

MANUAL

**RAPID HEALTH FACILITY
ASSESSMENT:**

**A TOOL TO ENHANCE
QUALITY AND ACCESS
AT THE
PRIMARY HEALTH CARE LEVEL**

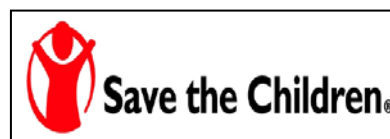


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ACRONYMS AND ABBREVIATIONS

ARI	Acute Respiratory Infection
BASICS	Basic Support for Integrated Child Survival (USAID-funded project)
CA	Catchment Area
CHW	Community Health Worker
COPE	Community Oriented Provider Efficient (facility assessment tool)
CORE	CORE Group of US-based PVOs implementing international health projects
CSHGP	Child Survival and Health Grants Program
CSTS+	Child Survival Technical Support Project Plus
DHO	District Health Officer
DHS	Demographic and Health Surveys
FBO	Faith Based Organization
HF	Health Facility
HFA	Health Facility Assessment
HW	Health Worker
IMCI	Integrated Management of Childhood Illness
LQAS	Lot Quality Assurance Sampling
MOH	Ministry of Health
NA	Not Applicable
NGO	Non-Governmental Organization
OPD	Outpatient Department
ORS	Oral Rehydration Salts
PDQ	Partner Defined Quality
QA	Quality Assurance
R-HFA	Rapid Health Facility Assessment
SPA	Service Provision Assessment of DHS
TTBA	Trained Traditional Birth Attendant
U5	(Children) Under Five Years of Age
WHO	World Health Organization

ACKNOWLEDGEMENTS

At the outset of this manual we want to recognize that the Rapid Health Facility Assessment (R-HFA) tool draws heavily on the structure and content of the BASICS Integrated Health Facility manual (1999). That pioneering effort made the assessment of health facilities a feasible and practical task for a small group of professionals. The survey also draws heavily on the Service Provision Assessment (SPA) of the Demographics and Health Survey (DHS). Many people contributed to the adaptation, simplification and augmentation of these instruments to make the R-HFA. This team was led by Jim Ricca (CSTS) who worked closely with Bolaji Fapohunda (MEASURE Evaluation). It was at her insistence that PVOs were represented on the International Health Facilities Assessment Network (IHFAN), which is housed at MEASURE-Evaluation and has representation from WHO, World Bank, and many other technical agencies. Her insight was fundamental to shaping the tool and aiding PVOs improve service capacity and provision worldwide. Nancy Fronczak (MACRO) also contributed to making R-HFA a practical tool for PVOs. La Rue Siems and Susan Otchere at Save the Children US / Saving Newborn Lives, advised the group on the addition of the newborn care questions and indicators. Kavita Singh (MEASURE Evaluation) helped to draft the indicators. Bill Weiss (Johns Hopkins University Bloomberg School of Public Health) made many valuable suggestions including the Geographic Access Worksheet.

At The World Bank we acknowledge the contributions of Joseph Valadez and his team members, Ciro Franco and Donald Whitson who participated in refining the instrument and making it field friendly. They also ensured that the malaria components were useful and practical for use by program managers. The Bank team also introduced the sampling component to the R-HFA which made it more rapid and gave it statistical rigor.

The entire Child Survival and Health Grants (CSHGP) team at USAID participated in the tool development. Susan Youll (CSHGP team leader at the time) urged the development of a concise set of indicators of quality and access – and it is because of her vision that this project was initiated. Many others in USAID's Global Health Bureau also contributed. The PVO community was heavily involved. We are most indebted to the Salvation Army World Service Organization (SAWSO) and Concern Worldwide who piloted the instrument in Zambia and Bangladesh, respectively. Many contributions came from the Monitoring and Evaluation Work Group of the CORE Group, the CORE Group Secretariat, and the individual PVOs with Child Survival grants. The involvement of these practical, field based organizations has been made R-HFA a richer and higher quality product.

We hope that the intimate involvement by all of these professionals and agencies will make the R-HFA the instrument of choice by PVOs, Program Managers, and MOHs for assessing first level health facilities and their associated community-level workers (CHWs and/or TTBA's) and using the data to improve services.

THE RAPID HEALTH FACILITY ASSESSMENT TOOL

Conducting and Supervising the Assessment

The R-HFA is contained in an Excel file. It consists of a set of worksheets which contain the measurement instruments – that are referred to as *modules*. The file also includes a brief set of instructions for the modules and their use. This document is meant to give additional detail for supervisors and surveyors. Please refer to the worksheets that contain the core indicators for the R-HFA and the Tab Plan which should aid the analyses. In the sections that follow we will refer to indicators by name and by their number reference.

An Overview of R-HFA

This section reviews the different components of the R-HFA and advises on how to manage the field work. This facility assessment evaluates first level health facilities for Maternal, Neonatal, and Child Health (MNCH) services, which in most countries account for well over half of all services provided, so this set of tools gives a good impression of the overall level of quality and access to primary health services. The tools specifically look at the following:

- The assessment, diagnosis, and treatment of children with the most common illnesses (diarrhea, fever/malaria, and acute respiratory tract infections)
- The availability of essential infrastructure, equipment, and supplies in health facilities, especially with reference to MCH services
- The quality of management processes in facilities (e.g., training, supervision, record keeping) in first level health facilities

The four modules are:

1. Clinical Observation – Six Sick Children
2. Exit Interview – Caretakers of Six Sick Children
3. Health Worker Interview and Record Review
4. Health Facility Checklist (Infrastructure, Equipment, Drugs, and Supplies)

Some general guidelines for conducting the assessment are described below, followed by a description of how to complete each section of the survey. In general, the survey will be conducted in the most common local language. During the next three days, all surveyors will need to practice administering the survey in English and in the local language.

Adapting the R-HFA to the Country Context

When adapting this generic R-HFA form for application in a specific country context, there should be a national level consultation with knowledgeable counterparts to introduce them to the form. During this consultation, several adaptations need to occur, and in particular the following:

1. Determine Districts where malaria is holoendemic. In these Districts, Intermittent Presumptive Treatment (IPTp) will be the norm for all pregnant women. In Districts where IPTp is not the norm, the IPTp component of Indicators 5c (Essential Drugs) should be eliminated.
2. The country norm for first line drugs for malaria, pneumonia, and dysentery needs to be specified and put into the following questions:

106A First line antimalarial

106B First line oral antibiotic for pneumonia

106D First line oral antibiotic for dysentery

314.02 First line oral antibiotic for pneumonia

314.03 First line oral antibiotic for dysentery

314.04 First line antimalarial

314.08 First line antibiotic for newborn sepsis

314.09 First line antibiotic for newborn eye infections

411.A2 First line antimalarial

411.B2 First line oral antibiotic for pneumonia

512.A2 First line antimalarial for CHW

512.B2 First line oral antibiotic for pneumonia for CHW

3. Determine the benchmarks that will be used for a “passing score” for a Health Facility (HF) for the following indicators:

