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PLANNING MEETING TO DISCUSS DEVELOPMENT OF A HEALTH FACILITY QUALITY REVIEW

WHO/CDR and USAID/BASICS

Geneva
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ACRONYMS

ARI	Acute Respiratory Tract Infections
BASICS	Basic support for Institutionalizing Child Survival
CDD	Control of Diarrheal Diseases
HFS	Health Facility Survey
ICM	Integrated Case Management
USAID	United States Agency for International Development
WHO/CDR	World Health Organization Division of Diarrheal and Acute Respiratory Disease Control

EXECUTIVE SUMMARY

A meeting was held between the USAID/BASICS project and WHO/CDR on May 15-19, 1995 to further develop the health facility quality review, a methodology for monitoring and evaluating integrated case management at health facilities. This document summarizes the major discussion points and outlines a timetable and budget responsibilities for future activities. The health facility quality review collects information in a range of combined case-management and facility support questions, and unlike the previous health facility surveys, puts an emphasis on regular monitoring as well as evaluation. It is proposed that a field test of this methodology be conducted in early 1996.

I. BACKGROUND

The health facility survey (HFS) has become an essential tool for the planning and evaluation of clinic-based, child-survival efforts. In the process of conducting such surveys, health officials and health workers are made aware of the problems with their programs and trained in the use of key indicators to evaluate program performance. Health facility results have multiple purposes: advocacy; identification of training needs; assessing new training curricula; and evaluation of child survival programs. The World Health Organization (WHO) has developed separate HFS instruments for the assessment of CDD and ARI programs. An instrument has not yet been developed however, for the assessment of the integrated case management (ICM) of sick children. The process of developing a methodology for collecting information on the quality of facility services in areas where integrated case management has been implemented was begun in April 1995 as a collaborative activity between the USAID/BASICS project and WHO/CDR. The working title for this monitoring and evaluation instrument is entitled, "Health Facility Quality Review: Case Management of Childhood Illness." This document summarizes the first phase of the development process. In 1996, a field test of the methodology and further modification of the survey package will be required. It is hoped that these materials will be used by BASICS country programs for the monitoring and evaluation of programs that implement ICM. In addition, the principles of the health facility quality review, as well as some of the key indicators for evaluating integrated health services delivery, will be used by the BASICS project to develop a rapid facility assessment instrument. This instrument will be used to conduct baseline assessments in countries which are planning to integrate health services delivery.

II. SUMMARY OF DISCUSSION

Introduction

Meetings to develop the instrument entitled, "The Health Facility Quality Review: Case Management of Childhood Illness," were held on May 15-19, 1995 in Geneva at the offices of the WHO Division of Diarrhoeal and Acute Respiratory Disease Control (CDR). On May 18, a larger group of WHO and BASICS representatives met to review the work of the development group and to plan the implementation of the quality review in countries where there will be training in childhood diseases ICM.

Present for the 15-19 May development group meetings were Jennifer Bryce (WHO), John Murray (BASICS), and Jane Lucas (BASICS consultant).

Present for the 18 May review meeting were Jennifer Bryce, Sandy Gove, Gottfried Hirnschall, Bob Hogan, David Robinson, and Jim Tulloch (WHO); Ekhardt Kleinau and John Murray (BASICS); and Jane Lucas (consultant).

The decisions accumulated during the week of meetings are as follows:

The Health Facility Quality Review - Update

A. Focus of Activities

1. Quality review activities reinforce the skills of health workers who have been trained in ICM. The purpose of the quality review visit is not to introduce new skills.

2. Although one aspect of a quality review is skill reinforcement, it also has other functions, including the important one of assessing case management and collecting useful information to improve the delivery of services. Other activities not part of the quality review may also be designed to reinforce skills (e.g., when the health worker returns to the training centre).

3. A quality review is facility based. Assessing health worker skills can be accomplished in a training centre where a range of cases is likely to be seen. However, important information on how case management is practised and the barriers health workers encounter to providing good case management can only be gathered at the health facility.

B. Personnel

1. It will be difficult to identify persons who can provide the ongoing monitoring activity; therefore, planning teams preparing for ICM training will need to identify possible people within or separate from a current supervisory structure. For the moment, we will call the persons who conduct the monitoring and evaluation visits *surveyors* rather than supervisors, as we do not yet know who can perform this role in different countries.

2. The ICM facilitators will need to go out on one or two monitoring visits with a surveyor (not the first time to all participants in training) to help the surveyor use the new skills he or she has learned.

