Quality of Care Child Health Indicators for Service Provision Assessment (SPA) Review

M&E Subgroup Meeting

June 3, 2021

Objectives and agenda for meeting

- Review Service Provision Assessment (SPA) revision processes overall
- Processes for child health revision
  - Provide overview of round 1 Child Health indicator submission and processes
  - Provide overview of round 2 revisions and processes
    - Approved methods and indicator numbers (within 2 weeks)
    - Harmonization with MNH and nutrition groups and inclusion of approved methods
- Review indicator prioritization by standard and discuss outstanding issues

SPA revision processes: Objectives

01

Select a set of indicators and develop questionnaires and survey tools for measurement that expressly address **Quality of Care (QOC),** while still responding to individual country needs.

02

Engage key **stakeholders**, including technical experts, Ministries of Health, and USAID Missions, in identifying data gaps and solicit recommendations for QOC indicators and measurement.

03

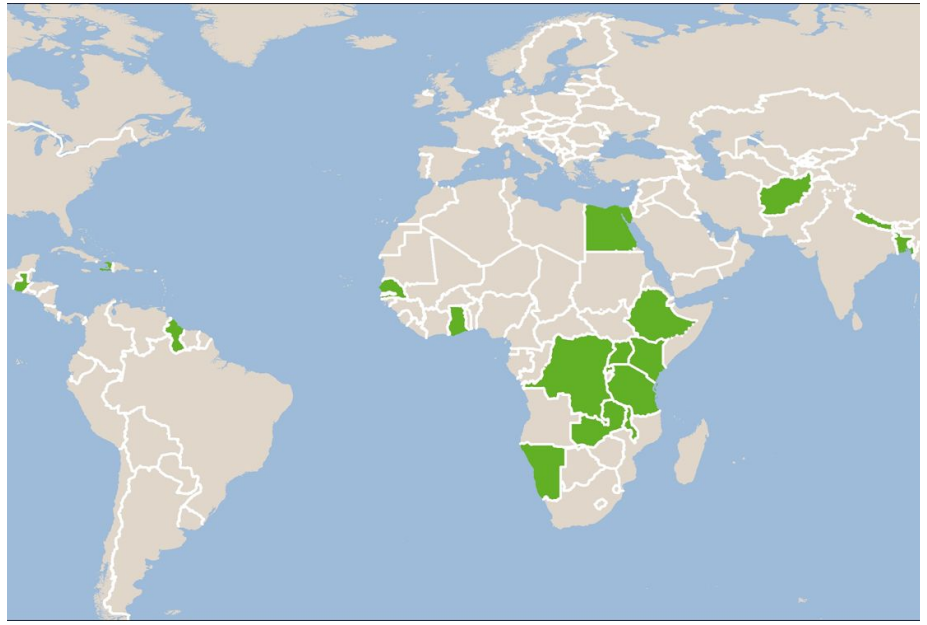
Promote the SPA & ultimately build demand and increase data use with documentation and new data use tools to assist countries in the improvement of QoC and health outcomes.

Source of slide content: SPA consultative meetings

Limited country uptake of SPA as compared to DHS and proposed revisions

Results from a DHS-7 mid-term evaluation of the SPA conducted for USAID indicated that barriers to SPA demand and use include:

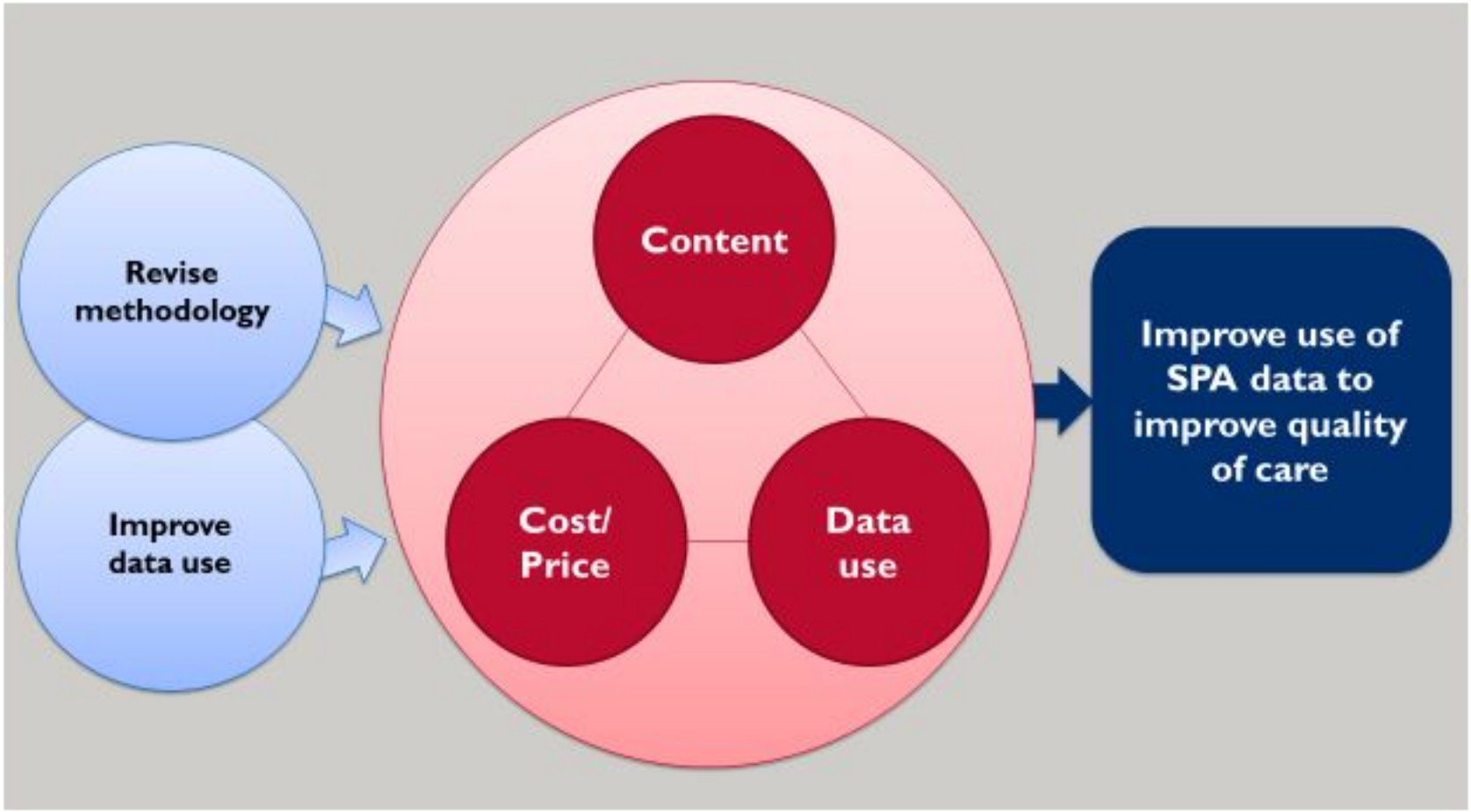
- lack of knowledge among funders and data users about the SPA
- *perceived high cost*
- *length and complexity*
- small number of SPA surveys conducted limits their value to the donor and academic community and may contribute to USAID missions not being aware of the SPA or its potential value.



The breadth of the SPA tools and the large number of indicators provided by the SPA are a strength of the assessment but also serve as a barrier to use.

Source of slide content: SPA consultative meetings

Limited country uptake of SPA as compared to DHS and proposed revisions



Streamline questions/modules and focus on quality of care

Source of slide content: SPA consultative meetings

Reminder: SPA sampling and data collection methods

Sampling

1. Health facilities: Representative sample at the national and sampling strata level
2. Health service providers: Staff who were at the facility on the day of the survey and provided services assessed in the SPA are sampled.
3. Observations & Exit Interviews

1. Clients are systematically selected for observation based on the number of clients at each service site on the day of the visit.
2. Exit interviews with all observed clients and caretakers of sick children.

Reminder: SPA sampling and data collection methods

Survey instruments (Existing and proposed)

1. Facility inventory
2. Health Provider interview
3. Observation protocol of patient consultations
    a. Antenatal care (ANC)
    b. Family planning
    c. Sick children
    d. ~~New to the revised SPA: Labor & Delivery, including essential newborn care~~*
4. Exit interviews with clients
    a. Family planning clients
    b. ANC clients
    c. Caretakers of sick children
    d. New to the revised SPA: Postpartum women at the time of discharge after delivery

*SPA suggested this but MNH group did not add this component

SPA revision processes

Round 1: Sept 2020 – Jan/Feb 2021

- Series of consultative meetings with SPA and technical groups set up as communities of practice (COP)
- The "ask" was not always clear
- Consultation within groups to come up with recommendations stakeholders, other stakeholders