Indicator 2. Percent of clinical staff present (in some places, the standard was 100%, while in other locations it was 80% or less)

Indicator 3. Key infrastructure available and/or in adequate condition. (There are 7 items. The analysis sheets give a score for only 3 of them that are most essential – water, latrine, and privacy)

Indicator 4. Key supplies in stock

Indicator 5. Key drugs without stockouts in last 6 months

Indicator 10. Key health care tasks performed adequately

Selecting Survey Teams

Each survey team is composed of two to three individuals. A three person teams consists of a supervisor and two surveyors. A two person team consists of two surveyors with one given supervisory responsibilities. Survey teams should be selected during the training week by the training facilitators in collaboration with program managers. An attempt should be made to balance teams according to the skills of the participants; some surveyors will have stronger skills

in the filling out the checklist and others will be better able to conduct exit interviews with caretakers. The supervisor should be the member of the team with the most experience and he/she will be in charge of conducting the observations of clinical care.

Assuming that one facility can be assessed in half a day, and that another half day is needed to move to the next facility, managers should choose the number of teams needed to carry out the work in one week.

Sampling Health Facilities

The sampling scheme uses a quality control approach similar to Lot Quality Assurance Sampling (LQAS). However, while that approach uses binomial probabilities, this one uses the hypergeometric. While the former is used when sampling universes are large, this is not the case for district level health facilities where the total number of HF is most often less than 100. What follows is a brief description of how to use this approach:

The driving assumption of this approach is that the R-HFA should identify whether or not a minimal proportion of HF in the district are performing to an acceptable standard. For the R-HFA we assume that at least 80% of HF have to perform adequately in order for the District to pass. Managers can adjust this performance standard upward or downward. But for this manual we will use a performance standard of 80%. The concept of *performance adequacy* is determined by the indicators presented elsewhere in this manual. However, when using LQAS principles, two thresholds are used. The first is the performance benchmark or *upper threshold*. The second one is the lower threshold which is an unacceptably low level of coverage that should not go undetected. It should provoke managers to identify the problem causing the failed service delivery and resolve it with a focused investment of time and resources. In this manual we assume the lower threshold to be 50%.

Once having selected the performance standard, two forms of error need to be defined: alpha and beta errors. Alpha error is a *health system risk (or producer risk)*; it measures the probability that the health program would invest unnecessarily to improve the performance of health facilities in supervision areas that have actually reached the performance standard (the upper threshold). In epidemiological terms, 1–alpha is equivalent to *specificity*, which is the probability of correctly identifying SAs that reach performance benchmarks. The beta error is *community risk*; it measures the probability that beneficiaries would receive health services that do not reach acceptable performance standard (the lower threshold). In epidemiological terms, 1–beta is equivalent to *sensitivity*, which is the probability of correctly identifying supervision areas that cover an unacceptably low proportion of the population (see, Dodge and Roming 1959). For this manual, both the alpha and beta errors are assumed to be less than 10%.

By using the software prepared for R-HFA we can now determine the sample size and interpret the results. If the universe size is 35 facilities, the performance standard is 80% (20% defective HF permitted), and the lower threshold is 50% then the sample size is 13 HF. At most 4 defective HF are permitted (referred to as the *decision rule*). Once the 5th HF is detected then the district is assumed to have not passed the performance standard. The actual alpha and beta errors resulting from the use of the hypergeometric are both about 6%.

The reason why the lower threshold is set 30 percentage points below than the upper threshold, is that the tool is set to be sensitive to districts whose performance is poor and in which most or nearly most HF under perform. The 50% lower threshold indicates a chronic problem in the district health system needing widespread improvement.

A randomizing process should be used to sample the HF. In this example as 13 HF are needed, then a simple random sample would suffice. Enumerate the HF from 1 to 35 (in this case). Then by using a 2-digit random number table, select 13 unique random numbers ranging from 01 through 35. Any HF can be sampled only once. Therefore, if a number is selected twice, simply sample a replacement HF to ensure that all 13 HF are unique.

The sample size of HF is directly related to determining the number of survey teams that will be needed in a district. Assuming that five health facilities can be visited by one survey team during one week, and assuming that a sample of 13 HF need to be assessed in a given district, then 13- survey team days will be needed to complete the work. This could mean that 2 teams would work one and one-third weeks to complete the task or that three teams would work four and on-third days. The choice should be made on the number of survey candidates that are available and on the time they are available to participate in the assessment.

The trade off is management of more teams versus obtaining skilled workers for longer periods of time.

Giving a unique code to Health Facilities

Once the facilities have been identified the program coordinator assigns a unique code to them for each catchment area being assessed. In the above example 13 HFs were sampled from the district. The coordinator would give a unique code to each one ranging from 001 through 013. If a second district is also being assessed, and let's assume the sample size is 15 HFs, then their corresponding codes would be 014 thorough 028.

All of theses must be kept secure by the coordinator and by each supervisor since the resulting data must be able to be associated with a specific health facility.

Surveying Areas or Districts

In this section, include the specific information that relevant for your application of the RHFA.

Prepare a table that lists the geographical areas, including village names and names of the health facilities so that surveyors are all informed about the extent of the R-HFA and the exact location. In these areas state the number of health facilities to be visited (including hospital outpatient departments, health center(s), and health posts). At least one health facility should be visited each day. It is ideal to conduct the assessment at each facility during the morning working hours of the clinic, usually 8:00 am-12:00 noon. The health facilities have already been selected. The survey areas and selected health facilities in each area are summarized below:

Sampling Sick Children and Exit Interviews

The second LQAS application is used to assess the skills of health workers. For this assessment we recommend managers assume that providers should deliver services using the correct

technique at least 95 percent of the time. This skill level has been used in many other LQAS applications (Valadez 1991; Valadez, Leisa Weld et al. 1995; Valadez, Transgrud et al. 1997; Leon 1999). The binomial formula is used to calculate the number of observations needed to assess the skill retention of a single provider. The LQAS decision rule recommended for R-HFA is: Observe a single provider delivering services to six consecutive children and allow no more than one error for any skill. If a second error occurs, judge the provider as not having retained the skill. This decision rule is 97% specific to providers who use the correct skills at least 95 percent of the time when delivering family planning services.

The tool assumes that the pattern in which children arrive at a health facility is not associated with the care they receive. Therefore, any 6 consecutive children can be used as the sample for the assessment. Should a mother bring more than one child for treatment for one of the diseases used by the tool, the survey should select one of them randomly and used as the index child. The other children (probably siblings) should be excluded from the study and the next care taker's child sampled.