3. The surveyors may become facilitators after they are trained and are more experienced with ICM.

C. Facilities

Currently plans for implementing training courses recommend selecting participants from one geographical area, and training as many health workers as possible within a facility. Clustering participants will also support follow-up activities in the quality review.

D. Health Workers Observed and Interviewed

The quality review tools are designed to be used with health workers who have completed ICM training. Other staff not trained in ICM will not be observed and interviewed.

E. Indicators

From the view of WHO participants, measurement of the indicators (identified in the review group minutes of March 29, 1995, at BASICS) can be limited to cases seen by health workers who have been trained in ICM. The limited scope of the indicators will need to be clear when indicators are reported at all levels of the health system and globally.

F. Series of Quality Review Activities

We should consider the monitoring and evaluation activities as one activity. Thus, the visits included in the quality review are 1) an initial visit soon after the ICM course, 2) follow-up monitoring visits, and 3) a periodic quality control visit to evaluate case management and gather information for planning programme activities.

G. Pre-Assessment for Program Planning

The tools are designed for use with health workers who have been trained in ICM and, as a result, are not designed to gather all the information needed for an initial assessment of conditions in a country before implementing ICM.

Murray of BASICS, however, is developing a pre-assessment tool to be used which will be used for the first time in June 1995. The proposed site for this activity is Eritrea. For consistency and in order to track progress on case management tasks and other facility conditions, a subset of items not entirely dependent on, but likely to be improved by, ICM training will be identified that can be tracked easily over time in pre-assessment and quality review visits. These basic measures include, for example, whether the health worker weighed the child, checked the status of immunizations, counted breaths if there was cough or difficult breathing, and asked about the colour of the stools if there was diarrhoea.

H. Process

1. In most situations, quality review activities will be initiated during planning discussions for the implementation of ICM training (see section below, "Implications for Strategy for Implementing ICM").

2. It is anticipated that technical support by a programme developer during the orientation and planning meetings for ICM training will be needed in order to ensure that needs for planning follow up to training and other quality review activities are also met.

3. Technical assistance will also be needed to train surveyors in the data collection and skill reinforcement abilities they will need in order to conduct quality review visits.

4. Some information collected during each visit by a surveyor will be used to monitor the progress of case management at the facility and the implementation of case management across facilities in the area visited by the surveyor. This information will be passed up the system to help programme managers monitor, plan, and improve health system support for facilities. An attempt will be made not to overload the monitoring system by limiting the amount of information to be reported.

I. Materials

1. Some materials to be developed to support quality review activities are:

- Forms to focus observations, interviews, and facility reviews.
- Forms to collect and organize data to provide better feedback to health workers.
- Forms or other tools to collect and organize data for the same facility across visits to monitor progress (e.g., check lists, trend charts).
- Forms to collect and organize data across facilities monitored by the same surveyor.
- Tally sheets and other tools to collect, analyze, interpret, and report information so that managers are able to use system data to plan interventions.
- Simple skill reinforcement models for surveyors to use with health workers (e.g., to set up ORT and immunization corners, demonstrate case management, provide cases management practice exercises, give feedback, solve problems interactively with health workers).
- Training plan and instructional materials for all of the above.

2. So that the manual is not so overwhelming, we need to separate some of the support materials (e.g., the training models, training plan, and instructional materials) from the quality review materials (e.g., forms, instructions, and data analysis tools).

J. Sampling

1. The quality review will recommend a 100 percent census for following all facilities where there are health workers who have received ICM training.

2. For the periodic evaluation visits, a sample of five facilities will be selected in each ICM area covered by a surveyor. The evaluation visits will be conducted about once every two years, consistent with the planning cycle. The manual will provide guidelines for how to select the five facilities.

K. Guidelines for Developing Forms

1. Content categories that will be covered in the forms are:

   a. Case observation: core tasks, information for indicators (treatment), selection and completion of treatment, "diagnostic" information to identify problems in ICM (assessment, classification, treatment, and follow up), and time (duration of time spent with child and mother).
   b. Case examination ("gold standard"): full ICM assessment, classification, and selection of treatment (not completion of treatment), information for indicators, and organization of indicator information (whether the health worker's results are the same as the surveyor's).
   c. Caretaker interview: knowledge of prescribed treatment (drugs, other home treatments).
   d. Health worker interview: facility problems and possible solutions; assessment of knowledge and skills.
   e. Review of records: quality of record keeping (i.e., whether records contain important symptoms and results of assessment, classification, treatment, and follow up needed). During the early pretests and field tests, we will identify whether the quality of ICM, especially for classifications of cases infrequently seen, can be assessed using the case records of health workers who have attended the ICM course.
   f. Review of facility space and furnishings (chair, table): in the examination and ORT areas (chair, table), and immunization area (refrigerator, thermometer, sterilizer, etc.).
   g. Review of availability of facility equipment and supplies: scale, timing device, case management charts, and age for weight chart.