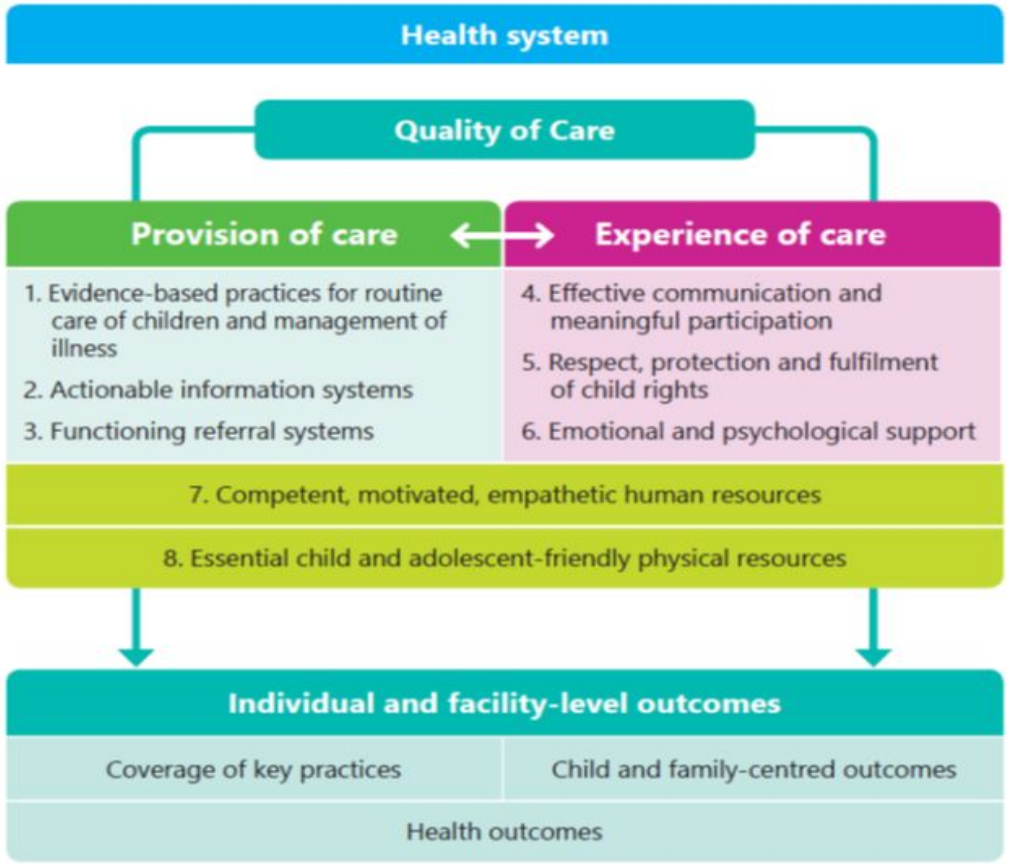
9 technical working groups

1. Maternal and newborn health
2. **Child health**
3. Nutrition
4. Family planning & reproductive health
5. Water, sanitation, and hygiene (WASH) and infection prevention control
6. Infectious disease
7. Natural disaster and pandemic preparedness.
8. Other: HSS and NCDs
9. Cross-cutting

Child Health SPA revisions: processes

- Map Pediatric QoC indicators (by standard) to existing SPA items
  - Recommend additional items needed for recommended indicators
  - Review and recommend additional methods/expansion of methods
- Consultat with small group of experts to finalize submission

Fig. 1. Framework for improving the quality of paediatric care



Round 1: Child health recommendations

- Mid-February 2021
- Initially submitted recommendations for 98 indicators across all 8 pediatric QoC standards and overall recommendations to improve measurement

Round 1: Child health recommendations examples

Inventory

- Broaden the service areas to include triage/emergency services and add service-specific inventory lists for OPD, and inpatient services
- Improve measurement of oxygen distribution, equipment and supplies
- Improve availability of medications and vaccin measures (pediatric doses, minimal stocks, valid units)
- Include experience of care readiness inventory

Sick child observation

- Include key data points in the sick child observation –classification, test results, diagnosis section to include malnutrition
- Expand the treatment options recorded in the sick child observation
- Include adequate medical documentation
- Include referral documentation
- Include experience of care measures