Sampling CHWs to Interview

If the project will be working with CHWs to increase access to services, then assessment of their skills and readiness is a good idea. Most districts will not have many MOH-recognized CHWs, and so it may be feasible to assess a large fraction of them. In any case, a simple random sample of 40-50 of them will give a sample that will more than suffice to measure significant changes in quality (in the range of 20% or more) which is quite feasible in many places. To select a simple random sample, a line listing of all CHWs is necessary. A feasible way to obtain such a sample is from the District Health Officer, or possibly your project staff's own information. Then after listing all of the CHWs, determine the sampling fraction (x) needed to choose 40-50, begin with a random start on the list and mark every x th CHW on the list.

GETTING STARTED: DISTRICT HEALTH OFFICER INTERVIEW

This chapter is taken with only slight modifications from: Johns Hopkins University, Pneumonia Tools, Geographic Access Tool

Objectives of DHO interview

There are dual objectives of the DHO interview form:

1. Initiate the planning for the entire Rapid Health Facility Assessment
 - a. Build rapport and partnership necessary with District health officials
 - b. Recruit (or obtain permission to recruit) the necessary number of District health staff to help in training and act as supervisors for data collection and analysis
2. Collect information for construction of the Geographic Access¹ core indicator
 - a. Obtain information on health facilities to be included in survey
 - b. Obtain information on populations and catchment areas
 - c. Determine which of these populations has year-round access to a health service provider

Key Definitions for Geographic Access indicator construction

1. Geographic access: Geographic access of a community to health provider is usually assessed by the physical distance between the community and the health provider. Geographic access, however, should be assessed by the “functional distance” to a health provider (Ayeni, et. al. 1987):

The functional distance to a facility may be much greater than the physical distance as measured to the closest facility. It is certainly not the case that all villages in the study region have direct road connections with their closest facility. Differences in physical terrain, availability of public or private transport, patient access to alternate forms of transport—motor vehicles, bicycle, and foot—affect this functional distance. (p. 1086)

Other factors that affect functional distance include two-way travel costs and travel time, and the seasons of the year that community members can travel to the facility (Stock, 1983). How much time and money, for example, is it reasonable to expect families to spend traveling to and from a health provider? How much money will they lose by not working that day? Are rivers impassible or roads unusable during the rainy season? These are issues generally beyond the scope of an individual health provider to improve upon, but are things a PVO can help improve or overcome in collaboration with communities and the government.

2. Authority to Treat: This tool will calculate the percent of the population with access to a service, not necessarily a facility. This distinction is made because some service providers may be trained community health workers; however, the CCHW should not be just *any* CHW. This is where the concept of “authority to provide a service” comes in. A health provider has the authority to provide a service if national or local government policy authorizes the provider to do

¹ In the literature, concepts in addition to “geographic access” are used to determine access to health providers such as: affordability of drugs and services, availability of drugs and trained personnel, language used by health providers, provider-patient interpersonal relations, hours of operation, and days of the week a provider works.

things necessary to actually provide that service. This is especially important in the case of pneumonia and malaria case management. In the case of pneumonia, the provider must have the authority to dispense or prescribe antibiotics for treatment of pneumonia. Usually, this is a government or private physician. In many countries, national or local government policy authorizes nurses, auxiliary health workers, and medical assistants to dispense or prescribe antibiotics. In some countries, government policy authorizes community health workers, drug sellers and/or traditional healers to dispense or prescribe antibiotics. Note that the health providers described above are different from a health provider who is currently treating pneumonia but does not have the authority from the government to do so. This category of health provider usually is not eligible to receive training in standard pneumonia case management and will not be eligible until authorized to treat pneumonia.

Rationale for geographic access indicator

To save the lives of sick infants and children, there are three key requirements: (1) sufficient numbers of health providers who consistently provide standard case management; (2) the beneficiary population of a project must have access to these providers; and, (3) caretakers in the project's beneficiary population whose children have signs and symptoms of disease must recognize those signs and symptoms and seek immediate treatment from these health providers. Geographic access is a significant factor in whether or not a caretaker will utilize a health provider to treat her child with signs of disease² in a timely manner.³ Therefore, geographic access to health providers with the authority to treat disease is a key requirement of a project's case management intervention. Unless health providers have the authority from the government to treat children with disease they will usually not be eligible for training (knowledge and skills) and receipt of equipment/supplies to provide standard case management.

Because geographic access is very important, a project planning to include a case management intervention needs to assess who in the project's beneficiary population has geographic access to health providers with the authority to treat sick children. This will help the project staff to decide: (1) if there is sufficient geographic access to health providers with the authority to treat sick children to justify a community case management intervention; (2) is it necessary and possible to increase geographic access; and (3) which communities or neighborhoods, if any, need increased geographic access. For example, projects can help make health providers more geographically accessible to a community with the following activities:

² Several studies have found that utilization rates of health providers declines significantly with distance. In Uganda, outpatient utilization of hospitals and dispensaries declined by 50% every 3 km and *per capita* utilization of aid posts declined by 50% every 1.5 km (King, 1966). In Ghana, 70% of those utilizing a health center lived within 5 km of the health center, representing 26% of the health center's catchment population (Danfa, 1979). In Nigeria, outpatient *per capita* utilization of hospitals and rural health centers declined at a rate 20% per km (Stock, 1983). In Bangladesh, utilization of formal modern health providers by sick persons was more than 40% lower for persons living more than 2 miles from a health center than for sick persons living one mile or less from a health center (Amin et. al., 1989). And, in Ethiopia, a study of health services utilization found a "rapid decrease in rates with distance away from facilities" (Kloos, et. al., 1990).

³ Studies have found that there is a relationship between distance from a facility and delays in seeking treatment. In Nigeria, 60% of fever cases for persons living within 2 km of a health facility were treated within 2 days of onset of fever, whereas 24% of fever cases for persons living 4-10 km from a health facility were treated within 2 days of onset (Stock, 1983).

- Make additional sources of transportation available for emergencies
- Decrease the two-way travel time/costs for members of that community to an existing health provider
- Increase the number of trained providers at an existing health facility
- Help provide, in or near that community, a new category of health worker with the authority and training to treat childhood illness (for example, drug sellers, community volunteers, and traditional healers)

Approach to measurement of geographic access

The approach outlined here estimates the functional distance from health providers to communities in the project area. Project managers can then use this estimate of functional distance to (1) estimate whether or not communities in the project area have geographic access to a health provider with the authority to treat illness and (2) to make conclusions about which communities need increased access to health providers.

