA indicator / WHO HF Survey indicator

Area	#	Domain	Indicator
Performance	9	**Utilization**	# sick child visits per year per U5 child in HF catchment area
	10	**HW Performance: Assessment^**	% HF in which all essential assessment tasks were made by HW for sick child (pass = 80% observed cases)
	11	**HW Performance: Treatment^**	% HF/CHW in which treatment was appropriate to diagnosis for child with fever, ARI, and/or diarrhea (pass = 80% observed cases for HF / 80% most recent cases in register for CHW)
	12	**HW Performance: Counseling^**	% HF in which caretaker correctly describes how to administer all prescribed drugs for malaria, ARI, and/or diarrhea (pass = 80% exit interviews)

R-HFA: Optional Indicators

*** IHFAN core indicator / ** Child health component of TWG core indicator / *** SPA indicator**

Area	#	Domain	Indicator
Inputs	**Opt1**	Availability of Immunizations	% HF with all nationally-mandated immunizations in stock on day of survey
	Opt2*	Availability of Guidelines	% HF with all nationally-mandated guidelines for care of children available and accessible on day of survey
	Opt3*	Infection Control	% HF with all infection control supplies and equipment on day of survey
Processes	**Opt4*****	HF-Community Coordination	% HF with routine community participation in management meetings (with evidence through notes) OR have a system for eliciting client opinion, AND evidence that client feedback is reviewed
	Opt5***	Community Referral	% HF that received at least one referral from CHW in the last month
	Opt6	Malaria Drug (ACT) Logistics	% HF with adequate logistics compliance for ACTs
	Opt7	ITN/LLIN Logistics	% HF with adequate logistics compliance for ITNs/LLINs
	Opt8*	Laboratory	% HF with adequate basic laboratory services on site or ability to send out
Performance	**Opt9a**	Utilization of Immunization Services	Annualized number of immunization encounters per U5 children in HF catchment area (should be 0.8 per U5 child)
	Opt9b	Utilization of Growth Monitoring Services	Annualized number of growth monitoring encounters per U5 children in HF catchment area (should be $\geq$ 2.0 per U5 child)

R-HFA: Should I do an HFA?

Should I do an HFA? The answer is "yes" if the project is working on

Project activity	Important HFA information	Important HFA indicators (modules where info is found)
Improving **quality** of facility-based services (e.g., HW training in IMCI protocols, logistics mngmt. for drugs or ITNs, etc.)	Establish baseline level of service quality and demonstrate improvement throughout project	• Indicators for inputs and processes (HF checklist / HW interv.) • Indicators for HW performance (Clin. Obs. & Exit Interv.)
Increasing **access** to services through training community-level workers (CHWs, TBAs)	1. Establish baseline level of access and demonstrate improvement throughout project 2. Demonstrate that level of quality of CHW/TBA is sufficient	1a. Geo Access (DHO interv.) 1b. Svc. Avail. (HW interv.) 2. Indicators for CHW/TBA quality (CHW/TBA forms)
Increasing **demand** for facility-based services through community mobilization and behavior change	Establish baseline level of service quality and show that it meets minimum requirements (or prioritize targeted actions for improvement)	• Indicators for inputs and processes (HF checklist / HW interv.) • Consider indicators for HW performance (Clin. Obs. & Exit Interv.)

R-HFA: Initial decisions

There are two initial decisions to make…

- Which units will be assessed?
  - R-HFA is only suitable for **first level facilities** (non-referral) and allied community service providers (CHWs / TBAs). If emergency obstetric care is an intervention, then you will need additional information about the hospital(s) and inpatient facilities.
  - If you will be working with **CHWs / TBAs**, the R-HFA offers a chance to establish a baseline. If this will be a new cadre of workers, you can assume a "zero baseline" and just incorporate quality indicators in your monitoring and supervision system to track progress

- How many units should be assessed?
  - If working mainly on community-based demand, you may only want to do the minimum necessary work to determine if facilities in the area meet the minimum quality requirements. In this case, a sample can be done (see later slide).
  - If the project is working on quality of services delivered in facilities (especially important for MNC interventions) then you may want to assess ALL eligible health facilities in the area (i.e., perform a census).