Additional tools

- Clinical reassessment
- Enhanced observation
- Clinical vignettes

SPA Round 2: Child health recommendations processes

Strategies for re-submission

- Ensure the survey design is driven by select key indicators in each priority program area
- Focus on service provision rather than provider knowledge or competency
- Avoid reliance on existing data and records at facilities
- Streamline the core questionnaires to balance cost and implementation practicality

SPA Round 2: Child health recommendations processes

Assessment will include four data collection methods

- Facility inventory
- Provider interview
- Observation
- Client exit interview

Child health will focus on the **outpatient department only** (e.g. no data collection for any of the methods in pediatric inpatient departments)

NO clinical vignettes or clinical re-examination and client exit interview will focus mostly on experience of care

SPA Round 2: Processes to date

- SPA asked for new recommendations to include 45 indicators in child health (and 45 for MNH) and for MNH, Nut and CH groups to coordinate (2 weeks ago)
  - Triage indicator recommendations based on updated data collection methods
  - Meet with MNH and nutrition groups to harmonize indicators
  - Review other groups recommendations (especially malaria, PHC and HSS) and remove any indicators already included
  - Share triaged indicators (n=74) for prioritization with child health task force M&E sub-group via survey
    - 11 respondents from US, Kenya, India and Ethiopia
  - Review of prioritization responses and flag any issues for group mtg
  - Meeting (now) to review

Standard 1: Evidence-based care and management of illness

Prioritized – readiness, assessment and treatment

1.2: % of health facilities with equipment and supplies for the essential IMNCI assessment in the child curative area (pediatric OPD)
1.3: % of health facilities with essential medications for pediatric emergency resuscitation
1.4: WHO CORE: % of sick children under 5 years of age who visited the health facility for medical care and were checked for danger signs (ability to drink or breastfeed; vomits everything; convulsions, lethargy)
1.5: WHO CORE: % of sick children under 5 years of age who visited the health facility for medical care and receive essential physical and clinical assessment (weight, respiratory rate, temperature, pulse, cough, difficult breathing/chest indrawing, diarrhoea/dehydration status and palmar/conjuctival pallor/nails checked for anemia)
1.6: % of health facilities with supplies of antibiotics (first- and second-line) for treatment of severe pneumonia and pneumonia.
1.11: % of health facilities with medicines and supplies to treat acute diarrhoea
1.14: % of health facilities with adequate supplies of first- and second-line antibiotics for treatment of bacterial infections and antimalarial agents for treatment of malaria

Standard 1: Evidence-based care and management of illness

Prioritized – readiness, assessment and treatment

1.7: % of children 2 months or older with cough or difficult breathing who are correctly assessed and investigated in accordance with WHO guidelines
1.8: % of children 2 months or older with cough or difficult breathing who are correctly classified according to severity of disease in accordance with WHO guidelines
1.9: WHO CORE: % of children aged between 2 months to 5 years who were classified with pneumonia in the health facility and received or were prescribed oral amoxicillin during the reporting period
1.12: WHO CORE: % of children 2 months to 5 years classified with diarrhoea and no or some dehydration who receive ORS + zinc
1.13: WHO CORE: % of children 2 months to 5 years with dysentery who receive antibiotics (cipro, azithro, IV ceftriaxone)

Standard 1: Evidence-based care and management of illness

Prioritized – readiness, assessment and treatment

1.15: WHO CORE: % of children who presented to the health facility with fever for whom malaria test results are available (results from microscopy or malaria Rapid Diagnostic Test)
1.17: % of parents or caregivers of children < 2 years old who were counselled and received information about BF and complementary foods
1.18: % of health facilities with adequate, functioning equipment (e.g. weighing scales, length and height boards, mid-upper arm circumference tapes) and other supplies for assessing acute malnutrition
1.20: % of all sick children aged < 5 years seen in the health facility whose nutritional status was assessed according to the IMCI guidelines.
1.21: % of all sick children aged < 5 years seen in the health facility whose nutritional status was classified according to the IMCI guidelines.
1.22: WHO CORE: % of children aged between 6 month and 5 years who were diagnosed with uncomplicated severe acute malnutrition in a health facility and received or were prescribed oral amoxicillin and RUTF during the reporting period
1.24: WHO CORE: % of children >2 months to 5 years old of age who were classified or diagnosed with anaemia in a health facility and treated/prescribed with Iron and mebendazole (if 1 year or older and not given mebendazole for last 6 months) during the reporting period