In order to estimate functional distance between health providers and communities, this approach suggests carrying out a map exercise. First, a project manager obtains maps of the project area (PVOs include the same types of maps in proposals and detailed implementation plans). With the map, the project manager identifies beneficiary communities with geographic access by considering physical distance, availability of transportation, and affordability of travel (time and money) to reach a health facility or provider. Second, after completing the map exercise, the project manager estimates the percentage of the beneficiary population that has geographic access to a health provider; this is done by summing the population of each *community with access* and dividing that number by the total beneficiary population of the project area. Last, the project manager reviews the findings of the exercise and makes conclusions about whether:

- It is necessary to increase geographic access
- Which communities or neighborhoods, if any, need increased geographic access
- Feasible strategies for increasing access

Collection and analysis of data for facility mapping and geographic access indicator

1. Obtain a map (or construct one) that includes: (a) each of the beneficiary communities/neighborhoods that the project is serving; and (b) the location of each health facility that serves the project's beneficiary population. (See example, Appendix A).
2. Identify the providers who have the authority to treat sick children in the project's beneficiary population.
 - 2.a. On the map, indicate the location of each **health facility** that serves the project's beneficiary communities and that treats sick children. (See example, Appendix A).
 - 2.b. Indicate which of these health facilities is a **primary health facility**. To be considered a "primary health facility," the facility should be one that is mandated to attend to children under the age of five directly from the community without a referral. This will exclude hospitals, for instance, but may include a hospital outpatient department (OPD).
 - 2.c. On the map, locate and indicate each community/neighborhood, if any, with a **community health worker** who is authorized to treat sick children.
 - 2.d. OPTIONAL: On the map, locate and indicate each community/neighborhood, if any, with a **private provider** who is authorized to treat sick children.⁴
3. Identify which communities/neighborhoods have "geographic access" to a health provider.⁵
 - 3.a. Identify which project beneficiary communities/neighborhoods on the map are **within five kilometers** from at least one of the health facilities/workers/private providers located on the map in Step 2 above. It is best if this distance is estimated along routes of travel instead of the straight line distance. However, straight line distance can be used in the absence of detailed maps.

Note: This tool suggests a radius of ≤ 5 km from a health provider as one of the general criteria for geographic access. WHO uses 3-5km as a measure of geographic access to a health facility. As described in footnote 2, studies have shown that utilization of health services decreases significantly with distance. This is a general criterion and projects may adapt this criterion, if needed, to one that is more appropriate for the project area for use in the project.⁶ However, the standard core indicator to be reported to CSHGP remains the same.

⁴ For example, a private physician. In some countries, this also may include nurses or pharmacists, if they have the authority to dispense antibiotics without a prescription from a physician.

⁵ For the purposes of this tool, "geographic access to health providers" concerns the distance, time and costs required to travel to and from a health provider who is authorized to treat pneumonia. Additional measures of access, such as language/attitudes of health providers and waiting time for care upon reaching a health provider can also cause more subtle problems of access.

⁶ Stock (1983) suggests that radii of 16 km or 8 km, which are used as catchment areas for rural health centers in many countries, are much too large for general health care delivery in rural Nigeria. He found that actual utilization of health services by persons living 5 km from a health center was less than one-third the amount of utilization by persons living less than 1 km from the health center.

3.b. Identify any additional beneficiary communities/neighborhoods whose members can reach one of the authorized health providers ***within one hour by means of local transportation.***

For example, members of communities more than 5 km from a health provider may have access to transportation that will allow them to reach the health provider within one hour (or a time period the project considers reasonable). Transportation sources may be the following: ambulance, public bus, bicycle, horse, or private vehicle. Note that this transportation should also be available throughout each day of the week.

3.c. Identify those communities in which ***most members can afford*** the two-way travel costs to the facility/provider serving that community: For each community identified in step 3.b. above, determine if most members of that community can afford the two-way travel costs from home to the facility/provider serving that community.

3.d. Identify those communities in which members ***can reach the facility/provider serving that community throughout the year:*** For each community identified in step 3.c. above, determine if members of that community can reach the facility/provider serving that community during each month of the year (for example, persons can travel to that facility during the rainy season, or during winter months, in a reasonable amount of time).

3.e. For the purposes of this indicator, the communities identified in step 3.e. can be considered as having “geographic access” to a health provider with authority to treat childhood illness.⁷

4. Map the communities with geographic access to health providers.

4.a. On the map, draw a circle around each facility. Include within the circle those communities/neighborhoods identified as having “geographic access” to that health facility. (See example, Appendix A).

4.b. On the map, draw a circle around each community that has a community health worker or private provider who is authorized to treat childhood illness.

5. Complete a “Percent of Population with Access to Health Providers Form” (See example, Table 1):

5.a. In column (a), list each community/neighborhood within the project area, listing first those communities “with geographic access” to a health facility and second those communities “without geographic access” to a health facility.

⁷ Project staff can use other tools in the Toolbox to validate and/or modify the list of communities that this tool identifies as having access to health providers for childhood pneumonia. For example, the project can conduct the *community group discussions tool* and/or the *pneumonia case narratives tool* in communities “with access” and in communities “without access.” These assessments will provide information on mothers’ beliefs about access to health providers - these beliefs will either agree or disagree with the findings of this *access to health providers tool*.

5.b. In column (b), place a “Y” for yes if the adjacent community in column (a) “has geographic access” to a health facility. Place an “N” for no if the adjacent community in column (a) “does not have geographic access” to a health facility.

5.c. In column (c), write the total population number of the adjacent community in column (a).

5.d. In column (d), write the cumulative population number summing the total population of the adjacent community in column (a) and the total population of the communities listed above the adjacent community in column (a).

5.e. In column (e), comment on the reason why a community “without geographic access” has been designated “without geographic access.” Possible reasons are: travel time, travel costs, and seasonal accessibility.

5.f. Below the chart, write the number for the population “with geographic access” to a health facility. This is the same number as the number in column (d) adjacent to the last community listed in column (a) “with geographic access” to a health facility; that is, the last community in column (a) that has a “Y” in the adjacent column (b).

5.g. Below the chart, write the number for the total population of the project area. This is the same number as the number in column (d) adjacent to the last community listed in column (a).

5.h. Divide the number for the population “with geographic access” to a health facility by the number for the total population of the project area. Multiply the divided number by 100. This is the estimated percent of the population with geographic access to a health facility.

6. Draw Conclusions:

6.a. Does a large enough proportion of the beneficiary population have geographic access to health providers to justify the project carrying out a community case management intervention?

6.b. If so, does the project need to help increase geographic access?

6.c. If so, does a large enough proportion of the beneficiary population have geographic access to health providers to justify providing health education to families about management of childhood illness (once quality of services is ensured)?

- If so, in which communities should the project provide health education about community case management (once the quality of health services serving that community is ensured)?
- If not, in which communities should the project make health providers accessible prior to conducting an education effort about management of child illness in the project area?

For example, projects may be able to help with the following:

- Make additional sources of transportation available for emergencies
- Decrease the two-way travel time/costs for members of that community to an existing health provider
- Increase the number of trained providers at an existing health facility
- Help provide, in or near that community, a new category of health worker with the authority and training to treat childhood illness (for example, drug sellers, community volunteers, and traditional healers)

6.d. What are the most frequent reasons why communities do not have geographic access to health providers?