h. Review of drug supplies: current day availability and stock shortages for the last month or thirty-day period; minimum drugs needed for ICM (specific drugs may be locally identified).
i. Review of vaccines available: current day availability and stock shortages for the last month or thirty-day period.
j. Review of other supplies: current day availability and stock shortages for the last month or thirty-day period, including syringes, needles (including those for children under age 2 months), and immunization cards.
k. Drug management: perhaps to be added as an option for countries which are also implementing the WHO/UNICEF drug management course.
l. Staffing: number, type, and whether trained in ICM.
m. Supervision: may be added during the evaluation visit to identify the last time and frequency of visits by surveyor.
n. Clinic organization: case management tasks covered or not covered by staff, schedule of services for children (official and actual days and hours), and problems.
o. Interventions: priority problems identified, possible solutions, interventions made during the visit by the surveyor, and planned interventions.

2. Data collection activities will be combined to limit the number of forms, including:

a. All information on a case: observation of case, examination of case, comparison of health worker and surveyor's results, caretaker interview.
b. All information on the facility: review of drugs, organization of activities, staffing, quality of records, etc.
c. All information gathered from the health worker: interview or other assessment of knowledge and skills; interview regarding problems and solutions.

L. Country Adaptation

The content of the quality review materials will need to be adapted to be consistent with the adaptations made in the ICM course materials and case management charts. An attempt will be made to permit adaptations by filling in blanks for recommended treatments, foods, etc., so that countries do not need to reformat the forms to make the adaptations.

M. Format

1. The format (e.g., size and style of forms, use of tables) will facilitate the recording and evaluation of results of a quality review visit so that information will be accessible for immediate feedback to health workers. Basic information (e.g., on indicators) to be shared with others and measures to be tracked over time will also

be organized and identified on the forms in order to facilitate transferring the results.

2. We will assume that countries have printers (i.e., bubble jet or laser printers) that will support a wide range of fonts and other format choices to help organize the recording and transfer of results.

Implications for Strategy for Implementing ICM

A. We will encourage countries who are planning to implement ICM training to also plan for activities to follow training, and we will try to provide or organize support for these activities. Agreement to include a quality review process is not a requirement for doing ICM training, but we will encourage countries to include plans for the quality review in order to maximize the resources they are investing in training.

B. As WHO and consultants help countries plan for implementing ICM training activities, they will also assist with making initial plans for the quality review. Although some of these tasks will not be part of the planning process until the Quality Review materials are ready, eventually they might include the following:

1. Select participants from within limited geographical areas and include as many health workers as possible within each facility. (This is already part of the WHO plan for implementing the training.)

2. Plan monitoring visits to follow ICM courses within one month after a participant has been trained.

3. Plan regular monitoring visits thereafter. More is needed to be learned about what is feasible, and the required frequency and duration of monitoring visits in order to have a sufficiently effective intervention.

4. Identify possible sources for surveyors who could provide monitoring and skill reinforcement. Persons who could be surveyors may or may not be found in the current supervisory structure within the health system. Who to use as surveyors will need to be determined locally.

5. Identify how and when surveyors might be trained in data collection techniques (observation, interviewing, record reviews, etc.) and in providing skill reinforcement (giving feedback, case presentation, doing interactive problem solving, etc.) The timing of surveyor training should not interfere with their basic ICM training.

6. Identify ways to provide logistical supports for monitoring and evaluation activities (e.g., transportation, printing, and per diem).

7. Identify ways to provide management support for these activities (e.g., quality control, reviewing and commenting on data collected, setting and monitoring schedules for visits, writing reports, and using information to intervene in the health system).

8. Consider the abovementioned activities as they plan a budget, and look for potential partners to help fund them.

C. A number of concerns about adding these quality review-related activities to the tasks required for implementing ICM training were expressed. For example, the guide will need to identify how to complete quality reviews under different and difficult conditions. Commitment to such a large package may be overwhelming to countries, and asking them to also do follow-up quality review activities may cause them to back away from doing the ICM course. During the first few planning visits, Hirnschall and others will attempt to feel out the level of country interest in quality review activities and the ways the quality review might be used under different local conditions.