Applying R-HFA: Which units to assess?

Obtain a line listing of “first contact points” from the District Health Officer in DHO Interview

1. First level health facilities

- Those that see children directly from the community (i.e., not referred)
- Free-standing or connected with larger facilities (e.g. hospital OPD)
- Free-standing facilities are called by different names – “health posts,” “health centers,” etc. – in different places
- Free-standing facilities may be stratified into different levels, but as long as they see children directly from the community, they should be included in the sampling frame for assessment

2. Community health workers

- Volunteer or paid
- Curative case management, referral, prevention and/or education

Applying R-HFA: How many units to assess?

1. First level health facilities (sample or census)

- In most project areas, there are no more than 30-40 first level facilities. In this case it is feasible to assess ALL facilities (i.e., perform a census of facilities). Assessing all facilities allows a service availability mapping to be done.
- If it is not feasible or desirable to assess all HF, then pick a stratified random sample (design effect = 1.0). HF are usually stratified by type, but can also be picked with probability proportional to size (i.e., utilization). The WHO manual on IMCI-focused HFA, chapter 2 (pgs. 23-24) describes the procedure in detail: http://www.who.int/child-adolescent-health/publications/IMCI/HFS.htm
- The table on the next slide shows the number of HF that need to be assessed to give 95% confidence intervals of 15% for indicators #1 – 9.

2. Community health workers (sample)

- You may collect data at same time on CHWs; alternatively, can do separately from HF data collection. You must decide which makes more sense logistically.
- If statistical analysis is done on results, this must be a **random sample**, not a convenience sample.
- One feasible way to generate a simple random sample (Design Effect = 1.0) is first to develop a line listing of all CHWs eligible to be assessed. This can be done by talking to the District Health Medical Team. From the line listing, one can choose a systematic random sample of 30-50 CHWs to be assessed. This sample will give 95% CI of 10-13% for the indicators on the CHW Form.

Sample size determination

The following sample sizes give a 95% confidence interval of ± 15% using a simple random sample (not LQAS)

Number of HF in area	Number of HF in R-HFA sample
10	8
20	14
30	18
40	21
50	23
60	25
70	27
80	28
90	29
100	30
120	31
140	33
160	34
180	35
220	36
260	37
340	38
400	39
600	40
1,000	41

Applying R-HFA: Which cases to observe & caretakers to interview?

R-HFA focuses its assessment of HW performance on **curative consults for child illness**. Observe **six** consecutive sick children with fever, ARI, and/or diarrhea. The caretakers of these six children are then interviewed using the Exit Interview form.

If you have done a census of HF

- This is equivalent to a simple random sample of cases (design effect = 1.0).
- For each HF/HW assessed, if they perform correctly in 5 of the 6 cases observed (indicators # 10, 11, & 12), then that unit is passed as "usually performing correctly." Using this LQAS reasoning, we are 90% certain that the HF "unit" performs the task correctly at least 80% of the time and we give this facility a "passing score" for the appropriate performance indicator.
- For an analysis of an aggregate sample of 120 cases observed (20 HF) throughout the project area, this is a cluster sample with a design effect of 1.5. This gives a 95% CI = ± 10% for the aggregate number of cases observed across the project area. Sample weights should be applied as well. In the aggregate, one can make inferences about the numbers of services done in the area (an alternative way to calculate from the KPC data) or the mix of cases seen in facilities (i.e., % malaria cases project area-wide, etc).

Applying R-HFA : Preparation (2-4 weeks)

Discussion with District Health Officer

- Inform them of desire to do HFA
- Agree on schedule for training and implementation
- Discuss participation of MOH staff on assessment teams
- Apply DHO Interview: Generate line listing of all HF, CHWs, and communities.
  - This is necessary to determine units to assess (census or sample)
  - This data also needed for calculation of Geographic Access indicator.

Adaptation of modules

- Project staff and MOH work collaboratively to adapt tools to local context (e.g., which antibiotic is mandated as first line for treatment of child pneumonia?)