6.e. In what ways are the communities with geographic access to health providers different from the communities without geographic access (ethnicity, language, socioeconomic status)?

**Table 1. Percent of Population with Geographic Access to Health Providers
PLAN/Bolivia Altiplano**

Province: Manco Karac

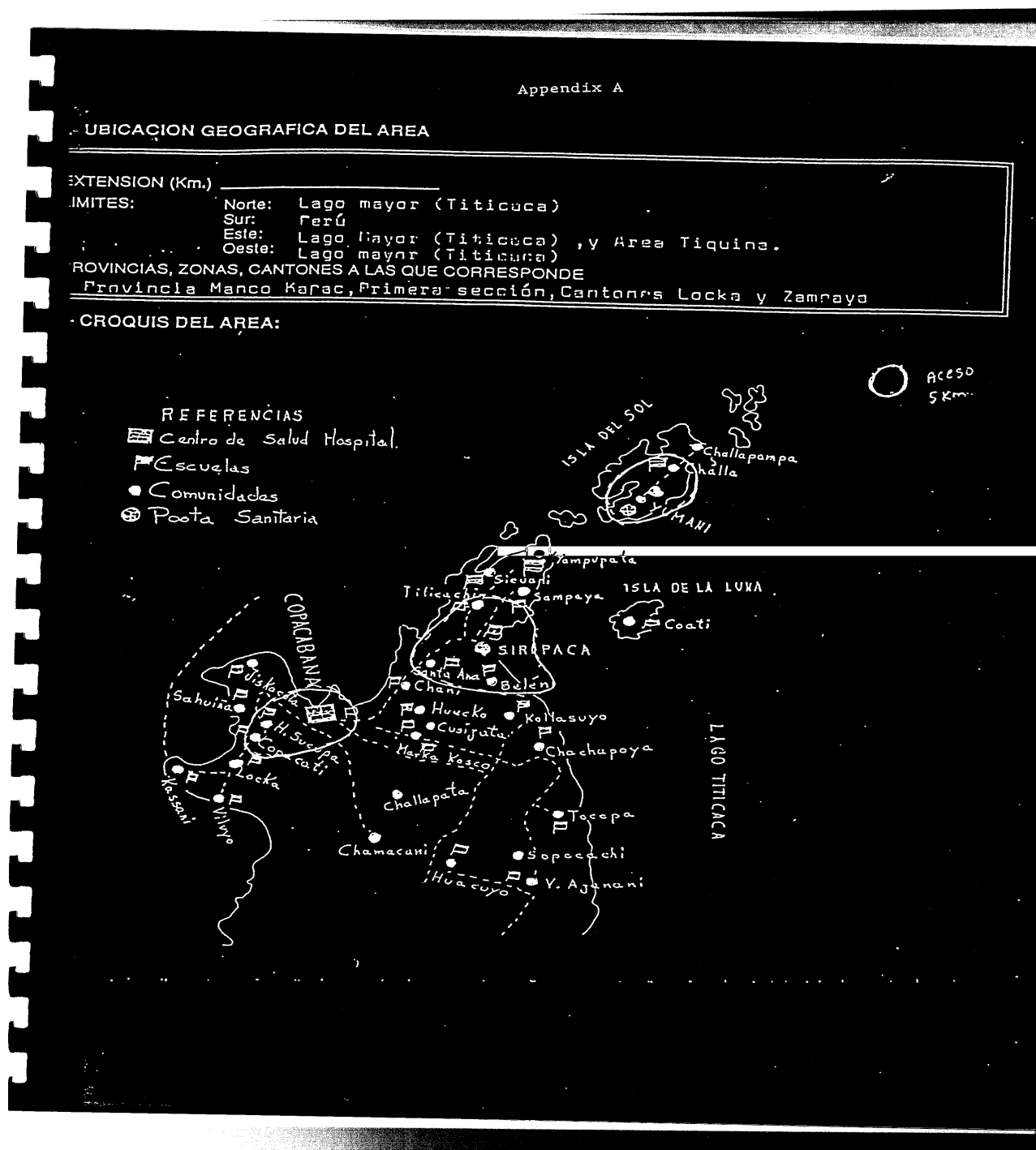
Section: First

Cantons: Locka and Zampaya

(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
Huecko	N	350	16559	Travel time
Chani	N	480	17039	Travel time
Kassani	N	270	17309	Travel time
Sampaya	N	1590	18899	Travel costs
Sicuani	N	1100	19999	Travel costs
Coati	N	967	20966	lake often impassable in rainy season; travel time
Huacuya	N	135	21101	Travel time/costs
Cusijata	N	240	21341	Travel time/costs
Challapata	N	180	21521	Travel time/costs
Tocopa	N	690	22211	Travel time
Sopocachi	N	632	22843	Travel time/costs
V. Ajanani	N	240	23083	Travel time
Chamacuni	N	210	23293	Travel time
Jiskacola	N	650	23943	Travel costs
Kollasuyo	N	447	24390	Travel costs
Sahuina	N	350	24740	Travel costs
Locka	N	490	25230	Travel costs
Viluyo	N	418	25648	Travel time
Chachapoya	N	765	26413	Travel time
Marka Kosco	N	200	26613	Travel time
Challapampa	N	550	27163	Travel time

Population with geographic access: 15,742
Total population: 27,163
% of pop. with geographic access: 58%

Example of geographic mapping of HF & communities, showing locations and populations with access



Scheduling Facility Visits

Data collection should be conducted during the week immediately following the surveyor training workshop. Training usually ends on Friday. Survey teams should be ready to begin field activities on the following Monday. Sampled health facilities will need to be divided among the survey teams.

Each team will visit a minimum of one health facility per day over a period of five or six days. In our experience, morning clinics are the best times to collect the observational data. The afternoon or late morning can be reserved for the other instruments. It is important, therefore, to assign each team to facilities that are relatively close to each other. Once each survey team has been assigned to a group of health facilities, logistics for the survey week can be planned using the draft itinerary prepared by the survey coordinator in advance of the training week. Teams should plan to attend child health clinics in the morning and to travel to the next location in the afternoon. It is important that each survey team arrive at the health facility before the child health clinic opens; the overnight stop should be close enough to allow this to occur.

Logistical arrangements for reaching one health facility each day will depend on the condition of roads and on the availability of lodging. In more remote areas, lodging may be scarce and arrangements may need to be made for survey teams to stay with local health staff. However, such problems are minimized by using senior staff who are familiar with the district. **Health facility staff should not be told in advance that a survey team will be visiting so the team can get a less biased picture of routine facility practice.**

Survey teams should complete a logistics plan for the survey week. An example is included in Table 1.