D. We are preparing drafts of tools or instruments and are looking for an opportunity to test them in the field with persons who have been trained in ICM. Moving forward quickly on the development of the quality review is a priority. As a result:

1. The quality review development group (Bryce, Murray, and Lucas) needs to be included in the training of consultants to facilitate ICM courses.

2. In principle, it would be advantageous to implement the quality review process in early-use countries as soon as it is available.

III. REVISED WORK PLAN

Completion date	Task	Person(s) responsible
1 June	1. Finalize note for the record of 15-19 May meetings	Lucas
	2. Finalize minutes of review group 18 May meeting	Lucas
	3. Plan and outline protocol for pretesting forms (Oct.)	Lucas

12 June	4.	Revise concept paper for use of USAID and other agencies	Lucas
1 August	5.	Finalize draft forms for pretest (Oct.)	Lucas with Bryce, Murray
	6.	Finalize protocol for pretesting forms	Lucas with Bryce, Murray
	7.	Plan and outline protocol for field test (Dec. or Jan.)	Lucas
October (date TBA)	8.	Complete ICM training and pretest forms	Lucas with Bryce, Murray
	9.	Draft guidelines for Quality Review	Lucas
17 November	10.	Finalize protocol for field test (Dec. or Jan.)	Lucas with Bryce, Murray
December or January (date TBA)	11.	Field test tools and monitoring process (with a curtailed planning process)	Lucas with Bryce, Murray

IV. BUDGET

A. Consultant

The consultant costs are shared by WHO and BASICS as follows:

March	Paid by:	WHO	(with travel to Geneva and Washington)
April		BASICS	
May		WHO	(with travel to Geneva)
June		BASICS	
July-December		WHO	(starting July 10)

B. Pretest of Forms and Field Tests

BASICS has planned to support the pretest of forms (possibly in October) and may be able to provide support for a field test of the quality review (possibly in December or January) including consultant travel costs, an additional facilitator or coordinator at field test, per diem and transportation for local surveyors, printing, and other local costs. Budgeting for the field-test of the quality review will be discussed and finalized during development of the BASICS workplans in June/July 1995.

ANNEX

Annex: Types of Facility Visits in the Quality Review
(both routine monitoring and skill reinforcement visits are needed in order to reinforce and support integrated case management training)

Character-istics:	Routine Monitoring and Skill Reinforcement Visits	Periodic Evaluation Visit
Focus	Sustained effort to reinforce skills and solve problems in case management; pass up minimum information for use by health system	Snapshot, intensive quality control; pass up evaluation information for planning cycles, use activity to sustain quality of monitoring and skill reinforcement visits, and provide some feedback and skill reinforcement to facility workers
Timing	Initial visit within one month after health workers complete ICM course, then minimally once every three months	About every two years; linked to review and planning cycles
Personnel	Initial visit: ICM facilitator or clinical instructor would accompany surveyor on some initial visits to provide supervision and skill development in surveyor skills Follow-up visits: surveyor	Team of two surveyors: surveyor from a different district and an additional surveyor (e.g., ICM facilitator, PM, country advisor, regional medical officer, WHO or UNICEF staff)
Training of surveyors	ICM course plus: - Data collection and organization skills (e.g., observation, interview, record review, reporting) - Skill reinforcement models (e.g., giving feedback, demonstrating cases, facilitating interactive problem solving, demonstrating the organization of clinic activities, records, and supplies)	Review of ICM, review of data collection procedures and skill reinforcement models, training for reliability in ICM and procedures
Selection of facilities	All facilities in ICM area	Five randomly selected from ICM district (one week in field)
Content of data collection	E.g., observation and confirmation of ICM; assessment of knowledge and skills;interviews with health worker regarding facility problems and solutions; exit interview of caretaker; record review; review of facilities, staffing, and supplies	Same as monitoring and skill reinforcement visits
Organiza-tion and use of data	Identification of problems and interventions needed, record of actions taken to improve performance and facility organization; minimal tracking of information across facilities in surveyor's area; minimal tracking of information across visits to the same facility; minimal information summarized and passed up the health system	Summary organization of indicators and other information needed by the system for planning and monitoring; interpretation of information to make recommendations and plans

1 June 1995