Standard 1: Evidence-based care and management of illness

Prioritized – readiness, assessment and treatment

1.26: % of health facilities with supplies of antiretroviral therapy and preventive therapy for infants and children exposed to and/or infected with HIV.
1.27: WHO CORE: % of children who visited/were admitted to a health facility during the reporting period for whom the HIV status of mother and/or child is known (positive or negative)
1.29: % of health facilities with a functioning refrigerator with a temperature monitoring device and has appropriate temperature
1.30: % of facilities with availability of paediatric vaccine(s), required by the national immunization calendar (including HPV, if applicable)
1.32: WHO CORE: % of children visiting the health facility for routine/acute care during the reporting period who had their vaccine record assessed
1.33: WHO CORE: % of children visiting the health facility for routine/acute care during the reporting period who had incomplete vaccination and were administered all catch-up immunizations

Standard 1: Evidence-based care and management of illness
De-prioritized

1.10: % of children with pneumonia to whom oxygen was appropriately administered for the clinical indication (signs of hypoxaemia or oxygen saturation ≤ 90%)]
1.25: % of health facilities with child-friendly single or fixed-dose formulations of anti-TB medicines]
1.28: WHO CORE: % of sick children who received care at the health facility during the reporting period and reported a cough duration >14 days or were diagnosed with SAM or had confirmed HIV infection, and were referred for or further assessed for TB
1.16: % of all children < 5 years in the health facility who have been assessed for growth]
1.31: % of all children 6 months- under 5 years of age who attended the health facility and received vitamin A supplementation in the past 6 months
1.1: % of facilities providing key child health services
1.36: WHO CORE: % of children 2 months-<5 years with diagnosis of cough and cold to whom antibiotic was prescribed]
1.37: WHO CORE: % of children 2 months to 5 years with diarrhoea but not dysentery who receive antibiotics (cipro, azithro
1.38: WHO CORE: % of children 2 months to <5 years with malaria who receive antibiotics]
1.35: % of health facilities with a designated area for managing seriously sick children that is close and easily visible to the nursing staff on the ward]
1.34: % of health facilities with a designated area for the management of children with minor surgical problems/screening for surgical issues by health professionals who are trained essential surgical skills]

Standard 2: Collection, analysis and use of data

Prioritized

2.1: WHO CORE: % of medical records of children who received care in the health facility which include completed information on patient demographics (age, sex), classification/diagnosis, and treatment]

2.2: WHO CORE: % of health facilities that have conducted paediatric deaths review and/or monthly paediatric QoC indicator data review during the last 6 months]

Deprioritized

2.3: % of children and/or their caregivers who participated in patient satisfaction surveys or provided feedback on the services received

Standard 3: Appropriate, timely referral and continuity of care

Prioritized

3.1: % of all children who require referral who received appropriate pre-referral treatment when indicated

3.3: % of children referred who had an appropriate referral note with summary of history, clinical findings, investigations, diagnosis, treatment given and the reason for referral]

Deprioritized

3.2: % of caregivers who received adequate information about referral

Standard 4: Effective communication with careseekers

Prioritized

4.1: WHO CORE: % of sick children and/or their caregivers seen in the health facility who were told what the diagnosis was, given instructions about treatment and/or care, can say the reason that a particular treatment was given (or child's condition) and how to take the treatment]
4.2: % of children and/or their caregivers who reported that they were satisfied with the quality of the health information and support they received from health care staff during their care.
4.3: WHO CORE: % of children and/or their caregivers who reported that their views were taken into consideration or sought in making decisions about their care
4.4 WHO CORE: % of caregivers of children who visited the health facility during the reporting period and reported being aware of the danger signs of their children, where to seek care and how to feed their children during the illness (giving extra fluids and continue feeding)]
4.5: % of children or caregivers who received health information (including written material) or counselling for the condition of their child

Standard 5: Child's rights respected, without discrimination

Prioritized

5.1: % of facilities with essential readiness to provide respectful care
5.2: % of children and their caregivers who report any form of discrimination or refusal of care because of their economic, social, religious, linguistic or other status
5.7: % of children and/or their caregivers in a health facility during the reporting period who reported experiencing physical or verbal abuse in the health facility (felt that they were being yelled at, or screamed at (verbal), or being hit, or pinched (physical abuse)

Deprioritized

5.6: % of caregivers satisfied with the level of visual and auditory privacy received
5.3: % of health facilities which visibly display and makes available information about the patients' charter in various formats including wall display, leaflets and posters, etc.
5.5: % of health facilities in which children can be examined with visual and auditory privacy when required.