Table 1. Logistics Plan for Survey Week for Single Survey Team

Day	Facility Name (if more than one facility can be visited then list them all)	Overnight Location	Distance to Travel
0	(Point of origin)		
1			
2			
3			
4			
5			

Starting Work at a Health Facility

Survey teams should arrive at the health facilities before the morning consultation session begins. The supervisor is responsible for introducing the survey team to the health worker in charge and explaining the purpose of the visit. It is important to ensure that health workers

understand that they should not change their routine practice. Please do not show the instruments to the staff as this would bias their behavior during the assessment. Once the local health staff are clear on the purpose of the visit, the following tasks need to be completed in preparation for the clinic session:

- ☐ **Identify the health worker who is normally responsible for seeing sick children.**
If more than one health worker is responsible for the sick child clinic, select the health worker who conducts sick child clinics most often or the most experienced health worker. For this assessment, observations of only one health worker are conducted at each facility. Please note that the most experienced health worker is not necessarily the oldest. The intention is that the assessment should be a best case scenario.
- ☐ **Decide how and where sick children for the survey can be identified for inclusion in the sample.**
Possible areas to screen children for the presenting complaint are the point of registration or at a common waiting area.
- ☐ **Select a suitable place where caretakers can be interviewed after the sick child consultation.**
Two chairs will be required. It is important that this interview be conducted away from other caretakers so that they do not hear the questions or responses in advance.
- ☐ **Decide which health worker will assist the surveyor in assessing the equipment, materials, and supplies of the clinic and when this will be done.**
Most sections of the health facility checklist can be completed by the supervisor during the clinic session with very little assistance. Specific areas may require more assistance.

Selecting Eligible Children for Observation and Caretakers for Exit Interviews

The supervisor is responsible for selecting children to include in the survey as they present to the health facility. **The first six children age 1-59 completed months presenting to the health facility during the survey period whose caretakers describe them as having fever/malaria, cough/difficulty breathing/pneumonia, or diarrhea/vomiting are included in the sample for the Observation of Clinical Care. The caretakers of these same six children are interviewed for the Exit Interviews.** The caretakers of the first six children meeting this definition are given an enrollment card which allows them to be followed through the facility and ensures that the surveyors include them in the survey. It is important that all children and caretakers coming to the clinic are identified and that caretakers are asked the reason for the visit. Only sick children meeting these criteria will be included in the survey; children described as having any other condition will not be included. If the number of sick children meeting the case definition is greater than six, then pick the first six from the register or in the waiting room. Should a caretaker bring more than one child for treatment (that suit the inclusion criterion as a sick child) then choose one of them randomly. The main reason for this choice is to ensure that six different caretakers participate in the exit interviews.

Completing the Survey Questionnaires

Each member of the survey team will administer the same questionnaire(s) at each health facility to improve the reliability of the results.

Supervisor (surveyor number 1): Observation of clinical care of sick children and health worker interview

After picking the children to be seen, the supervisor should be located in the examination room close enough to the health worker to be able to hear and observe the consultation clearly and accurately. It is important that surveyors be as unobtrusive as possible and that they do not disrupt the consultation session. A new observation questionnaire should be completed for each infant or child seen. Remember that if a caretaker has more than one sick child, then one child should be selected randomly for inclusion in the assessment. At the end of each observation, the surveyor must ensure that the observation form is completed (all Y and N responses circled) before the next observation. In addition, at the end of each consultation, surveyor #1 must ensure that the caretaker goes to Survey #2 to have an exit interview completed. At the end of the consultation session, surveyor #1 should complete a single health worker interview questionnaire for the observed health worker. S/he should conduct the HW interview with the supervisor, as there may be questions the supervisor needs clarified on the HF Checklist. Interviewing the HW together with the supervisor will allow all questions on both forms to be answered in the most efficient way.

Surveyor number 2: Exit interview with caretakers of sick children (the same children seen for clinical care)

Following the consultation, caretakers of sick children should be interviewed as quickly as possible. It is often easier to interview the caretaker outside the health facility, a short distance away from other caretakers and children. It is important to avoid caretakers who are waiting to be seen; participation by a group may hinder the exiting caretaker from answering spontaneously. In addition, caretakers who are waiting for an exit interview should not hear the questions and responses in advance. Because exit interviews often take longer than the clinical consultation, there should be a place for caretakers to wait for the interview with their children. In some areas, it may be necessary to use an interpreter to ask questions in the local language. A local interpreter should be identified by the supervisor, as required, at each health facility. The ideal, however, is to have an interviewer who speaks the local language and the Exit Interview form translated into the local language.

Surveyor 2 (or Survey number 3 if there is a 3-person team): Health Facility Checklist (Infrastructure, Equipment, Supplies, Drugs)

The majority of this assessment requires direct observation. However, several questions require interviewing the HW. If there is a third person in the observation team, then the first 8 questions can be done during the consultation session when the HW is not available. The remaining questions ask for observations of equipment and conditions in the consultation room or require interaction with the HW (e.g., to determine the location of the drugs, supplies, stock cards). This HW does not have to be the same one who is participating in the clinical observations. In fact, it may be best to engage a different HW at the facility so as not to overburden on person; however, if only one HW is available then these questions should wait until the consultation session has ended, and the HW is available. Speaking with the HW at the end of the consultation session should occur at the same time as Surveyor Number 1 is conducting the HW interview. Should there be only 2-surveyors, the checklist can be used once the patient observations and the exit interviews have finished.

If CHW interviews (Module 5) are to be done, then two members of the team can conduct this after the other data collection is complete.

Using the Questionnaires

It is important that each questionnaire be administered **exactly** as agreed upon during the training. **DO NOT GUESS**. If a surveyor is uncertain about what to do or has any questions, then she/he should ask the supervisor. The validity of the results obtained will depend on each person administering the questionnaire in exactly the same way.

Completing the Questionnaires

It is important that the questionnaires be completed clearly and legibly. The following are important:

- Write legibly
- Always use a pencil to complete questionnaires
- Make sure that check marks do not overlap more than one answer
- For questions where there is a *yes* or *no* response, circle **Y** for *yes* or **N** for *no*.
- If there is more than one possible answer, place a check next to the one that most closely resembles the response given
- If the caretaker or health worker gives a response other than those suggested, check the space "*other*" and write in the response that is given.

Obtaining Supplementary Information

It is important that forms are filled out as simply as possible and that only the appropriate spaces are checked. However, if a surveyor thinks it is necessary to document any additional information that might be helpful, then discuss it with the supervisor. This information can be written in the margins near the question concerned or at the end of the form under "Qualitative Observations."

Skipping Questions

Depending on the response that the caretaker or health worker gives to some questions, it may be necessary to skip one or more questions. If so, it is important to skip to the number that is indicated. If there are no instructions, always go to the next question.

Courtesy

Survey teams should always be polite and respectful. In addition, they should try to complete the exit interviews with caretakers as quickly as possible so that they do not have to wait at a health facility for longer than is necessary. It is important to always thank caretakers for their cooperation and to answer any questions that they may have. If interviewers do not know the answers to questions asked by the caretaker, then they should check with their supervisor.