Choice of personnel for assessment teams

- HFA supervisors – should be health workers (can be “lent” by DHMT)
- HFA interviewers – usually from project staff

DHO Interview: Geographic Access Indicator

(a) Community	(b) Access*	(c) Total Population	(d) Cumulative Population	(e) Reason for No Access
Tilicachi	Y	870	870	
Siripaca	Y	3560	4430	
H. Sucupa	Y	990	5420	
Yumani	Y	1350	6770	
Copacati	Y	700	7470	
Santa Ana	Y	632	8102	
Beleni	Y	1060	9162	
Copacabana	Y	5800	14962	
Challa	Y	780	15742	
Yampuputa	N	467	16209	Travel time
Kassani	N	270	17309	Travel time
Sampaya	N	1590	18899	Travel costs

Mapping HFs / CHWs /Communities

Applying R-HFA : Training & Implementation (2 weeks)

Training (4 days)

- Training should take 4 days – One day prep with supervisors only. Training should include both classroom discussion & experiential learning in nearby health facility
- 2 trainers can feasibly train no more than 5-6 assessment teams with 15-18 assessors

Implementation (4 – 6 days)

Team composition

- Each team has 2 (if not using modules 1&2) or 3 members; at least one member of each team is a health worker (i.e., nurse, doctor, etc.)
- Need enough teams so that the assessment can be finished in 4-6 days.
- Example: If there are 25 HF to assess, 5 teams can assess them in 5 days. With 3 person teams, this will be 15 assessors total.

Agenda for each day

- Each team can assess one HF in one day, starting in the morning
- Supervisor then reviews all forms for completeness and quality of data; recodes for indicators #11 and #12; and gives feedback to HF staff before leaving
- CHWs can be assessed either at the same time as HF if assessment team is large enough or after HF assessment is finished for the day
- In the afternoon, supervisor transcribes data into Excel data entry and analysis program; team moves to the next HF to be assessed.

Training Tips

- Using MOH staff from the area on the teams as supervisors is very useful. This gives your team acceptance by HF staff and knowledge about HFs. The down side is that they might be biased assessors. To minimize potential bias an assessor should never assess his/her own HF.
- One day prior to start of training, meet with supervisors to adapt instruments and plan logistics for training and implementation
- Length & intensity of training depends on experience of participants with health facilities and their assessment.
- Pick a training site with a nearby HF for practice during training. Preferably this HF is not one in the sample to be assessed. Arrange practice visit beforehand with staff at HF.
- Suggested training agenda is an annex in manual

Summary of Logistics

Timeline (6 – 10 weeks total)

- 2-4 weeks for preparation (partnership, hire team, choose units, etc.)
- 3-4 days for training
- 4-6 days for data collection and data entry
- 2-4 weeks for report writing and dissemination

Data collection

- 2-3 people per team
- Best if supervisor is a health worker; better yet if they are from local MOH

Analysis

- Excel data entry and analysis program is focused on core indicators and key tables, which are calculated automatically

Summary

- CSHGP projects get most of their impact from community-based interventions
- However, health facilities are main actors for interventions to improve **quality** and also play key roles to support increased **access.** They can even play a role in supporting and sustaining community-level behavior change.
- **Almost all grantees already assess health services** in order to strengthen partnership between MOH & communities; assess access and quality, and prioritize project interventions. However, there has been **little standardization** of indicators, hindering planning and advocacy.
- **R-HFA** helps collect core standard indicators
  - It gives rapidly collected, valid, and comparable information
  - It gives basic information and grantees may want to supplement it

Questions

R-HFA documents available in a zip file on CSTS website

www.childsurvival.com

- Data collection tools in Excel (DHO interview form for planning, five data collection modules, brief instructions, tabulation plan)
- Data entry and analysis program in Excel
- Instruction manual (sampling, logistics, training guide, instructions, etc.)
- Presentations for training (introduction & implementation; data analysis)
- Sample R-HFA report (thanks to WR/IRC/Concern Rwanda project)

Questions or consultation

Get in touch with Jim Ricca at CSTS:

+301-572-0317

James.G.Ricca@macrointernational.com