Standard 6: Educational, emotional and psychological support provided

Prioritized

6.2: % of parents or caregivers who reported that their child's pain were alleviated by the action of health workers.

6.3: % of children or caregivers who reported of being triaged within 15 minutes of arrival in health facility and were satisfied with overall timeliness of care

Deprioritized

6.1: % of health facilities with dedicated spaces for age-appropriate play, which are accessible to all children, including those with a disability.

Standard 7: Competent, motivated, empathic staff providing care

Prioritized

7.3: % of health facilities with at least one provider with training in key child health or childhood illnesses in the previous 24 months
7.5: % of health facilities with external supervision to improve clinical competence and/or performance in the past 6 months
7.6: WHO CORE: % of health workers providing care for children who had interactions with professional mentors or participated in continuous professional development to ensure clinical competence and improve performance in the past 3 months
7.7: % of health facilities holding at least one meeting/activity specifically for quality improvement in the last 3 months (1) review data, 2) monitor performance, 3) make recommendations to address any problems, 4) honor good performance and 5) encourage staff or teams who are struggling to improve quality)
7.8: % of pediatric care providers who participated in a quality improvement activity (meeting, audit, project) in the health facility during the reporting period

Deprioritized

7.4: % of health professionals who care for children who received in-service training and/or refresher sessions within the past 24 months]

Prioritized, but calculate with included items or recommend to other groups

7.1: % of sick children who were attended by health professionals specifically trained in child health care.
7.2: % of health professional and support staff in the health facility who are satisfied with their workload in terms of their roles and responsibilities in the facility or the unit to which they are assigned

Standard 8: Appropriate, child-friendly physical environment with adequate supplies

Prioritized

8.1: % of children and their families who attended the health facility who would recommend the health facility to friends and family.
8.4: % of facilities with functional oxygen source in key service areas
8.5: % of facilities with essential equipment and supplies for the delivery of oxygen in key service areas

Prioritized - but recommend to other groups?

8.3: % of health facilities with an updated inventory of medical equipment, with documentation of breakage or malfunction and dates of repair or replacement.

8.6: % of health facilities with an on-site pharmacy with trained pharmacists or dispensers

Deprioritized

8.2: % of children and their families who attended/received care in the health facility who observed that the health providers washed their hands or used an alcohol rub before examining them

WHO CORE indicators not prioritized

Rank	Indicator
48	5.4: WHO CORE: % of children or their caregivers in the health facility during the reporting period who reported being adequately informed about their rights to care (free treatment, medication, food, bedding, room-in etc.)
53	4.3: WHO CORE: % of children and/or their caregivers who reported that their views were taken into consideration or sought in making decisions about their care
54	1.28: WHO CORE: % of sick children who received care at the health facility during the reporting period and reported a cough duration >14 days or were diagnosed with SAM or had confirmed HIV infection, and were referred for or further assessed for TB
63	1.36: WHO CORE: % of children 2 months-<5 years with diagnosis of cough and cold to whom antibiotic was prescribed
63	1.37: WHO CORE: % of children 2 months to 5 years with diarrhoea but not dysentery who receive antibiotics (cipro, azithro etc)
70	1.38: WHO CORE: % of children 2 months to <5 years with malaria who receive antibiotics

Deprioritized indicators and rationale - among indicators initially ranked in top 45

Rank	Indicator	Rationale
39	1.19: % of health facilities that are managing children with complicated severe acute malnutrition that have adequate medical and nutrition supplies available	Complicated SAM is largely managed in an inpatient setting and inpatient and emergency care is deprioritized by the SPA
27	7.1: % of sick children who were attended by health professionals specifically trained in child health care.	Almost the same data elements as another indicator
33	7.2: % of health professional and support staff in the health facility who are satisfied with their workload in terms of their roles and responsibilities in the facility or the unit to which they are assigned	A broader health facility indicator
16	8.6: % of health facilities with an on-site pharmacy with trained pharmacists or dispensers	A broader health facility indicator - Recommend to HSS/PHC
34	8.3: % of health facilities with an updated inventory of medical equipment, with documentation of breakage or malfunction and dates of repair or replacement.	A broader health facility indicator - Recommend to HSS/PHC

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