Checking and Reviewing Questionnaires

Surveyors should check and complete each questionnaire after it has been administered. This is particularly important after each patient observation and exit interview. Immediate review of questionnaires will allow surveyors to ask questions of the health worker or caretaker in order to complete skipped or missed questions. In addition to the self-reviews of each questionnaire, supervisors should periodically review questionnaires for completeness during the course of the morning. At the end of each clinic session, supervisors should sit down with surveyors to review all questionnaires prior to leaving the HF.

Providing Feedback to Facility Staff

Surveyors should give some immediate feedback to health workers on the day of the assessment prior to leaving the HF. The focus of any feedback should be to improve the quality of clinical and management practices. All positive findings should be emphasized. Supervisors and surveyors can provide feedback in the following areas:

- Strengths and problems in case management, particularly in the assessment and treatment of sick children
- Quality of home-care advice and communication between health workers and caretakers
- Inappropriate use of medications
- Problems in record keeping
- Ways to improve clinic organization
- Major barriers to effective practice

It is good to say something before leaving, but be cautious in this initial debriefing about how much is said, as you do not want to contradict anything that the District Health Officer might have told the health workers in a facility. For example, a practice which was rated at below standard might actually have been performed in that manner at the instruction of the DHO.

Supervising the Assessment

What to Do with Completed Questionnaires

If possible, completed and checked survey questionnaires should be returned to a central coordination point for checking and data entry each day. Completeness, consistency, and coding of returned questionnaires should be conducted by the survey coordinator in collaboration with data entry staff. Ideally this should be conducted with the survey teams present so that questions can be asked if required. The frequency of questionnaire return will depend on the logistics and itinerary for each survey team. Arrangements should be made in advance with team supervisors for the return of completed questionnaires. Possible arrangements could include:

- Survey teams return the questionnaires at the end of each day if the itinerary allows.
- Survey teams return questionnaires every two or three days when the itinerary allows.
- The survey coordinator collects the questionnaires every two or three days when visiting survey teams in the field.

Arrangements for collecting completed questionnaires will probably vary by team because the logistics for each team will be different. Some teams will visit facilities that are accessible to the central coordination point and some will visit remote facilities. Some teams may decide the best strategy is to carry out the data entry after the survey is completed.

Role of the Supervisor

Adequate supervision of survey activities at each health facility is critical to the collection of high-quality data. The survey coordinator should oversee and supervise survey activities by visiting teams in the field during the survey week. Team supervisors have the following responsibilities:

1. Introduce survey teams and explain survey activities at each health facility; ensure that preparations are made to allow efficient conduct of survey activities at each facility.
2. Identify the six sick children and caretakers to observe receiving clinical care and participate in exit interviews, respectively. The supervisor should follow-up these children and their caretakers to ensure that they are the ones included in the sample.
3. Oversee and manage survey activities at each facility, including monitoring of patient flow, answering questions from local health staff, and providing feedback at the end of the visit. In order to give surveyors enough time to complete and review a questionnaire after observing the sampled children, supervisors may decide to include non-sampled children between sampled children.

4. Observe the performance of each surveyor periodically during the survey, especially during the first few days. The supervisor should independently complete each questionnaire while it is being completed by the surveyor and then compare the two. If the surveyor makes frequent errors, the observations should be more frequent. However, ideally much of this quality control in instrument use should have taken place during the initial training. Since the supervisors are responsible for the clinical observations, these spot checks will tend to be made of the remaining instruments.
5. Review questionnaires completed by each surveyor both during the clinic session and at the end of each health facility visit. It is important to ensure that they are complete and internally consistent. Immediate feedback should be given to surveyors of errors identified. Supervisors should complete the coding boxes for each questionnaire during the clinic session or at the end of the clinic session. All coding should be completed the same day the data are collected. Supervisors should refer to the coding guidelines presented in the question-by-question summary.
6. Provide support to surveyors. Supervisors should answer questions and discuss and attempt to solve any problems encountered. In addition, supervisors should provide support as needed during facility visits.
7. Collect all filled out forms, review them to ensure they are complete, and fill out the Cover Sheet.
8. Give any initial debriefing to the health facility supervisor on the preliminary findings.

Supervisor's Checklist of Survey Tasks

Introductions

- ☐ Meet the officer in charge to introduce the survey team and explain the purpose of the visit.
- ☐ Identify the type and the number of health workers managing children and who should be observed and interviewed.
- ☐ Determine the method for identifying children to be selected (registration, waiting room). Give an enrollment card to the caretaker of each selected child.
- ☐ Locate a room or a quiet corner for the exit interview of the caretaker.

Observe Clinical Care

- ☐ Ensure that the selected caretakers and selected children are identified and directed toward the HW selected for the assessment.
- ☐ Observe as the health worker manages the child and completes the questionnaire.
- ☐ Make sure that the caretaker goes to the exit interview or the waiting area.

Exit Interview the Caretaker

- ☐ Administer the questionnaire away from other caretakers.
- ☐ If necessary, correct any misinformation the caretaker has on how to treat the child at home. However, these corrections must take place only after the exit interview finishes.
- ☐ Thank the caretaker for his/her cooperation. Answer the caretaker's questions, if there are any.

Interview the Health Worker

- ☐ Conduct the interview of the health worker being observed at the end of the clinic session or after the sixth child is observed (this depends on the wishes of the HW).

Complete the Health Facility Checklist

- ☐ Assess the facility and complete the questionnaires.
- ☐ Ask for assistance from health workers if needed.

Feedback to Staff

- ☐ Give feedback to the health staff about their knowledge and practices. Present major findings (strengths and weaknesses) and give examples.
- ☐ Thank the staff for their cooperation and the opportunity to visit their health facility.

Meet with Survey Team to Review Survey Questionnaires

- ☐ Meet as team to review all the completed questionnaires. Check for missing information or inconsistencies.
- ☐ Obtain missing information prior to leaving the HF.
- ☐ Collect and organize all completed and reviewed questionnaires.

ANNEX A: Schedule for Surveyor Training

Day	Activities
1	<p>AM: Opening & General Information</p> <p>Opening</p> <ul style="list-style-type: none"> • Introduction of the participants • Administrative information <p>General information</p> <ul style="list-style-type: none"> • Purpose of the survey • Training objectives • Survey protocol and techniques • Introduction of Participant Guidelines • Clarification of participant expectations or concerns <p>PM: Intro to first 2 formats - Clinical Observation & Sick Child</p> <p>Clinical Observation - Sick Child</p> <ul style="list-style-type: none"> • Review the instrument • Role play <p>Caretaker Exit Interview – Sick Child</p> <ul style="list-style-type: none"> • Review the instrument • Role play
2	<p>AM: Health facility visit for Clinical Observation and Caretaker Exit Interview</p> <ul style="list-style-type: none"> • Visit to health facility for practice of Clinical Observations and Exit Interviews • Debriefing of the health facility visit <p>PM: Intro to Health Worker Interview and HF Checklist</p> <p>Health Worker Interview</p> <ul style="list-style-type: none"> • Review the instrument • Role play <p>Health Facility Checklist</p> <ul style="list-style-type: none"> • Review the instrument • Role play
3	<p>AM: Health facility visit for HW Interview and HF Checklist</p> <ul style="list-style-type: none"> • Visit to health facility to practice the HW interview and using the HF Checklist • Debriefing of health facility visit <p>PM: Sampling HF and Data Analysis</p> <p>Sampling HF in districts.</p> <ul style="list-style-type: none"> • Explanation of how HF were sampled in each district • Reviewing list of HF sampled and to be visited during the assessment <p>Analysis of R-HFA data</p> <ul style="list-style-type: none"> • Analysis of data at the HF level. Identifying strengths and areas of needed improvement • Analysis of data at the district level. Identifying areas of needed improvement

4	<p>AM: Continuation of Data Analysis</p> <p>PM: Wrap-up</p> <ul style="list-style-type: none"> • Review any particular difficulties in application of the forms • Team identification for field survey • Developing the itinerary and travel schedule • Review role of supervisor • Final comments and questions • Evaluation of training
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Additional days of training and field practice can be scheduled as needed to ensure that the surveyors are well trained in using the instrument and that data collection can commence without problem.

ANNEX B: Sample Tracking Card for Children Selected for Clinical Observation and Their Caretakers Participating in Exit Interviews

The supervisor has six cards (best to put on sturdy card stock and if possible on brightly colored paper) which she/her gives to the selected child. The cards aid the interviewer to easily identify the caretaker and child to include in the assessment.

- The supervisor asks the caretakers in the waiting area the age of their child (eligible = 1 - 59 completed months of age) and the reason for the visit (eligible = any one of three reasons for visit – fever/malaria, cough or rapid/difficult breathing, diarrhea).
- Once an eligible caretaker and child are identified, the supervisor obtains informed consent.
- The supervisor then fills in the card
 - Case number (1,2,3,4, 5 or 6)
 - Age of child in completed months (should be 1 -59 months)
 - Reason for visit (should be one or more of the following: fever/malaria, cough or difficult/rapid breathing, diarrhea)
- The supervisor then hands the card to the caretaker and tells her that one surveyor will observe the care she receives and the other will interview her after her visit.

HEALTH FACILITY ASSESSMENT

You have been randomly chosen to be in a health facility assessment. We would like to observe the care that your child receives and interview you afterwards.

Case #: (leave a space to write in 1,2,3,4, 5 or 6)

Age of the child (in completed months):

Reason for the visit: (circle all that apply)

- **Fever / Malaria**
- **Diarrhea**
- **Cough or Rapid/difficult breathing**

ANNEX C: TALLY SHEET FOR THE SICK CHILD REGISTER REVIEW (Q.411)

Instructions

- Ask to see the curative care register
- Look over the last month of cases
- Look at only those cases that are children under 5 years of age (that is, 1 to 59 months old)
- For each case of
 - o Malaria or Fever, put a tick in box A1
 - o Pneumonia or Difficult or Rapid Breathing or ARI, put a tick in box B1
 - o Diarrhea without blood, put a tick in box C1
- For each case of
 - o Malaria treated with first line antimalarial, put a tick in box A2
 - o Pneumonia treated with first line antibiotic, put a tick box B2
 - o Diarrhea without blood treated with ORS (and/or Zinc if that is the protocol) but not an antibiotic, put a tick in box C2
- Transfer these numbers to the boxes in Q.413 labeled A1, A2; B1, B2; C1, C2
- There are grids for each of the Health Facilities that you visit.

Health Facility Code: _____

	Number of children U5 with Diagnosis	Number Children U5 with First Line Treatment
Malaria or fever	A1	A2
Pneumonia or Rapid/Difficult Breathing or ARI	B1	B2
Diarrhea without blood	C1	C2

Health Facility Code: _____

	Number of children U5 with Diagnosis	Number Children U5 with First Line Treatment
Malaria or fever	A1	A2
Pneumonia or Rapid/Difficult Breathing or ARI	B1	B2
Diarrhea without blood	C1	C2

ANNEX D: SAMPLE PARTICIPANT EVALUATION FOR TRAINING

For the following questions, please read the sentence and then show much you agree. If you circle a 1 it means that you completely disagree. If you circle a 2 it means that you disagree less strongly and so on to 5 which means that you completely agree.

	Do not agree			→	Agree	
	1	2	3		4	5
1. I think that health facility assessments are important	1	2	3		4	5
2. I understand why health facility assessments are done	1	2	3		4	5
3. I feel confident in gathering information using						
a. The clinical observation form	1	2	3		4	5
b. The exit interview with mothers	1	2	3		4	5
c. The health facility checklist	1	2	3		4	5
d. The health worker interview	1	2	3		4	5
4. I understand the role of the supervisor on the team	1	2	3		4	5

We would like your honest answers for the last two questions. This will help us to improve the training in the future.

5. The part of the training that I liked best was:

6. My suggestions for improving the training are:

Thank you for your answers and for your participation in this important work. Good luck gathering the information.

Key References

1. Service Provision Assessment (SPA) instrument of the Demographic and Health Survey (DHS) is described on the MEASURE / Evaluation website:
<http://www.cpc.unc.edu/measure/publications/html/ms-02-09-tool06.html>
2. WHO IMCI-based Health Facilities Survey tool from the World Health Organization is quite similar to the BASICS Integrated Health Facility Assessment tool. The tool and manual are available at WHO's website:
<http://www.who.int/child-adolescent-health/publications/IMCI/HFS.htm>
3. The BASICS Integrated Health Facility Assessment:
<http://www.basics.org/publications/pubs/hfa/>
4. Dodge, H. F. and H. G. Roming (1959). Sampling Inspection Tables. Single and Double Sampling, 2nd ed. New York, John Wiley.
5. Leon, F. P. (1999). Peru: providers' compliance with quality of care norms, final report of the project Monitoring family planning providers' compliance with the quality of care norms of Peru's Ministry of Health." New York, Population Council.
6. Valadez, J. J. (1991). Assessing child survival programs in developing countries: testing lot quality assurance sampling. Boston, Harvard University Press.
7. Valadez, J. J., Leisa Weld, et al. (1995). "Monitoring community health workers' performance through Lot Quality-Assurance Sampling." American Journal of Public Health **85**(8): 1,165-1,166.
8. Valadez, J. J., R. Transgrud, et al. (1997). "Assessing family planning service-delivery skills in Kenya." Studies in Family Planning **28**(2): 143-150.